

2012 Strategic Plan

Health & Long-Term Care Access

(Health Care Delivery Infrastructure and Health Care Workforce Resources)

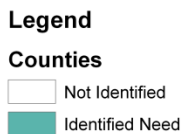
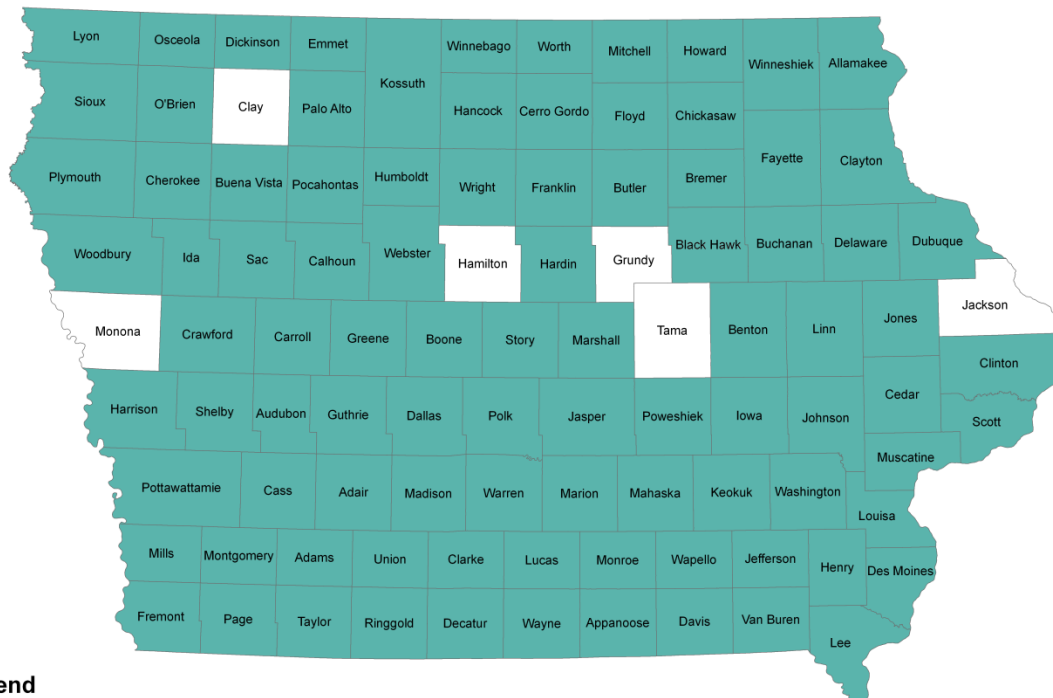
**Iowa Department of Public Health
January 2012**

**Division of Health Promotion & Chronic Disease Prevention
Bureau of Oral & Health Delivery Systems
[http://www.idph.state.ia.us/HLTC Advisory Council/](http://www.idph.state.ia.us/HLTC_Advisory_Council/)
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Executive Summary

As a result of assessing health needs in their local communities, Iowans in 93 counties have identified Access to Health Services as a need.¹

Access to Health Services Issues



The Health and Long-Term Care Access Advisory Council plans to address this need through concentration on two areas of focus: Health Infrastructure and Workforce.

Health Infrastructure

The Council concluded that there can be no expectation that new funding will be available to address issues due to the already strained economic situation affecting the health system. Therefore, the key to strategic direction moving forward will be Effectiveness and Efficiency with a focus on Quality. Discussion must focus on how the system can accomplish more with less, increasing the use of cost- and time-saving tools and methods. Examples cited by the Council included telemedicine and case management or care coordination. The group also believes it is necessary to move to reimbursement methods that pay for what is expected (services, products, and outcomes).

Workforce

Although the focus for the Council during the first phase of the strategic plan was workforce, the Council concludes that there are still needs in this area. There are four main areas of strategic direction for the next work cycle of the Council. These include:

1. Issues no one is raising
2. Recruitment and retention
3. New types of professionals (expansion)
4. Scope of practice of health professionals

In the timeline below, the subcommittee(s) responsible for the action step is labeled with “I” for the Infrastructure subcommittee and with “W” for the Workforce subcommittee. If no label is present, this indicates the action step happens outside the HLTCA AC. This timeline is subject to adjustment by the Health and Long-Term Care Access Advisory Council in collaboration with the IDPH.

	Action Steps	Timeline
I/W	Review and approve Action Steps and Timeline	February 2012
I/W	Determine subcommittee membership and assess needed additional participation	February 2012
I/W	Review HLTCA AC Goals & Objectives Recommended to IDPH from 2010 Strategic Planning. Determine which recommended items should be carried forward	February 2012
I/W	Review statutory language in 135.163 and 135.164 and consider realignment of statute with strategic direction and IDPH mission – develop recommended revisions if appropriate	February 2012
I	Determine efficiency strategies to target for further examination (cost- and time-saving tools and methods); if further research is needed to further define targeted strategies, determine necessary steps to gather needed information and responsible parties	February 2012
W	Assess and list existing recruitment and retention strategies used in Iowa	February 2012
W	Specify the health and long-term care workforce issues to be addressed by this group to address gaps in Iowa’s workforce strategies (issues no one is raising); if needed, determine additional research needed to fully identify gaps	February 2012
I	Create a list of factors and stakeholders influencing the implementation of targeted efficiency strategies; stakeholder list should include specific individuals and contact information where possible	April 2012
I	Develop communication strategies explaining targeted efficiency strategies and rationale	April 2012
W	Report progress on identified gaps (issues no one is raising) and determine top three gaps to be addressed; determine steps	April 2012
W	List anticipated new types of professionals needed along with rationale and background for each; where further expertise is needed, engage appropriate partners	April 2012
W	Specify the areas of scope of practice to be addressed in order of priority and identify gaps in information to move forward; identify stakeholders for each area of priority, including entity, contact person, and contact information	April 2012

	Action Steps	Timeline
	Authorize funding to continue implementation of requirements in 135.163 and 135.164	May 2012
W	Examine effectiveness of existing recruitment and retention strategies used in Iowa	May 2012
I	Inform HLTCA AC about at least one chosen efficiency strategy through presentation to the Council; design detailed action steps to expand the strategy in Iowa	July 2012
I	Members provide inventory of telemedicine use within organizations they represent	July 2012
I	Create list of telemedicine stakeholders with contact information	July 2012
I	Members provide status of care coordination initiatives within organizations they represent	July 2012
I	Create list of care coordination stakeholders	July 2012
W	Research recruitment and retention strategies used by other states that have not been implemented in Iowa; list results	July 2012
W	Conduct literature review regarding overall effectiveness of recruitment and retention methods	July 2012
W	Report on research regarding new types of professionals needed; determine next steps including information-gathering or decision to pursue	July 2012
W	Identify specific scope of practice issue(s) to address in the coming year; determine first three steps for each	July 2012
I	Determine three specific low-cost or no-cost strategies to increase use of telemedicine and identify potential grants or other funding sources	September 2012
I	Determine three specific low-cost or no-cost strategies to increase use of care coordination and identify potential grants or other funding sources	September 2012
W	Carry out steps determined regarding new professionals needed; report on progress; assign next tasks	September 2012
W	Analyze results of previous action steps regarding recruitment and retention strategies and determine the top three most promising strategies for Iowa	September 2012
W	Report on scope of practice progress on steps identified in July; identify next steps	September 2012
W	Report progress on gaps (issues no one was raising); identify next steps	September 2012
I/W	Prepare, post, and distribute interim progress report and plan on strategic directions, including enhanced detail; include action steps for December 2012 through December 2013	November 2012
I/W	Assess needed changes to Advisory Council and Subcommittee Membership	November 2012
I/W	Carry out action steps per interim progress report and plan	December 2012 – October 2013
	2014 Health & Long-Term Care Access Strategic Plan Submitted	October 2013

Introduction

History

The Health & Long-Term Care Access Strategic Plan [Strategic Plan for Health Care Delivery Infrastructure and Health Care Workforce Resources] was established by House File 2539 during the 2008 Legislative Session (see 2008 Iowa Acts Chapter 1188). Requirements for the strategic plan are codified in Iowa Code Chapters 135.163 and 135.164. These chapters require the Iowa Department of Public Health (IDPH) to produce a strategic plan every two years and set forth requirements about the content of the strategic plan.

The requirements are broad in scope, and they include descriptive elements, data collection and distribution requirements, and planning strategies. This document, along with its appendices, is respectfully submitted in fulfillment of the charge.

Membership

The Phase 1 Strategic Plan for Health Care Delivery Infrastructure and Health Care Workforce Resources was submitted in compliance with statute in January 2010.² That initial plan was completed with stakeholder involvement from nineteen stakeholder interests. Development of this 2012 plan has continued this involvement. These include: long-term care provider organizations; consumers; safety-net providers and organizers; community providers; an organization of physicians; academic departments, including economics; payers; health systems; a hospital organization; and family planning. Membership of the council includes:

Carol Alexander	Office of Statewide Clinical Education Programs, The University of Iowa
Cindy Baddeloo	Iowa Health Care Association
Roy Bardole	Consumer
Shelly Chandler	Iowa Association of Community Providers
Libby Coyte	Iowa PCA
Michele Devlin	Iowa Center on Health Disparities, University of Northern Iowa
Brian Farrell	Mercy Health Network
Wendy Gray	Area Health Education Center
Ryan Hopkins	Iowa Alliance in Home Care
Steve Johnson	Magellan Behavioral Care of Iowa
Brian Kaskie	College of Public Health, The University of Iowa
Susan Lutz	Iowa Pharmacy Association
Laura Malone	Iowa Hospital Association
Leah J. McWilliams	Iowa Osteopathic Medical Association
Daniel Otto	Department of Economics, Iowa State University
Catherine Simmons	Iowa Health System
Kyle Carlson	Family Planning

Meetings held

IDPH convened the Council five times in 2010 and three times in 2011. Meetings were used to educate council members on the topics necessary to provide informed assistance toward recommended strategic plan goals and objectives. They were also used as a means of gathering input and perspective. The following presentations were provided toward the design of the 2012 strategic plan:

<i>Description of Plans for the eHealth Assessment Update on SF 2092 and IowaCare</i>	<i>Kory Schnoor, eHealth, IDPH Anne Kinzel, Legislative Health Care Coverage Commission</i>
<i>Direct Care Worker Advisory Council</i>	<i>Jennifer Furler, State Public Policy Group, Inc.</i>
<i>Introduction to the Center for Rural Health & Primary Care</i>	<i>Gloria Vermie, State Office of Rural Health, IDPH</i>
<i>Joint Session with the Rural Health and Primary Care Advisory Committee</i>	<i>Laine Dvorak, M.D., Chair</i>
<i>Certificate of Need 101</i>	<i>Barb Nervig, IDPH</i>
<i>Health Workforce Planning Grant Application</i>	<i>Todd McGee, IWD</i>
<i>Health Workforce Resources</i>	<i>Erin Drinnin, IDPH</i>
<i>Iowa's Medicare Rural Hospital FLEXibility Program (FLEX)</i>	<i>Kate Payne and Andria Seip, IDPH</i>
<i>eHealth Project Update and "Emerging Trends"</i>	<i>Karith Remmen and Leslie Grefe, IDPH</i>
<i>Health Information Technology Regional Extension Center (HITREC)</i>	<i>Sarah Cottingham, Iowa Foundation for Medical Care (IFMC)</i>
<i>Rural Health Plan component – periodic status updates</i>	<i>Gloria Vermie, IDPH</i>
<i>Health Care Facilities and Services Plan and Health Care Data Resources Plan components – status update</i>	<i>Barb Nervig, IDPH</i>
<i>Prevention and Chronic Care Management Advisory Council</i>	<i>Angie Doyle-Scar, IDPH</i>
<i>Medical Home System Advisory Council</i>	<i>Abby McGill, IDPH</i>
<i>Iowa Department of Public Health Updates</i>	<i>Julie McMahan, IDPH</i>
<i>Community Health Needs Assessment</i>	<i>Meghan O'Brien, IDPH</i>

2010 Strategic Plan description

The 2010 Phase 1 Strategic Plan for Health and Long-Term Care Access focused on the health and long-term care workforce. This plan emphasized the following goals:

1. To support IDPH in its charge to “coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, diverse and sustainable health care workforce in this state,” codify the Iowa Health Workforce Center as the state’s coordination point to address health workforce concerns in Iowa.
2. Target and fund loan repayment programs and other recruitment and retention efforts to attract and retain health and long-term care professionals to underserved areas and underserved populations. Target and fund financial assistance programs for students of minority status.
3. Support educational institutions, including Area Health Education Centers, and other entities in their efforts to create or update training, curricula and practicum experiences and in providing targeted continuing education opportunities for existing health professionals to support health care reform efforts. This includes training and curricula to support the medical home model, interdisciplinary and inter-professional practice models, practice in rural areas, service to low-income populations, development of new levels of practitioners who will serve underserved populations, service to people with disabilities, geriatrics, cultural competence, training on the use of health information technology and electronic health records, prevention and chronic care management, and service to ethnic and racial minorities.

The IDPH submitted legislation to establish the Iowa Health Workforce Center in Iowa Code; however, this initiative was not adopted. Funding through the American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA) resulted in increased usage of loan repayment programs. Following a year without federal funding, the Iowa Area Health Education Center (AHEC) secured a one-year federal AHEC grant. The IDPH received a federal grant to advance the training and credentialing recommendations of the Direct Care Worker Advisory Council, an initiative which is now called the Direct Care Workforce Initiative.

Background

As context for understanding the health system delivery needs for Iowa, it is important to consider the State's demographic make-up and the population health characteristics that our state experiences. This section of the strategic plan provides an overview of factors considered in development of the strategic direction. It also provides insight for policymakers and stakeholders about what information is collected and methods for data collection and distribution.

Iowa's Health Status

Iowa is one of the nation's older states. The 2010 Census³ demonstrates that the largest age cohort is the 45-64 population, encompassing many of the Boomer generation. Approximately 24 percent of the population is under the age of 18 while almost 15 percent is over the age of 65. Iowa has a much larger elderly population than its regional counterparts and the national average. Given changes in birth rates, migration patterns, and natural aging, the relative share of Iowa residents over the age of 65 will be increasing rapidly over the next few decades. According to the US Census Bureau Population Projections,⁴ every age cohort under age 45 is expected to decline through 2030, while the over 65 age cohort is expected to increase approximately 52 percent between the 2000 Census and 2030. With age comes a higher incidence of chronic disease. The disease burdens described below document the annual trends and are compiled by the Integration Team, Data/Surveillance Committee in their Annual Chronic Disease Reports.⁵

Diabetes is a leading cause of death in Iowa for all age groups, 10-14 years and over and 2,800-3,600 Iowa children under 17 years have diabetes, most of which is type 1. The age-adjusted prevalence rate of diagnosed diabetes among Iowa adults has doubled since 1991 rising from 3.8 percent to 7.6 percent in 2009. From Healthy Iowans 2010, Iowa fell short of goals that affect those with diabetes: at least one annual foot exam by a professional (target 90%, reported 74%); advised to discontinue tobacco use (target 100%, reported 78.2%); and being seen by a health professional for their diabetes within the past year (target 95%, reported 88.1%). The goal set for prevalence of diabetes was 5 percent. Current rate is 6.7 percent.

Cardiovascular Disease - In 2009, 6,912 Iowans died of heart disease; the state's leading cause of death since 1920. Iowa ranks 38th out of the 50 states in CHD mortality. Seventy-five percent of heart disease mortality (5,161 deaths) was due to Coronary Heart Disease (CHD). Since 1999, Iowa's male CHD death rate has been higher than the national male average (see Figure 1). In 2007, Iowa's male CHD death rate was higher than the national average by 17 deaths per 100,000. Though CHD is an age-related disease, about 1,200 (42%) males vs. 400 (17%) females who died from CHD were younger than age 75. CHD is also a leading cause of premature, permanent disability in the Iowa workforce. Approximately 138,000 Iowans (Six percent of adults) have had a heart attack or CHD.⁶

Community Health Needs

Every five years, local boards of health lead a community-wide discussion with stakeholders and residents about their community's health needs. After identifying needs in the community the next step is to identify strategies to address those needs. The process, Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP), is a fundamental piece of statewide health planning. CHNA & HIP has more than a 20 year history in Iowa and represents local action to promote and protect the health of Iowans.

In February 2011, all 99 counties submitted a brief report on their needs assessment and health improvement plans to the Iowa Department of Public Health (IDPH). Thousands of Iowans participated in the process in their communities. Community engagement included community-wide meetings with residents and health stakeholders, survey participation, and direct comments.

For the first time, IDPH has completed a comprehensive analysis of the CHNA & HIP submissions and issued a report, [Understanding Community Health Needs in Iowa](#). The report demonstrates the scope of Iowa's health needs and identifies critical issues affecting the health of Iowans. This report is part of IDPH's commitment to use local input and health needs to guide statewide health improvement planning. In the report, health needs are divided into six focus areas. The second most frequently cited focus area was Health Infrastructure. Needs related to Health Infrastructure were identified by 93 counties and represented 19 percent of the total needs identified. When comparing the focus areas by the number of unmet health needs (those needs not addressed in a local health improvement plan), it is clear that **Health Infrastructure has the greatest outstanding need**. This will be discussed further in the Strategic Directions section of this document.⁷

IDPH Data Warehouse

The IDPH Data Warehouse⁸ is an active, web-based application that organizes and stores health data from a variety of sources. The application also provides basic reports that summarize health data. By having a number of important datasets in one central place, users are able to easily obtain snapshots of the health of individual counties and the state of Iowa as a whole. The vision of the data warehouse is to provide access to health data to help Iowans make more efficient and effective decisions in promoting and protecting the public's health. Data are available in four subject areas-Birth, death, statewide inpatient discharge, and Behavioral Risk Factor Surveillance System (BRFSS). The most recent census data is used to calculate rates and extrapolate data when missing. In addition, county snapshots provide brief glimpses into the health of counties throughout Iowa. These snapshots contain indicators with statistics for the county and the state. Access to the data warehouse is currently limited. However, a public access portal will be developed over the next two years.

The [Iowa Public Health Standards](#) outline the Iowa Department of Public Health's responsibility for establishing and maintaining a data warehouse. This will result in:

- **Improved public health decision making:** Take advantage of high quality, accessible data and decision support tools.
- **Healthier Iowans in healthier communities:** Use data to perform thorough community health needs assessments and to create and implement impactful health improvement plans.
- **Increased opportunities for funding:** Use data to support grant applications and ensure secured funds are used on programs that provide the most value to Iowans.
- **Better use of time and resources:** Spend less time searching for data and more time using the data for value-added activities.

There are several major initiatives planned for the data warehouse. The following is a breakdown of the goals for improving and expanding the application over the next few years:

2012

- Development of the public access portal
- Addition of 2011 data for existing datasets
- Addition of Environmental Public Health indicator data

2013

- Availability of the public access portal
- New reporting functions, data view tools and user access levels
- Addition of 2012 data

Impact of Iowa's Rural and Agricultural Status

The [Rural and Agricultural Health and Safety Resource Plan \(RAHSRP\)](#)⁹ (see Appendix 1), includes seven sections that focus on “rural”. Each section is designed to reveal information, data, graphics, and resources at the national and state level. Most important, each section highlights “**in Iowa**” information, and promising practices which assist the reader to an understanding of the issues, challenges, complexities, and community victories associated with health, safety, and wellness in rural Iowa.

Health care access is directly related to economic and structural community development. Rural areas rely heavily on government programs and funding to improve and sustain infrastructure and public access. There have been several beneficial economic and health related community projects in rural communities. For farm families and those from remote residential areas—having a home town nearby that offers some of the necessary services and supplies is critical. Many rural communities are not expecting to grow in population or size; rather, they just want to sustain and to have a safe, healthy town.

There are numerous issues affecting access to health care in rural Iowa. Most of the barriers mirror the health care access challenges reported throughout the nation’s rural areas. However since 90 percent of the land mass in Iowa is considered rural and in production agriculture, and half of the population live in what is considered a rural area, the issue of health care access is more evident in Iowa. Transportation and community development are two vitally important issues relating to health care access. To briefly summarize---rural areas that have public transportation systems, and economically effective, health conscious communities are more likely to have adequate access to quality health care.

There are numerous factors that contribute to why and how a person in rural Iowa might need health care, seek it out, receive quality care or---possibly not receive all the services required. The health care services components included in RAHSRP are: Clinics, dental/oral health, emergency medical services, hospitals, long term care, mental/behavioral health, pharmacy, and veterans’ health care. Overall while there is high level of quality care services in rural Iowa, health care access for rural residents is not always equal to the services and costs available in urban areas.

Health Delivery Infrastructure

The Health Delivery Infrastructure was described in the RAHSRP, and portions are excerpted here. Specific source citations are available in the main document. Please refer to the RAHSRP (Appendix 1) for more details about the types of health services offered in Iowa and particularly for their impact on rural areas. In addition, please refer to Appendix 2 which lists the types of health facilities in Iowa, along with the number of each type of facility and the total capacity.

CLINICS

In Iowa, approximately 400 clinics are owned by hospitals, groups of physicians, individual providers, or corporations. They offer comprehensive primary care services to patients primarily with insurance (private or government) or those who self-pay. These clinics are not required to be located in a health professional shortage area or offer free services or reduced cost services. Many of these for-profit clinics are located in rural communities. They enhance overall health care access to rural areas and offer valuable community benefit programs. These clinics also refer patients to hospitals or specialty providers in other clinics as necessary.

Four clinic programs in Iowa that offer primary care services to underserved clients are:

- **Community Health Centers (CHC)** and **Rural Health Clinics (RHC)** are primary health care clinic programs that offer comprehensive health services, are government-funded or reimbursed and have specific federal and state operating guidelines. In Iowa, 13 CHCs and one FQHC Look-Alike provide medical, oral health and behavioral health services to 154,020 patients. Each year, health centers across the state provide services to an increasing number of patients. Over the last ten years, Iowa's health centers have more than doubled the number of patients served, and the number of annual patient visits has increased by 126 percent. In Iowa, as of January 2011, there are 140 CMS certified Rural Health Clinics (RHC) in 58 counties. This number varies as clinics decertify, change ownership, or apply and receive certification. Current challenges for RHCs include meeting federal guidelines to be eligible for implementing electronic health records systems and retaining physicians, physician assistants and nurse practitioners.
- **Free Clinics** are primary care, do not offer comprehensive care, and traditionally do not receive federal or state funding; however, in Iowa some received limited state funds. Free clinics offer basic health care services through volunteer physicians, nurses and other health care professionals. Some clinics also offer dental and vision services. There are 41 free clinics in Iowa.
- **Proteus Clinics** are primary care, do not offer comprehensive care, are government-funded, and have specific federal and state operating guidelines related to migrant workers. **In Iowa**, the main office is located in Des Moines with satellite offices in Iowa City and Fort Dodge. A full-time physician assistant (PA) is the year-around medical provider and serves as clinical director. Typically, one or two licensed PAs are hired part-time throughout the summer to assist in seeing patients and providing direct medical care. Supportive staff for each site includes a full-time bilingual, migrant health aide and two temporary health aides hired during the summer for the peak migrant season when migrant workers and their families assist farmers with field and livestock. Patients are usually seen at grower sites, at motels, in apartments and on occasion, at small town libraries.

Specialty Clinics

In addition to primary care clinics, Iowa also has clinics that offer specific services. Some consider them specialty clinics. These clinics usually include staff and providers with expertise, equipment and resources to best serve a unique clientele with a designated diagnosis or health need. There are four types of clinics that fall in this category: AgriSafe Clinics; Family Planning Council of Iowa clinics; Planned Parenthood Clinics; and Local Public Health Agency Clinics.

EMERGENCY MEDICAL SERVICES

EMS is provided as a public safety function supported by the National Highway Transportation Safety Administration (NHTSA) as well as state and local governments. EMS is not supported through Health Resources and Services Administration (HRSA), the main federal coordinating and funding agency for medical and health care programs. Today, due to a shortage of qualified workforce, costs related to

training volunteers, expense of equipment and low to nonexistent reimbursements, EMS agencies in some rural Iowa counties are struggling to operate. In Iowa, urban EMS transport is provided by hospital-based, private, or fire department-based ambulance services that include paid certified staff. In rural or small cities, EMS departments typically include volunteer staff or limited paid positions with a volunteer base. Iowa continues to have a majority of volunteer EMS providers serving rural communities.

HOSPITALS

In Iowa, there are currently 121 hospitals, including three Veterans Administration (VA) hospitals. Of the 118 hospitals that are not VA hospitals, all are certified by Medicare and licensed by the State of Iowa. Such certification and licensure ensures the hospitals meet the minimum requirements for organization and operation.

Ninety of Iowa's 99 counties have at least one community hospital, leaving no Iowan more than 25 miles from a hospital. Twenty-two community hospitals are classified as urban hospitals because they are located in areas with a population of greater than 50,000 (also referred to as a Metropolitan Statistical Area or MSA). The large majority of Iowa's community hospitals, ninety-two in all, are classified by Medicare as rural hospitals because they are located in areas with a population of less than 50,000. Of the 92 rural hospitals, 82 hospitals are also classified as critical access hospitals. Additionally, six rural hospitals are classified as rural referral centers because they are rural hospitals that have operating characteristics similar to urban hospitals.

Long Term Care

Long-term care as we knew it a generation ago is changing – medical advances are allowing people to live longer and Americans are demanding more options and services closer to home. Rural areas face particular challenges meeting Americans' needs for quality, accessible long-term care; rural Iowa is no exception. With a growing elderly population and declining rural populations, long-term care presents significant issues and priorities for rural Iowa.

The Continuum of Long-Term Care

Long-term care services can be most simply defined as “services and supports that meet health or personal needs over an extended period of time”. Long-term care is a phrase that is more commonly used when referring to services for the aging; the disability community often refers to these services as community supports or supports for independent living. For the purposes of this report, long-term care will be used to refer to the entire continuum of health, rehabilitative and residential services available to individuals with chronic illness or disabilities.

Long-term care is different than medical care in that it meets ongoing needs to improve functioning or assist someone with limited functioning. Long-term care can be delivered in a variety of different ways, such as a stay in a nursing home; a spouse providing personal cares (such as bathing or dressing) at home; a home health aide assisting with cleaning and cooking; daily assistance in a group residential setting; or support meeting employment goals in the community. Generally, long-term care is provided either in a facility or in the home and community. Facilities are listed in Appendix 2.

Certificate of Need

Iowa's CON process¹⁰ is part of what determines Iowa's health infrastructure. Certificate of Need (CON) is a regulatory review process that requires application to the Department of Public Health for and receipt of a certificate of need prior to the offering or development of a new or changed institutional health service. Potential applicants include hospitals, nursing homes, outpatient surgery centers or anyone purchasing medical equipment valued above \$1.5 million. Projects proposed by providers are reviewed by department staff and the State Health Facilities Council against the criteria specified in the law.

The [State Health Facilities Council](#) is a five-member body appointed by the governor and confirmed by the State Senate. Members are appointed to a six-year term. Authority for the State Health Facilities Council is contained in the Code of Iowa Chapter 135.61-.83. The responsibility for providing administrative support for the Council rests with the Iowa Department of Public Health. It is the Council's mandate to assure that growth and changes in the health care system occur in an orderly, cost-effective manner and that the system is adequate and efficient.

Thirty-six states have some form of CON process, retaining the practice after federal mandates were dropped in the late '80s. "The basic assumption underlying CON regulation is that excess capacity (in the form of facility overbuilding) directly results in health care price inflation." (source: <http://www.ncsl.org/default.aspx?tabid=14373>).

The State Health Facilities Council and IDPH remain responsive to stakeholder input regarding Iowa's CON process.

Workforce

The "Health and Long-Term Care Workforce" includes a wide range of professionals who provide health care services to individuals. It also includes public health professionals who provide and support population-based health services. The workforce consists of health care providers with varying degrees of education that span a continuum of care, including physicians, nurses (licensed and credentialed at several levels), dental hygienists, social workers, mental health counselors, physician assistants, pharmacists, physical and occupational therapists, laboratory workers, direct care workers and others. Services are provided by these professionals in a wide variety of settings including nursing homes, home health agencies, residential facilities for persons with disabilities, hospitals, clinics, and schools.

Iowa's demographic situation, including a high number of older Iowans (those placing greater demand on the health and long-term care system), means that the state's efforts to address health and long-term care workforce concerns are acute. The nationwide impact of baby boomer retirements impacts the supply of health care workers at all levels. In Iowa an increasing percentage of elderly in rural counties along with the trend of workers leaving rural counties means the shortage of health care workforce is magnified in rural areas.

Employers of health professionals experience the impact of shortages on a day-to-day basis as do health professionals themselves. Of course, citizens as recipients of health and long-term care services also experience these impacts making the need to find solutions to the health workforce shortage a priority for everyone.¹¹

Health Professions Shortages

Health Professional Shortage Areas (HPSAs) are determined according to federal guidelines. They include geographic areas, populations, or facilities which have fewer than a designated number of health professionals per population. The Office of Shortage Designations the HRSA Bureau of Health Professions National Center for Health Workforce Analysis develops shortage designation criteria and uses them to decide whether or not a geographic area or population group is a **Health Professional Shortage Area** or a **Medically Underserved Area or Population**. Several federal programs depend on the shortage designation to determine eligibility as a funding preference.

There are 55 **Primary Care Health** Professional Shortage Areas in Iowa that comprise a variety of shortage designation types in 62 Iowa counties.¹² This means that the population to physician ratio in these counties is greater than 3,500:1 for a geographic designation or that the population to physician ratio is greater than 3,000:1, and at least 30 percent of the population is below 200 percent of the federal poverty level. Iowa would need to recruit 67 practitioners to resolve all of its primary care HPSAs. To achieve a ratio of 2000:1, Iowa would need to recruit 138 practitioners.¹³

Sixty-nine of Iowa's counties are **Dental Health** Professional Shortage Areas. There are 11 Geographic designations in which the population to dentist ratio exceeds 5,000:1. Fifty-eight Iowa counties are special population (low income and Medicaid) designations with at least a 4,000:1 population to dentist ratio and at least 30 percent of the populations is at or below 200 percent of the federal poverty level.¹² Iowa would need to recruit 52 practitioners to resolve all of its dental health HPSAs. To achieve a ratio of 3,000:1, Iowa would need to recruit 66 practitioners.¹³

Ninety of Iowa's counties are **Mental Health** Professional Shortage Areas.¹² This means that there is at least a 30,000:1 population to psychiatrist ratio within a designated "catchment area." Iowa is divided into 22 catchment areas. Most catchment areas contain multiple counties. Criteria for catchment areas are established according to section 238 of the federal Community Mental Health Centers Act. Iowa would need to recruit 25 practitioners to resolve all of its mental health HPSAs. To achieve a ratio of 10,000:1, Iowa would need 117 practitioners.¹³

Linking Health Care Consumers to Transportation Services

Transportation has long been a challenge for health care providers and organizations seeking to assist patients and clients in accessing health care services. Rural transit in particular has multiple challenges. Linking people to transportation will require greater collaboration between the worlds of health care and transit. Iowa has 35 designated transit systems. Sixteen of these are rural systems and 19 are urban.

The service area of each of Iowa's 16 regional transit systems includes multiple counties. Service is provided within each of Iowa's 99 counties, as well as between counties and between regions. These regional systems are organized in various ways. Some are public agencies, while others are private, non-profit entities. Contact information for these transit areas can be found at <http://www.iowadot.gov/transit/agencies.html>.

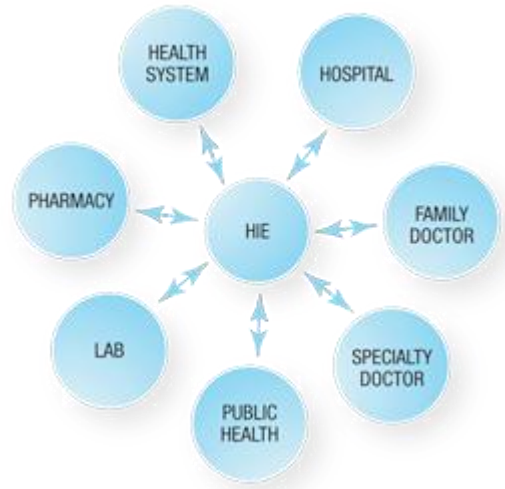
On the planning side, Iowa has nine Metropolitan Planning Organizations and eighteen Regional Planning Affiliations which are responsible for intermodal transportation planning in their area, including the programming of federally funded transportation projects. Six of the MPOs provide the staffing for their surrounding RPA. In several areas, the county's planning boundaries are not necessarily the same as the transit areas. Currently, of the 18 RPAs, only eight have boundaries identical to the transit regions. The other ten RPAs cover eight transit regions, with two transit regions each falling partially in three different

planning regions. Contact information for Iowa's MPOs and RPAs can be found at http://www.iowadot.gov/systems_planning/distplannercontact.htm.¹⁴

Trends in Technology Related to Health Services Delivery

The Iowa Department of Public Health has formed Iowa e-Health - a collaboration among consumers, health care providers, insurers, state government, and health care purchasers - to build the Iowa Health Information Network (IHIN) and encourage Iowa providers to use electronic health records (EHRs).

The IHIN will allow health care providers to access vital patient health information no matter where the patient has secured medical services in Iowa. Think of the IHIN as a "hub" that connects different EHRs throughout the state, which allows patient information to flow between providers in a secure and confidential way through secure provider to provider messaging



Whether in an emergency or during a regular visit with your primary care physician, your health information will be exchanged quickly and accurately through the IHIN.

Initially, the type of information that will be exchanged through the IHIN include:

- continuity of care document (summary of a patient record)
- clinical lab results
- immunization list
- medication history

The 5 Domains of Iowa e-Health:

Governance: convening stakeholders, setting direction and goals, and providing oversight to ensure accountability

Finance: identifying and managing financial resources to achieve short and long-term sustainability

Technical Infrastructure: implementing and managing the core infrastructure and standards to enable the electronic exchange of health information among providers

Legal and Policy: establishing policies and trust agreements to safeguard privacy and security of electronic health information

Business and Technical Operations: performing day-to-day activities to support Iowa e-Health operations and alignment with broad health reform¹⁵

Telemedicine

As reported in the RAHSRP,⁹ telemedicine is the application of clinical medicine where medical information is transferred through interactive audiovisual media for the purpose of consulting, patient visits and remote medical procedures or examinations. In rural areas where the shortage of health professional is more prevalent, the use of telemedicine to monitor patients and deliver care is especially

important. Effective telemedicine practice can increase the ability of health providers to expand their scope of care across miles.

In April 2011, Iowa Department of Public Health Director, Dr. Marinette Miller-Meeks was quoted as saying, “Telemedicine will be very important in a state like this because it is rural”. Miller-Meeks said, “With telemedicine, we will be able to do more”. The problem with the technology is that it is “expensive,” but once it is in place it can help cut down on costs and provide greater access. The Public Health Information program would put into place the infrastructure and processes to ramp up the system.

Telemedicine challenges – While the benefits to telemedicine are not disputed the issues that prevent widespread adoption are similar to other technology related areas. They include:

- 1) Workforce – training and costs related to reliable staff that can maintain equipment. Additionally, training and re-training for health providers.
- 2) Security – As technology improves the issues related to patient information security are resolved.
- 3) Equipment – Costs including maintenance are a challenge for some small hospitals and clinics.
- 4) Reimbursement - telemedicine is now becoming widely recognized as both cost and clinically effective. Insurance reimbursement varies from state to state. Reimbursement rates and percentages of cases that are being reimbursed for are not well tracked. In some cases Medicare is reimbursing at a rate 100 percent for submitted claims while in others the reimbursement rate is closer to 40 percent. Additionally, reimbursements for patients in bordering states present a unique challenge. Centers for Medicare and Medicaid finalized their specific/limited reimbursement proposal for CY 2011. Until a recent Center for Medicare and Medicaid (CMS) ruling (May 5, 2011) hospitals had to undergo extensive and expensive processes to secure credential and privileges for each practitioner providing telemedicine. Rural hospitals often use consultants for telemedicine, thus the credentialing process was difficult. The new ruling removed this burden especially for critical access hospitals.

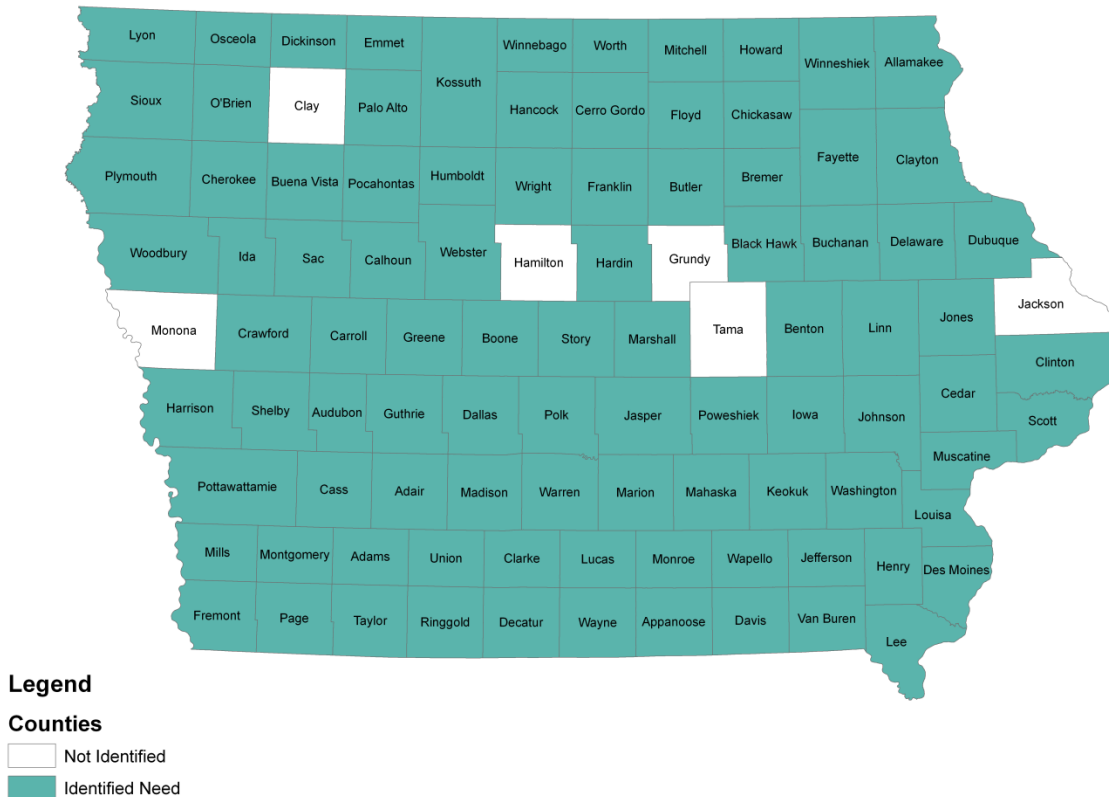
Strategic Direction

Upon completion of the 2010 Phase 1 Strategic Plan, the Health and Long-Term Care Access Advisory Council expanded its focus from health workforce to examine the other required components of the Strategic Plan as set forth in statute. Because the membership of the Council includes a set of stakeholders with a variety of areas of expertise, a portion of the Council’s time included cross-education about topics to be addressed. The series of presentations that was offered is listed on page 6.

At its concluding meeting, the Council determined the Strategic Direction for 2012. While viewing “Access” as the overarching concern, the Council agreed to divide its work into two major categories for the coming period: Infrastructure and Workforce.

Key to the Council’s discussion were findings of the report, [Understanding Community Health Needs in Iowa](#)⁷ which compiled the results of local Community Health Needs Assessment and Health Improvement Plan efforts. This report showed that 93 Iowa counties found Access to Health Services to be a need.¹

Access to Health Services Issues



Within the category of Access to Health Services, the following needs were identified by counties: Lack of Transportation; Lack of Mental Health Services/Providers; Lack of Insurance/Underinsured; Economic

Barriers to Health Access; Lack of Dental Services/Providers; Lack of General Services/Providers; and Lack of Services/Infrastructure – Elderly.

When the needs identified by local areas were analyzed in comparison to the plans in place to address needs, the category of Health Infrastructure emerged as the greatest magnitude of unmet need in Iowa. Within this, Access to Transportation was a significant issue, along with Access to Mental Health Services.

Health Infrastructure

The Council concluded that there can be no expectation that new funding will be available to address issues due to the already strained economic situation affecting the health system. Therefore, the key to strategic direction moving forward will be Effectiveness and Efficiency with a focus on Quality. Discussion must focus on how the system can accomplish more with less, increasing the use of cost- and time-saving tools and methods. Examples cited by the Council included telemedicine and case management or care coordination. The group also believes it is necessary to move to reimbursement methods that pay for what is expected (services, products, and outcomes).

Workforce

Although the focus for the Council during the first phase of the strategic plan was workforce, the Council concludes that there are still needs in this area. There are four main areas of strategic direction for the next work cycle of the Council. These include:

1. Issues no one is raising
2. Recruitment and retention
3. New types of professionals (expansion)
4. Scope of practice of health professionals

In the timeline below, the subcommittee(s) responsible for the action step is labeled with “I” for the Infrastructure subcommittee and with “W” for the Workforce subcommittee. If no label is present, this indicates the action step happens outside the HLTCA AC. This timeline is subject to adjustment by the Health and Long-Term Care Access Advisory Council in collaboration with the IDPH.

	Action Steps	Timeline
I/W	Review and approve Action Steps and Timeline	February 2012
I/W	Determine subcommittee membership and assess needed additional participation	February 2012
I/W	Review HLTCA AC Goals & Objectives Recommended to IDPH from 2010 Strategic Planning. Determine which recommended items should be carried forward	February 2012

	Action Steps	Timeline
I/W	Review statutory language in 135.163 and 135.164 and consider realignment of statute with strategic direction and IDPH mission – develop recommended revisions if appropriate	February 2012
I	Determine efficiency strategies to target for further examination (cost- and time-saving tools and methods); if further research is needed to further define targeted strategies, determine necessary steps to gather needed information and responsible parties	February 2012
W	Assess and list existing recruitment and retention strategies used in Iowa	February 2012
W	Specify the health and long-term care workforce issues to be addressed by this group to address gaps in Iowa’s workforce strategies (issues no one is raising); if needed, determine additional research needed to fully identify gaps	February 2012
I	Create a list of factors and stakeholders influencing the implementation of targeted efficiency strategies; stakeholder list should include specific individuals and contact information where possible	April 2012
I	Develop communication strategies explaining targeted efficiency strategies and rationale	April 2012
W	Report progress on identified gaps (issues no one is raising) and determine top three gaps to be addressed; determine steps	April 2012
W	List anticipated new types of professionals needed along with rationale and background for each; where further expertise is needed, engage appropriate partners	April 2012
W	Specify the areas of scope of practice to be addressed in order of priority and identify gaps in information to move forward; identify stakeholders for each area of priority, including entity, contact person, and contact information	April 2012
	Authorize funding to continue implementation of requirements in 135.163 and 135.164	May 2012
W	Examine effectiveness of existing recruitment and retention strategies used in Iowa	May 2012
I	Inform HLTCA AC about at least one chosen efficiency strategy through presentation to the Council; design detailed action steps to expand the strategy in Iowa	July 2012
I	Members provide inventory of telemedicine use within organizations they represent	July 2012
I	Create list of telemedicine stakeholders with contact information	July 2012
I	Members provide status of care coordination initiatives within organizations they represent	July 2012
I	Create list of care coordination stakeholders	July 2012
W	Research recruitment and retention strategies used by other states that have not been implemented in Iowa; list results	July 2012
W	Conduct literature review regarding overall effectiveness of recruitment and retention methods	July 2012
W	Report on research regarding new types of professionals needed; determine next steps including information-gathering or decision to pursue	July 2012
W	Identify specific scope of practice issue(s) to address in the coming year; determine first three steps for each	July 2012
I	Determine three specific low-cost or no-cost strategies to increase use of telemedicine and identify potential grants or other funding sources	September 2012
I	Determine three specific low-cost or no-cost strategies to increase use of care coordination and identify potential grants or other funding sources	September 2012

	Action Steps	Timeline
W	Carry out steps determined regarding new professionals needed; report on progress; assign next tasks	September 2012
W	Analyze results of previous action steps regarding recruitment and retention strategies and determine the top three most promising strategies for Iowa	September 2012
W	Report on scope of practice progress on steps identified in July; identify next steps	September 2012
W	Report progress on gaps (issues no one was raising); identify next steps	September 2012
I/W	Prepare, post, and distribute interim progress report and plan on strategic directions, including enhanced detail; include action steps for December 2012 through December 2013	November 2012
I/W	Assess needed changes to Advisory Council and Subcommittee Membership	November 2012
I/W	Carry out action steps per interim progress report and plan	December 2012 – October 2013
	2014 Health & Long-Term Care Access Strategic Plan Submitted	October 2013

Appendices (Links)

1. IA Rural & Agricultural Health & Safety Resource Plan (RAHSRP). Available at: http://www.idph.state.ia.us/hpcdp/rural_health.asp.
2. Department of Inspections and Appeals, Health Facilities Division, Entities Book, Health Care Facilities in Iowa. Available at: https://dia-hfd.iowa.gov/DIA_HFD/Process.do
3. CHNA & HIP *Understanding Community Health Needs in Iowa*. Available at: <http://www.idph.state.ia.us/chnahip/default.asp>.
4. IDPH Data Warehouse. Available at: http://www.idph.state.ia.us/adper/data_warehouse.asp.
5. Iowa eHealth. Available at: www.iowahealth.org.
6. Certificate of Need, Iowa Health Facilities Council. Available at: http://www.idph.state.ia.us/adper/cert_of_need.asp.

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- ¹ Iowa Department of Public Health. (2011, December 14). Bureau of Communication and Planning. *Access to Health Services Issues*. Des Moines, IA, USA: Iowa Department of Public Health.
- ² Iowa Department of Public Health. (n.d.). *Health & Long-Term Care Access Advisory Council*. Retrieved from http://www.idph.state.ia.us/HLTC_Advisory_Council/Resources.aspx
- ³ U.S. Census Bureau. (n.d.). 2010 Decennial Census.
- ⁴ U.S. Census Bureau, Population Division. (2005, December 31). *U.S. Population Projections*. Retrieved December 14, 2011, from U.S. Census: <http://www.census.gov/population/swww/projections/statpyramid.html>
- ⁵ Shipley, K., & Schadle, J. (2011, November). personal communication. *Information also available from:* <http://www.idph.state.ia.us/ChronicCare/Resources.aspx>.
- ⁶ Iowa Department of Public Health. (n.d.). *Behavioral Risk Factor Surveillance System*. Retrieved from <http://www.idph.state.ia.us/brfss/>
- ⁷ Iowa Department of Public Health. (2011, May). *CHNA & HIP*. Retrieved from Understanding Community Health Needs in Iowa 2011: <http://www.idph.state.ia.us/chnahip/default.asp>
- ⁸ Iowa Department of Public Health. (n.d.). *IDPH Data Warehouse*. Retrieved from http://www.idph.state.ia.us/adper/data_warehouse.asp
- ⁹ Iowa Department of Public Health. (2011). *Bureau of Oral & Health Delivery Systems*. Retrieved from IA Rural & Agricultural Health & Safety Resource Plan: http://www.idph.state.ia.us/hpcdp/rural_health.asp
- ¹⁰ Iowa Department of Public Health. (n.d.). *Certificate of Need; State Health Facilities Council*. Retrieved from http://www.idph.state.ia.us/adper/cert_of_need.asp
- ¹¹ Iowa Department of Public Health. (2008, January). *Health & Long-Term Care Workforce Review & Recommendations*. Retrieved from http://www.idph.state.ia.us/hpcdp/health_and_longterm_care_workforce_review.asp

¹² Iowa Department of Public Health. (2011, July). *Bureau of Oral & Health Delivery Systems*. Retrieved from Primary Care Office: http://www.idph.state.ia.us/hpcdp/primary_care.asp

¹³ U.S. Department of Health & Human Services; Health Resources and Services Administration (HRSA); Bureau of Health Professions. (2011, December 11). *Office of Shortage Designation*. Retrieved from Designated Health Professional Shortage Area (HPSA) Statistics: http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2

¹⁴ Iowa Department of Public Health. (2011, October). *Bureau of Oral & Health Delivery Systems*. Retrieved from Access Update: <http://www.idph.state.ia.us/IdphArchive/Archive.aspx?channel=AccessUpdate>

¹⁵ Iowa Department of Public Health. (n.d.). *Iowa eHealth*. Retrieved from [iowaehealth.org](http://www.iowaehealth.org): <http://www.iowaehealth.org/>