FACT SHEET
Direct Care Workforce Initiative

Background

Direct Care Professionals (DCP) are the largest single profession in the state

- Conservatively estimated between 47, 000 to 52,000 workers – a bigger workforce than teachers, law enforcement, and nurses

Demand for direct care services is increasing at rates exceeding capacity of the workforce

- Iowa Workforce Development estimates that Iowa needs 10,000 additional DCPs by 2016
- Iowa Medicaid members receiving waiver services increased 35.8 percent between 2005 and 2010
- Increasing population of aging Iowans demanding services in their homes and communities
- Need to establish capacity for this workforce to provide service in settings of choice (Olmstead)

Staggering turnover rates and retraining costs

- Employers report average turnover rates of 64 percent for certified nurse aides in Iowa and 52 percent nationally for direct support professionals
- One source estimates $784 million annually spent in the U.S. on turnover for the sector of the workforce supporting individuals with intellectual disabilities

ACA Personal and Home Care Aide State Training Grant

- Iowa is one of six states to receive funding to develop a national model for training and credentialing the workforce
- $2.25 million ($750,000 per year for three years) to pilot the career pathway recommendations of the Direct Care Worker Advisory Council
- Activities include:
  - Development of competencies and curriculum that align with state and national regulations and credentials
  - A pilot project that partners with provider agencies and community colleges to provide training of direct care professionals in two regions in the state
  - Leadership, retention and mentoring support for DCPs
  - Development of an information management system to credential and track the workforce
  - State and national level evaluation of curriculum, retention success, training and retraining costs
  - Long-term sustainability planning for establishment of Board of Direct Care Professionals

Direct Care Worker Advisory Council

- Charged with advising IDPH on education and credentialing of direct care professionals
- Key Activities 2011 – 2012:
  - Complete recommendations on core training, Board responsibilities, and workforce data
  - Complete recommendations and timeframe for transition of the current workforce
  - Assist IDPH with development and testing of the information management system
  - Continue and expand statewide outreach to DCPs, employers, educators, and the public
  - Provide stakeholder leadership and guidance to IDPH for pilot implementation and planning

For Additional Information: **Erin Drinnin- EDrinnin@idph.state.ia.us**

http://www.idph.state.ia.us/hcr_committees/direct_care_workers.asp

February 8, 2011

DIRECT CARE
WORKFORCE INITIATIVE

DIRECT CARE PROFESSIONAL CAREER PATHWAYS

SPECIALTY ENDORSEMENTS

Autism, Alzheimer's/Dementia, Advanced Nurse Aide, Brain Injury, Crisis Intervention, Hospice & Palliative Care, Medication Aide, Medication Manager, Mental Health, Mentoring, Positive Behavior Supports, Paid Nutritional Assistant, Psychiatric Care, Rehab Aide, Wellness & Prevention

Specialty Endorsements will be developed by experts in those subject or professional areas and approved by the Iowa Board of Direct Care Professionals. Specialty Endorsements currently have or may have unique regulatory requirements.

Optional education open to all Certified Direct Care Associates. Some Endorsements may be required for workers based on regulations for those specialties.

Requirements: Active Certification status.

Credential Received: Endorsement

Continuing Education: Determined separately for each Endorsement. Continuing education completed for a specialty will count toward hours to maintain Certification or Advanced Certifications.

Title: Determined separately for each Endorsement.

CORE TRAINING CORE

Direct Care Associate

Basic foundational knowledge and introduction to profession.

Required for all direct care workers, except individuals providing services only to family or one individual.

Requirements: Must meet minimum age for employment and pass a background check to be employed.

Credential Received: Certification; must be renewed every two years

Continuing Education: 6 hours every two years

Title: Certified Direct Care Associate

ADVANCED TRAINING MODULES

HCL Home & Community Living

Services to enhance or maintain independence, access community supports and services, and achieve personal goals.

IADL Instrumental Activities of Daily Living

Services to assist an individual with daily living tasks to function independently in a home or community setting.

PS Personal Support

Services to support individuals as they perform personal activities of daily living.

PADL Personal Activities of Daily Living

Services to assist an individual in meeting their basic needs.

HMM Health Monitoring & Maintenance

Medically-oriented services to address health needs and maintaining health.

ADVANCED TRAINING CREDENTIALS

Community Living Professional

Optional education open to all Certified Direct Care Associates.

Requirements: CORE + HCL + IADL + PS + active Certification status
Credential Received: Advanced Certification; must be renewed every two years
Continuing Education: 20 hours every two years
Title: Advanced Certified Community Living Professional (CLP)

Personal Support Professional

Optional education open to all Certified Direct Care Associates.

Requirements: CORE + PS + PADL + active Certification status
Credential Received: Advanced Certification; must be renewed every two years
Continuing Education: 20 hours every two years
Title: Advanced Certified Personal Support Professional (PSP)

Health Support Professional

Optional education open to all Certified Direct Care Associates . Certification is required for individuals performing health support functions in nursing facilities and home health/care agencies.

Requirements: CORE + HMM + PADL + active Certification status
Credential Received: Advanced Certification; must be renewed every two years
Continuing Education: 20 hours every two years
Title: Advanced Certified HealthSupport Professional (HSP)

FACT SHEET
Health Benefits Exchange

Background

- The Patient Protection and Affordable Care Act (PPACA) is a federal statute that was signed into law on March 23, 2010. Health Benefit Exchanges (HBE) are a tenant of new law. HBEs are entities that will be in states to create a more organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them.

Funding

- On September 30, IDPH received a $1 million, one-year, planning grant from the Office of Consumer Information and Insurance Oversight (OCIIO) to start planning for the establishment of a HBE. PPACA requires that states have exchanges operational by January 2014, or the federal government will operate an exchange for the state.

Interagency Workgroup

- IDPH is collaborating with the Iowa Insurance Division (IID), Iowa Department of Human Services (DHS) and the Iowa Department of Revenue (IDR) as part of an Interagency Planning Workgroup to assess the support of, need for, and creation of the HBE. The workgroup will issue final recommendations to the Governor, policymakers, and the public for the establishment of a HBE.
  - DHS received $445,727 and will identify IT requirements for program interoperability and seamless enrollment into coverage plans. DHS will also evaluate business processes and IT solutions that will integrate Medicaid and CHIP eligibility determination, enrollment and covered services into the HBE, and new eligibility procedures for tax credits.
  - IID received $102,523 and will lead in developing insurance market assessments, assess integration to the current insurance information exchange call center, review filings for premium rates, and survey carriers benefit designs and survey carrier and provider market competitiveness.
  - IDR received $23,424 and will provide leadership for financial modeling, develop specifications for accounting and financial systems, determine budget impacts, work to ensure that a system is in place to issue appropriate tax credits and subsidies to eligible individuals, and develop a system that can be easily audited and understood by the taxpayers.

Regional Meetings and Focus Groups

- A series of regional meetings and focus groups were held across Iowa to ensure considerable stakeholder involvement throughout the planning of the HBE. They gained consumer buy-in and created transparency. Community stakeholder groups were given a chance to voice concerns and solicit ideas and expectations from what Iowans want out of an HBE.
- Information that was collected included what benefits should be incorporated in the benefits packages, how information should be delivered and what tools should be available to access services. The information from the meetings will be shared with stakeholders and policymakers. A Stakeholder Advisory Council will also be formed to lead this effort.

State Choices

Federal rules will clarify that the following policy areas, among others, are State decisions, although HHS may offer recommendations and technical assistance to States as they make these decisions:

- Whether to form the Exchange as a governmental agency or a non-profit entity
- Whether to form regional exchanges or establish interstate coordination for certain functions
- Whether to elect the option under the Affordable Care Act to use 50 employees as the cutoff for small group market plans until 2016, which would limit access to exchange coverage to employer groups of 50 or less
- Whether to require additional benefits in the Exchange beyond the essential health benefits
- Whether to establish a competitive bidding process for plans
- Whether to extend some or all Exchange-specific regulations to the outside insurance market (beyond what is required in the Affordable Care Act)

HBE Establishment Grants

- HBE establishment grants were announced on January 20, 2011 that recognize that states are making progress toward establishing Exchanges but are doing so at different paces. States that are moving ahead on a faster pace can apply for multi-year funding. States that are making progress in establishing their Exchange through a step-by-step approach can apply for funding for each project year.
- States may initially apply for either level one or level two establishment grants, based on their progress. State can also choose when during this year to apply for grant funding based on their needs and planned expenditures. Moving forward, States will have multiple opportunities to apply for funding as they progress through the Exchange establishment process. This process gives States maximum flexibility and ensures that States can move forward on their own timetables as they work to build an Exchange.
    - **Level One Establishment Grants:** These grants provide up to one year of funding to states that have made some progress under their Exchange planning grant. States may plan to reapply for a second year of funding under the level one establishment grants if necessary to meet the criteria to apply for level two establishment grants.
    - **Level Two Establishment Grants:** This category of grants is designed to provide funding through December 31, 2014 to applicants that are further along in the establishment of an Exchange.

For Additional Information: **Julie McMahon- jmcmahon@idph.state.ia.us or Angie Doyle Scar- adoyle@idph.state.ia.us**
http://www.idph.state.ia.us/hcr_committees/health_benefit_exchange.asp

FACT SHEET
Prevention and Chronic Care Management Advisory Council

Background
The purpose of the Prevention and Chronic Care Management (PCCM) Advisory Council is to advise and assist the IDPH to develop a state initiative for prevention and chronic care management as outlined in HF 2539.

Advisory Council Recommendations, presented to State Board of Health, June 2010:

1. Create the Iowa Prevention and Chronic Care Advisory Council to provide guidance and oversight for prevention and chronic care management;
2. Empower people with the knowledge and resources to live healthy lives and manage their own chronic illnesses;
3. Identify and recommend consensus guidelines for the use in chronic care management beginning with those that address the state chronic disease and prevention priorities;
4. Establish a chronic disease practice registry product that could be easily and readily incorporated into medical practices;
5. Improve incentives for prevention and chronic disease management by providing support for care through payment systems, organization and delivery of care, and care coordination;
6. Improve the health workforce and their skills in prevention and chronic disease management; and
7. Create a societal commitment to health through implementing policies to remove barriers that prevent Iowans from leading healthy lives. Empower and expect Iowans to take personal responsibility for being as healthy as genetically possible and improving their own health, as well as the health of those around them.

The PCCM Advisory Council develops progress reports annually to summarize the activities and advancements of the Council. The Council has developed issue briefs to highlight important topics related to PCCM in Iowa. The briefs and reports are located at: http://www.idph.state.ia.us/hcr_committees/prevention_chronic_care_mgmt.asp

Supportive Information
- The dramatic growth of chronic diseases is a huge burden to America. An alarming 75 cents of every health care dollar is spent on chronic diseases, and they account for 7 out of every 10 deaths. If this problem is ignored, the cost of treating chronic conditions such as diabetes, cancer, and obesity could overwhelm American health care.
- America's current health care system is set up to focus on treating people once they become sick. Some experts describe this as "sick care" instead of health care. Keeping people healthier by increasing preventive care and managing chronic conditions are very effective strategies to reduce health care costs and improve the health of Iowans.
- Experts widely agree that three of the most important factors that influence our health are: 1) Physical activity, 2) Nutrition, and 3) Whether or not we smoke. CDC estimates that eliminating these three risk factors would prevent 80% of heart disease and stroke, 80% of type 2 diabetes, and 40% of cancer.

Key PCCM Advisory Council Activities
Prevention and chronic disease management are distinctively different and require separate strategies for intervention. To acknowledge this, two different subgroups have been identified:

- The **Chronic Disease Management Subgroup** is focusing on SF 2356 to develop a plan to coordinate care for individuals with diabetes who receive care through community health centers (CHC), rural health clinics, free clinics, and other safety nets. The plan may include a diabetic registry to provide drugs and to collect data to assist providers in tracking the care of their patients with diabetes.
- The **Prevention Subgroup** is focusing on HF 2144 to submit recommendations by December 15, 2011 on strategies to collect and provide statistically accurate data concerning chronic disease in multicultural groups of racial and ethnic diversity in the state. Following implementation of the strategies and collection of data, the council shall also make evidence-based recommendations to the director to address and reduce identified disparities.
- The Legislative Health Care Coverage Commission created four workgroups to focus on particular aspects of health care coverage and assure that national health reform is implemented in Iowa in an efficient, high-quality, and practical way. The PCCM Advisory Council's coordinator sat on the Wellness Workgroup and offered input in the development of their recommendations.
- The PCCM Advisory Council is collaborating in submitting an application for the Affordable Care Act: Childhood Obesity Research Demonstration Grant. The objective of the research demonstrations is to determine whether an integrated model of primary care and public health approaches in the community can improve underserved children's risk factors for obesity.

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http://www.idph.state.ia.us/hcr_committees/prevention_chronic_care_mgmt.asp

February 8, 2011

FACT SHEET
Medical Home System Advisory Council

Background

- The purpose of the Medical Home System Advisory Council (MHSAC) is to advise and assist IDPH to develop a plan for implementation of a statewide patient-centered medical home (PCMH) system as outlined in HF 2539.
- The MHSAC develops progress reports annually, which summarizes the activities and advancements made throughout the year. They have also developed issue briefs on a variety of important topics related to the spread of the PCMH in Iowa. These can be found under the "Resources" tab at the MHSAC website: http://www.idph.state.ia.us/MedicalHome/
- *A* "medical home" means a team approach to providing health care that:
  - originates in a primary care setting
  - fosters a partnership among the patient, the personal provider, other health care professionals, and the patient's family when appropriate
  - utilizes the partnership to access all medical and non-medical health-related services needed by the patient and family to achieve maximum health potential.
  - maintains a centralized, comprehensive record of all health-related services to promote continuity of care
- It includes the following characteristics: a personal provider, a provider-directed medical practice, whole person orientation, coordination and integration of care, quality and safety, enhanced access to health care, and payment.
- The PCMH system will strive to:
  - reduce disparities in health care access, service delivery, and health status;
  - improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage within a sustainable health care system; and
  - provide a pragmatic method to document that each Iowan has access to health care.

Research

- Significant effectiveness research suggests that increased adoption of the PCMH will yield considerable measurable benefits including:
  - better health outcomes
  - reduced mortality
  - fewer preventable hospital admissions for patients with chronic diseases
  - lower utilization
  - improved patient compliance with recommended care
  - lower Medicare spending
- If the PCMH model is implemented properly and fully supported, primary care, which currently receives about 7 percent of health care expenditures, can help reduce the remaining 93 percent of expenditures. Therefore, additional spending on the PCMH would result in cost-saving benefits over time.
- North Carolina has a best practice medical home model of care in its Medicaid program called Community Care of North Carolina (CCNC). Evaluations of the program suggest it has resulted in both improved care and cost savings. Studies show that CCNC saved the state approximately $60 million in fiscal year (FY) 2003, $124 million in FY2004, $231 million in FY2005 and FY2006, and $147 million in FY2007.

Key MHSAC Activities

- A Medical Home Multipayer Collaborative Workgroup has formed with members from the MHSAC, key PCMH stakeholders and payors to develop a multipayer pilot project for Iowa.
- The MHSAC continues to collaborate with Medicaid in the development of the IowaCare Medical Home Model,. The expansion will phase in Federally Qualified Health Centers (FQHCs) to provide primary health care services to the IowaCare population and to comply with certification requirements of a Medical Home. On October 1, the rollout began with FQHCs in Waterloo and Sioux City.
- IDPH is working on drafting and adopting rules for certification. The MHSAC recommends Iowa use NCQA's Physician Practice Connections®- Patient-Centered Medical Home™ as the method to certify medical homes. .
- Iowa was one of eight states that participated in the National Academy for State Health Policy (NASHP) Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program (CHIP) Participants. More than 30 states have been seeking to improve Medicaid and CHIP beneficiaries' access to high functioning medical homes. Iowa recently submitted a second application for an additional year of the technical assistance program.

For Additional Information: **Beth Jones- bjones@idph.state.ia.us or http://www.idph.state.ia.us/MedicalHome/**

February 8, 2011

Data Resource Center for Child & Adolescent Health

Your Data... Your story

A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

www.childhealthdata.org

Medical Home Profile at a Glance

Iowa: 57.4%

National Rate: 47.1%

Range across States: 36.9% - 57.4%

IOWA

Medical Home Performance Profile for CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)
Data Source: 2005/06 National Survey of Children with Special Health Care Needs (NS-CSHCN)

Prevalence of Medical Home in Iowa

CSHCN (age 0-17)	State	HRSA Region VII	Nation
Met all medical home criteria	57.4%	54.0%	47.1%
Age of Child			
0 - 5 years old	61.8%	57.0%	50.4%
6 - 11 years old	61.5%	55.3%	47.4%
12 - 17 years old	52.0%	51.3%	45.2%
Sex of Child			
Male	54.4%	52.5%	46.7%
Female	61.4%	56.0%	47.8%
Household Poverty Level (Federal Poverty Level [FPL] Guidelines)*			
0% - 99% FPL	50.7%	39.8%	34.0%
100% - 199% FPL	51.9%	44.9%	41.2%
200% - 399% FPL	58.7%	60.5%	51.1%
400% FPL or higher	65.3%	63.0%	56.3%
Race/Ethnicity of Child			
Hispanic	NA**	46.5%	32.2%
White, Non-Hispanic	59.2%	55.9%	52.8%
Black, Non-Hispanic	NA**	46.4%	36.6%
Multi-Racial/Other, Non-Hispanic	NA**	47.9%	43.9%
Type of Insurance			
Private insurance only	59.7%	58.1%	53.3%
Public insurance such as Medicaid or SCHIP	55.5%	45.2%	38.9%
Both private & public insurance	45.2%	50.4%	37.0%
Uninsured	NA**	38.0%	26.5%

* For more information on FPL guidelines please visit: http://aspe.hhs.gov/poverty/07Poverty.shtml

Components of Medical Home

Accessibility	State	HRSA Region VII	Nation
Has a personal doctor or nurse	96.1%	95.1%	93.5%
Family-Centered Care (% who report "usually" or "always")			
Doctor spends enough time	85.0%	83.7%	78.7%
Doctor listens carefully	93.3%	92.9%	88.8%
Doctor provides specific needed information	86.7%	86.2%	83.1%
Doctor helps parent feel like partner in care	92.8%	91.9%	87.6%
Comprehensive			
Has problem getting referrals when needed	12.7%	14.0%	21.1%
Has a usual source for both sick and well care	95.4%	93.2%	92.9%
Coordinated (% among CSHCN receiving 2 or more types of services)			
Received any help arranging or coordinating care	32.9%	33.0%	33.2%
Reported getting all help needed arranging care for child	66.8%	65.6%	59.2%
Very satisfied with communication between doctors, when needed	70.2%	69.3%	63.8%
Very satisfied with communication between doctors and school, when needed	60.0%	55.2%	52.1%
Culturally Effective (% who report "usually" or "always")			
Doctor is sensitive to family customs and values	94.6%	93.1%	88.9%
Availability of interpreter, when needed	NA**	NA**	56.3%

Citation format: Child and Adolescent Health Measurement Initiative. 2005/06 National Survey of Children with Special Health Care Needs Medical Home State Profile. Data Resource Center for Child and Adolescent Health website. Retrieved [mm/dd/yy] from www.medicalhomedata.org.

** NA Estimates based on sample sizes too small to meet standards for reliability or precision. The relative standard error is greater than or equal to 30% and/or the number of responses is less than 20.

For more information on the Medical Home concept, resources related to Medical Home, or more Medical Home data, please go to www.medicalhomedata.org.

Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) in collaboration with the American Academy of Pediatrics (AAP), with funding from the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Departent of Health and Human Services.

Data Resource Center for Child & Adolescent Health

Your Data... Your story A project of the Child and Adolescent Health Measurement Initiative (CAHMI)

www.childhealthdata.org

IOWA

Medical Home Performance Profile for ALL CHILDREN
Data Source: 2007 National Survey of Children's Health

Medical Home Profile at a Glance

Iowa: 66.9%

National Rate: 57.5%

Range across States: 45.4% - 69.3%

Prevalence of Medical Home in Iowa

All Children (age 0-17)	State	HRSA Region VII	Nation
Met All Medical Home Criteria	66.9%	65.1%	57.5%
Age of Child			
0 - 5 years old	70.0%	71.5%	64.0%
6 - 11 years old	64.6%	63.2%	55.2%
12 - 17 years old	65.9%	60.8%	53.4%
Sex of Child			
Male	66.0%	65.7%	56.8%
Female	67.9%	64.6%	58.2%
Household Poverty Level (Federal Poverty Level [FPL] Guidelines)*			
0 - 99% FPL	53.4%	48.1%	39.4%
100 - 199% FPL	57.4%	60.4%	49.4%
200 - 399% FPL	72.3%	70.1%	62.5%
400% FPL or higher	73.0%	73.2%	69.3%
Race/Ethnicity of Child			
Hispanic	39.3%	40.0%	38.5%
White, Non-Hispanic	70.2%	70.3%	68.0%
Black, Non-Hispanic	NA**	44.9%	44.2%
Multi-Racial/Other, Non-Hispanic	70.5%	61.3%	55.6%
Type of Insurance			
Public insurance such as Medicaid or SCHIP	57.0%	55.6%	45.4%
Private health insurance	71.5%	71.1%	66.5%
Currently uninsured	54.6%	47.4%	35.7%
Children with Special Health Care Needs (CSHCN) Status			
CSHCN	60.5%	56.0%	49.8%
Non-CSHCN	68.5%	67.5%	59.4%

* For more information on FPL guidelines please visit: http://aspe.hhs.gov/poverty/07Poverty.shtml

Components of Medical Home

Accessibility	State	HRSA Region VII	Nation
Has a personal doctor or nurse	94.9%	93.8%	92.2%
Family-Centered Care (% who report "usually" or "always")			
Doctor spends enough time	86.9%	84.9%	79.3%
Doctor listens carefully	92.7%	92.2%	89.4%
Doctor provides specific needed information	89.9%	88.5%	84.8%
Doctor helps parent feel like partner in care	91.8%	90.5%	87.6%
Comprehensive			
Has a problem getting referrals when needed	15.4%	16.4%	17.7%
Has a usual source for both sick and well care	95.5%	95.0%	93.1%
Coordinated (% among children receiving 2 or more types of services)			
Received any help arranging or coordinating care	20.4%	19.3%	20.7%
Reported getting all help needed arranging care for child	72.4%	70.7%	68.7%
Very satisfied with communication between doctors, when needed	73.6%	73.5%	72.3%
Very satisfied with communication between doctors and school, when needed	63.1%	60.2%	62.3%
Culturally Effective (% who report "usually" or "always")			
Doctor is sensitive to family customs and values	94.6%	93.4%	89.2%
Availability of interpreter, when needed	NA**	57.0%	64.2%

Citation format: Child and Adolescent Health Measurement Initiative. 2007 National Survey of Children's Health Medical Home State Profile. Data Resource Center for Child and Adolescent Health website. Retrieved [mm/dd/yy] from www.medicalhomedata.org.

** NA Estimates based on sample sizes too small to meet standards for reliability or precision. The relative standard error is greater than or equal to 30% and/or the number of responses is less than 25.

For more information on the Medical Home concept, resources related to Medical Home, or more Medical Home data, please go to www.medicalhomedata.org.

Prepared by the Child and Adolescent Health Measurement Initiative (CAHMI) in collaboration with the American Academy of Pediatrics (AAP), with funding from the Maternal and Child Health Bureau (MCHB), Health Resources and Services Administration (HRSA), U.S. Departent of Health and Human Services.

FACT SHEET

Maternal, Infant, Early Childhood Home Visiting Program

Sec. 2951 Public Law 111-148 - Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act establishes a home visiting grant program for states administered through the U.S. Department of Health and Human Services (DHHS). This is accomplished by amending the Title V Maternal and Child Health (MCH) block grant program.

The provision:

1. Requires states to complete a needs assessment to identify communities that have few quality home visitation programs and are at risk for poor maternal and child health as a pre-condition for receiving Title V and home visiting grant funds.

2. Provides $1.5 billion over 5 years for maternal, infant and early childhood home visitation programs. Grantees are required to use evidence-based program models and establish quantifiable, measurable 3 and 5 year benchmarks that demonstrate:

- improvements in maternal and child health,
- childhood injury prevention,
- school readiness and achievement,
- crime or domestic violence,
- family economic self-sufficiency, and coordination with community resources and supports.

Funding for Iowa: $886,395 – annually

Iowa Priorities:

- Increase the number of families served by evidence-based home visiting programs
- Develop a statewide maternal, infant and early childhood home visiting data systems capabilities
- Reduce barriers to access to health care, mental health care, substance abuse treatment and counseling, and dental care for low income families
- Develop home visiting infrastructure with focus on quality and systems coordination
- Support healthy home environments and stable family relationships to protect families from domestic violence and child abuse and neglect

Next steps:

- Complete final phase of federal application process
- Conduct a series of focus groups with parents and service providers
- Release community-based request for proposals
- Provide at a minimum, quarterly updates

For Additional Information: Janet N. Horras- **Janet.Horras@idph.iowa.gov**
http://www.idph.state.ia.us/hpcdp/family_health.asp

February 8, 2011

FACT SHEET
Health & Long-Term Care Access Strategic Plan

Background

The Health Care Access section of HF 2539, codified as 135.163 and 135.164, requires a biennial strategic plan. The strategic plan is required to:

- Describe the existing health care system
- Describe and provide a rationale for the desired health care system
- Provide an action plan for implementation
- Provide methods to evaluate the system

Required components of the strategic plan include:

- A health care system assessment and objectives component
- A health care facilities and services plan
- A health care data resources plan
- An assessment of emerging trends in health care delivery and technology
- A rural health care resources plan (Rural & Agricultural Health & Safety Resource Plan)
- A health care workforce resources plan

Supporting Information

- 20% of the U.S. population is scattered over 90% of our nation's landmass, yet only 9% of physicians practice in rural America.
- Nearly half of Iowans live in rural areas.
- Iowa's physician workforce is aging along with the rest of the nation, average hours worked are falling, and many physicians are nearing retirement just as there is a growing demand for physician services.
- Fifty-five Iowa counties include a Primary Care Health Professional Shortage Area.
- Ninety Iowa counties are Mental Health Professional Shortage Areas.
- Almost half of Iowa's dentists (49%) are over age 50. Sixty-nine Iowa counties are in a Dental Health Professional Shortage Area.
- Long-term care facilities face costly high turnover of direct care workers, and Iowans cope with less continuity of care.

Strategic Plan Recommendations – Phase 1, January 2010

	Objective	Current Status
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.	SSB 1071 includes language to accomplish this objective.
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.	All available federal programs are accessed and used as appropriate: • There are 75 current National Health Service Corps NHSC loan repayment recipients in Iowa • Twenty-four Iowans received PRIMECARRE Loan Repayment (national State Loan Repayment Program (SLRP)) 2008 – 2010
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.	IDPH tracks and disseminates grant opportunities (including ACA) as offered. IDPH is not an eligible applicant for and AHEC grant; however, IDPH works with AHEC grantees. SF 58 addresses required non-federal match for this objective to move forward.

The next iteration of the plan is due January 2012. The technical advisory committee, named the Health & Long-Term Care Access Advisory Council, has most recently received presentations from IDPH staff regarding required components pertaining to certificate of need and rural access. The next meeting of the HLTCA AC is Tuesday, March 29, 2011.

ACA Grants

- Nine health workforce ACA grants were issued during the summer of 2010. Of these, states were eligible applicants for only four. IDPH, IWD, and DHS worked together to apply for three of the four. The fourth was an implementation grant, and only one grant was to be awarded nationwide. Of the three applications, Iowa received one grant of approximately $750,000 per year for three years – the Personal and Home Care Aide State Training Program. Erin Drinnin will address this further in her presentation today.
- Many health workforce ACA grants do NOT name states as eligible applicants. Instead, institutions of higher education, accredited residency programs, accredited training programs and others are named as eligible applicants. IDPH monitors grants.gov for these opportunities and disseminates the information to known eligible applicants. IDPH requests, but does not always receive, information about who has applied.
- Have received several comments that timelines are too tight for Iowa's eligible applicants to apply for the grants.

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http://www.idph.state.ia.us/hcr_committees/care_access.asp