Public Hearing

Comprehensive and Affordable Health Care for Families and Businesses bill

Monday, January 29, 2007—Capitol Room 116 From 7:00 PM—8:30 PM

5 Minutes Speaking Time in Order of Sign-up (3 copies of testimony required)

Sponsored by the Health and Human Services Appropriations Subcommittee

Co-Chairpersons: Senator Jack Hatch and Representative Ro Foege

Name	Address	Organization	Phone
John Hale	422 NE 37th Lane, Ankeny IA 50021	Iowa Care Givers Association	515 313 7766
Di Findley	"	"	"
Cindy Ramer	"	"	"
Anthony Carroll	600 E Court. Ave Ste 100, DM, IA 50309	AARP Iowa	515 697-1015
Paula Dierenfeld	700 Walnut, Suite 1600 Des Moines 50309	Federation of Iowa Insurers	515-490-8023
Jennifer Lightbody	905 Franklin St, Waterloo 50703	People's Community Health Clinic	319 272 4300
Craig Mahoney, MD.	411 Laurel Des Moines, IA 50314	Polk County Medical Soc.	2478400
Kelly Reed, D.O.	86th St URBANDALE, IA 50322	" " " "	2880172
RANDALL HANSON, MD.	1221 Pleasant, Des Moines 50309	" " " "	288-0172
George Gregory	PO Box 682 Iowa City 52244	Christian Science churches	319 621-2653
Kerry Hill	939 Office Park Road Ste 200 WDM 50265	Iowa psychology Assn.	226-2512

"The SUPPORT, EDUCATION, and Rewards have impacted my family. These things will carry with us throughout our lives and I believe we continue to be better off for it."
-Kristie, mother of six

"I have two little ones who go through more diapers than I could of imagined."
-Tuyet, mom of two

"This program has helped to motivate our clients to follow through with healthy behaviors, such as obtaining prenatal care, well-child care, following through with immunizations, exercising, parenting education, cease smoking, along with various other healthy choices."
-Vickie, Stork's Nest Point Manager

"This helps participants experience success in their parenting efforts and become inspired to continue to learn and become a more educated parent."
-Kenya, Stork's Nest Point Manager

Are you interested in participating in the Stork's Nest?

1) Contact the Stork's Nest Coordinator for more information
2) Attend an appointment to enroll and receive your Stork's Nest Point Card
3) Start earning your points through your healthy behaviors
4) Spend your points on needed baby items at the Stork's Nest

Do you want to help "Feather the Nest"?

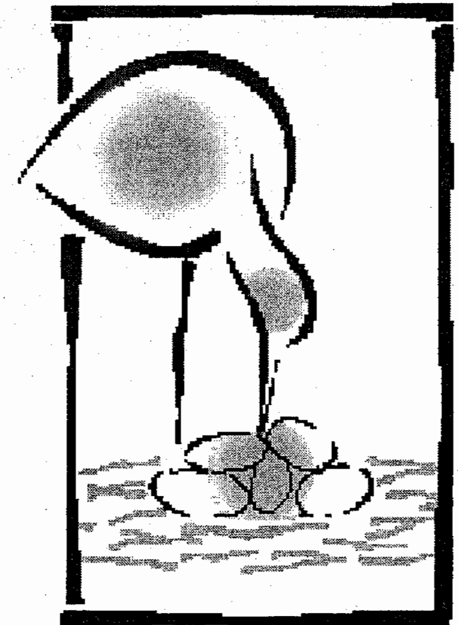
As a community-based program, the Stork's Nest relies on the kind generosity of others to provide incentive items to program participants through the following:

- ♥ Donate new essential baby items
- ♥ Make a monetary donation
- ♥ Hold a Baby Shower within an organization or company to collect new baby items
- ♥ Make others aware of the Stork's Nest program

For more information, to register or to make a donation, contact:

Stork's Nest Coordinator
Visiting Nurse Services
1111 9th Street, Suite 235
Des Moines, Iowa 50314
515-558-9950
storksnest@vnsdm.org

March of Dimes
saving babies, together



Stork's nest

The Stork's Nest is an educationally based incentive program of Visiting Nurse Services with the goal of improving the overall health of pregnant women, their babies, and ultimately their families.

Visiting Nurse Services

What is the Stork's Nest?

- Part of a national cooperative project of Zeta Phi Beta Sorority, Inc. and the March of Dimes, the Stork's Nest of Polk County was created in 1993 as a response to Des Moines' high infant mortality rate for a city of its size.
- The Stork's Nest of Polk County relocated to become a program of Visiting Nurse Services in 1998 and has since served over 1920 at-risk pregnant women and their babies.
- The program is an educational incentive program working to improve the health of at-risk pregnant women, their babies, and ultimately their families.

Who is eligible?

Any at-risk pregnant woman at or below 100% of the Federal Poverty Level who resides in Polk County may enroll in the Stork's Nest and remains in the program until her baby turns one year of age.

What does the Stork's Nest offer?

The program offers, in cooperation with community agencies, a comprehensive educational program through classes on topics of importance and interest to parenting men and women such as prenatal care, nutrition, preparing for the birth of their baby and parenting.

Promoting Healthy Babies.... One Point at a Time

How does the program work?

Participants register through community trained Stork's Nest Point Managers or the Stork's Nest Coordinator. Participants are given a Stork's Nest point card to keep track of points received for participating in healthy behaviors. These points are then redeemed for essential baby items at the Stork's Nest.

Stork's Nest participants earn points for healthy behaviors, such as:

- ♥ prenatal doctor visits
- ♥ educational classes
- ♥ breastfeeding
- ♥ dental check ups
- ♥ well child checks
- ♥ smoking cessation
- ♥ case manager home visits
- ♥ insurance enrollment
- ♥ school enrollment
- ♥ WIC enrollment and education

They then are able to use these points for needed baby items, such as:

- ♥ Infant & Toddler Clothing
- ♥ Highchairs
- ♥ Crib Sheets
- ♥ Receiving Blankets
- ♥ Nail Clippers
- ♥ Diapers
- ♥ Baby Wipes
- ♥ Diaper Bags
- ♥ Digital Thermometers
- ♥ Bath Towels
- ♥ Pacifiers
- ♥ Grooming Set
- ♥ Cribs
- ♥ Onesies & Sleepers
- ♥ Swings
- ♥ Car seats
- ♥ Breastpumps
- ♥ Cabinet latches
- ♥ Bath Tubs
- ♥ Baby Shampoo, bath wash, & lotion
- ♥ Children's Books
- ♥ Bouncer seats
- ♥ Bottles & bottle brushes
- ♥ Sippy Cups

Point Card

Name: ______________________ Birthdate: __________

Welcome to the Stork's Nest of Polk County.

The purpose of the Stork's Nest is to improve the health of pregnant women, their babies, and their families.

Your enrollment began on _________ and will end on your child's first birthday.

<u>Located at:</u>
Visiting Nurse Services
1111 9th Street, Suite 235
Des Moines, Iowa 50314

<u>Stork's Nest Hours:</u>
Wednesdays, 12:00 – 4:30pm
Fridays, 9:00am-12:00pm

<u>For more information, please contact:</u>
Laura Schlesselman, Coordinator
Phone: 558-9950
E-mail: StorksNest@vnsdm.org

Stork's Nest Information

Please get proof of the healthy behaviors you participate in and give this proof to your Stork's Nest Point Manager or to the Stork's Nest Coordinator to receive points

Participants can earn points from the date they enroll in the Stork's Nest until they discharge from the program.

Upon discharge, you have up to one month past your discharge date to use any unspent points. If points are not used by that time, they are no longer valid.

You are responsible for this card. Please keep it in a safe place. If you lose the card, you will get a new card You will lose the points earned on the lost card

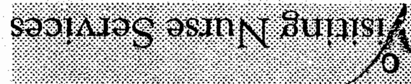
Please contact the Stork's Nest if:

*you have your baby

*your baby turns one year old

*you get pregnant before your baby turns one year old

*you plan to move or have moved



Point Opportunities

Stork's Nest participants have the following opportunities to gain points for healthy behaviors.

ACTIVITY	POINTS
Stork's Nest Sign-up	25
Medicaid Sign-up	100
Prenatal Doctor Visits	25
Point Manager Home Visits	25
Well Child Exams	25
Immunization	25
Post Partum Doctor Visit	100
Educational Classes • Prenatal • Parenting • Nutrition • ESL • GRADS	25/week

ACTIVITY	POINTS
Creation of Exercise/Health plan (please consult your doctor before starting any exercise program)	50
Lead Testing or Education	25
Car Seat Safety Instruction	25
Infant Care or CPR course	25
Completion of Job Training Program	100
Employment (must have completed or be working towards high school equivalent)	50/month
Breastfeeding Attempted	25
Breastfeeding Continued	50/month
Birth Control	50/month

Date of Service	Healthy Behavior/Activity	Point Manager Signature	Stork Stamp	Points Earned	Points Spent	Balance

Service	Healthy Behavior/Activity	Point Manager Signature	Stork Stamp	Points Earned	Points Spent	Balance

Counseling	25/week
Support Groups	25/week
WIC Sign-up	50
WIC Education	25
Stop Smoking Attempted	25
Stop Smoking Continued	50/month
GED Subject completed	50
GED Completion	100
High School/College Attendance	50/month
High School/College Graduation	100

Delivery Information 50

Note: Please contact Stork's Nest Coordinator when you have your baby to receive these points – points awarded only by Stork's Nest staff

Goal Setting and Accomplishment

**Must be approved by Stork's Nest Coordinator

All other healthy behaviors/activities

**Must be approved by Stork's Nest Coordinator

Please contact the Stork's Nest Coordinator for questions on how to earn more points or if you have questions on if you should get points for an activity not listed above.

How points are given:

Points are to be put on Stork's Nest Point Card by Trained Stork's Nest Point Managers only and are to be marked with official Stork Stamp.

For those activities for which a Trained Point Manager is not present, please turn in signed Stork's Nest Attendance Slips from appointments, community classes, or other approved healthy behaviors to a trained Point Manager and they will record the points on your Stork's Nest Point Card for those activities.

Effective 4/1/02

Point Value List

Stork's Nest participants are able to redeem their points earned through healthy behaviors for essential baby supplies.

Medical	Point Value
Digital Thermometer	100
Ear/Nose Syringe	50
Medicine Spoons	25
Furniture	**Point Value**
Bath Tubs	300
Booster Chair	300
Bouncer Seat	600
Crib Mattress	300
Crib	700
Highchairs	600
Infant Car Seat up to 20lb	500
Convertible Car Seat up to 40lb	500
Booster Car Seat	500
Portable Play Yard	1000
Stroller	1200
Swing	1000
Umbrella Stroller	400

Safety Items	Point Value
Cabinet Latch	50
Car Sun Shade	100
Doorknob Cover W/Lock	50
Outlet Plugs	25
Safety Starter Kit	150
Security Gate	400
Sun Screen	100
Baby Accessories	**Point Value**
Books	50-200
Boppy Pillow	400
Diaper Bag	150-400
Infant Carrier (Snugli)	400
Monitor	400
Receiving Blanket	50
Toys	25-400

Feeding	Point Value
Bibs	50
Bottle Brush	50
Bottles	50
Breast Milk Storage Bags	150
Breast Pump, Electric	600
Breast Pump, Manual	300
Burpee Cloth	50
Disposable Drop Ins	50
Formula	200
Nipples 2ct	50
Nipples 3ct	75
Nipples 4ct	100
Nipples Single	25
Nursing Pads, Disposable	50
Pacifier	50
Pacifier 2 Pk	75
Pacifier Attacher	50
Sippy Cup 2pk	100
Sippy Cup Spill-Proof Valve	25
Spoon and Fork Set	50
Spoons 4 pk	100
Spoons 2 pk	50

Date of Service	Healthy Behavior/Activity	Point Manager Signature	Stork Stamp	Points Earned	Points Spent	Balance

Date of Service	Healthy Behavior/Activity	Point Manager Signature	Stork Stamp	Points Earned	Points Spent	Balance

Diapers/Hygiene	Point Value
Baby Bath Wash	50
Baby Lotion	50
Baby Oil	50
Baby Powder	50
Baby Shampoo	50
Baby Washcloth Set of 2	50
Baby Wipes	100
Baby Wipes Travel Size	50
Bedtime Bath Wash	50
Diaper Ointment	50
Diaper Pins	50
Diapers, Cloth	150
Diapers, Newborn	200
Diapers, Small	200
Diapers, Medium	200
Diapers, Large	200
Diapers, X-Large	200
Grooming Set	150
Hooded Bath Towels	100
Infant Bath Aid	100
Nail Clippers	50

Clothing	Point Value
Baby Hand Mits	50
Hats	50
Jacket/Coat	200
Onesies	50
Shoes	50
Single Item	100
Sleepers	100
Socks	50

Bedding	Point Value
Blankets	100
Crib Sheet	100
Quilts	200

Please note:

☆ *Items are not guaranteed to be in stock at all times.*

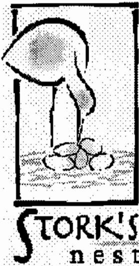
☆ *Point values may change at any time.*

VNS does not deal in goods distributed through the Stork's Nest and does not have knowledge particular to these goods. Clients should follow manufacturer's instructions and recall notices for all items. VNS makes no express or implied warranty of any kind. VNS makes not warranty that the goods provided to the client will be fit for a particular purpose. VNS shall under no circumstances be liable to Client for any special exemplary, punitive, incidental or consequential damage, regardless of the cause.

Updated 4/1/02

Service	Healthy Behavior/Activity	Point Manager Signature	Stork Stamp	Points Earned	Points Spent	Balance

Date of Service	Healthy Behavior/Activity	Point Manager Signature	Stork Stamp	Points Earned	Points Spent	Balance



Stork's Nest/Family Nest Intake

Mail to: **Stork's Nest**
Visiting Nurse Services
1111 9th Street Suite 320
Des Moines, IA 50314
Phone: (515) 558-9950 FAX: (515) 288-0437
email: Storksnest@vnsdm.org

For Office Use Only

Client ID: ____________________

Admission ID: ____________________

VNS Participant ID: ____________________

Participant's name *(first, middle, last)*:______________________________ Maiden name:____________________

Birth date: ____/____/____ Gender (m/f):____________ Home phone:(____)__________

Street address:______________________________ Apt#:________ Bldg#:____________

City:____________________ State:____________________ Zip code:____________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific ☐ White ☐ Other Specify ____________________

Is participant of Hispanic/Latino descent? ☐ Yes ☐ No

If Hispanic/Latino, region of origin: ☐ Central America ☐ Cuba ☐ Mexico ☐ Puerto Rico ☐ South America ☐ United States ☐ Other Specify____________

Ethnic group with which participant identifies:
☐ African ☐ African (Sudanese) ☐ Asian ☐ Asian (Vietnamese) ☐ American ☐ European ☐ Hispanic/Latino ☐ Other Specify____________

Languages spoken: ☐ Arabic ☐ Dinka ☐ English ☐ Mabaan ☐ Madi ☐ Nuer ☐ Shillik ☐ Spanish ☐ Vietnamese ☐ Other Specify ____________

Is English the primary language? ☐ Yes ☐ No

Is a translator needed? ☐ Yes ☐ No If yes, what language?____________________

Participant enrolled in: ☐ Stork's Nest ☐ Family Nest Is participant currently enrolled in a VNS program? ☐ Yes ☐ No

Current marital status: ☐ Divorced ☐ Married ☐ Significant other ☐ Separated ☐ Single ☐ Widowed

Highest grade participant completed: ☐ 5th grade or less ☐ 6th-7th grade ☐ 8th grade ☐ 9th grade ☐ 10th grade ☐ 11th grade ☐ High school graduate ☐ GED ☐ Some college ☐ College degree ☐ Technical training ☐ Other

Employment: ☐ Full time ☐ Part time ☐ Unemployed ☐ Student ☐ Self-employed ☐ Homemaker ☐ Disabled ☐ Temporary ☐ Retired ☐ Other

Place of employment:____

Family's annual income:______________________________ *(eligible if 100% or below FPL)*

How many supported by this income?________ How many employed in household?________

What is the correct way to position baby while sleeping? ☐ *Only on baby's back* ☐ *Baby's side or back* ☐ *Baby's stomach*

Is the baby's father involved with pregnancy/infant/child? ☐ Yes ☐ No Age of father:________

Is this first pregnancy/child? ☐ Yes ☐ No

Assessment for healthy behaviors Name____________________ Date________ Referral___ Discharge__
Telephone__________ Address____________________________________ Family Nest _____ Stork's Nest______

(Please rate the following by writing your choice, 1 to 5, in the final column): **Rating**

	1	2	3	4	5	Rating
1. Prenatal appointments	No appointment(s) scheduled or attended	Misses most appointments; not likely to reschedule	Attends half of appointments	Attends almost all appointments; tries to reschedule missed appointments	Attends all appointments as scheduled with provider	
2. Education	No high school diploma or GED	Got information about high school diploma or GED	Currently working on high school diploma or GED	Will graduate or get GED within 6 months or completed 1-4 GED tests	Has high school diploma or GED	
3. Employment	Never employed or not currently employed	In job training	Actively looking for employment	Working part-time	Currently employed full-time	
4. Family planning	Not using birth control now or did not before pregnancy	Has a plan to get & use birth control	Sometimes uses birth control	Uses birth control most of the time	Uses birth control all the time according to directions	
5. Counseling, Therapy, Support Group	Recommended or referred to, but never attended	Attended one appointment	Attends half of scheduled appointments	Attends most of scheduled appointments	Completed recommended number of appointments/ Does not apply	
6. Exercise	No regular exercise	Occasionally exercises	Exercises 1-2 days a week	Exercises 3-4 days a week	Exercises 5 or more days a week	
7. Smoking	Smokes 20 or more cigarettes daily	Smokes 10-19 cigarettes daily	Smokes less than 10 cigarettes daily	Quit less than 1 year ago	Never smoked or quit 1 or more years ago	
8. Prenatal Vitamin or Regular Vitamin	Does not take prenatal vitamins or multi-vitamin with folic acid when not pregnant	Takes vitamin 1 day a week	Takes vitamin 2-3 days a week	Takes vitamins 4-5 days a week	Always takes vitamin 7 days a week	
9. WIC/ Supplemental foods	Never uses	Seldom uses or have a scheduled appointment	Uses some of the time; not as much as could use	Frequently uses; seldom misses an appointment	Always uses; uses as much as possible	
10. Alcohol use	Drinks 5 or more days a week	Drinks 3-4 days a week	Drinks 1-2 days a week	Drinks less than 4 drinks a month	Never drinks alcohol or no drinking in pregnancy	
11. Street Drug use	Uses every day	Frequently; Uses at least once a week	Sometimes; Uses once or twice a month	Rarely; Uses a few times a year	Never uses street drugs	

Used alcohol during the three months prior to pregnancy? ☐ Yes ☐ No

Does someone regularly smoke cigarettes, cigars or pipe tobacco around you? ☐ Yes ☐ No

Used illegal drugs during the three months prior to pregnancy? ☐ Yes ☐ No

Preventive Health Care/Exams

Had a cholesterol check within the past 2-5 years?	☐ Yes	☐ No
Had a blood pressure check, every 1-2 years?	☐ Yes	☐ No
Had a dental exam within the last year?	☐ Yes	☐ No
Had a vision exam in the last four years?	☐ Yes	☐ No
Had all childhood immunizations during your childhood?	☐ Yes	☐ No
Had a tetanus shot in the last ten years?	☐ Yes	☐ No
Had a pap smear within the last 1-3 years?	☐ Yes	☐ No
Had a mammogram with breast exam within past 1-2 years?	☐ Yes	☐ No
Do a self breast exam every month?	☐ Yes	☐ No

Family Income____________________Number in Family_________ Case Manager____________________________ Total_______

Comments:____

____

Pregnancy Information:

Previous child with birth weight under 5 pounds 8 ounces? ☐ Yes ☐ No

Currently pregnant? ☐ Yes ☐ No

Complications with pregnancy: ☐ Bed rest ☐ Other Specify other: ____

Due date:_____/_____/______

Receiving prenatal care? ☐ Yes ☐ No What week of pregnancy did prenatal care begin?____________

Taking prenatal vitamins? ☐ Yes ☐ No How many prenatal vitamins per week?______________

Planned feeding method? ☐ Breastfeeding ☐ Formula ☐ Breast and formula ☐ Undecided

Referral Date:________/_____/______ Active Date:____/______/_______

Agency:____________________________ Point Manager:____________________________

	Name	Date
Form completed by:		
Data entered by:		
Quality assurance inspection:		

January 29, 2007

To: The Honorable Sen. Jack Hatch, Chair
The Honorable Rep. Ro Foege, Chair
Members, Health and Human Services Appropriations Subcommittee

From: Gerd W. Clabaugh
Chair, Legislative Committee
Iowa Public Health Association

Re: Public Hearing on Health Reform

On behalf of the statewide membership of the Iowa Public Health Association (IPHA), thank you for providing the opportunity to address you on the important issue of ensuring access to health care for Iowans. IPHA has been dedicated for over 80 years to the public health and well-being of Iowans, and I am very excited to be here tonight to provide some perspectives on this important topic.

The draft legislation we're discussing tonight includes a variety of reforms. One of these-increasing the tobacco tax- is one IPHA supports. Because there are other legislative vehicles currently addressing this topic, I want to reserve my remarks tonight to focus on health reform. But I want to emphasize IPHA's support for this critical health policy proposal as well.

I believe there is little doubt among policymakers that all citizens should have access to a plan of health coverage that is affordable, reliable and comprehensive. The question is most often not "whether" but "how. Expansion in access to health care and health insurance is a nonpartisan issue which enjoys unprecedented support from Iowa's citizens. Our membership encourages you to meet the challenge for universal access to care with innovation and compassion for all our citizens. IPHA is proud to stand with you in working toward this type of solution.

Iowa has been a leader in past years on health policy issues just as this, and there is no reason that we can't demonstrate that leadership again. Iowa was a leader in establishing the Iowa Health Data Commission in the 1980's. We were a pioneer in authorizing our Medicaid recipients to enroll in managed care programs. We were a leader in the 1990's in health care reform. Iowa, as "the insurance capitol of the nation", is in a unique position to join other states, like Massachusetts and California, in pioneering a universal health care plan that will be a working model for others in the future.

While universal access to health insurance has long been a goal, you are well aware that solutions to the impediments we face are complex and costly, and make achievement of the goal difficult. Among the factors complicating a solution to the problem of universal access are:

1) Health insurance is an employer-sponsored benefit in the US – employers have a major stake in the provision of health insurance. Its favorable tax treatment provides incentives for employers to offer and for employees to take-up these offers. As a result, according to US General Accountability Office in 2002, 67% of adults in the US with insurance received it through employers. Just a few years later, this percentage is 61%. Clearly, as cost burdens increase, some employers-typically small employers- may drop coverage, increasing the number of uninsured.
2) Health insurance contributes to excess consumption of health care services in the US – while it is clear that access to health insurance improves health, it also generates health care expenditures which can add to the overall growth in health costs in the US. Assuring that we get the greatest value for the dollar expended will be our greatest challenge.
3) Health costs escalate at about twice the US inflation rate- health services are very costly. Various sectors of the health care economy including hospital, physician, and pharmaceutical services, all contribute to health care cost increases in various proportions.
4) The uninsured tend to be comprised of the younger population and workers –our public health system of providers including community and migrant health centers, rural health clinics, public health nursing agencies, maternal and child health centers, in addition to public hospitals and the physician community, serve as the providers of last resort for these populations.

Fifteen years ago, Iowa's most recent comprehensive health care reform effort began with a major report issued by the Iowa Leadership Consortium on Health Care. This effort was broadened further by Governor Branstad's appointment of a 60-member Iowa Health Reform Council which issued a comprehensive set of recommendations for health reform. Its process included meetings in every corner of Iowa, and engaged an additional 400 Iowans directly on 16 topical subcommittees.

The Council's recommendations resulted in numerous reforms, as enacted by the legislature and signed into law by the Governor, and ranged from health insurance market reforms, authorizing new provider organizing strategies, group insurance purchasing reforms, to income tax, health data and administrative simplification initiatives. While Iowa was given credit for being a very active, progressive state in enacting reforms, our uninsured rates have consistently ranged from 7-12% since 1987, with the 2005 rate at 8.6% of Iowans, according to the US Census Bureau. And while these rates are not high compared to many states, our challenge is to have an impact by further reducing this number.

We believe your draft legislation is an important first step in developing a plan that is workable for Iowa. The Iowa Public Health Association, its agencies and members across Iowa stand ready to support your efforts at achieving realistic goals to expand access to care for all Iowans. We encourage you to establish goals which are achievable, measurable, and for you to have a continual focus on this topic.

We're happy to help. Our members represent a very deep, well-informed resource for information and action to assist you in working through the challenge of developing a well-designed plan. Our members are on the frontlines providing services to people who slip through the cracks in the system. Our members are from academia and have thoroughly studied the approaches to delivering health services and the pitfalls attendant with various methods. Our members manage the delivery of important services to Iowans, many of which are not provided elsewhere. We pledge to be a resource for the discussion and look forward to working with you.

Taxation of Tobacco Products

2007 Advocacy Statement

Background:
Recent cigarette tax increases enacted by a number of states to reduce smoking and its related public health costs illustrate the need for Iowa officials to take similar action this legislative session. The last increase in Iowa's cigarette tax came under Republican Governor Terry Branstad, nearly 15 years ago. At 36 cents a pack, Iowa is rated 42nd in the country in state tobacco taxes behind all of its bordering states except Missouri. The overall national average is 96.1 cents/pack.

Iowa's youth access 11.1 million packs of cigarettes each year; they are the most price sensitive group and stand to gain the most protection offered by a cigarette excise tax increase. Scientific studies show that even a 10% increase in the price of cigarettes reduces youth smoking rates by roughly 7% and overall cigarette consumption by about 4%. According to a study by the Campaign for Tobacco-Free Kids, the combined effect of the cigarette tax increases approved or implemented in 2005, will prevent more than 250,000 kids from starting to smoke, spur more than 150,000 adults to quit and prevent more than 125,000 smoking related deaths while raising more than $1 billion in annual revenue.

The American Cancer Society and American Heart Association report tobacco use remains the nation's leading preventable cause of death. Tobacco was responsible for five million deaths worldwide in 2004, a yearly total that will rise to 10 million by 2020, according to the American Cancer Society. Nearly 87% of all lung cancer cases are direct results from smoking, which kills 150,000 Americans a year.

Youth and adult health care savings in Iowa accrue over the lifetimes of kids who quit or do not start because of tax increase. Despite shorter life spans, smokers' total lifetime health care costs average $16,000 higher than nonsmokers. Annual health care costs in Iowa directly caused by smoking total $937 million. The state covers $277 million of this through its Medicaid program. Iowa's economy is burdened by another $919 million attributed to smoking-caused productivity losses.

Health advocates characterize the 2005 Iowa State Legislature's failure to increase the tobacco tax as a blow to the health of Iowans, especially Iowa's youth. Furthermore, polls conducted in 2004 and again in 2005 showed that more than 70% of Iowans support an increase in the state's tobacco tax. Lawmakers could garner an early and important victory for Iowa if they approve a substantial cigarette tax increase at the start of the 2007 session.

Policy Recommendation:
- Increase Iowa's tax on cigarettes by $1.00 per pack and increase the tax on other tobacco products by a percent consistent with the increase of the tax on cigarettes.

For more information, contact:
Mary O'Brien
Phone: (515) 558-9981
E-mail: mary@vnsdm.org

Eileen Fisher
Phone: (319) 335-4224
E-mail: Eileen-fisher@uiowa.edu

Universal Health Care

2007 Advocacy Statement

Background:
It is time for a major overhaul of the health care system in the United States. All citizens should have access to a universal plan of coverage that is affordable, reliable and comprehensive. What may have started as a utopian idea has now become the most important breakout issue to face our health system in the 21st century.

Businesses, health care providers, doctors, nurses, hospitals and patients have joined together in the call for change. State legislators have a nonpartisan issue with unprecedented support from Iowa's citizens. We must meet the challenge for universal care with innovation and compassion for all our citizens. Trading off the pursuit of excellence in health coverage at the expense of those who can not afford insurance is not acceptable.

The bottom line is that health care is a social service that should target patient needs, not a merchandised commodity based on ability to pay. Iowa as "the insurance capitol of the nation" is in a unique position to join other states (Massachusetts and California) in pioneering a universal health care plan for Iowans that will be a working model for others in the future.

Policy Recommendations:

- Support the appointment of a Governor's task force to examine universal health care including all types of financing and make recommendations for immediate action by our legislators.

For more information, contact:

Jan Susanin
Phone: (515) 725-1525
E-mail: jsusanin@uhl.uiowa.edu

Testimony to
Joint Appropriations Subcommittee on Health & Human Services On

AFFORDABLE HEALTH CARE FOR SMALL BUSINESS AND FAMILIES BILL
(LSB 1043XS 8.3)
January 29, 2007

On behalf of the membership of the Iowa Nurses Association, we appreciate the opportunity to offer these comments.

1. The Iowa Nurses Association has a position to "Promote access to affordable and available health care coverage for all Iowans".
    a. Increase the number of registered nurses who assist the uninsured to identify health coverage programs they are eligible for and to apply for health insurance coverage.
    b. Strategies and mechanisms to increase affordable and available health care coverage will be reviewed and supported based on the consensus and experience of the Iowa Nurses Association membership and in accordance with the Social Policy Statement of the American Nurses Association. This means that giving high value to health prevention and promotion activities will be endorsed.
    c. The Association supports improvement of payment for mental health services through a variety of mechanisms: Medicaid, HAWK-I, private insurance, and community services.

2. The Iowa Nurses Association has a position to "Support requirements for the adequate presence of school nurses in Iowa school buildings.
    a. Healthy kids make better learners—student achievement is directly related to health and attendance.
    b. School nurses (RN's) provide a critical link in case management for students with chronic health concerns (asthma, diabetes, mental health concerns, etc.)
    c. School nurses provide early assessment of health concerns (including but not limited to physical and emotional concerns), in-school interventions, and referral into the health care system for students with health concerns.
    d. School nurses guide families in establishing a medical home and/or health insurance (through HAWK-I) or other programs for all children in Iowa.
    e. School nurses provide an opportunity for all families with school age children access to a health professional without a cost to the family or an insurance company.

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f. The "Collaborative Safety Net Provider Network" would benefit with consideration of the addition of a school nurse in every school building at a ratio of one school nurse to every 750 students.
g. The Healthy Children's Task Force report completed December 2006 has recommendations directly related to school nursing: 1) 1 RN per school district and 2) school districts with more than 750 students will be required to hire pro-rated number of RN's to meet the ratio of 1 RN:750 students.

h. There should be increased use of mental health professionals in the school setting to identify youth with mental health concerns in order to intervene early.

3. The Commission on Affordable Health Care should include representation of school nurses and advanced practice nurses who could contribute a different dimension to the discussion.

4. The Iowa Nurses Association supports the increase of services in the area of dental care.

   Healthy Children's Task Force Report completed December 2006 suggested that "all students must show proof of a dental exam before entering first grade".

   We are supportive of oral health needs being addressed in the schools, but there are concerns. To accommodate this, providing proof for low socio-economic students may be challenging since many are usually are in need of services and it is often hard to find a dental provider who may take them (due to lack of security/amount of payment). In addition to lack of providers, there are some parents who are just not "in-tune" with dental health (for whatever reason). A third concern that without more health providers (school nurses) in the school. We would ask who is going to make sure students have this proof of dental exam and who will help guide them to a dental provider and help find funding if there is not a school nurse to assist in this?

5. The Association supports the increase for "personal needs allowances" to be increased.

6. The Association supports the reduction of the waiting lists for Home & Community Based Services as well as Child Mental health services.

Thank you for the opportunity to comment on this proposal.

The Honorable Senator Jack Hatch
Iowa State Capitol
State Capitol
Des Moines, IA 50319

Senator Hatch:

We are excited about your current initiative to reform health care in Iowa. Iowa has waited for years for leadership on this issue, and we are grateful that you and your colleagues are stepping up to this great challenge. We look forward to working with you to find solutions to Iowa's health care crisis.

We have looked over your bill carefully, and would like to share with you our thoughts on the commission you have proposed. You will find our suggestions attached to this letter.

You have made a number of comments, both to the press and to the public, that you are introducing a bill that will achieve universal health coverage for all Iowans. We are deeply committed to that goal – health care for all – and applaud and support attempts to achieve it. We are concerned, however, that nowhere in your bill is such a goal stated. Rather, the commission's task is to "analyze possible reforms to make health insurance more affordable for small businesses and families in this state." While this is a laudable goal, it gives the commission a task that is quite different from figuring out how to provide coverage for all Iowans. We believe that health care is a basic human right, and that all major reforms must move us toward universal health care. With that in mind, we'd like to see the commission charged with a bolder task – the one reflected in your public comments about the intent of this initiative: health care for all.

We believe that Iowa is ready for such reforms. We look forward to working with you and your colleagues on this matter, and will work with you to find the best possible health care solution for Iowa.

Sincerely,

Iowa Human Needs Advocates
Amy Knudsen, Iowa Coalition on Housing and the Homeless, IHNA Co-Chair
Lana Ross, Iowa Community Action Association, IHNA Co-Chair

Iowa Human Needs Advocates – Suggestions for Hatch-Foege Health Care Bill

Charlie Wishman, Iowa Citizen Action Network
Phillip Cryan, Iowa Citizen Action Network
Mary O'Brien, Visiting Nurse Services
Tom Lapointe, Every Child Counts

1. We are concerned about the make up of the commission. First, we strongly believe that direct health care providers should be represented among the voting members of the commission. Second, we are concerned that there are only two voting spots reserved for health care consumers on a commission of sixteen members. Third, we are concerned that there are no plans to include further consumer groups among the ex-officio members. And fourth, we believe there should be more balance between legislators and non-legislators among the voting members of the commission.
2. The stated goal of the commission is to "analyze possible reforms to make health insurance more affordable for small businesses and families in this state." While this is a laudable goal, we believe that health care is a human right, and that all major reforms must move us toward universal health care. Since this language charging the commission is not a specific policy prescription but the articulation of a goal for the commission to seek to fulfill, why not articulate the broader goal of providing health care to everyone?
3. On page 4, line 8, the bill reads "The commission may hold public hearings to allow persons and organization to be heard and to gather information." We believe that the words "may hold public hearings" should be stricken and replaced with "must allow substantial public input, through public hearings and other mechanisms." We strongly believe that any and all health care reforms need to be discussed and debated with the public, and on a statewide basis.
4. The word "comprehensive" is used in the first line of the bill, but hardly (if at all) thereafter. We believe that making sure coverage is "comprehensive" should indeed be an important part of the goal, and that this should be reflected throughout the bill.
5. We believe that, while the goal of covering young adults up to age 23 is important; we must not forget that many young people leaving college in their mid twenties face the same problem. We believe this age should be raised, as well as to consider that there are many adults who have retired before age 65, and are uninsured or underinsured. If there is to be an incremental approach, we believe that we must also address the concerns of those in their later years as well as into their mid to late 20s.
6. In the list of specific reform possibilities that the commission is charged with considering, the range of options seems prematurely limited. There is only one path to universal coverage included in this list is possibilities -- a mandate that everyone buy health insurance coverage. While this possibility certainly should be evaluated by the commission, the commission should also be charged with evaluating other paths to health care for all. Though the bill's text states that the list of possibilities should not be understood as excluding other options, a better

approach would be to include other options – such as single payer, and various public/private approaches that do not rely on the "individual mandate" – in the list of possibilities the commission is charged with evaluating.

7. Page 5, Line 2, in the section regarding the "health care data research council," there seems to be a mistake, using the word "commission" in place of "council." We believe that this should read "The council shall include the following members:"
8. We also strongly believe that the Health Care Data Research Council should have a representative of the Iowa Department of Public Health, bringing all of the knowledge and expertise of public health professionals to the commission. We also believe that there should be knowledgeable public policy organizations and individuals with access to research and data included as a part of the Health Care Data Research Council, such as the Iowa Policy Project, or the Academy of Pediatrics. In addition to the expertise of the University of Iowa, Drake University, and Des Moines University, we should also utilize expertise at Iowa's other fine higher education institutions, such as the University of Northern Iowa, and Iowa State University.

Good Evening,

My name is Mary O'Brien. I am the Community Policy Liaison for Visiting Nurse Services located in Polk County.

Thank you for the opportunity to provide input regarding this health initiative bill. Visiting Nurse Services is the recipient of local Title V funding. Those public health dollars allow us to provide some of the services identified in your bill. We provide Medicaid clients the link with EPSDT services. We assist with signup for the Hawk-I program. We are serving as a pilot site for the Healthy Mental Development Program. We have hired a dental hygienist and are developing a dental home for those unable to access dental care. We provide home case management for high-risk and our fragile elderly. We are, above all, an essential part of a safety net of services.

Because this bill is attempting to improve access to services, it is important that I share with you the current situation of public health funding in Iowa.

Funding for Public Health

<u>Iowa ranks last in the country (50/50) with only 0.5% of state appropriations going to public health!</u> Within Iowa's Health and Human Services budget, public health receives only 2.4%. This low percentage indicates that Iowa has not made public health a priority. Public health issues such obesity in our children, disparities in health access, and a booming aging population highlight the critical need for increased public health infrastructure in Iowa.

Public Health is an important partner in providing safety net services for the underserved and uninsured. Only 17% of Iowa's underserved population (those who are uninsured, underinsured or have other barriers to health care services) had access to needed health services in 2006.

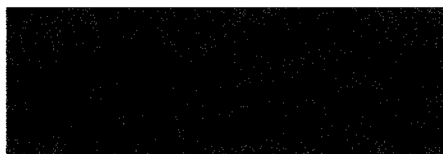
- CHRONIC UNDERFUNDING. Vital programs such as Public Health Nursing and Local Public Health Services have suffered from a lack of funding. Local Public Health Agencies provide nursing services to clients in their homes to decrease the placement in nursing homes and reduce the burden on Medicaid. An increase to Public Health Nursing and Local Public Health Services funding can dramatically benefit vulnerable adults in their homes and contribute to the rebalancing of long term care in Iowa. Often, it is the home nursing component alone that provides the last critical link to independence.
- MANY PROVEN BENEFITS. Local Boards of Health are charged with ensuring that all people in their communities (infants through adults) can access programs and services that promote healthy behaviors. Public health nursing has been in the forefront of home visiting for decades. Increasing funding to local Boards of Health will allow all at-risk families to receive necessary home visits by nurses to address issues such as domestic abuse, child abuse, drug use, developmental delays, difficulties with immunizations, low-birth weights, lack of prenatal and postpartum education and depression screening. Specific nurse home visiting programming has been tested in New York, Tennessee, and Colorado and has demonstrated the following outcomes: improved prenatal health, fewer childhood injuries, fewer subsequent pregnancies, increased intervals between births, increased maternal employment, and improved school readiness. Home visitation by nurses provides a return of $17,180 per family served (Washington State Institute for Public Policy, 2004).

Policy Recommendation:

- Recognize the critical role that public health in improving the lives of Iowans and evaluate current funding levels
- Appropriate additional funding to the Department of Public Health in the following areas that are under funded or are seeing a decrease in funding:
- General Fund Appropriation
  - Local Board of Health
  - Child Health Nursing
  - Public Health Nursing
- Tobacco Fund Appropriation
- Local Public Health Services

<u>For more information contact:</u>

Mary O'Brien, Visiting Nurse Services, (515-558-9981;maryo@vnsdm.org)



America's Health Rankings

A Call to Action for People & Their Communities

Intro and Findings

Foreword and Introduction

Measures of Success

2006 Results

Changes from 2005, 1990

Comparison to Other Nations

Health Disparities

Seven Tips That Work

Components

Selection of Components

Description of Components

Determinants ▷

Outcomes ▷

State Snapshots

State-by-State Snapshots

All State Snapshots

Methodology

Methodology

Weighting of Components

Scientific Advisory Committee

Commentaries

Letter from Michael Leavitt, Secretary, US Health and Human Services

A National Action Agenda: Eliminating Health Disparities by Admiral John O. Agwunobi, M.D., M.B.A., M.P.H, Assistant Secretary for Health, US Health and Human Services

Children's Health Insurance by Marian Wright Edelman, President and Founder, Children's Defense Fund

Tobacco at a Crossroads: An Opportunity to Translate Progress into Fundamental Change by Matthew Myers, President, Campaign for Tobacco-Free Kids

Perspectives: Determinants of Health Status

Variations In The Costs And Quality Of Medical Care: Is More Always Better?, by Elliott S. Fischer, M.D., M.P.H., Dartmouth Atlas Project

Improving America's Health: Personal and Public Solutions, by Thomas C. Ricketts, Ph.D., M.P.H., University of North Carolina at Chapel Hill

Partner Commentaries and Notable State Activities

Reducing Disease Burden: Engaging the Public, American Public Health Association

We Can Take Action Toward Better Health for All Americans Now, Partnership for Prevention

Washington's Healthiest State, Washington Health Foundation

Taking Health Ranking to the Next Level: the Wisconsin County Health Rankings, University of Wisconsin Population Health Institute

Healthy Vision 2010 Summits by the Texas Medical Association

Fetal and Infant Mortality Review (FIMR) by National Fetal and Infant Mortality Review Program

Per Capita Public Health Spending

Per Capita Public Health Spending measures the dollars per person that are spent on public or population health in a state. High spending on these health programs are indicative of states that are proactively implementing preventive and education programs targeted at improving the health of at-risk populations within a state.

This measure includes expenditures in three categories as defined by the National Association of State Budget Officers (NASBO):

Direct Public Health Care Services: Includes local health clinics, Ryan White AIDS Grant expenditures, and American Indian health. Expenditures may include funds spent on pharmaceutical assistance for the elderly, childhood immunization, chronic disease hospitals and programs, hearing aid assistance, adult day care for persons with Alzheimer's disease, health grants, services for medically handicapped children, the Women, Infant, and Children

Table 29 - Per Capita Public

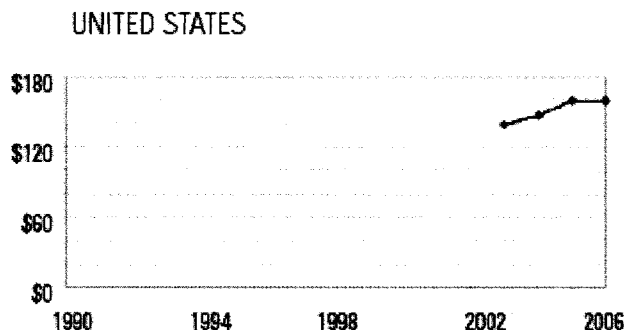
ALPHABETICAL BY STATE				RANK
2006 RANK (1-50)	STATE	$/PERSON	SCORE	2006 RANK (1-50)
20	Alabama	$159	-2	1
1	Alaska	$482	114	1
44	Arizona	$81	-50	1
49	Arkansas	$64	-61	4
29	California	$132	-19	5
41	Colorado	$92	-43	6
16	Connecticut	$173	7	7
8	Delaware	$246	52	8
27	Florida	$143	-12	9
28	Georgia	$138	-15	10
1	Hawaii	$499	114	11
48	Idaho	$70	-57	12
12	Illinois	$190	17	12
34	Indiana	$117	-28	12

(WIC) program, pregnancy outreach and counseling, chronic renal disease treatment programs, AIDS testing, breast and cervical cancer screening, tuberculosis (TB) programs, emergency health services, adult genetics programs and phenylketonuria (PKU) testing.

Community-Based Services Health Expenditures: State funds spent on health services provided in a community setting. Examples include rehabilitation services, alcohol and drug abuse treatment, mental health community services, developmental disabilities community services, and vocational rehabilitation services. These expenditures do not include funds spent on services eligible for Medicaid reimbursement, which are reported under Medicaid.

Population Health Expenditures: Includes programs such as AIDS and other STD control, screening, outreach, and monitoring, including data collection and registries, immunization, including the cost of vaccine and infrastructure only, infectious disease control, including analysis and monitoring, emerging infections, microbiology lab services, food and lodging licensing and inspection, food safety and inspection, fish consumption advisory, pest eradication (such as rats, roaches, and mosquitoes), and veterinary diseases affecting the food chain, such as mad cow disease.

Table 29 displays the 2006 ranks, based on 2003 data (National Association of State Budget Officers). It ranges from more than $400 per person in Alaska and Hawaii to less than $75 per person in Iowa, Arkansas, Idaho and Utah. The data has not changed from the 2005 Edition.



Comparable data was not available prior to 2003.

50	Iowa	$59	-64	15
39	Kansas	$95	-41	16
36	Kentucky	$112	-31	16
33	Louisiana	$121	-25	16
21	Maine	$158	-3	19
12	Maryland	$189	17	20
26	Massachusetts	$150	-7	21
24	Michigan	$154	-5	21
6	Minnesota	$249	54	23
11	Mississippi	$197	22	24
25	Missouri	$153	-6	25
5	Montana	$293	81	26
12	Nebraska	$190	17	27
23	Nevada	$155	-4	28
21	New Hampshire	$158	-3	29
9	New Jersey	$231	43	29
35	New Mexico	$113	-30	31
4	New York	$316	95	32
31	North Carolina	$128	-21	33
16	North Dakota	$174	7	34
32	Ohio	$127	-22	35
29	Oklahoma	$131	-19	36
16	Oregon	$174	7	37
7	Pennsylvania	$247	53	38
19	Rhode Island	$168	4	39
10	South Carolina	$219	35	39
37	South Dakota	$110	-32	41
43	Tennessee	$91	-44	41
15	Texas	$179	11	43
47	Utah	$72	-56	44
41	Vermont	$93	-43	44
38	Virginia	$97	-40	46
44	Washington	$81	-50	47
39	West Virginia	$95	-41	48
46	Wisconsin	$79	-51	49
1	Wyoming	$354	114	50
	United States	$162		

Source: 2003 data, National Association of State Budget
Comparable data was not available prior to 2003.

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Administration and Regulation	86,021,492
Ag. and Natural Resources	39,614,264
Economic Development	30,458,183
Education	1,008,154,611
Health and Human Services	1,156,502,089
Justice	588,144,994
Unassigned Standings	2,387,606,376
	5,296,502,009

Health and Human Services	
Elder Affairs	4,328,306
Public Health	28,061,211
Human Services	1,108,522,673
Veterans	15,589,899
	1,156,502,089

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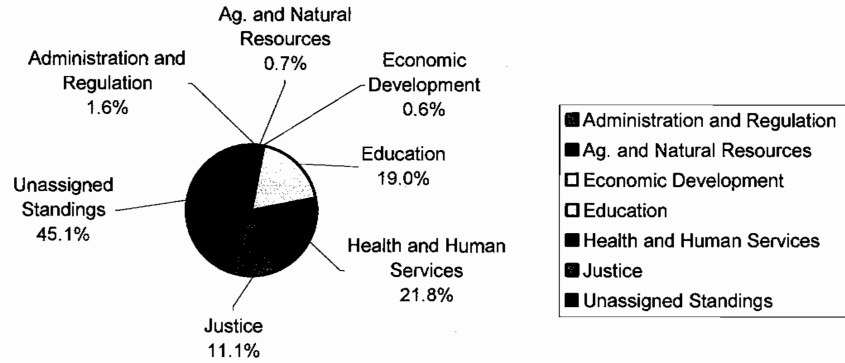

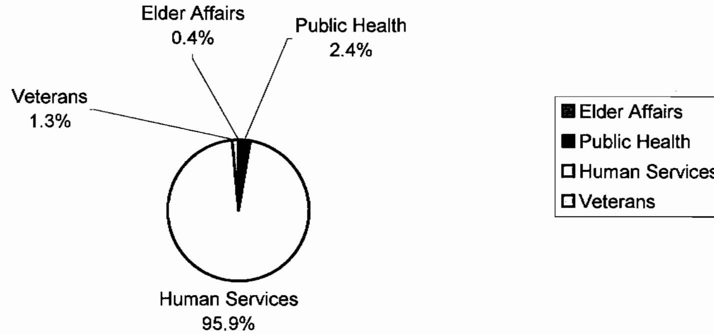

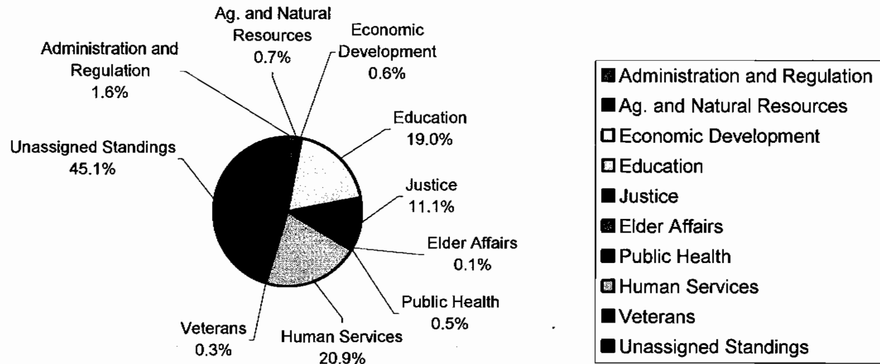

Public Hearing

Comprehensive and Affordable Health Care for Families and Businesses bill

Monday, January 29, 2007—Capitol Room 116 From 7:00 PM—8:30 PM

5 Minutes Speaking Time in Order of Sign-up (3 copies of testimony required)

Sponsored by the Health and Human Services Appropriations Subcommittee

Co-Chairpersons: Senator Jack Hatch and Representative Ro Foege

Name	Address	Organization	Phone
Mellisaa Juhl	418 South Marion St, R	Greater sue	712-786-3250
Nancy Van Milligen	807 Cacey Court Dubuque IA	Crescent Comm. Health Center	563-588-2700
Doug Reichardt	4330 Greenwood Dr. DSM	self	515-229-6844
Lorelei Heisinger	411 Four Seasons Drive Waterloo IA	March of Dimes	319-230-4686
Liz Williams-Chaffin	1501 41st St. DSM 50311	AMOS	707-2795
Gary Streit	PO Box 2107 CR 52406	American Cancer	515 707 2147
Patrick O'Brien	Polk Co. Health Service Board Des Moines 50309	Polk Co. Health Services Board	
Rik Shannon	631 E. Locust 50309	Key Coalition / Gov's DD Council	515.281.9084
Kelly Huntsmann	2350 SE 14th DSM	Tri Mary Health	515-248-1400
Carrie Fitzgerald	218 E 6th Ave DSM	Child + Fam. Policy Ctr.	280-9027
Dan Ramsey	5601 Douglas	American Lung	309-9507

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Name	Address	Organization	Phone
Ron Askland	Mercy Hospital		643-2896
Susan Roberts	8830 NW 35th St Ankeny 50023	Iowa dietic Assn	515 965 3859
Mary O'Brien	Visiting Nurse Service 1111 9th St Suite 320		558-9981
Charles Wishman	3520 Beaver Ste D	IOWA CITIZEN Action Network	515-277-5077
Phillip Cryan	" — "	" — "	" — "
Paula Connelly			
Carrie Fitzgerald			
Gerd Clabaugh	6027 Redbud Court Johnston	IA Public Health Assn	210-2900
MEG OBERREUTER	3928 TERRACE HILL DR NE CEDAR RAPIDS		C. 319-361-8185 H. 319-378-1241
Linda Goeldner	1501 42nd		515-225-0495
Dr Peter Densen	200 Camb University of Iowa, IC 52242		319 335 9825

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Co-Chairpersons: Senator Jack Hatch and Representative Ro Foege

Name	Address	Organization	Phone
Jen Harbison	100 E Grand DSM 50309	Academy of Family physicians	283-9320
Tonya Diehn	PO Box 1172 Waukee 50263	March of Dimes	333-1202
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Emily Smith	2111 W. Green st., Adel 50003	West Central Mental Health	515 993-4535
Dana Petrosky	1701 48th st Ste 203 WDM 50266	IAHSA	440-4630

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Timothy G. Kenney, M.D.
Jeffrey M. Farber, M.D.
Kyle S. Galles, M.D.
Scott A. Meyer, M.D.
Cassim M. Igram, M.D.
Rodney E. Johnson, M.D.
Martin S. Rosenfeld, D.O.
Daniel W. Vande Lune, M.D.
Mark R. Matthes, M.D.
Joseph F. Galles Jr., M.D.
Stephen A. Ash, M.D.
Craig R. Mahoney, M.D.

Hand Surgeons
Scott M. Shumway, M.D.
Michael A. Gainer, M.D.
Ze-Hui Han, M.D.

Physical Medicine & Rehabilitation
Kurt A. Smith, D.O.
Camille Rivera, M.D.

Pain Management
Thaddeus Ray, D.O.

Podiatric Medicine & Foot Surgery
Dennis A. Kessler, D.P.M.
Bryan M. Trout, D.P.M.

Physician Assistants
Robey Orewiler
Nichole Friessen
Dudley Phipps
Marc Goeders
Chad Quist
Brian Haupts

Chief Executive Officer
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Pella, IA 50219
641-621-1390

Trinity Regional Health
Fort Dodge
515-574-8333

IOWA ORTHOPAEDIC CENTER, P.C.
A Center of Excellence

January 29, 2007

Re: Iowa State Legislature Testimony

Health Care Provider Access

- **Small business owner** employing 150 tax paying, voting, Iowans
- My small business **depends on reimbursement** to keep the doors open
- Iowa's **uninsured** have always created some level of strain on the system
- However recently, Iowa's **underinsured** have compounded that strain via employer cost shifting to employees (higher co-pays, coinsurance, deductibles, & more recently high deductible health plans), or simply no longer offering benefits as a part of employment
- Allowing small business owners, such as myself, the ability to **deduct some of the small business losses** we experience is both reasonable and appropriate (e.g. this would be similar to the favorable tax treatment banks get regarding uncollectible "bad" loan balances)
- Favorable tax treatment for the difference between amounts charged and received (under medical assistance program, Hawk-I, Medicare, and for the uninsured), where the providers income is reduced by 10% or more, allows me to:
  - **Reinvest** in my small business
  - **Bring** new orthopaedic technologies to Iowans
  - **Expand** orthopaedic care availability
  - **Increase** the affordability of healthcare for all Iowans
- I **urge you** to pass this measure into law, and give healthcare providers in the state of Iowa some needed relief from a quickly deteriorating situation

Volunteer Health Care Provider Program

- While I applaud the strides made here (i.e. employee of the state, no claims payment), **this measure falls short** of enhancing a specialists efforts to work within the physician community to provide volunteer care
- Malpractice premiums are at an all time high, due to the recent "hard" market climate, and **this bill still allows those premiums to be adversely affected** by me providing volunteer care where a recipient sues
- What needs to be addressed here is the **fundamental issue of fairness**, one where a person who receives well intentioned volunteer care can still sue and make life miserable for a volunteer specialist in the state of Iowa
- I support volunteer care, and believe that **unless gross negligence** is involved, those recipients of volunteer care should have to forgo the right to bring suit against a physician delivering care under the program

Health Care Reform Public Forum
January 29, 2007
By Di Findley and Cindy Ramer
Iowa CareGivers Association
515-241-8591 (w) 515-249-0138 (c)
di.findley@iowacaregivers.org

Iowa CareGivers Association (ICA) was founded in 1992.
Mission: Enhancing the quality of care by providing education, recognition, advocacy, and research in support of direct care workers.

ICA and Better Jobs Better Care Coalition (BJBCC) sponsored Massachusetts Day in Iowa in December 2006.

We serve thousands of Certified Nurse Aides (CNAs), Home Care Aides (HCAs) and other direct care workers (DCWs) who provide care and supportive services to Iowans of all ages and in all care settings.

9-10% of Iowans are uninsured.
25% of CNAs in Iowa's nursing homes are uninsured.
12% rely on public assistance.

"Just because you have health care coverage doesn't mean you have access!"
We face an increasing shortage of DCWs:

- The aging of Iowa's population and the dramatic increase in the number of people needing the services of caregivers coupled with a dwindling workforce is contributing to a serious care gap.
- Shortage that occurs when workers leave the fields of direct care at alarming rates (73% leave annually).
  - One of the main reasons they leave?
    - The lack of health care coverage.

Health care access for the health and long term care workforce is a vital component of the infrastructure needed to ensure access.
Expanding health care to kids is noble, important, and the right thing to do.
Assisting small businesses is noble, important, and the right thing to do.

But the uninsured and underinsured who "Give" the care to those who will be accessing the expanded services you propose need to be helped as well. We hope you will do the right thing here, too, and not leave these caregivers behind.

Thank you.

1/29/07 Comments to the Health and Human Services Appropriation Subcommittee

By John Hale, Policy Director, Iowa CareGivers Association

The video and Cindy Ramer's and Belinda Ely's presence here this evening sends a very clear message about health care reform...while it's easy to look at this as *policy* issue, the reality is that it's a *personal* issue. It's a *personal* issue for 275,000 Iowans without coverage, the thousands more who fear losing the coverage they have, the thousands more who are paying premiums that they can't afford for coverage that doesn't meet their needs, and the thousands more who can't get the insurance they are willing to pay for due to pre-existing conditions.

For them, it's a crisis. Their message to you is our message to you:

Let's get serious about health care reform.

Let's seize the moment to do this right, and produce legislation that provides accessible, affordable and comprehensive coverage **for all, not just for some.**

I'll leave you with the words of three people that I hope you will use as guideposts as you continue your work on health care reform:

First, Rep. Ro Foege, who at the Press Conference introducing this effort on January 10th, said that it is "morally wrong" for Iowa to have 275,000 uninsured residents.

Second, the Rev. Martin Luther King, who said that "Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

And finally, a quote inscribed on the wall of this Capitol in a place where few can see it, but which needs to be seen and referred to regularly; a quote attributed to the ancient Greek lawmaker Solon ... "The ideal state—that in which an injury done to the least of its citizens is an injury done to all."

Is the status quo morally wrong? Is it an injustice? Is it an injury that's being done to our citizens? Unfortunately, the answer is YES. It is our hope, therefore, that you will conclude that the status quo can no longer be justified, and that simply tinkering with the system and tweaking it here and there will not produce the result that Iowans want and deserve.

You are the legislators that Iowans are looking to for big ideas and bold leadership. We applaud the work you are doing and pledge our support to you in finding solutions that move Iowa closer to being that ideal state that Solon referred to!

Thank you.

REAL PEOPLE...REAL STORIES

Stories from Direct Care Workers about Health Care Coverage

Imagine

Health care coverage is not an academic issue or an abstract public policy debate. It's a subject that deeply affects real people in Iowa; your friends, business associates, co-workers, neighbors, and relatives.

Approximately 275,000 Iowans have no health insurance coverage. Thousands more have inadequate coverage—coverage that they pay too much for or get too little from.

Those faces need to seen. Those voices need to be heard. Public policy discussions need to be conducted with them in mind.

Imagine if you or your spouse or children were one of these Iowans.

Imagine not being able to get the care that is needed when it's needed because of an inability to pay. *Imagine* not getting the routine tests that are needed to identify problems before they become severe. *Imagine* the worry that flows from an emergency hospitalization and the mountain of unpaid health care bills. *Imagine* needing to consider leaving a job you love for something else you have no passion for just so you can get health care coverage.

Imagine what life would be like.

What's been lacking in the conversation about the uninsured and underinsured is the real faces and real voices of the all-too-many Iowans that are impacted.

Those faces need to seen. Those voices need to be heard. Public policy discussions need to be conducted with them in mind.

What follows is a sampling of the abbreviated stories of impacted Iowans, told in their own words. All of these Iowans work in the field of long term care, providing support and assistance to Iowans who are unable to care for themselves.

Our hope is that these stories will cause the reader to pause, to say that "This shouldn't happen. This isn't right. Something needs to be done." AND to work with our Iowa legislators to bring about meaningful change.

Real Story: 1

...our family always relied on him for our health insurance through his employment. That's all changed.

My husband was killed in an automobile accident about one and a half years ago at the age of 50, and our family always relied on him for our health insurance through his employment. That's all changed.

Since his death, I've had a terrible time finding insurance that would accept me or that I could afford. Before his death, I had chest pain. My doctor ordered some tests including an angiogram that was normal. After he died, my doctor also treated me for depression and a bout with high blood pressure but nothing that called for medication or treatment.

Now, because the angiogram was performed, because of the high blood pressure, and because of the depression, these conditions are considered "pre-existing" and I've been refused coverage.

Real Story: 2

I have had seizures and have about $30,000 worth of bills in a shoebox.

I've been a Certified Nurse Aide for 13 years and haven't had health insurance. I have had seizures and have about $30,000 worth of bills in a shoebox. My employer doesn't offer health insurance and I can't afford to buy it.

I am working two days a week and going to school in hopes of getting a better job at Quaker Oats or somewhere that has health benefits (and so I can earn more money to pay off my existing medical bills).

Real People, Real Jobs, Real Challenges, Real Difference

Direct Care Workers

We are real people who do real work and have real impact.
We care for your friends, neighbors and loved ones and enhance their quality of life.
We care about the work we do.
We view our work, not as just a job, but as a profession.

Direct Care Workers and CareGiving Are in Crisis

Too few enter the field; too few stay in the field.

People don't enter, or they leave all too soon, because the work is difficult, the pay is low and the fringe benefits are few, training and continuing education are inadequate, and there are too few opportunities for advancement within the field of direct care.

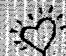
The shortage and the turnover of workers leads to less quality of care. If there is one thing that's certain, people want to see a familiar face walking through their door to assist them. When it's someone they don't know and have no relationship with, client satisfaction declines dramatically.

The worker shortage and the turnover are occurring at a time when the demand for services is growing at an alarming rate. According to a recent report by Brown University, "...the long term care system in the United States is threatening to collapse under the weight of the aging Baby Boom generation."

What We Ask of You:

To enhance the direct care profession and enhance the quality of care to Iowans, we need your help to:

Finish the job of the Direct Care Worker Task Force established via House File 781. The report of the Task Force was provided to the Governor's Office on December 15, 2006. Its recommendations now need to be implemented by the Department of Public Health. We ask you to name the Department as the implementing agency and fund their implementation efforts.

 Finish the job on expanding health care coverage to all Iowans. Over 91% of Iowans have health coverage. However, that leaves 275,000 Iowans WITHOUT coverage. That 275,000 includes thousands of direct care workers and their families. We believe that health care is a right for all, not a privilege for some. We all deserve adequate and affordable health care coverage and we urge you to help lead the effort to reach that goal.

I'm proud to be a direct care worker or a supporter of direct care workers. I thank you for your support and for your time today!

My Name ______________________________

Address ______________________________

Contact Information ______________________________

____

For further information or if we can be of any assistance please contact me at the number listed above or contact the Iowa CareGivers Association at 1117 Pleasant Street, Suite 221, Des Moines, IA 50309; email: information@iowacaregivers.org; phone: 515-241-8697; web site: www.iowacaregivers.org.

STATEMENT OF IOWA HEALTH CARE REFORM PRINCIPLES

Produced by the Iowa CareGivers Association and the Better Jobs Better Care Coalition Health Care Reform Workgroup

As a state grounded in Midwestern sensibilities and a national leader in insurance, all Iowans can and must move forward to establish our own vision of health care reform. Our goal is healthier Iowans leading longer, more enjoyable and more productive lives. This goal will become reality as we create a health care system that delivers quality, value and improved health outcomes.

The principles that will guide the reform movement are as follows:

- Iowa's economic vitality requires the availability of affordable health care coverage to attract and retain a skilled workforce.
- All Iowans will have access to affordable health care coverage to promote health security and treat illness or injury.
- Health care coverage for Iowans will be comprehensive and will give increased focus to preventive-care vs. sick-care.
- Health care coverage and health care service delivery need to be simple to understand and easy to use.
- Health care coverage will be available to all Iowans at all times. If an individual changes jobs, reduces hours of paid work or leaves the workforce, an alternative to employer-provided coverage will be available.
- Access to health care coverage does not guarantee access to health and long term care services. In order for Iowans to have access to the services they need, an adequate supply of health and long term care professionals must exist throughout the state.
- Iowans will promote their own health and well-being by becoming better educated about health promotion and by adopting healthier lifestyles. They will contribute as they are able to the cost of their health coverage and their health care.
- Iowa businesses will partner with Iowans by contributing to the cost of health care, by assisting in promoting health education and wellness, and by expecting excellence from all providers involved in caring for employees and their families.
- Reform of health care delivery and financing will be accomplished in an inclusive way; involving individuals, employees, employers, organizations, the medical and insurance communities, and government.
- The government will promote health care quality, access and affordability for all Iowans, and assist in financing the health care costs of Iowans with lower incomes.

The Iowa CareGivers Association is a nonprofit, nonpartisan organization. Our mission is to enhance the quality of care by providing education, recognition, advocacy, and research in support of direct care workers. We do not have a political action committee (PAC), endorse political candidates, or contribute money to political parties or political candidates' campaigns.

Statement
By Dana Petrowsky, President/CEO

Comprehensive and Affordable Health Care for Families and Businesses
Monday, January 29, 2007
Des Moines, IA

Since 1964, the Iowa Association of Homes and Services for the Aging (IAHSA) has represented providers of high quality healthcare, housing and services for seniors. Our mission-oriented and community-sponsored members number 148 nonprofit nursing facilities, continuing care retirement communities, senior housing, residential care facilities, assisted living programs, and community service providers.

We commend you for having this public hearing and talking with the public and seeking ideas and advice of experts and leaders from health care, business and government.

The 2006 IAHSA Member Satisfaction Survey revealed the number one most challenging issue faced by member's organizations is a quality and stabile workforce and within that issue is finding affordable health care benefits for their staff which is made worse by skyrocketing health costs. Health care cost increases are easily outpacing wages allowing long-term care employers less money for wage increases and other employee benefits.

These rising costs have caused employers to shift more of the cost burden directly to their employees, leaving many Iowans without affordable coverage.

Iowans want and deserve a health care system that delivers high quality services at an affordable price. Everyone must do their part to help realize this vision, including individuals, communities, those who work in the system and those who finance it.

As to specifics in the proposal, the interim commission on affordable health care plans for small businesses and families and a health care data research advisory council are a great start in seeking recommendations for changing the way health care is delivered in Iowa.

Iowa Association of Homes & Services for the Aging
1701 48th Street, Suite 203 • West Des Moines, Iowa 50266 • Phone: (888) 440-4630 or (515) 440-4630 • Fax: (515) 440-4631
Website: www.ageiowa.org • Email: iahsa@ageiowa.org

Statement
By Dana Petrowsky, President/CEO

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Monday, January 29, 2007
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Section 22 pertains to Long-Term Care; IAHSA recommends including an increase in the elderly waiver cap.

At the current rates of reimbursement, many home and community-based programs in Iowa will no longer be able to continue to provide services at the current levels, let alone expand services. Preserving and expanding home and community-based service alternatives saves the Iowa taxpayer money by delaying nursing home placement. The current cap of $1,084 should be increased so providers will be able to continue their services to the frail seniors and potentially be able to expand or develop new services.

Elderly Waiver services can be provided in a person's home, which includes an assisted living apartment. Elderly waiver services are individualized to meet the needs of each senior.

The following services are available:

- Adult Day Care
- Assistive Devices
- Chore Services
- Consumer Directed Attendant Care
- Emergency Response
- Home and Vehicle Modifications
- Home Delivered Meals
- Home Health Aide
- Homemaker Services
- Mental Health Outreach
- Nursing Care
- Nutritional Counseling
- Respite
- Senior Companions
- Transportation

Also in Section 22 Long-Term Care; IAHSA recommends including an increase in the residential care facility or RCF rate. Residential care facility reimbursement rates are well below the cost of providing services. $26.50 provides room, board, supplies, personal assistance and other essential daily living activities.

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At $26.50 per day, RCFs are being reimbursed a mere $1.10 per hour for a room, three meals a day, medication administration, assistance with bathing, laundry services, scheduled activities and 24-hour staffing. The residents living in RCFs are closer in care level to what used to be nursing facility residents. Based on cost reports actual costs are closer to $2.34 per hour. It is hard to hire and retain quality staff on such a low-level of reimbursement.

An additional $200 - $400 a month is available to RCFs through the Medicaid Elderly Waiver, for Medicaid eligible residents. However, this is bottom dollar care. Iowa has a goal to reduce the occupancy in nursing facilities, and prolong the time before entering a nursing facility. While assisted living programs are an alternative to nursing facility placement so are RCFs are another viable option.

Some RCFs were forced into the ARO program by the counties and now that program is ending, the RCF residents are in the middle. The counties are telling RCFs that their budgets cannot cover the additional cost for services, so the portion of that funding that RCFs used to receive to help make up the difference in the State payment will not be available.

Without an increase, RCFs do not know how they will break even.

We know that some of these changes can be implemented immediately; however, many of the changes will require years of work and will succeed only if there is steady leadership from committed individuals, such as yourselves. IAHSA stands committed to help.

Thank you.

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Iowa Physician Assistant Society
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Toll Free: (877) 837-6982

Testimony on the Comprehensive Affordable Health Care Bill
Monday, January 29, 2007
Presented to the Joint Appropriations Subcommittee on Health and Human Services Bill

My name is Libby Coyte. I am a physician assistant currently working at Primary Health Care Inc, a federally certified community health center here in Des Moines. I also work at a rural health clinic in Redfield, Iowa. Also, I am a member of the Board of Directors for the Iowa Physician Assistant Society. I have been a member of the leadership group for the Safety Net Provider Network for the past year and a half as a representative of rural health clinics. I am representing the 700 PAs licensed to practice in Iowa, the Iowa PA Society and the Safety Net Provider Network.

I want to thank the Joint Appropriations Subcommittee on Health and Human Services for having this public hearing on the critical issues of comprehensive affordable health care. The issues brought forward in this proposed legislation are important to physician assistants and the physicians they work with, since PAs provide services in rural Iowa at a higher percentage of the profession than other comparable health care providers in Iowa. PAs have had a tradition of working with physicians to provide increased access to medical care to the citizens of Iowa in rural and in urban underserved areas. We look forward to being a part of the discussion to address strategies on how to provide health care to the uninsured and underinsured patients in Iowa since these are the issues we struggle with daily in our practices.

Because of the above reason, I suggest that the commission on affordable health care plans for small business and families include a representative of the Iowa PA Society as a nonvoting, ex officio member of the commission by adding to Section 1, d (page 2 between line 19 and 20) the following:

(16B) A representative of the Iowa Physician Assistant Society.

The Iowa PA Society is in strong support of Section 1, 3b (page 3 line 7-17) which establishes the office of insurance consumer advocate. There are several issues concerning insurance rules, rates and regulations that effect PA / physician practices which negatively affect health care access that could be effectively addressed by this insurance consumer advocate.

The Iowa PA Society suggest that several provisions of Divison III on Dental Home be expanded or clarified that they included physician assistants as nondental providers. For example, Section 13, 8 (page 11, line 27) should be amended as follows:

> 8. "Nondental health care provider" means a physician , physician assistant or nurse who provides screenings, fluoride varnish applications, education or referrals to dentists.

A large proportion of PAs practice in rural areas where dental services are very sparse and where nondental health care provider may be a viable alternative so it only makes sense to include PAs in this definition.

Section 14, 5 (page 12, line 14) should be amended as follows:

> …creating a dental screening reimbursement code and specific reimbursement for physicians and physician assistants under the medical assistance program, ……

This change is necessary to make sure that medical practices are reimbursed for dental services provided by a PA as a nondental provider. In the past, there are many incidents when an insurance carrier would not reimburse a practice for a physician services provided by a PA unless this was specifically provided for in the law.

The Iowa PA Society continues to support the legislative provisions of the safety net provider network. Physician Assistants work for all the current participants of this network (community health centers, rural health clinics and free clinics) and are often recruited by these entities as health care providers. Because of this, section 41, 1 (page 33, line 5) needs to be expanded to include the following:

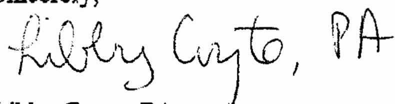
> The program shall include the development, in conjunction with colleges of medicine, dentistry, nursing and <u>physician assistant education</u> in this state,......

Both PA programs in Iowa have been involved in past recruitment efforts for physician assistants to work in safety net provider sites and should be part of any future efforts as well.

Finally, the Iowa PA Society suggests that section 46, 3 on the children's healthy development initiative commission be amended by enlarging the commission membership to include a representative of the Iowa PA Soceity by adding "<u>the Iowa physician assistant society</u>" between c and d (page 36, lines 23 and 24). PAs currently work in pediatrics in Iowa and all the PAs who work in family practice and rural medicine see a high proportion of chilren in their clinical practice. PAs should be part of this important new initiative.

Again, the Iowa PA Society is please to provide these comments on the proposed comprehensive affordable health care bill and look forward to working with you on this bill to find cost effective solutions to the current problems faced by the Iowa health care system as it tries to provide increased access to health care for patients who lack health insurance coverage.

Sincerely,



Libby Coyte, PA
Iowa Physician Assistant Society Board of Directors
Safety Net Providers Network Leadership Group

Good evening. I am Dr. Myra Lussman. I am a children's dentist.

The State of Iowa has an enormous responsibility to provide health care for its children.

The number one chronic disease affecting 5-17 year old children in America is tooth decay. How many of you knew that? Now let's talk little children. More than one fourth of children ages 2 to 4 have dental decay. By the ages of 6 to 8 half of those first and second graders have cavities, according to the Centers for Disease Control. That's a lot of cavities.

Iowa's children have the right to be seen by a dentist. Small children need the care of a children's dentist. Iowa has the responsibility to provide access to professional dental care, providing the dental home for children at the dental office.

Children with untreated cavities miss school and are often seen in emergency rooms for urgent care for toothaches, swollen faces, and infections. The emergency room doctor may prescribe antibiotics in pill form or intravenous antibiotics. The child may even require hospitalization.

When a child is sick, Parents take their children to the Doctor's office for treatment. Medical care is provided by a physician.

How is a parent to know if their child has cavities? Cavities don't hurt. When a tooth hurts the tooth is almost gone. The parent may not know the child has a cavity. The child's Doctor may not know the child has a cavity. Children need early screening by a dentist.

I would like to invite the Iowa senators and representatives to our office and follow our treatment for dental decay. I would be delighted to share our prevention programs. I am asking for help from the Iowa senators and representatives so dentists can continue to provide care for children's teeth, focusing on the dental home at the dental office. Please help us do what we've spent years in school training to do. Please help us care for the oral health of Iowa's kids. They deserve professional care at the dental office as their dental home. Help us.
Thank you.

The Stork's Nest Program in Iowa

Testimony on behalf of the

March of Dimes

Before the Iowa Legislature's Public Hearing on
Health Insurance Issues

January 29, 2007

Presented by:

Tonya Diehn, Public Affairs Chair of the

March of Dimes Iowa State Chapter

I'm Tonya Diehn and I have been a long-time supporter and volunteer of the March of Dimes. I'm the Program and Public Affairs Chair for the Central Division Board, as well as the State Chapter Board. I was the State Coordinator for Genetic Services at the Iowa Department of Public Health for three years and is a member of the Center for Congenital and Inherited Disorders Advisory Committee. With my extensive knowledge, I'll be able to provide expert testimony in order to ask your support to provide funding to an effective program called Stork's Nest.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects, premature birth, and infant mortality. We do this through programs of research, community services, education, and advocacy. Chapter volunteers and staff have long been interested in finding ways to reach out to our state's widely dispersed population of women and children. The vision of the volunteers was to provide much needed maternal health information to families that do not live in urban areas with readily accessible health care professionals and services. Fifteen years ago, the March of Dimes partnered with the Zeta Phi Beta sorority to start an outreach program called the Stork's Nest in Iowa.

Stork's Nest (NEST) is a prenatal education and incentive program that provides much needed health care coordination and maternal health education to low income and high risk pregnant women, including those who live in rural areas. The program takes their services out into communities rather than waiting for women to seek them out. NEST motivates women to get early, regular

prenatal care, to avoid harmful substances/environments, and to bring their baby to well-baby exams through earned incentives of needed child care items such as diapers, wipes, clothes, car seats, books, etc. In addition, Stork's Nest provides support and encouragement for continued education and healthy behaviors. The Stork's Nest programs facilitate finding a physician locally or out of the community for high-risk pregnancies and 100 percent of their clients receive prenatal care. NESTs have a major impact on a priority area of March of Dimes—consumer education about preterm birth. The programs that track client outcomes are showing better than average rates of preterm deliveries.

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, churches and many others. Collaboration expedites a system of cross referrals and strengthens client relationships—a win/win situation for everyone involved.

Today, the Iowa Stork Nest's program is a cohesive network of 40 urban and rural sites, each diverse, working to meet their individual community needs. Our Stork Nest's program is the strongest and largest in the country. 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. **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. **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. **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. 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.

The March of Dimes establishes community contacts, provides guidance, publicity, and supplies start-up funds in the first three years for the Stork's Nests but is unable to provide ongoing funding. While Stork's Nests receive donations of incentives, in-kind support and some fiscal support from their community partners, they are unable to serve all those in need because of current financial constraints. In the last year, the Nest in Sioux City and Dubuque had to close because of a lack of funding. The March of Dimes urges members of this

committee to protect infants, children, and pregnant mothers in communities throughout our state by securing ongoing financial support for the Stork's Nest program. NEST is an excellent vehicle for targeted case management and care coordination.

Thank you for allowing us to provide testimony on this successful issue.

Carla Marcellus, State Public Affairs Manager for the March of Dimes, 2910 Westown Parkway, Suite 301, West Des Moines, IA 50266. (515) 243-2244, 1-800-627-2412, or cmarcellus@marchofdimes.com

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Comprehensive, Affordable Health Care for All Iowans

Testimony for the Health and Human Services Appropriations Subcommittee

January 29, 2007

Susan Roberts, JD, MS, RD[1]
The Iowa Dietetic Association

Thank you for the opportunity to testify regarding comprehensive, affordable health care for all Iowans. I am representing the Iowa Dietetic Association.

The rapid rise in the prevalence in chronic diseases such as obesity, diabetes and related diseases among Iowans is a grave concern as the health and quality of life of those afflicted plummets and health care costs and societal burdens soar. Epidemiologist have determined that the longevity of our children today will be cut by nearly one decade compared to their parents due to the obesity pandemic. This startling prediction makes our efforts on this issue even more critical and urgent. We must reverse this alarming childhood obesity pandemic that threatens an entire generation. Lifestyles that prevent and manage these diseases and promote health through good nutrition, for both individuals and the population of Iowa as a whole, are a major focus of Registered Dietitians in Iowa.

We believe that it is important that all Iowans have health care insurance. We also believe that it is important to insure that this health care coverage leads to improved health for Iowans in a cost effective way. This must be done if our state is to survive and thrive. Otherwise, run away health care costs associated with chronic diseases, such as obesity, have the potential of bankrupting our state treasury and private employers.

Poor nutrition is a key factor in eight out of the ten leading causes of death in Iowa.[2] Whether in **nutrition services to prevent chronic diseases**, such as obesity in children, or in **medical nutrition therapy services in management of existing diseases** such as diabetes, nutrition services for Iowans provided by registered, licensed dietitians through health care insurance are a critical need of Iowans. These services are rarely occurring now because they are not generally a covered health benefit. Or if there is a benefit, it is minimal. Iowans, both those afflicted with these chronic diseases and those paying the bills, are losing.

Not only will the health of individuals improve with nutrition services, these services have a demonstrated cost benefit. For example, the Oxford Health Plan saved **$10 for every $1 spent** on nutrition counseling for at risk elderly patients. Monthly costs for Medicare claims alone tumbled from $66,000 before the nutrition program to $45,000 afterwards.[3] In another study, the Lewin Group documented a **9.5% reduction** in hospital utilization and **23.5% reduction** in physician visits when medical nutrition therapy was provided to persons with diabetes mellitus.[4] These and similar savings could be happening in Iowa.

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[1] Contact information: susan@susan-roberts.net; 515.965.3859

[2] *See* CDC, Deaths, Percent of Total Deaths and Death Rates for the 15 Leading Causes of Death, United States and each State, 2003, *available at*: http://www.cdc.gov/nchs/data/dvs/lcwk9_2003.pdf

[3] Oxford Health Plan's pilot nutrition screening program applied to Medicare population in New York, between 1991-1993

[4] Johnson, Rachel. The Lewin Group – What does it tell us, and why does it matter? J Am Diet Assoc. 1999, 99:426-427

In addition, not only is there health care savings not being utilized in Iowa, there is significant unmet need. In the Medicaid program alone there is significant need for nutrition services which are not being provided. For example:

1) Iowa's Child Health Specialty Clinics estimates that nearly 40,000 children in Iowa may have special nutritional needs that require registered dietitian counseling services.
2) Approximately 3500 Medicaid clients receive health care services at the Center for Disabilities and Development, University of Iowa Hospitals and Clinics yearly. Studies nationally indicate increased nutrition risk, (such as obesity prevalence in 40%), for individuals with disabilities.
3) Ninety one percent of low-income older adult diets are categorized as poor based on the USDA Healthy Eating Index. The Iowa Department of Elder Affairs Program registration data for FY 2005 identified 37% of home delivered meal clients aged 60-74 at high nutrition risk. This is in many instances the same population served by Medicaid Elderly Waiver Program. Currently, 1% of the Elderly Waiver clients are receiving nutrition counseling.
4) In 2004, 14.6% (over 4,000) children who are Iowa WIC participants between the ages of 2-5 were considered overweight.

Despite the evident need for dietary counseling services, Iowa Medicaid claims data show that **less than 1% of the population received nutrition services**, provided by a registered, licensed dietitian, during 2003 – 2005, for all nutrition related diagnoses.

Iowa, in this comprehensive health care for all Iowa legislation will greatly benefit by having nutrition services as part of the package. Lack of reimbursement for registered dietitian's nutrition therapy services creates inadequate access to the health promoting, disease preventing, and cost saving advantages of nutrition services for Iowans.

We recommend including in the legislation nutrition services similar to what has been done for dental, mental health and pharmaceutical services.

We request at a minimum you:

1. Assure that nutrition services provided by a registered, licensed dietitian are a covered service for all Iowans whether through private health care insurance or through state provided health care insurance.

And

2. Assure that registered, licensed dietitians are available to Iowa schools through the Area Education Agencies to assist with nutrition care and school wellness policies in the educational system.

We look forward to working with you to improve the health of Iowans through the cost effective means of nutrition services as this important legislation continues to be drafted and debated.

Dear Ladies and Gentlemen,

My name is Dan Ramsey and I work with the American Lung Association. I have been a smoking cessation counselor for over 7 years and during that time I have come to understand the difficulty that smokers face in quitting the addiction to nicotine. Studies show that close to 80% of smokers would like to quit. My own personal experience tells me that this is true, but I the biggest reason why smokers continue to smoke is that many lack sufficient motivation to move their desires into action.

Based upon my experience and by scientific studies, two of the most significant motivators are price and environment. I have had many smokers tell me that one of the reasons they want to quit is the price. A two pack a day smoker will currently spend over $200 a month to feed their addiction. This is especially true for smokers facing economic difficulties. They are very price sensitive and studies tell us that people that have lower economic means are more likely to smoke by two to one and they are the most likely to quit if the cost increases. By increasing Iowa's tobacco tax a dollar, it is estimated that 20,200 Iowans will quit, many of these will be Iowans who make less than $30,000 a year.

Many smokers feel like they are bad people. They feel that way because society is telling them that secondhand smoke is bad. The smoker hears that they are bad. They feel like they are bad people because more and more places are going smoke-free. They feel alienated and pushed out into the cold. Their children come home and tell their parents that smoking is bad and that scares them. Parents hear that they are bad because they smoke. Smokers are not bad people. They are addicted people which doesn't make them good or bad...just addicted. Smokers feel like government and society are pushing them out and they want help. I believe that any increase should help smokers quit by offering smokers Nicotine replacement and other drug therapies. There is no magic pill so any drug therapy should always be coupled with strong cessation counseling.

Testimony before the
Health and Human Services Appropriations Subcommittee

Comprehensive and Affordable Health Care for Families and Business Bill

January 29, 2007

By Kelly Huntsman
Executive Director, Primary Health Care, Inc.

My name is Kelly Huntsman and I am the Executive Director of Primary Health Care, Inc. in Des Moines. I am here to testify in support of the Iowa Collaborative Safety Net Provider Network provision of this bill.

Through five clinic sites in Des Moines and Marshalltown, Primary Health Care provides medical, dental, and mental health services to nearly 19,000 patients – 54 percent of whom have no insurance and 97% who fall below 200% of the federal poverty level. As one of Iowa's 12 Community Health Centers, Primary Health Care receives federal funding to help offset the cost of providing care to the uninsured and underserved. Although this funding enables health centers to serve more than 100,000 Iowans, it falls short of helping us serve everyone in the state who cannot afford care because they do not have health insurance.

Through the creation of the Iowa Collaborative Safety Net Provider Network the Legislature has recognized the vital role safety net providers such as community health centers, rural health clinics, and free clinics play in caring for those who struggle to find affordable health care. Increased support for the Network's ongoing activities will provide the resources necessary to implement the three initiatives, which are increasing

access to pharmaceuticals, access to specialty care services, and developing a statewide recruitment effort for health professionals.

The benefits we have realized through the Network over the past year have been significant. With the Network's direct provider awards, the community health centers were able to secure technical assistance from a nationally recognized 340B pharmacy expert. The federal 340B program allows eligible entities, such as community health centers, to access reduced price prescription drugs for their patients. This technical assistance is helping CHC pharmacy programs remain viable by identifying efficiencies and exploring cost savings opportunities. Viable CHC pharmacy programs mean that uninsured and underserved patients continue to have access to affordable pharmaceuticals. In 2006, the Community Access Pharmacy, which is operated by Primary Health Care, Inc. filled nearly 30,000 prescriptions, serving nearly 1,500 uninsured individuals each month.

In addition to the individual funding awards for safety net providers, we are particularly excited about the collaborative activities planned through the three priority initiatives for pharmacy, specialty care and recruitment. I'd like to make brief comments on two of the three initiatives.

As a health care provider who serves a large number of uninsured patients, we experience, on an almost daily basis, significant barriers in accessing specialty care services for patients who lack insurance coverage. The process occurrs one patient at a time, resulting in calls to numerous physician practices attempting to find a specialist who is willing to see the uninsured patient. The process is time consuming (oftentimes taking several hours for one patient), sometimes fruitless, and most often frustrating.

But staff continue because the patient stories are heart wrenching – a five year old boy, who was not a U.S. citizen, who had difficulty breathing at night and was in need of an ENT physician to perform surgery, or the 27 y/o female patient who had an advanced stage of cervical cancer and needed OB/GYN consultation and surgery. On a local level, efforts to form a volunteer physician network to provide access for specialty services has proven to be a light at the end of a very dark tunnel for those in Polk County. Although still in its infancy, the process offers a coordinated and consistent approach to match the needs of patients with specialty physicians who are willing to volunteer their services. This is an excellent example of what the safety net legislation is seeking to do across the state.

For our organization the strategy to coordinate recruitment efforts also holds great promise. Hundreds of hours and thousands of dollars are invested each year by community health centers throughout the state to recruit health care professionals. This is particularly challenging for providers in underserved and rural areas with limited budgets to compensate quality providers. The Network's proposal to create a statewide, integrated recruitment program for safety net providers will reduce time and costs invested in these efforts and will result in better matches between provider and community. And just as significantly, the money this program will save providers can be reallocated to direct patient care where it is desperately needed.

Your continued support of safety net health care providers through efforts such as the Iowa Collaborative Safety Net Provider Network is commendable and greatly appreciated. By coordinating with other existing complimentary efforts, the Network

can continue to maximize the State's investment to the benefit of the uninsured and underserved.

I encourage you to continue your support of the Network through the passage this bill.

Thank you.

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My name is Carrie Fitzgerald and I work as a Senior Health Policy Associate at the Child and Family Policy Center in Des Moines. The Child and Family Policy Center urges the General Assembly to take a leadership role in quickly enacting the Family Opportunity Act in Iowa.

On February 8, 2006, the Family Opportunity Act was enacted as part of the final budget law, the Deficit Reduction Act (DRA). This provision went into effect on January 1, 2007. The federal law includes a phase-in approach.

The Family Opportunity Act would allow low- and middle-income families to access appropriate health care for their child with a disability through the Medicaid program. Medicaid is currently the only health insurance package with sufficient benefits to meet the needs of many children with significant disabilities. In addition, states can establish a demonstration program for children with potentially severe disabilities. Medicaid services would be available under this program to children with disabilities that will become more severe unless the children receive appropriate services.

Families that can benefit from the Family Opportunity Act have incomes between approximately $17,050 and $60,000 for a family of four, have children with disabilities that meet the Supplemental Security Income definition of disability, or have the potential to meet this definition if appropriate health care services are not provided, or have children receiving inpatient psychiatric services.

Families will benefit in the following ways:

Children with significant disabilities can receive the health care services they need to reach their potential.

Parents can accept raises, promotions or new jobs that increase family income above the poverty line.

Parents who have remained single to keep family income under the poverty line can get married.

Parents no longer have to choose between paying for the health care for their child or other necessary family expenses such as food, clothing and shelter.

Parents no longer have to place their child out of the home or to forgo custody of their child in order to access appropriate health services.

In the first year, states can offer Medicaid services to families with incomes up to 200% of poverty for a family of four if their child is under the age of 6. In the next year, children up to age 12 can participate and in the third year, children under the age of 18 can participate. Iowa families need the General Assembly to pass legislation to implement the Family Opportunity Act. Carrie Fitzgerald, 6124 Harwood Drive, Des Moines, Iowa

Senator Hatch, Representative Foege, Members of the Subcommittee,

Thank you for giving us this opportunity to present our comments on your proposed health care reform bill. I am speaking to you tonight on behalf of the Key Coalition, a united group of some 20 statewide organizations that have come together to improve Iowa's system of disability services. Member organizations represent thousands of Iowans with disabilities and their families, advocates, service providers and others who share an interest in the growth of Iowa's citizens and communities.

The Coalition formed in 1995 in response to changes to the service delivery system and an effort to create a state-county partnership in funding that system. Since that time, adequate funding for the mental health and disability services system has been a top priority, and is never more important than this year.

We appreciate your focus on public health, dental health, and prevention in this proposed legislation. Access to primary and dental care is a challenge and an important issue for persons with disabilities, and we applaud your efforts in these areas. Unfortunately, mental health services seem to have been overlooked in this expansive bill. While we certainly appreciate broadening the list of mental illnesses covered by our limited parity law, we recommend you expand that list to all mental illnesses. Your list currently excludes many of the illnesses and disorders diagnosed in childhood.

We also appreciate your effort to appropriate funds to relieve pressure on growing Home and Community-Based Services waiver waiting lists. We ask though that you not forget the thousands of Iowans with disabilities who will begin losing their services because the state has not lived up to its funding commitment to the MH/MR/DD/BI system. This important service system allows Iowans with disabilities to live and work independently. By failing to fill the $23 million hole in this system, the health and well being of those individuals will be at risk. We believe this is a public health crisis, and one that must not be overlooked. We encourage you to add $23 million in funding for the MH/MR/DD/BI system and increase the local levy capacity in order to prevent thousands of Iowa citizens from losing of all or part of their essential services and supports.

Thank you again for this opportunity to speak.

My name is Kathleen Brown; I am a home Child Care Provider. I am speaking on the behalf of many childcare providers that are in the same, or similar position that I am in, no Medical Health Care Coverage. I have been checking around since last year after hearing that each State has to come up with their own Heath care rule. Last year, the state of New Jersey proposed for their state a law that each individual must have insurance coverage or they could be fined. The first thing that came to my mind was, "Is this going to be a state-to-state trend". So I have been searching for affordable medical health insurance since last year. Only to find that I could not afford it for myself and two children. Yearly low Essentials Coverage was $4,500-Yearly high Enhance Coverage $7,500.00, and this doesn't include the deductibles for medication which is $500.00, and it also does not include the amount you would have to pay out-of-pocket for Essential Coverage. Preventive Care, Mental Health Care, is not covered under Essential; and Maternity Care is covered ONLY, if there is a complication with the pregnancy.

Since I have started my In-home Child Care Business I have been without medical health insurance; so I had a spin down account set up. I have had three Hospital Admissions over the last seven years, and several emergency visits. When I tried to quit smoking cigarettes because of my Blood Pressure, I was prescribed a medication that I had an adverse reaction to which, initially, caused me to have seizures; and I was Hospitalized for a week. This is sad to say but, I' am still paying Hospitals Bills from 2004.

I once went to Grand View's "free clinic" to have a splinter removed from my hand, thinking it would be cheaper for me. I received a bill for $380.00 plus the cost of my medication. I have high blood pressure, and only one of my medications are affordable and the other is not. I only go to the Dr.'s office when I have get lab work drawn which is very costly. Sometimes this visit determines if I can pay my utilities, or if I have to cut back on my food purchase for that month. This was much different situation when I worked in the co-operatives work place. I had a group rate package, with major medical, dental, vision, and life insurance family coverage that was affordable. Now I feel that I am forced to choose between what's not affordable but is necessary, and what is needed that is: rent, utilities, food, clothes, and all of my business expenses. I choose the essentials that I need to live, hoping and praying that I stay in good health. I do not think we should have to make that choice. Please support and help us to obtain affordable medical health insurance.

My name is Jim Wallace. I am pastor of Central Presbyterian Church in Des Moines. Central, along with 30-some other congregations—Protestant, Jewish, Catholic in Des Moines and now Ames—are members of AMOS (A Mid-Iowa Organizing Strategy). AMOS is a grass roots, congregation based organization that seeks to involve itself in the public life of the community by engaging issue that impact the common good and what the faith tradition calls social justice. These 30 some congregations represent 15 to 20,000 citizens in mid-Iowa.

Would AMOS here tonight, please stand?

This fall, AMOS congregations conducted 300 gatherings, what we call "house meetings." This is where members of our congregations gather with anywhere from eight to 25 people to surface their concerns as citizens and members of Iowa. And in these 300 meetings with 3,000 or more citizens in attendance, the number one issue was health care. This concern was voiced in Ames, the east side of Des Moines, the Drake Neighborhood on the north side, members of congregations that live south of Grand, people out the western suburbs. The one urgent issue on everyone's mind was the need for affordable and accessible healthcare for everyone.

In AMOS we have found so many people in our congregations who have good jobs, two incomes, or who are hard working people trying to do what's right, but they can't afford healthcare and provide a place to stay or buy food or clothe their kids. They have to choose between the basics of life and that should not be so. People like Kathleen Brown, a member of an AMOS congregation, who is a daycare provider. Kathleen, would you in just a minute please tell this group how difficult it has been for you not to have basic health insurance and what kind of fear that brings.

Kathleen Brown...

There are not just 100's of people like Kathleen across our state, but 1,000's People who are decent, hardworking citizens of this state who are doing important work in our communities, but who live in fear that one trip to the hospital and any chance at a decent life will be wiped out, the rest of their life living in dept without a chance of getting a foot up. People who put off going to the clinic because they can't afford to purchase a prescription and something treatable becomes a debilitating condition.

In the faith tradition that AMOS congregations share there is a belief that the measure of a community, the measure of a society is not how well we care for the most powerful, the privileged, but how well we care for the vulnerable, and that we have an imperative, a responsibility to care and act for the good of all.

We are here tonight to say tonight that the 30 congregations of AMOS, the 3,000 people who met this fall and the 15 to 20,000 members of our congregations stand behind this effort to provide accessible and affordable healthcare for all Iowans. Thank you.

Rev. Jim Wallace, Co-chair AMOS Health Care Team
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The Issue of PKU in Iowa

Testimony on behalf of the

March of Dimes

Before the Iowa Legislature's Public Hearing on Health Insurance Issues

January 29, 2007

Presented by:

Tonya Diehn, Public Affairs Chair of the

March of Dimes Iowa State Chapter

I am Tonya Diehn, a long-time supporter and volunteer of the March of Dimes. I am the Program and Public Affairs Chair for the Central Division Board, as well as the State Chapter Board. I was the State Coordinator for Genetic Services at the Iowa Department of Public Health for 3 years and worked daily with the Iowa Neonatal Metabolic Screening Program. I am currently a member of the Center for Congenital and Inherited Disorders Advisory Committee. My extensive background, allows me to provide expert testimony in order to ask your support in securing insurance coverage of medical treatment for persons with Phenylketonuria (PKU) and other metabolic disorders.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects, premature birth, and infant mortality. We do this through programs of research, community services, education, and advocacy. An issue important to us is insurance coverage of the medical treatment for Phenylketonuria (PKU). Phenylketonuria is an inherited disorder of body chemistry that, if untreated, causes severe mental retardation. People with PKU cannot process phenylalanine, an amino acid found in all proteins (including meats, dairy, soy beans, nuts, eggs, and artificial sweeteners). As a result, phenylalanine builds up in the bloodstream and the brain; causing brain damage. Fortunately, through the Iowa Neonatal Metabolic Screening Program, all newborns with this disorder are diagnosed and treated early in our state. However, life long treatment with a specific medical formula and medical foods is critical to preserve cognitive and behavioral function in individuals with PKU and other metabolic disorders. Children and adults who do not follow the required

treatment can have mental retardation, learning disabilities, behavioral issues, and mental illness. During pregnancy, high blood levels of phenylalanine in the mother are devastating to the fetus. If the mother is not on a PKU diet prior to and during pregnancy, there is a 100% chance that child will have a birth defect, mental retardation, or microcephaly. These babies do not inherit PKU, their health concerns are entirely caused by their mothers' high phenylalanine levels during pregnancy. Women with PKU must have metabolic control and their required medical treatment prior to and throughout their childbearing years.

Individuals maintained on the required metabolic treatment have good physical and mental health. Treatment prevents mental retardation and a decline in mental function. However, insurance coverage of the required treatment is substandard in Iowa.

Because the treatment of PKU is not a pill or an injection, but medical formula and foods, insurance coverage is variable. Many children and adults with PKU do not receive insurance assistance with their required and prescribed medical treatment. Some insurance companies pay for medical formula but none pay for the prescribed medical food.

According to the University of Iowa Medical Genetics Clinic, medical formula costs between $2,000 and $7,500 per year per individual and for each individual able to eat food, there is an additional cost of $1,000 to $9,000 each for the medical food. For a total estimated annual cost of $460,000 (based on 120 patients; University of Iowa Metabolic Clinic and March of Dimes estimate). Families are often unable to cover these costs. Families and individuals pay for

insurance to cover and assist with their medical expenses. Without insurance assistance, it is more likely that individuals with PKU and other metabolic disorders will not maintain the required treatment and will suffer adverse health effects, which can be severe and result in avoidable suffering and cost.

The March of Dimes urges members of this committee to protect infants, children, and pregnant mothers in communities throughout our state by securing insurance coverage for PKU and other metabolic disorders. Thank you for allowing us to provide testimony on this important issue.

Carla Marcellus, State Public Affairs Manager for the March of Dimes, 2910 Westown Parkway, Suite 301, West Des Moines, IA 50266. (515) 243-2244, 1-800-627-2412, or cmarcellus@marchofdimes.com

Statement Regarding the Iowa Affordable Healthcare Act 1.29.2007

Thank you for this opportunity to speak this evening as a physician caring everyday for the uninsured at Broadlawns, Polk County's public safety net hospital.

Even though Iowa has long faired better than the national average in providing health insurances, currently ranking #2 with 8.6% uninsured vs. the national average 15.9%. We can and should do the essential and just thing; provide comprehensive health insurance for all Iowans.

I praise your current effort to remove barriers to access and expand coverage; to include mental health parity, pharmaceuticals, and dental care - approaching the true definition of comprehensive care. I also accept your intent to seek and fully apply tobacco tax revenues, making such expansion revenue neutral for the state. In a perfect world we would penalize the offending industry rather than its victims, but I'll also hope that higher costs further discourages tobacco usage as well.

I've long been frustrated by the slow pace and greater cost of the incrementalism that currently passes for reform while the number of uninsured grow and the coverage others enjoy shrinks in scope and security. The incoherent hodgepodge of payers with its complexity, inefficiencies, and administrative waste costs us twice what other nations pay to cover everyone and we can't even brag of better outcomes. My personal hope for true national reform can be paraphrased as "Medicare for all," consistent with HR 676 now before the US congress.

Acknowledging that, in 2005 I was skeptical of IowaCare, the Iowa Medicaid expansion. Another increment. To avoid litigation with HHS over *intergovernmental transfers*, Iowa leveraged all monies set aside for uncompensated care - the U of Iowa's *state papers* from this legislature and Broadlawns' Polk Co *property tax levee* - to create IowaCare, a five year demonstration project serving those uninsured at ≤ 200% Federal Poverty Level. Although we continue to incur significant costs due to uncompensated care in populations beyond the scope of this program, each day I see patients newly insured by IowaCare. They view this as an asset not an entitlement, they are more able and willing to enter into a continuous provider relationship, pursue health maintenance and preventative care; all essential if we truly hope to change outcomes.

Tonight, I seek your assurance that continued support for all current aspects of the IowaCare program is implicit in your intent to add drug benefit and an expanded provider network. Assuming those conditions are met, I would not criticize limiting parental Hawkeye Medicaid enrollment to 50% of FPL, an otherwise much too austere limitation if you are truly aiming for all those at greatest risk and least able to provide health insurance for themselves. Those between 50 and 200% FPL should then have access to IowaCare.

I hold hope that your *Commission on Affordable Healthcare* will be empowered to look far beyond the status quo in its duty to aid groups and families secure comprehensive

coverage. I'm disappointed that rather than a mechanism to enroll and deliver care, we have what will be criticized as another study group. I wonder how such efforts will be evaluated without specific target metrics. If the many components of this bill absorb most tobacco tax monies, where do we expect the additional costs of caring for future expanding populations will come from?

I'm skeptical of any efforts that seek employment based solutions. Employment based health coverage undermines insurance portability and business competitiveness. Insisting that all employers provide "*at a minimum, catastrophic coverage,*" as your bill does, fails the core goal of true comprehensive coverage. It seems disingenuous to simply lower the number uninsured when the insurance they hold fails to meet true needs.

Lastly, in Section 36, the bill builds upon the Iowa Collaborative Safety Net Provider Network created in 2005. Thus far, this collaborative has cultivated a network of various community based clinics serving the underserved and uninsured. The Collaborative was charged then and now to include *all safety net providers* and to work to *develop a referral system for ambulatory and specialty services.* Both of these directives would be well served by specifically including Broadlawns Medical Center in the Collaborative. I assume that the exclusion of this longstanding keystone of central Iowa's safety net up has been an oversight or perhaps a too narrow definition of safety net.

I thank you for your time and attention and look forward to your finished product.

Dr Bret McFarlin
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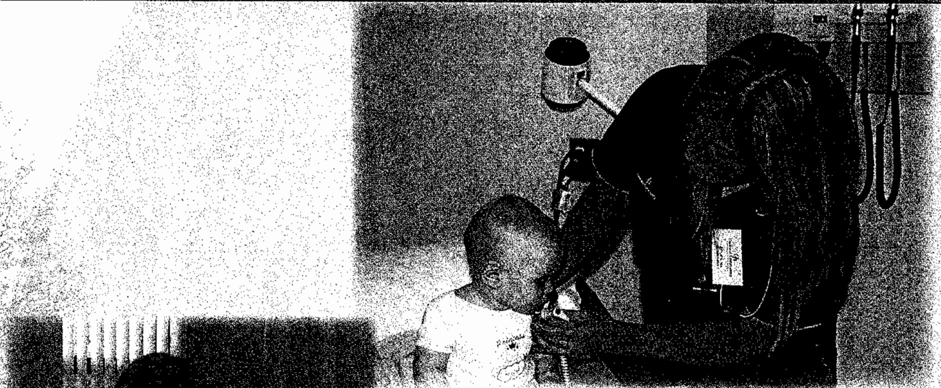
CITY FOCUS

FALL 2006



Crescent Community
HEALTH CENTER

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THE CITY OF
DUBUQUE

Showing the Spirit.

City Manager's Message

In this issue of City Focus, we highlight a new non-profit organization in our community, the Crescent Community Health Center. The completion of this project epitomizes how Dubuque partnerships are improving our community. It also demonstrates what can happen when community members unite with a shared vision, an attitude of cooperation, community generosity, and some persistence. It is fitting that it is the first of the Envision 2010 top 10 ideas to be completed.

Although the Crescent Community Health Center is not a City facility or department, the City of Dubuque has been a proud partner in its creation. In September 2004, the City Council identified "regional healthcare center promotion" as an action item in the 2004-2010 Strategic Plan. "Community Health Center Project and Funding" was an element of the City Council's 2005-2007 Policy Agenda and it was listed as a top priority in the 2006-2007 Management Agenda. The community health center's location is also a key component of the Washington Neighborhood Revitalization Strategy, another City Council priority.

Specificially, the City's support of the community health center project includes the involvement of Dubuque Public Health Specialist Mary Rose Corrigan, the contribution of $250,000 for capital build-out and an additional $647,000 in funds and staff oversight for the parking lot development and construction, and providing office space for the health center staff while the facility was completed. The City also acquired the necessary property and created a new neighborhood park across the street at a cost of $320,000 at the request of the Washington Neighborhood Association.

The story behind the creation of the Crescent Community Health Center is one of diverse groups coming together to meet an unmet need in the community. Over 45 individuals, businesses, nonprofits and government agencies have given of their time, resources and have made financial commitments to make it a reality. The list of project partners includes well-known Dubuque families -- the Schmids, the Rhombergs and the Piekenbrocks, who worked with the Community Foundation of Greater Dubuque to invest in their community by creating a $1.3 million endowment to help cover annual operational expenses. Titus Schmid was the founder of Crescent Electric Supply Company and the Crescent Community Health Center is named after that family-owned business.

The partnership behind the health center also includes Dubuque's healthcare providers – the Finley Hospital, Mercy Medical Center, Medical Associates Clinic, the Tri-States Independent Physicians Association, the Visiting Nurse Association, and others. The Dubuque Racing Association provided $500,000 through its Future Fund. State and federal legislators supported the project and secured critical funding with $1.3 million in State funds and $130,000 in Federal funds. Educational institutions and many community-based and social service organizations also contributed their efforts to move this project forward. Of course, numerous volunteers and advocates donated their time, resources, and energy to plan the project.

Each year thousands of area residents either go without or delay health care due to the lack of health insurance or personal resources. We should take great pride in the fact that all Dubuque residents now have access to quality health care.

Sincerely,

Michael Van Milligen

Michael Van Milligen
City Manager

Community Health Centers 101

Community health centers provide affordable, accessible, and acceptable primary healthcare. These centers, located all over the country, primarily serve indigent, medically underserved, and underinsured populations and assist special populations through grants and programs. Community health centers are not "free clinics," but operate using a sliding fee scale.

Community health centers are safety net providers. They provide several health services to the community, including comprehensive health services with a variety of physician specialties, general dentistry and community health programs involving oral health education and dental screening, prenatal care, health screenings, immunizations, case management and pharmacies.

Cost-effective
Community health centers are subject to ongoing federal scrutiny of their cost-effectiveness and quality of care; there is no comparison to this level of monitoring in the private sector. Cost screens applied to health centers by the U.S. Public Health Service and the Center for Medicare and Medicaid Services, such as administrative costs and costs per patient visit, are virtually unparalleled in the healthcare industry. The result of all of these factors is that community and migrant centers provide quality, comprehensive primary care to some of the hardest-to-reach patients in the health system at an affordable price.

Comprehensive
Community health centers offer comprehensive, "one-stop" primary care rather than the traditional medical model for chronic and acute care. Prevention is the focus. Centers also offer health/nutrition education and case management.

Community Oriented
Community health centers are also categorized by the high degree of community responsiveness of the programs they offer because they are required to conduct annual service area needs assessments and must be governed by community boards.

What is a Community Health Center?
The term community health center has both broad and narrow meanings. In the broad sense, community health centers are providers of primary healthcare to medically underserved populations. Unlike the medical model of healthcare delivery, community health centers focus not only on improving the health of individual patients, but on improving the health status of the entire community. This community-oriented focus means community health centers differ from traditional health care providers in several ways. Needs assessment, program development, and evaluation are all framed in terms of both community health needs and patient health.
The services of a community health center are accessible to the target population, comprehensive, and coordinated with other existing social services. The health center is also accountable to the community which it serves by involving members and health center users in program planning and organizational governance.

In a more narrow definition, the federal government uses the term "community health centers" to describe public or non-profit centers that receive federal funding under the Health Centers Consolidation Act of 1996 amended section 330 of the Public Health Service Act to provide comprehensive primary care services to medically underserved populations. All individuals within the health center's service area may receive health services at a community health center regardless of ability to pay.

Federally Qualified Health Centers (FQHCs)
The goal of the CCHC is to become a FQHC within the next three years. The advantage of FQHC designation is the health center can receive cost-based reimbursement for Medicaid and Medicare patients.

In addition, FQHC status may offer health centers certain other benefits, such as access to federally funded and supported technical assistance, higher rates of payment under Medicaid managed care, and eligibility for the Public Health Service Drug Pricing Program.

Program Expectations
Because community health centers serve a wide range of communities, from inner cities to rural areas, there is no one model health center. However, every community health center should have a sound infrastructure able to respond to the needs of its community within the constraints of its resources. Each community health center should develop processes and procedures designated to ensure the provision of high quality health services supported by strong management and governance.

To receive federal funding, a community health center must meet the program expectations of the U.S. Public Health Service, which include:
- Needs Assessment and Planning
- Governance
- Management and Finance
- Clinical Program/Health Services

Source: *The Iowa/Nebraska Primary Care Association (IA/NEPCA) website. The IA/NEPCA is a bi-state non-profit membership association comprised of community health centers and other safety net providers in Iowa and Nebraska. The Crescent Community Health Center is a member of the IA/NEPCA.*

Crescent Community Health Center Details

The Crescent Community Health Center (CCHC) is a freestanding, not-for-profit corporation created solely for the purpose of becoming a Federally Qualified Health Center (FQHC).

LOCATION
The CCHC is located in Dubuque's Washington Neighborhood at **1789 Elm Street** on the first floor of the Washington Court Building, formerly known as the Dubuque Casket Company. Gronen Properties of Dubuque is restoring the building and the upper three floors are being renovated, creating 36 affordable apartments. Gronen Properties is leasing the first floor to the CCHC and Project Concern. The two organizations will have a symbiotic relationship that will benefit the citizens of the neighborhood and the entire Dubuque community. This location also allows for future expansion of the health center.

The Crescent Community Health Center was named after the extended Schmid family of Dubuque, founders of the Crescent Electric Supply Company, who made an endowment gift of $1.3 million to the Community Foundation of Greater Dubuque to support the community health center.

FACILITY
The CCHC is a 7,300 square-foot facility. It contains six medical exam rooms, five dental exam spaces, consultation rooms, lab stations, a central reception area, and administrative offices. The parking lot for the health center is is located at the corner of Elm Street and 18th Street.

SERVICES
Specific services provided at the CCHC include:
- Primary health care services by physicians and allied health professionals (i.e. nurse practitioner)
- Oral health services provided by a dentist and dental hygienist
- Diagnostic laboratory services
- Diagnostic X-ray services
- Preventive health services
- Patient case management
- Pharmacy services
- Preventive and restorative dental services
- Translation services

STAFF
The Crescent Community Health Center employs a full-time physician (soon to be hired), nurse practitioner, registered nurse, licensed nurse or certified medical assistant, dentist, dental hygienist, two dental assistants, and support staff. Staff will increase as the client volume grows.

TARGET POPULATION
The primary populations the CCHC will serve are individuals and their dependents on Medicaid and Medicare, as well as those who are uninsured and underinsured. However, anyone in the tri-state area, including Illinois, Wisconsin and other Iowa counties, are welcome to use this high-quality health care facility.

The target population includes:
- 22,249 residents of Dubuque County who are below 200% of the Federal Poverty Index.
- 8.2% of individuals in Dubuque County report no health insurance coverage.
- Only 51% of eligible children are enrolled in hawk-i, the State insurance program for impoverished children.
- 16.2% of the Dubuque County's employers do not offer health insurance benefits affecting approximately 8,774 employees.

A MEDICAL/DENTAL HOME

Each year, thousands of area residents either go without or delay health care due to the lack of health insurance or personal resources. As a result, patients enter the area's hospital's emergency rooms for conditions that could have been prevented by seeing a primary care physician or dentist. Due to the cost of health care and the restricted access, a community health center is needed to provide the area's low-income and uninsured individuals a "medical/dental" home where care is not determined on their ability to pay.

Daily, public and private health care agencies in Dubuque hear many cries for medical and dental care assistance. Some actual examples include:
- A woman whose front teeth are fractured and so sharp that when she is home she covers them with silicone earplugs so they don't cut her lips or tongue.
- A man who had gone several years without medical and dental care and required same-day surgery for multiple tooth extractions. On the pre-op chest x-ray, lung cancer was detected.
- A 43-year-old woman who hadn't seen a dentist for three years, and had frequent oral abscesses she lanced herself.
- A sick child with no health insurance, unable to get an appointment to see a doctor.
- A 45-year-old man with an infected tooth, employed at a job with no dental insurance.
- A 15-year-old who needed a tetanus booster.
- A 40-year-old woman with a lump in her breast, unable to afford a mammogram.
- An 8-year-old whose teeth hurt "all the time" and had never been to the dentist.

In every instance, had care been initiated routinely, or at least earlier in the disease process, the emergent situations, incredible discomfort, and expense could have been avoided or greatly minimized. ◆

• 42.6% of the Dubuque County's employers do not offer dental insurance affecting approximately 23,072 employees.

REVENUE SOURCES TO SUPPORT THE CENTER

- Federal grants (Federally Qualified Health Center)
- State of Iowa "incubator funds"
- Cost-based reimbursement from Medicaid and Medicare clients
- Iowa, Wisconsin, and Illinois Departments of Human Services and Public Aid
- State Children's Health Insurance Program (SCHIP) programs in Wisconsin, Illinois and Iowa (hawk-i)
- Contractual relationships with private insurers
- Private pay
- Donations, fundraising and grants

PROJECT COST

The capital/construction budget for the project was $1.2 million. The center's three-year operational budget is $5.5 million.

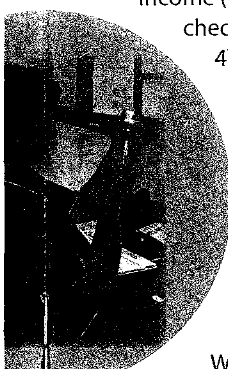
COSTS OF SERVICES

Patients without insurance are evaluated for an income discount. Patients can receive up to a 100% discount of all services provided in the center, depending on income. A $25 co-payment is due at the time of visit, but won't prevent someone from being seen. All other services are discounted per the income discount.

APPOINTMENTS

A simple process has been established to utilize the services provided at the CCHC.

1) Call 563-690-2850 to make an appointment
2) Arrive on time and check in with the receptionist
3) Complete financial assistance forms based on proof of income (monthly paycheck stubs, tax return, disability/SSI check stub) and family size
4) Meet with a financial counselor
5) Establish a payment plan based on a sliding fee income scale
6) See the doctor, nurse practitioner, or dentist
7) Some patients may be referred to a specialist or follow-up appointments may be necessary



HOURS OF OPERATION

Monday, Tuesday, Thursday, and Friday:
8 a.m. to 5 p.m.
Wednesday: 10 a.m. - 7 p.m.

CONTACT INFORMATION

Crescent Community Health Center
1789 Elm Street, Suite A
Dubuque, Iowa 52001
Telephone: 563-690-2850
Fax: 563-557-8488
www.crescentchc.org

envision

TEN COMMUNITY PROJECTS BY 2010

"Envision 2010: Ten Community Projects by 2010" was a project facilitated by the Dubuque Area Chamber of Commerce and the Community Foundation of Greater Dubuque, and funded by the Dubuque Racing Association.

The goal of the nine-month Envision process was to solicit "big ideas with broad acceptance that will have a long-term, positive impact on the growth and quality of life of the greater Dubuque community." It generated almost 2,300 ideas submitted by somewhere between 10,000 and 20,000 tri-states' citizens. The list of ideas was narrowed down to 300, then 100, then 30, before the top 10 were announced in January 2006.

One of the top 10 ideas was a Community Health Center: *"Build a Community Health Center that would provide high quality affordable medical, dental and preventive care for all, regardless of ability to pay, for those who are uninsured and underinsured. The Center would provide laboratory and x-ray services, patient case management, pharmacy services, translation and transportation assistance."*

The CCHC is the first of the Envision 2010 Top Ten Ideas to be completed.

The Iowa Great Places program calls on state agencies to partner with Iowans in a new way by combining state resources with local assets to make Iowa's communities, neighborhoods, districts and regions great places where people want to live, work and raise a family.

As one of the Envision 2010 Top Ten Ideas, the CCHC was also featured in Dubuque's application to be designated as an Iowa Great Place by the Iowa Department of Cultural Affairs. Following a competitive application and site visit process in October 2006, Dubuque was one of six Iowa places to receive this distinction for 2006. ◆

Crescent Community Health Center:
Health Care for All, the Gift of Many

by Mary Rose Corrigan, City of Dubuque Public Health Specialist

Health care access and meeting the health care needs of the poor and underserved, along with the uninsured and underinsured, has been identified as a need in Dubuque for many years. Formal discussions started in 1999 when Loras College and Clarke College gathered community representatives to plan for a Community Outreach Partnership Center (COPC) grant, which included creating a neighborhood clinic in the area surrounding the two colleges. Although COPC grant applications were not successful, the need and momentum for a community health care clinic was not forgotten. In the spring of 2002, I was completing my master's of nursing in a graduate seminar class at Clarke College, and we discussed forming a nurse-managed community clinic. We brought in experts to discuss the concept, including representatives from the Iowa Department of Public Health and local hospitals. It soon became evident that the need for a community clinic for the underserved was pressing. The graduate class conducted community surveys and decided to move forward with assisting the community to tackle the need. In June 2002, a committee formed to explore and then initiate planning and development activities for a community health center. A broad spectrum of community leaders assembled, due to the leadership of Sr. Helen Huewe, OSF, including representatives from:

Dubuque County/Board of Health
City of Dubuque
Mercy Medical Center
The Finley Hospital
Visiting Nurse Association
Hillcrest Family Services
Clarke College
Gannon Center for Community Mental Health
Substance Abuse Services Center
Dubuque Community School District
Medical Associates
Independent Physician Association
Iowa Department of Human Services
United Way
Iowa/Nebraska Primary Care Association
Women's Wellness Center
Jackson County Hospital
Dubuque Historical Society
Sisters of St. Francis
Telegraph Herald
Dubuque Area Labor Management Council
Tri-State Health CARE Coalition
Project Concern
Dubuque Main Street Ltd.
Hispanic Ministry-St. Patrick's
Scenic Valley Area Agency on Aging
Pines Healthcare for Women
Dubuque Rescue Mission
Northeast Iowa Community College
O'Connor & Thomas Law Offices
Woodward Communication
Tri-State Independent Physician Association
St. Mark Community Center
Community Foundation of Greater Dubuque

The original 21-member board was formally approved on March 19, 2003:

Sr. Catherine Dunn, BVM (Chairperson) - Clarke College
Mary Rose Corrigan, RN - City of Dubuque Health Services
Gary Gansemer - Hillcrest Family Services
Teri Goodmann - Dubuque County Historical Society
Sr. Helen Huewe, OSF - Mt. St. Francis
Tammy Klavitter - (Staff) Mercy Medical Center
Russell Knight - Mercy Medical Center
John Knox - Finley Hospital
Dr. Maria Locher Claus, DDS
Brendan Quann - O'Connor & Thomas PC
Kathy Ripple, RN - Visiting Nurse Association & Finley
Art Roche - Mercy Medical Center
Brian Schatz - Medical Associates Clinic
Sid Scott - Woodward Communications
Mike Stoll - Tri-State Independent Physicians Assoc. Inc
John Tallent - Medical Associates Clinic and Health Plans
Ken TeKippe - City of Dubuque Finance Department
David Tjarks - Gannon Center
Rod Tokheim - Mercy Medical Center
Michael Van Milligen - City Manager
Nancy Van Milligen - Community Foundation of Greater Dubuque
Julie Woodyard - Hillcrest Family Services
Julie Blum - IA/NE PCA

Mary Rose Corrigan, RN

This original board still serves in an advisory capacity today.

In March 2003, the first application for a Federally Qualified Health Center (FQHC) was submitted. This, along with applications submitted in April 2004 and June 2004, was not funded, due to extreme national competition. Along the way, the CCHC was awarded Federal Planning and Equipment Grants with the help of Senator Tom Harkin, totaling over $130,000. These grants, along with Sr. Helen Huewe volunteering as the health center staff, helped keep the momentum moving forward. For the next three years, the community health center was also a priority issue for the Dubuque Area Chamber of Commerce legislative trip to Washington, DC.

Since 2002, the board of directors worked with the Iowa/Nebraska Primary Care Association (IA/NE PCA). With their assistance, legislation was proposed and approved in the 2005 and 2006 Iowa Legislature for "incubator funds" of $650,000 to assist Community Health Centers who were not successful on the Federal grant application process to get up and running. Because of steep competition on the Federal level, being operational is extremely important for securing the Federal grant. After several trips to Des Moines and meetings with legislators, the Iowa Legislature awarded a second year "incubator fund" contract for the Crescent Community Health Center (CCHC). Since the majority of these funds must be used for operational expenses, additional fundraising was necessary. The Dubuque Racing Association then supplied a generous $500,000 grant for capital and buildout of the center.

The Community Foundation of Greater Dubuque then stepped in to secure a $1.3 million endowment from the owners of Crescent Electric Supply Company, specifically the Schmid, Rhomberg, and Piekenbrock families. This generous gift would provide a source of ongoing funding and a local name for the center.

In August 2005, the decision was made to locate the community health center in the Washington Court Building at 1789 Elm Street. John Gronen, owner and developer of the property, worked with the CCHC Board to provide a low-cost lease and partner in the center's development and construction. John's commitment went far beyond the lease and construction, and without his passion for serving those in need, the total project would not be what it is today.

The CCHC could not have been built without the financial support of many in the Dubuque community and the state of Iowa, including the Mayor and City Council who made the new facility a City priority. Many individuals from health care institutions and social service agencies, higher education and community-based organizations committed countless time and effort to establish the CCHC. Establishing this Health Center is more than constructing a building. Business and marketing plans, policies and procedures, staff hiring, and a myriad of startup activities had to be completed. This could not have been done without the help of all of our partners: a culmination of an exemplary collaborative effort. The Dubuque community should be proud of its efforts for establishing the Crescent Community Health Center. ◆

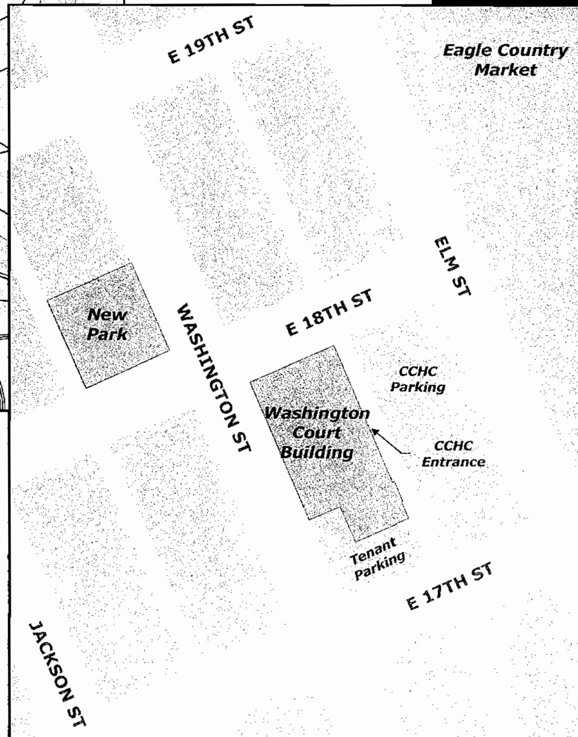
Open House

The Crescent Community Health Center will host an open house for tri-state area residents to visit and tour the facility and learn more about the CCHC.
The public is invited to attend.

Tuesday, December 12
Noon - 6 p.m.
1789 Elm Street, Suite A
(First Floor, Washington Court Building)

For more information, please call 563-690-2850.

(PLEASE NOTE: The community health center will not provide services during the open house.)



Crescent Community Health Center

MISSION

The mission of the Crescent Community Health Center is to improve and maintain the health and well being of our communities by providing affordable, client-friendly, and comprehensive, high-quality health care services in collaboration with other community organizations and resources. Anyone in the Tri-state area, including Illinois, Wisconsin and other Iowa counties is welcome to use this high quality health care facility.

GOVERNANCE

A community health center's board of directors has full authority and responsibility to establish program policies. The board of directors governs within the context of a long-term strategic mission and goals, as well as an annual operating plan. The majority of the board members must be users of the center's services. A set of by-laws governing the organization describe the structure and functions of the board, and meet the requirements of federal, state, and local laws and regulations.

BOARD OF DIRECTORS

Sr. Helen Huewe, OSF (Chairperson)
Mary Rose Corrigan (Vice Chairperson)
Alan Krueger (Treasurer)
Nancy Van Milligen (Secretary)
Kevin Anderson (Executive Director)
Lauria Bartolotta
Doug Brotherton
John Davis
Vernita Glass
Rev. Austin/Berlen LoKeijak
John Michalski
Florence Siefker
Karen St. George
Rich Whitty

Front Row (L-R): *Mary Rose Corrigan, Nancy Van Milligen, Sr. Helen Huewe, OSF, Alan Krueger.*
Back Row (L-R): *Rich Witty, Doug Brotherton, Kevin Anderson, John Michalski, Karen St. George, Lauria Bartolotta, Florence Siefker, Rev. Austin/Berlen LoKeijak.*
Not pictured: John Davis and Vernita Glass.

STAFF

Kevin J. Anderson, Executive Director
Yolanda Apel, Phone Operator/Receptionist
Sarah Brown, ARNP, Family Nurse Practitioner
Penny DeBuhr, Dental Hygienist
Mary Jane Driscoll, RN
Brenda Eickert, Certified Medical Assistant
Kelsey Gibbons, Certified Medical Assistant
Steven Haas, MD
Kathy Haverland, Dental Assistant
Amanda Huseman, Dental Assistant
Joan Schuster, Executive Assistant
Bill Souto, DDS, Dental Director
Diana Wallace, Dental Assistant

Kevin Anderson

Sarah Brown, ARNP

Bill Souto, DDS

Dubuque City Council

Roy D. Buol, Mayor
Ann E. Michalski, At-large
Ric W. Jones, At-large
Kevin J. Lynch, 1st Ward
Karla A. Braig, 2nd Ward
Joyce E. Connors, 3rd Ward
Patricia A. Cline, 4th Ward

The Dubuque City Council meets at 6:30 p.m. on the first and third Monday of the month in the third-floor auditorium of the Carnegie-Stout Public Library, 360 West 11th Street.

Editorial Information

City Focus is a publication of the City of Dubuque.
Editing & Layout: Randy Gehl, Public Information Officer

For up-to-date information on events and programs, visit our website: **www.cityofdubuque.org**

Feedback

The City of Dubuque welcomes your comments and suggestions about your city government or anything appearing in this publication. Inquiries must include your name, address, and telephone number, or an e-mail address so a response can be provided.

E-mail or use the form below and send to:

City Manager's Office
50 West 13th Street
Dubuque IA 52001-4864
publicinfo@cityofdubuque.org
563.589.4110 (phone)
563.589.4149 (fax)

Clip and Send Your Comments to the City Manager's Office, 50 West 13th Street, Dubuque, IA, 52001-4864

Name ______________________ Address ______________________
City ____________ ST ________ Zip ____________ Phone ______________ E-mail ____________
Comments:

CRESCENT COMMUNITY HEALTH CENTER (CCHC)
FUNDING HISTORY

START UP		TURNING POINT	FUNDS LEVERAGED	
2002 - 2004		2005 - 2007	2005-Present	
Planning/Capital Funds		Capital/Operational Funds	Capital/Operational/Endowment	
Dubuque Co.	$25,000		Federal Planning Grant	$30,000
Mercy Medical Center	$25,000		Finley Hospital	$100,000
McKesson Foundation	$50,000		Independent Physicians Association	$25,000
Dividends	$1,070	Iowa Department of Public Health Incubator Funds	Mercy Medical Center	$300,000
Federal Planning Grants	$98,853		Dubuque Racing Association	$500,000
American Trust	$10,000	$650,000*	Endowment	$1.3 million
City of Dubuque CP2 (CDBG Funds)	$50,000	$650,000**	City of Dubuque	$250,000
DuTrac Credit Union	$15,000		City of Dubuque (parking lot)	$647,000
Medical Associates Clinic	$25,000			
IDPH	$4,500			
TOTAL	**$304,423**	**$1.3 million**		**$3,152,000**

* July 1, 2005; contract received December, 2005

** July 1, 2006 – June 30, 2007; contract not yet received

COMMUNITY FOUNDATION

of Greater Dubuque

FEDERALLY QUALIFIED COMMUNITY HEALTH CENTER

Access to primary health and dental care has been identified as a critical need for the citizens of Dubuque County, particularly low-income children and families. In addressing this crucial issue, many organizations and agencies, including health care and education providers, social service, business, religious and philanthropic have come together over the past five years to develop a community health center for Dubuque and the Tri-State area.

Since 2002, the board of directors worked with the Iowa/Nebraska Primary Care Association (IA/NEPCA). With their assistance, **legislation was proposed and approved in the 2005 and 2006 Iowa Legislature for "incubator funds" of $650,000 each year to assist Community Health Centers who were not successful on the Federal grant application process to get up and running.** Because of steep competition on the Federal level, being operational is extremely important for securing the Federal grant. Dubuque received these funds from the Iowa Department of Public Health in December 2006 and will continue in 2007. Since the majority of these funds must be used for operational expenses, additional fundraising was necessary for capital and build-out of the center. We are grateful to the Iowa legislators for their support.

The Community Foundation of Greater Dubuque then stepped in to secure a $1.3 million endowment from the owners of Crescent Electric Supply Company, specifically the Schmid, Rhomberg, and Piekenbrock families. This generous gift would provide a source of ongoing funding and a local name for the center.

The Crescent Community Health Center (CCHC) is a non-profit organization structured to receive federal funding under the Health Centers Consolidation Act of 1996 as amended by section 330 of the Public Health Service Act. The clinic, open since October 2006, provides comprehensive primary care services to all individuals using a sliding fee scale regardless of ability to pay.

Now that the CCHC is operational, an FQHC or Look-A-Like designation is the next step. Applications for both of these were submitted to HRSA/BPHC in December 2006 and January 2007. FQHC status is absolutely essential for the long-term viability of CCHC. Although generous grants and donations helped build CCHC, they will not be able to sustain clinic operations and services. Congress must approve expanded funding for New Access Points (NAP), or Crescent Community Health Center will not have the opportunity to achieve FQHC status. Significant time and resources have already been spent preparing this NAP grant application, which will be wasted if expanded funding is not approved. Dubuque has proven its community support, commitment, and ability to operate an FQHC.

HISTORY OF A COMMUNITY HEALTH CENTER FOR DUBUQUE
Crescent Community Health Center (CCHC)
(formerly) Tri-State Community Health Center (TSCHC)
Status Report to Iowa Legislative Committee Public Hearing
January 29, 2007 – Des Moines, Iowa

September 2002	Community planning for Dubuque FQHC begins
April 2003	First application for FQHC submitted to BPHC/HRSA
August 2003	TSCHC receives notice of not being funded - Score of 76 - category of "fully acceptable".
Sept. 1, 2003	HRSA Planning Grant ($49,675) received. HRSA Equipment Grant ($49,178) received.
November 2003	Consumer Board for TSCHC installed and active as the Governing Board.
Nov. 24, 2003	Second TSCHC application submitted to BPHC/HRSA
April 30, 2004	BPHC/HRSA Notification - TSCHC not funded. Score: 87. Reviewer's recommendation: Approval, but not funded.
June 17, 2004	Third application TSCHC submitted to BPHC/HRSA. Planning grant funds expended. Other funds raised are for capital/infrastructure. Difficult to keep momentum going.
October 14, 2004	Dubuque is not awarded FQHC grant for third application. Score of 90 with very few weaknesses noted by the objective review team. Recommended Approval, but not funded.
May 2005	HRSA/BPHC cancels New Access Point (NAP) grant round.
July 2005	TSCHC awarded Iowa Dept. of Public Health “incubator funds" of $650,000 to establish CHC!! Thank You Iowa!
December 2005	Contract for IDPH funds received.
January 2006	TSCHC fundraising *case statement* developed. HRSA/BPHC announced no grant funding for NAP's in 2006.
May 2006	Construction underway In Washington Court Building.
August 2006	Professional Executive Director hired. City provides office space and staff support.
September 19, 2006	Dubuque Racing Association (DRA) awards $500,000 Future Fund Grant

September 23, 2006	Schmid, Piekenbrock, Rhomberg families give $1.3 million endowment. TSCHC name is changed to Crescent Community Health Center (CCHC).
October 2006	CCHC open for business!
December 12, 2006	Ribbon cutting ceremony/open house
December 2006	City of Dubuque parking lot for CCHC complete $627,000 for improvements
December 6, 2006	New Access Point Grant application submitted to HRSA/BPHC.
January 2007	Continuing Resolution proposed by Congress. NAP grants may not be funded.
January 5, 2007	Look-A-Like application submitted to HRSA/BPHC

The Dubuque Community and the State of Iowa have proven commitment for a FQHC. The need continues as Hispanic immigrants from the Tri-state area seek health care through our hospital emergency rooms, and as employers contribute less for health care insurance, especially for the working poor. Health Care institutions increase in charity care and bad debt continue to escalate, all while many have no medical home.

An incredible degree of assistance has been provided by donors who freely gave of their corporate wallets. Thousands of hours of assistance have also been provided by non-profit and community-based agencies, every health care organization, etc.

The citizens of Dubuque County thank you for your commitment to opening and operating a successful FQHC. We truly could not have done it without the "incubator funds". Not only did it provide needed capital, it was the catalyst that brought in city, grant and donor support. Dubuque has proven its organization, drive and commitment for a Community Health Center. If LAL or FQHC funds continue to be delayed, we may need to ask for your support with one more year of incubator funds.

For further information, please contact:

Nancy Van Milligen, President and CEO
Community Foundation of Greater Dubuque
700 Locust St., Suite 195
Dubuque IA 52001
(563) 588-2700
nancyvanm@dbqfoundation.org

KEY:
TSCHC - Tri-State Community Health Center
BPHC - Bureau of Primary Health Care
HRSA - Health Resources and Services Administration
FQHC - Federally Qualified Health Center
IA/NEB PCA - Iowa/Nebraska Primary Care Association
IDPH - Iowa Department of Public Health
NAP - New Access Point

418 S. Marion Street • Remsen, IA 51050 • 712-786-2001
www.mid-siouxopportunity.org

January 29, 2007

Good Evening,

Thank you for giving me a chance to speak about the need for the community health center incubator program. My name is Melissa Juhl and I am the Development Director at Mid-Sioux Opportunity, Inc., a Community Action Agency serving Northwest Iowa and I am also representing the Greater Sioux Community Health Center.

In 2001, local community agencies recognized an increase in the number of uninsured, underinsured and underserved families. Local families cannot afford to seek the medical, dental, mental health and substance abuse help they need. One seven year old girl had several apses on her gums that had gone untreated for an extended time. The parents knew the child needed to see a dentist or a doctor but could not afford the exam or the antibiotics. The problem went untreated for so long it destroyed several of her teeth and eventually would have lead to bone deformity. Cases like this is why Sioux County and the surrounding area needs a health center with a sliding fee scale.

In 2006, a twenty member steering committee from a wide variety of community members was formed and the Greater Sioux Community Health Center was formally incorporated. The committee decided to apply for federal assistance to the Health Resources & Services Administration for a New Access Points in Programs Funded Under the Health Centers Consolidation Act of 1996.

The first step in the grant process included conducting a needs assessment. Out of the 31,589 residents of Sioux County, 25% are living at or below 200 percent of the federal poverty guidelines. Think about that. One in four residents is living in poverty. 37% of those people do not have any type of insurance.

Major health disparities identified in the needs assessment include: late entry into prenatal care; lead poisoning; food insecurity; percent of minority and poverty in the population; diabetes rate; hypertensive heart disease and cerebrovascular disease; obesity; percent of elderly; lack of dental care; and depression rate.

The response from the residents to the Greater Sioux Community Health Center has been overwhelming. Sioux Center officials have assisted the committee in securing a location. The Orange City Health System has donated over 100 items including 6 exam tables for the health center. Another organization, Bezora, has volunteered to assist with construction of the new clinic site for free.

The data shows a tremendous need for a community health center, the Sioux County community supports the project and the steering committee has a 184 page document outlining a needs assessment, business plan, health plan and budget. The question is, will there be any funding? Can this plan become a reality?

Competition for funding for new health centers at the federal level is highly competitive. New site applications like the Greater Sioux Community Health Center rarely get funded. They have no historical data to prove the number of user encounters or the financial stability of the center. It is hard to allocate funds to a center that isn't operational when there are so many equally needy health centers who can supply hard data because they are already serving patients using other funding sources.

Iowa's community health center's incubator program provides a tool to make Iowa applicants more competitive for federal funding. It is an opportunity to prove the community need and demonstrate what success a community health center can have in rural Iowa.

Please continue funding the Iowa community health center's incubator program. The expansion of community health centers in Iowa depends on it. Affordable health care for low-income Iowa residents depend on it.

Thank you for your time and consideration.

Melissa Juhl, Development Director
mjuhl@mid-siouxopportunity.org

UNIVERSITY of IOWA
CARVER COLLEGE
OF MEDICINE

University of Iowa Health Care

Office of the Dean

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Good evening, I am Peter Densen, the Executive Dean for the Carver College of Medicine. I am here tonight to address the committee regarding issues related to Iowa's physician work force.

In1973 the Iowa Legislature passed a bill entitled and establishing "The Statewide Medical Education System". Today, this system, guided by the Office of Statewide Community Education Programs at the University of Iowa, continues to function extremely effectively on behalf of the state and its practicing physicians. Among its many charges is responsibility for helping communities recruit and retain physicians, and tracking the workforce for various health care providers including: physicians, physician assistants and more recently nurses. This tracking system is unique to Iowa. No other state has as robust a data base – nearly 35 years of trend data – to draw on to help Iowa's stake holders accurately identify fluctuations in the health care workforce and potential opportunities to address them. For example, for calendar year 2006 we know that the Iowa physician workforce experienced a net gain of 70 physicians; that this net gain represents the difference between 330 new physicians entering and 260 physicians leaving practice in Iowa. And, we can tell you in which county they are located and in which specialty they are trained.

In July 2006, because of growing concerns about Iowa's physician workforce, Dean Robillard and CEO Katen-Bahensky charged a task force comprised of leaders from Iowa's health care systems, physicians and individuals knowledgeable about undergraduate and graduate medical education to ascertain the current supply in Iowa, to study trends in the physician population, and to make recommendations for all who have a stake in this important element of our health care delivery system. The Task Force's report should be available to all of Iowa's stake holders in a few short weeks. But given the relevance of that report to this committee's deliberations, we thought it extremely important to share some of the most vital conclusions with you tonight.

- Any computation of physician supply requirements should consider the important service contributions of all health care providers, including physician assistants and nurse practitioners.
- Due to the complexity of the issues, there is no single solution to workforce needs. Iowa's needs, as well as the possible solutions to address these needs, differ depending for example, on whether one considers rural counties or metropolitan areas or if one considers neurosurgery versus primary care.

- For all levels of supply, that is, medical students, medical residents or practicing physicians, Iowa's biggest opportunity lies in efforts centered about retention
  - The single biggest opportunity lies in retention of currently practicing physicians who will, or have, relocated to another state.
  - Better understanding of the reasons that practicing Iowa physicians relocated is urgently needed.
- The Task Force developed a method for measuring the intensity of demand across medical specialties by comparing the current count of job openings to the current supply for each specialty studied.
- Addressing issues related to the physician work force will require collaboration among all of Iowa's health care stakeholders.

Thank you for allowing me to address the committee this evening. I look forward to sharing the report of the Task Force in the immediate future.

Health Care Reform 2007
Mental Health

I want to start by thanking Senator Hatch and the members of the Health and Human service Budget sub-committee for working on this complex but important issue.

I want to address the mental health aspects of health care. My two main concerns are parity and the lack of an adequate number of mental health providers in IA- especially in rural areas.

Two years ago IA passed a **parity** bill, a bill that required a certain class of insurers (not all) to pay for mental health services the same as what are traditionally considered physical health disorders. Meaning the co pays, deductible, and limits on visits had to be the same. But they were only required to treat certain mental health disorders with parity.

- At that time there was concern this would drive up premiums and thus stop health coverage for some people. I know of no evidence that that happened. Proposing parity is a reasonable way to provide mental health coverage for more Iowans.

- In trying to figure out the cost of mental health parity one needs to remember the cost of not delivering it. Mental health issues reduce workers productivity on the job and increase the cost of physical health treatment. There are a significant number of people that go to a physician and present their problems as physical symptoms –when they are really an expression of unidentified mental health issues.

- We talk a lot in this state about getting more people to relocate to IA to increase our workforce. Having good health/mental health insurance makes IA more attractive.

Next I want to turn to the issue of the **shortage of health care workers** in IA.

Iowa Department of Public Health's report (March 2006) on the mental health workforce in informs us that:

- IA is ranked 47th in the nation in the number of psychiatrists per 100,000.

- IA is ranked 46th in the nation in the number of psychologists per 100,000.

- 47% (nearly half) of IA's Psychologists are 55 or older.

- Of the 24 "health care professions" the Department of Public Health looked at they found that psychologists are the oldest in terms of provider's age. Thus, they are at high risk of attrition.

- Adequate funding for services attracts providers and adequate funding for services is part of what will make it possible to train and retain new psychologists.

In closing I urge you to support this bill –it increases parity of mental health services slightly. And I encourage you to work on full parity in the future.

Full parity may increase the likelihood of local opportunities for training and clinical experience (a recommendation of the 2006 workforce study).

And I encourage you to work on ways to support local training in the future.

Thank You

Kerrie Hill,
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Iowa Psychological Association

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January 29, 2007

Address to Health and Human Resources Appropriation Subcommittee

As a Christian Scientist, I am encouraged by the comprehensive work of this subcommittee to consider reforms that will make good health care available to every Iowan. Your openness in listening to every concern is exemplary. My reason for coming before this subcommittee is to ask you to remember that medical care is only one form of health care. Spiritual healing also belongs within the consideration of legislative reforms. Effective healing through Christian Science has been practiced for over a century. Christian Science practice is purely spiritual and is not a supplement to conventional medicine.

I am aware that there are questions in many minds about whether prayer methods are effective in physical healing. Spiritual healing certainly was a significant theme in the New Testament of the Bible. And, what about today? I can certainly testify to wonderful healings in my personal experience. As a teenager, I was healed of a debilitating disease. Several years ago, my eyesight was healed so that I no longer wear glasses or employ any other corrective measure. For the first time ever, my driver's license does not have a restriction. That's only the beginning of healings in my family. I can add that comprehensive spiritual attention is also preventive so that we have had relatively few health issues.

Individuals are not instructed by Christian Science churches or by church directives regarding the form of health care they are to employ. Many Christian Scientists choose spiritual based healing for the same reason others may choose conventional medicine: Because they've seen it to be effective in their own lives.

In Division I, Section 1.3 outlines items that the commission will review and analyze for reform. Item (f) includes the proposal: "Requiring all residents of the state to have health insurance coverage and subsidizing participation in government health insurance programs or private health insurance plans for low-income Iowans." Christian Scientists encourage the work that provides for every Iowan to have affordable health care and coverage by insurance. However, those practicing spiritual methods of healing and prevention do not gain a benefit from medical insurance. We ask that legislation include the provision that individuals shall be exempt from having health insurance when sincerely held religious beliefs are the basis for not having health insurance. Such an individual would be liable for providing or arranging for full payment for medical health care if he or she should receive medical care. ANOTHER OPTION WOULD BE TO INCLUDE CHRISTIAN SCIENCE TREATMENT AS AN APPROVED HEALTH CARE EXPENSE UNDER SECTION 213 OF THE INTERNAL REVENUE CODE.

A health insurance requirement was enacted by Massachusetts last year. I have included wording of the accommodation for religious practice below for easy reference.

Massachusetts:

In 2006, the Massachusetts legislature passed a new law that will require every Massachusetts adult resident to obtain and maintain health insurance coverage as of July 1, 2007. The new law will also require every Massachusetts resident who files an income tax return to indicate on the return whether or not they are covered by health insurance.

There is a religious accommodation in this law that allows an exception to the requirement to obtain and maintain health insurance coverage if the individual files a sworn affidavit with his tax return that he did not have health insurance coverage and that his sincerely held religious beliefs are the basis for his refusal to obtain and maintain health insurance coverage during the taxable year for which the return was filed.

The accommodation reads:

> "Section 3. An individual shall be exempt from section 2 if he files a sworn affidavit with his income tax return stating that he did not have creditable coverage and that his sincerely held religious beliefs are the basis of his refusal to obtain and maintain creditable coverage during the 12 months of the taxable year for which the return was filed. Any individual who claimed an exemption but received medical health care during the taxable year for which the return is filed shall be liable for providing or arranging for full payment for the medical health care and be subject to the penalties in subsection (b) of section 2."
> **[House Bill 4850, signed by the Governor on April 12, 2006]**

COMPREHENSIVE FAMILY AND SMALL BUSINESS CENTER PROPOSAL

I am Randall Hanson. I am president of Polk County Medical Society and a practicing physician in Des Moines. I am involved in care of the uninsured as well as the underinsured at Iowa Methodist Medical, Iowa Lutheran Hospital and Broadlawns Polk County Medical Center. I feel that the medical care for this group is now becoming even more critical. It is critical in regard to disease prevention as well as disease treatment in its population. It is also critical from a financial standpoint to these individuals, to the healthcare provider, to the healthcare system and to the economic health of the state. I and the Polk County Medical Society are in agreement with provisions to extend health and dental care to all children. We also support the healthcare provider access provisions in this proposal found in Section 53. This will fund the Iowa Healthcare Collaborative, which will allow funding to keep the special referral service operational as well as to pilot other areas of the state. As you might expect, all of the physicians in the state are involved to a degree with providing free healthcare. The provision in Section 54 deals with tax exempt status for physicians giving uncompensated care. I feel this additional tax benefit would allow recognition and reward for this service that has not been heretofore available. Polk County Medical Society would like to go on record as supporting the aforementioned provisions of this Bill as they go through the phases of the legislative process.

Testimony before the
Health and Human Services Appropriations Subcommittee

Comprehensive and Affordable Health Care for Families and Business Bill

January 29, 2007

By Jennifer Lightbody
Executive Director, Peoples Community Health Clinic
Chair, Iowa/Nebraska Primary Care Association

My name is Jennifer Lightbody and I am the Executive Director of Peoples Community Health Clinic in Waterloo. I am here to testify in support of two programs included in this bill: the Iowa Collaborative Safety Net Provider Network and the Community Health Center Incubator Program.

Peoples Community Health Clinic provides medical, dental, and behavioral health services to more than 17,000 patients living in the Cedar Valley – one third have no medical insurance while half of the dental patients we see have no dental coverage. As a community health center director for over 10 years, first in Sioux City then in Waterloo, I have experienced first-hand the immense challenges faced by individuals who cannot afford basic primary health care services.

Without the services of our health center and other safety net providers, many of these individuals would go without basic health care and let chronic conditions worsen. They would continue to use the local hospital emergency room for ailments that could easily be treated in a primary health care setting – all simply because their employers cannot offer affordable health insurance coverage, or they do not qualify for Medicaid or Medicare, or cannot afford to purchase insurance on their own.

Although community health centers have the benefit of federal dollars to help offset the cost of providing care to the uninsured and underserved, those funds fall far short of meeting the need for our services. Iowa's 12 community health centers provide care for nearly 100,000 individuals; however, today in Iowa more than 300,000 children and adults have no health insurance, and thousands more only have insurance to cover catastrophic events.

With the creation of the Iowa Collaborative Safety Net Provider Network in 2005, the Legislature provided a framework within which safety net providers – including community health centers, rural health clinics, and free clinics – work cooperatively to address common barriers to providing care for the neediest of Iowans in a cost-effective manner.

The Network is focusing its efforts on the three most pressing needs identified by safety net providers: access to pharmaceuticals, recruiting health care professionals, and access to specialty care. Through the input of providers and other public and private health care stakeholders, the Network is building on existing resources to address these needs.

The funding included in this bill will provide the necessary resources to make significant progress in implementing the strategies that have been developed by the Network.

A network approach is needed to improve access to specialty care for many patients. Last week we attempted to refer a 9 year old child with a serious health condition to a local specialist. The boy had Medicaid coverage. That physician refused to see the child because the family had an unpaid balance at the office. Another

community specialist agreed to see the child, so care was provided, but only after we had spent a considerable amount of time negotiating on behalf of the family.

I would also like to take a few moments to speak in support of continued funding for the Community Health Center Incubator Program.

Over the past five years the federal government has undertaken an aggressive initiative to double the number of individuals served through new or expanded health centers. Since this initiative began, Iowa's community health center network expanded with the addition of sites in Burlington, Lamoni, Leon, Keokuk, Marshalltown, Storm Lake, and Fort Dodge.

With expansion comes increased competition for funding. The total number of applications each funding cycle greatly exceeds appropriations.

Preparation for the application is rigorous. Applicants must demonstrate significant community support and involvement, the level of need and a comprehensive plan for meeting that need. Primary and preventive medical, dental and behavioral health care is required in addition to transportation, interpretation, outreach and other support services. Successful grantees must demonstrate the ability to begin seeing patients within 4 months of receiving the grant award.

The Legislature created the Community Health Center Incubator Program in 2005 to help Iowa communities become more competitive in applying for federal health center funding. Iowa communities who achieve all the federal requirements but are not funded may now open their doors and begin caring for patients while they continue to secure federal funding.

Crescent Community Health Center in Dubuque was the first recipient of incubator program support and has already demonstrated a tremendous impact on the community, as you will hear later tonight from a Dubuque representative.

The State's commitment to this program ensures that expectant mothers receive prenatal care, children receive regular checkups, diabetics have access to life sustaining medications, and comprehensive, high quality, affordable health care is available to all.

The passage of the Comprehensive and Affordable Health Care for Families and Business Bill will continue these two programs that are helping address the needs of the uninsured.

Thank you.

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REMARKS TO THE HEALTH AND HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE ON AFFORDABLE AND ACCESSIBLE HEALTHCARE

PUBLIC HEARING
JANUARY 29, 2007

The Federation of Iowa Insurers is an association of 24 insurance companies and health maintenance organizations (HMOs) domiciled and doing business in Iowa. The Federation's member companies provide life insurance, health insurance, annuities and other financial services to hundreds of thousands Iowans across the state. About one-third of the Federation's member companies provide coverage for healthcare services. As you continue your work in the legislature to further define the healthcare issues you want to address, we at the Federation are available to serve as a resource to assist you in your discussions.

Health Insurance Affordability and Accessibility

Because of the good work of many of you and your predecessors, most Iowans have access to affordable health insurance. Over the past ten or fifteen years, the legislature has established HIPIowa for the uninsurable and *hawk-i* for uninsured kids, and has enacted both small group insurance reform and individual insurance reform. As a result of the laws and regulations we have in place, Iowa ranks high relative to other states in terms of affordability and access to healthcare coverage.

- **Iowa has a low percent of uninsured.**

Iowa ranks second among the states in having the lowest percentage of residents that are uninsured. According to the U.S. Census Bureau only about 9 percent of Iowans are uninsured – which is nearly 6 percentage points below the national average of 15.9 percent.

U.S. Census Bureau data also shows that Iowa ranks second among the states in the percent of residents covered by private insurance. Only Minnesota has a higher percentage of residents covered by private insurance.

- **Iowa health insurance premium costs are among the lowest in the nation.**

In a recent study by America's Health Insurance Plans (AHIP), Iowa ranks third among the states in having the lowest average annual premium for single coverage under an individual health insurance policy – and comes in second for having the lowest average annual premium for family coverage under an individual policy.

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In another recent study by AHIP, Iowa ranks fifth in having the lowest average monthly premium for small group health insurance for both single coverage and family coverage.

Health Insurance Premium Increases Reflect the Increasing Costs of Healthcare

As you consider the cost of health insurance, it is important to keep in mind that the cost of health insurance premiums is primarily a reflection of the overall cost of healthcare. Over time, premium increases have very closely followed increases in healthcare spending. Increased utilization due to increased consumer demand, new medical treatments and more intensive diagnostic testing is the primary contributor to rising healthcare costs. An aging population and increasingly unhealthy lifestyles are also contributors.

Approximately 86 cents of every premium dollar goes directly to pay for healthcare services such as hospital care, physician care, prescription drugs, and other services that directly benefit consumers. Of the remaining 14 cents, five cents goes to pay for other consumer services and marketing and six cents goes for government payments, regulation and administration. Health plan profits represent only three cents of the premium dollar.

Federation's Proposed Small Group Health Insurance Changes

Iowa can be proud that nearly 91 percent of its population has health insurance. The Federation recognizes however that the increasing costs of healthcare can make purchasing health insurance particularly difficult for small businesses.

The Federation believes the increasing costs small employers have experienced can be moderated by improving the health status of their employees. The Federation also believes that because of the affinity between Iowa trade associations and their members, trade associations can be particularly effective advocates to encourage their members to support participation in wellness programs and disease management programs by the members' employees and their families.

- **Pooling of Small Businesses to Purchase Health Insurance**

The Federation supports legislation allowing small businesses increased flexibility to pool together through trade associations to purchase health insurance for their employees. Such pooling arrangements should be authorized only under Iowa's small group health insurance law to ensure that those participating in the association plans benefit from the existing protections of Iowa's small group law.

- **Wellness Program Incentives for Small Businesses**

Wellness programs generally reward individuals for making smart lifestyle choices, such as stopping smoking, regular exercise, losing weight, or lowering their cholesterol levels. Providing incentives to individuals to engage in healthy behavior can reduce healthcare costs and health insurance premiums. The Federation supports legislation that would provide insurance carriers increased flexibility to pass premium savings along to small businesses with successful wellness programs.

Other Initiatives to Consider

The Federation supports the following additional initiatives to make health insurance more affordable and available to Iowans.

- **Premium Assistance for Low Income Iowans**

The Federation supports state programs that provide targeted financial assistance to help low-income Iowans afford health insurance. Such programs could provide varying levels of assistance based on the recipients' income and insurance needs.

- **Publicly Funded Reinsurance of Catastrophic Claims**

The Federation supports a publicly funded program that provides reinsurance for small businesses facing a large claim by an employee covered under a business's health insurance plan.

- **Tax Incentives**

The Federation supports providing tax credits or other tax incentives that help businesses or individuals purchase health insurance.

- **Consumer-Driven Health Care**

The Federation supports efforts to encourage the use of consumer-driven health care, such as health savings accounts and increased transparency of health care quality and costs, which allows consumers to make informed decisions about the health care that is best for them.

A Final Thought - Mandates increase the cost of health insurance.

The old adage "you can't have it both ways" comes to mind when mandates are proposed at the same time legislators are struggling to figure out how to make health insurance more affordable and available. Efforts to reduce the cost of health insurance are undermined when new mandates are imposed to provide coverage for certain specific diseases, providers or procedures. Although lawmakers generally have good intentions when they propose mandate legislation, they need to recognize that mandates increase the cost of health insurance. According to a recent report by the Council for Affordable Health Insurance, Iowa currently has 23 mandates in place, each having a cost impact ranging from less than 1 percent to as high as 10 percent. While one mandate may increase the cost of a policy by only 1 percent, it is the cumulative effect of all mandates that can make health insurance unaffordable.

Source Documents

America's Health Insurance Plans, *Individual Health Insurance: A Comprehensive Survey of Affordability, Access, and Benefits* (August 2005)

PricewaterhouseCoopers, *The Factors Fueling Rising Healthcare Costs 2006* (January 2006)

Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2006* (March 2006)

America's Health Insurance Plans, *Small Group Heath Insurance in 2006: A Comprehensive Survey of Premiums, Consumer Choices, and Benefits* (September 2006)

Council for Affordable Health Insurance, *State Health Insurance Index 2006: A 50-State Comparison of the Nations Health Insurance Market* (October 2006)

America's Health Insurance Plans, *Health Insurance: Overview and Economic Impact in the States* (December 2006)

Testimonial Summary of AARP Iowa volunteer: Karen Antle of Marshalltown, IA
Public Hearing 1/29/07

Message on proposed "Comprehensive and Affordable Health Care for Families and Businesses Act":
As the state looks to target Iowans who lack adequate health care coverage, remember older Iowans.

Karen's Story:

Karen Antle, age 66, is very grateful, because for the first time in five years, she has health insurance — through Medicare. About six years ago, at age 60, Karen left her job as an office administrator with great benefits in Des Moines to be closer to, and help care for her parents in Marshalltown, but quickly learned firsthand how prohibitive health care costs can be without sponsorship from an employer, and how unaffordable services can be when you need them. Karen's new job in Marshalltown didn't offer coverage, and she couldn't afford the premiums as a single, 60-year-old woman on her own.

In Karen's mind, her only option was to forego insurance — and hope she'd stay healthy. Unfortunately, she contracted the Epstein-Barr virus, a disease associated with lymphoma, and needed treatment. It was shocking how fast the bills for tests and doctor's appointments and medications added up. In spite of the difficulties she faced paying for her treatment, Karen feels fortunate on two accounts: First, she was able to find a doctor's office that was willing to even take the tests to diagnosis her illness (not an easy task). Secondly, Karen's most recent heart problems came after she began receiving Medicare coverage. Karen underwent quadruple bypass surgery last fall 2006, mere months after receiving health coverage through Medicare.

Karen's message to the Iowa General Assembly:

- **Thank you** for undertaking the process of tackling health care reform at the state level. The proposed bill is a start, and the heavily scheduled meetings/hearings around the bill are even better. But for Karen, and other AARP members around the state, the commitment to meaningful health care reform from Iowa legislative leaders is the most important piece.

- As Iowa moves forward with health care coverage expansion legislation, remember that children are an important demographic to target, but not the only target. **Remember aging Iowans**, especially those who are not yet 65. Karen's story shows not just the perils of lapsed coverage, but the common problems aging Iowa consumers face in moving into jobs that have less health coverage or no health coverage before they reach 65.

- Karen's fortune of having access to a provider who readily treated her (someone without health coverage) also illustrates the need for Iowa to continually reassess **adequacy of access to services for uninsured and underinsured Iowans, particularly in rural Iowa.**

- **Pass no less than a $1 increase in Iowa's tobacco tax, and put the money towards health care.** A $1 tobacco tax increase is concrete health care reform on its own.

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AFFORDABLE HEALTH CARE FOR SMALL BUSINESS AND FAMILIES ACT

Health and Human Services Appropriations Subcommittee
Senator Jack Hatch and Representative Ro Foege, Chairs
Public Hearing--January 29, 2007

Thank you very much, Senator Hatch and Representative Foege, for your continued interest in and support of legislation that is directed to maintaining and improving the health of all Iowans. I sincerely appreciate the opportunity to offer some very brief comments this evening.

My name is Gary Streit. I live in Cedar Rapids and have practiced law there since 1975. I have been an American Cancer Society volunteer since 1978, having held numerous positions at the local, state, regional and national levels. I served as the volunteer Chair of the Board in 2003-2004. One of my primary interests has been the legislative initiatives of the American Cancer Society, primarily as they relate to tobacco control and access to health care.

We are all painfully aware of the terrible toll exacted by the use of tobacco products in Iowa. Approximately 4,500 adults die in Iowa each year from their own smoking, and at least another 400 will die from others' smoking—secondhand smoke and pregnancy smoking. There are approximately 4,200 new youth smokers in Iowa each year; 206,000 youth now alive in the State of Iowa will become smokers, of whom approximately 66,000 will die from smoking—nearly one third. Direct smoking-related health care costs exceed $1 billion on an annual basis in the state of Iowa, with another $900 million in smoking-caused productivity costs. The total of State and Federal Medicaid program's total health expenditures caused by tobacco use are approximately $300 million on an annual basis. $568 per Iowa household each year is spent in federal and state taxes to cover smoking-related government costs. Each pack of cigarettes sold in the state of Iowa causes health costs and productivity losses of $8.04 per pack—more than 20 times the current tax per pack. Iowa's current tax rate of 36 cents per pack currently ranks 42nd in the country—ahead only of tobacco producing states.

I congratulate you and commend you for a proposed increase in the cigarette tax of $1 per pack, to take effect immediately upon passage. While there are many who think the state of Iowa should "settle" for a 64 cents per pack increase, an increase of 64 cents per pack falls far short of what Iowans deserve. As Representative Foege himself said in a recent legislative forum in Cedar Rapids, there are those who believe that the tobacco companies can find ways to mitigate the impact of an increase of only 64 cents. Tobacco lobbyists are saying they can "live with" an increase of 64 cents to $1. Simple logic tells us that anything the tobacco companies will not oppose cannot be very effective. Remember, this is an industry that spends $195 million per year in Iowa alone to market and promote its products—over $500,000 per day! This is an industry

that spent almost $70 million in the state of California last fall to fight a referendum to raise California's cigarette tax. This is an industry that has increased the concentration of nicotine in its products by 11% since the year 2000 in an effort to assure that smokers who are hooked stay hooked.

An increase of $1.00 per pack to $1.36 per pack will result in 38,600 fewer future youth smokers, 20,200 fewer adult smokers, 12,300 youth smoking deaths avoided, 5,300 adult smoking deaths avoided, and $867.4 million in long-term health care savings. These long term savings will dwarf any decline in revenues from cigarette taxes as consumption ultimately declines. Furthermore, due to the inelasticity of the demand for cigarettes, a $1.00 per pack increase, rather than a 64 cent increase, will be 50 per cent more effective in terms of the decline in the number of packs sold per year and the decline in the number of youth and adult smokers, as well as increases in the number of youth and adult smoking deaths that are avoided and overall long-term health savings. Finally, the argument that businesses that sell cigarettes in border towns will be hurt because Iowans will drive to other states where the tax rate is less to buy their cigarettes is not supported by the facts, especially when one considers the fact that 70% of cigarettes that are sold are sold in single packs. Very few, if any, people are going to drive to another state to buy a single pack of cigarettes. Studies in states where the cigarette tax has been increased have shown that this border effect is minor—reducing sales by less than 5%. In point of fact, South Dakota just raised their tax by $1.00 per pack as a result of a 61% to 39% popular vote, and the governor of Wisconsin last week announced that he is seeking a $1.25 per pack increase in that state's cigarette tax and a complete ban on smoking on bars and restaurants and work places. Minnesota is already at $1.23 per pack (not including a 26 cents per pack wholesale sales tax. Illinois is at 98 cents per pack. I am also deeply troubled by the ethics of our state, in effect, encouraging smokers to come here from other states to buy their cigarettes through our extremely low tax rate.

I commend Dr. George Weiner's excellent editorial that appeared in the Des Moines Register last Thursday to you for your reading. Dr. Weiner, as you know, is the director of the Holden Comprehensive Cancer Center at the University of Iowa and is the chair of the Iowa Consortium for Comprehensive Cancer Control.

Please hold firm with your proposal to raise the tax by a full $1.00 per pack.

I will respectfully disagree with appropriating the full amount of the cigarette tax increase to the Health Care Improvement Fund. While the goals of the Health Care Improvement Fund are important, the simple fact is that Iowa's current funding of $6.5 million for tobacco control programs is only 28% of the minimum prescribed by the Centers for Disease Control. If we are going to be serious about reducing tobacco consumption in the state of Iowa, we have to

couple a $1.00 per pack tax increase with a comprehensive tobacco control program. Results from tobacco control programs that have been adequately funded (the states of California and Massachusetts, for example) clearly show sharp drops in smoking rates, particularly among youth. In addition, without adequate cessation programs, the immediate declines in cigarette consumption due to a tax increase may not be sustained.

Finally, I commend you for your efforts to work in a bipartisan and collaborative manner to make quality health care accessible to even more Iowans. Access to quality cancer care is a major factor in a person's ability to effectively overcome a diagnosis of cancer. I would caution you, however, to proceed with caution in the area of association health insurance plans or other similar pooling arrangements. When such bills have been proposed on a national level, they have eliminated mandatory coverage for many of the most effective forms of cancer screening—including those for breast cancer, cancer of the cervix, colon cancer and prostate cancer. These screening techniques have proven that they can save thousands of lives each year and should not be put at risk.

Finally, I want to put a human perspective on these facts and figures, particularly those relating to tobacco and its toll on the lives of all Iowans. A little over a year ago, one of Cedar Rapids finest businessmen and most generous philanthropist died of cancer. He was not a smoker. Yesterday morning, I looked across the aisle at church and saw a dear friend and long time volunteer for the American Cancer Society with most of her hair gone as a result of her treatment for breast cancer. She was also not a smoker. My point is simply this—organizations like the American Cancer Society and the Iowa Health Initiative and the American Lung Association and the American Hearth Association and AARP and the Iowa Hospital Association and the Iowa Medical Society—are spending significant amounts of time and money each year fighting the effects of tobacco consumption. If we just do the right thing and raise the cigarette tax by at least $1.00 per pack, perhaps these resources could be directed toward research programs that will one day find more cures for cancer or lead to earlier detection of cancers when they can be more effectively treated particularly for the 2 people I just referred to. We cannot let another day go by without preventing this needless loss of life.

Thank you for your time and attention this evening. Thank you for your leadership in introducing the Affordable Health Care for Small Businesses and Families Act.

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Vaccine Safety Bulletin
Before You Take the Risk, Find Out What It Is.

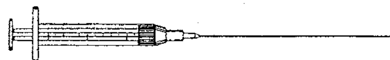
America and America's Children are in the midst of an epidemic of chronic disease and disability. Today, the Centers for Disease Control admits that **1 American child in 6 is developmentally delayed.**

In the past 25 years, the number of American children with learning disabilities, ADHD, asthma and diabetes **has more than tripled**. Autism increases range from 200 percent to over 5,000 percent in some states.

In the past 25 years, the number of doses of vaccines that pediatricians give American babies and children under age 6 **has more than doubled**.

In 1969, 1 in 7,100 children were diabetic. ▶	**Today 1 in 450 children is diabetic.**
In 1970, autism affected 4 in 10,000 children. ▶	**Today 1 in 175 children is autistic.**
In 1976, there were 796,000 learning disabled children. ▶	**Today there are 3 million learning disabled children.**
In 1979, there were 2 million asthmatic children. ▶	**Today there are 9 million asthmatic children.**
In 1997, there were 1.6 million children with ADHD. ▶	**Today there are 4 million children with ADHD.**
In 1980, the Centers for Disease Control (CDC) and American Academy of Pediatrics (AAP) said children should get 23 doses of 7 vaccines by age six years with the first vaccinations given at 2 months old. ▶	**Today the CDC and AAP tell pediatricians to give children 48 doses of 14 vaccines by age 6 with the first dose given at 12 hours old in the newborn nursery. At 6 months old a child can receive 8 vaccines on a single day. At age 15 months, a child can receive as many as 12 vaccines on a single day.**

Outstanding Question: Is the atypical manipulation of the immune system with more and more vaccines in early life setting some children up for chronic disease and disability? **Is less better?**



National Vaccine Information Center (NVIC)

x204 Mill Street, Suite B-1 | Vienna, VA 22180 | 703-938-0342 | www.NVIC.org

48 Doses Of 14 Va

Before Your Child Is Put At Ris

Birth (12 Hours)

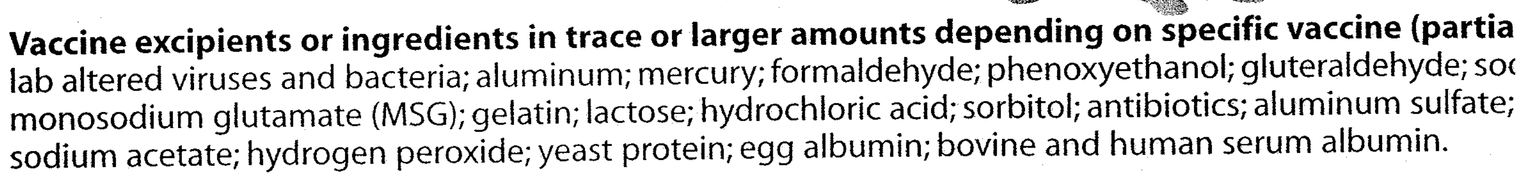
Hepatitis B

2 Months

Diphtheria
Tetanus
Pertussis
HIB
Polio
Pneumococcal
Rotavirus
Hepatitis B

4 Months

Diphtheria
Tetanus
Pertussis
HIB
Polio
Pneumococcal
Rotavirus



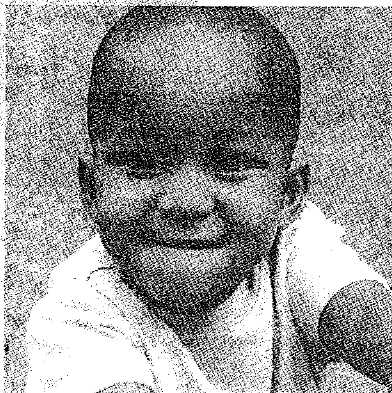
Vaccine excipients or ingredients in trace or larger amounts depending on specific vaccine (partia
lab altered viruses and bacteria; aluminum; mercury; formaldehyde; phenoxyethanol; gluteraldehyde; so
monosodium glutamate (MSG); gelatin; lactose; hydrochloric acid; sorbitol; antibiotics; aluminum sulfate;
sodium acetate; hydrogen peroxide; yeast protein; egg albumin; bovine and human serum albumin.

cines Before Age 6?
—Learn More About Vaccines.

6 Months
- Diphtheria
- Tetanus
- Pertussis
- HIB
- Pneumococcal
- Rotavirus
- Hepatitis B
- Flu

15 Months
- Diphtheria
- Tetanus
- Pertussis
- HIB
- Polio
- Measles
- Mumps
- Rubella
- Chicken Pox
- Pneumococcal
- Flu (plus dose at 2, 3, and 4 years)
- Hepatitis A

5 Years
- Diphtheria
- Tetanus
- Pertussis
- Polio
- Measles
- Mumps
- Rubella
- Flu
- Hepatitis A



:
chloride;
ım borate;

National Vaccine Information Center (NVIC)

204 Mill Street, Suite B-1 | Vienna, VA 22180
703-938-0342 | www.NVIC.org

If You Vaccinate Your Child,

Learn How To Recognize the Signs and Symptoms of Vaccine Reactions.

VACCINE REACTIONS	MOTHER'S DESCRIPTIONS
High Fever (over 103 F°)	*"His temperature was 105 °. I had to put cool towels on him to bring it down."*
Skin (hives, rashes, swelling)	*"There was a big, hot, red swollen lump at the site of the shot that stayed for weeks."*
High Pitched Screaming	*"It was a pain cry, a shrill scream and lasted for hours and nothing would help."*
Collapse/Shock	*"She turned white with a blue tinge around her mouth and went completely limp."*
Excessive Sleepiness	*"He passed out and we couldn't wake him to feed or do anything for over 12 hours."*
Convulsion	*"Her eyes twitched, her chin trembled, her body went rigid and then would shake."*
Brain Inflammation	*"He just laid in his crib with his eyes wide open then would arch his back and scream and go unconscious. Now he has seizures."*
Behavior Changes	*"She won't sleep or eat. She throws herself down and screams for no reason. She was sweet and happy and is now out of control. She changed into a totally different child."*
Mental/Physical Regression	*"My 18 month old son stopped talking and walking after those shots. He developed severe allergies, constant diarrhea, ear infections and was sick all the time."*
Blood Disorders	*"She got big purple bruises on her skin. The doctor told me she was bleeding because her blood couldn't clot."*

Other (such as loss of muscle control, arthritis, paralysis, sudden death)

If your child's health deteriorates after vaccination, your child may be eligible for federal compensation. Vaccine reactions should be reported to the federal Vaccine Adverse Events Reporting System (VAERS) by calling 1-800-822-7967 and to NVIC's Vaccine Reaction Registry at www.NVIC.org.

Meg Oberreuter
319-378-1241
moberreuter@mchsi.com

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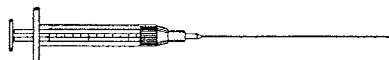

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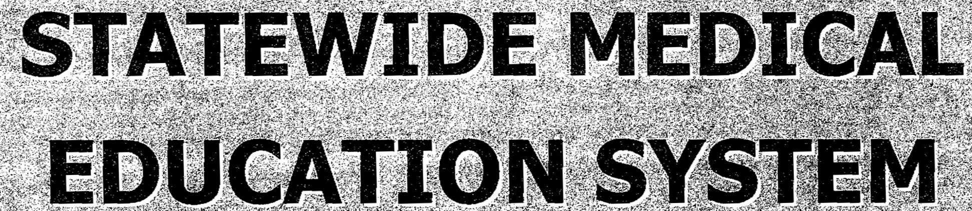
ANNUAL REPORT



STATEWIDE MEDICAL EDUCATION SYSTEM

Carver College of Medicine
The University of Iowa
2005

OSCEP/GRAPHICS/POWERPOINT/SMES/SMES
REPORT COVER PAGE 2005.INDD

Background

In 1970, the Carnegie Commission on Higher Education published a report on the nation's health. The report included a recommendation that some of the clinical education programs conducted by university health science centers be offered at health education centers in regions remote from the university. The aim was to improve the geographic distribution of health professionals. The report prompted the establishment of primary care residency programs in many community-based settings across the nation.

In 1972, federal policymakers used the Carnegie Commission's decentralized training concept as the basis for a new federal contract initiative. It was named the "Area Health Education Center Program," and it is still operating today. The University of Iowa failed to receive one of the first generation federal awards for establishing Area Health Education Centers (AHECs) within Iowa. The College of Medicine took its own initiative rather than wait for the next round of awards. The College asked for (and helped draft) state legislation that would enable the development of an AHEC-like system for medical education across Iowa.

The College's vision called for University-affiliated regional centers that would provide clinical settings for the training and education of resident physicians, medical students, physician assistants and other health professionals. With encouragement from the practicing medical community and the Governor's Office, the Iowa legislature responded in 1973 by passing a bill entitled "The Statewide Medical Education System."

OSCEP

The Carver College of Medicine established the Office of Statewide Clinical Education Programs (OSCEP) in 1973 and assigned it the responsibility of developing the Iowa Family Practice Residency Network as the foundation for what would become the College's Statewide Medical Education System. With guidance from OSCEP, the "system" has evolved over the past three decades as evidenced in this report.

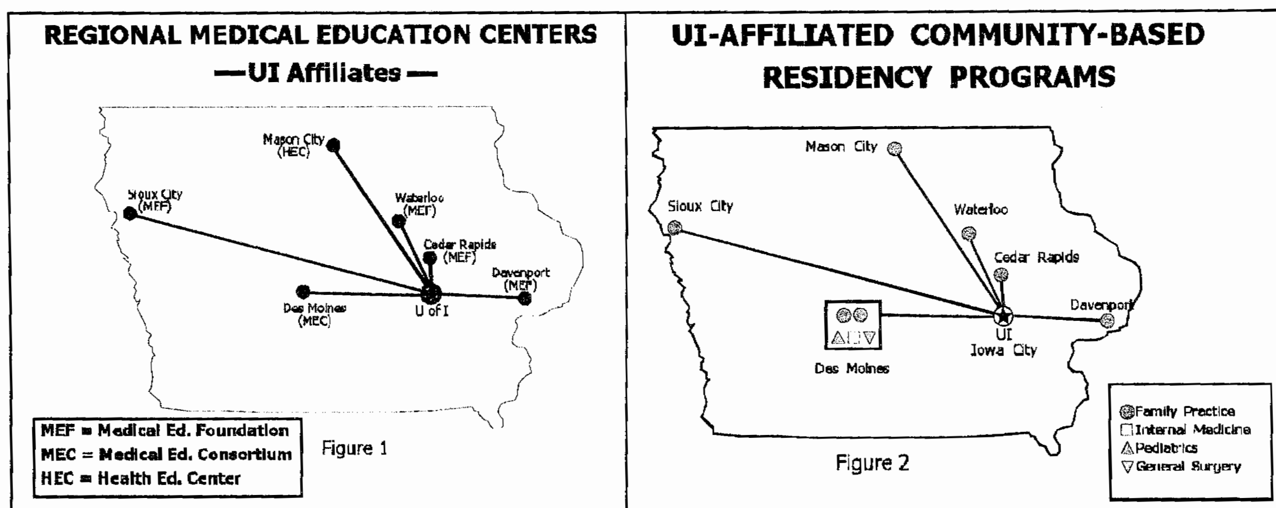
OSCEP is responsible for coordinating community-based clinical education activities for both the College of Medicine and University of Iowa Hospitals and Clinics. This role includes:

1. Liaison with University-affiliated hospitals and Regional Medical Education Centers;
2. Recruitment of community-based faculty;
3. Fostering regional faculty development programs; and
4. Tracking the records of clinical teachers and UI learners in community-based settings.

OSCEP staff also helps course directors and residency directors identify new clinical teaching resources in communities across Iowa.

Family medicine residency programs and their respective training centers were envisioned as regional training hubs for residents and students, and as a source of continuing education for the practicing physicians. UI health professions colleges, especially the College of Medicine, were expected to send students to the regional training centers, depending on local interest, needs, and educational opportunities. This vision has evolved into the Iowa version of the federal AHEC prototype.

Regional Centers



As part of the statewide system, the Carver College of Medicine and University of Iowa Hospitals and Clinics have formal affiliations with six community-based medical education entities that serve as the University's Regional Medical Education Centers in their corresponding regions *(Figure 1)*. The six medical education entities have their own residency programs and training centers *(Figure 2)*, and are financed mostly with local support. In addition to training primary care residents, the regional centers provide clinical education and training for several categories of learners, which vary depending on the site. The learners include students in medicine, pharmacy, and dentistry, and also physician assistants, pharmacy residents, and University residents in several specialties *(Exhibit A)*.

The affiliated regional centers (and the community hospitals that sponsor them) provide lodging and meals for UI students and residents. They coordinate clinical education activities for the University in their respective regions. They offer clinical teaching conferences, which UI learners attend. They manage the relations between UI learners and the medical staff offices of the local teaching hospitals. The centers provide counseling services, computer facilities with internet connections, and teleconference facilities. They also help recruit clinical teachers to provide instruction and supervision, and recommend clinical faculty in their region for appointment in the Carver College of Medicine.

In return, the College makes grants to support the administrative role of the centers, provides computers and software, appoints qualified clinical teachers to the collegiate faculty, offers faculty development workshops in the community, conducts regional faculty recognition events, and has invested in local teleconference facilities. *Exhibit B* shows the cumulative community-based faculty development activity since 1997.

Community-Based Clinical Education

Each year, University of Iowa medical students, residents, and physician assistant students spend a significant amount of time in clinical settings in Iowa communities. Much of this experience, but not all of it, is coordinated by the UI-affiliated centers and some of it occurs in the facilities of the centers.

For medical students, community-based experiences start in their first year of medical college with the Clinical Shadowing Program. Each student has three shadowing experiences in settings within 45 minutes of Iowa City. The distance is limited to allow students to attend classes during part of the day that they have a shadowing experience *(Exhibit C)*.

During the summer between the first and second year of medical college, students may elect a community-based experience in the MECO Program. MECO stands for Medical Education and Community Orientation. It exposes the student to community health care systems with an emphasis on hospital and medical office operations, but not to the exclusion of other elements of local health care systems. The duration of the experience in the community is 4-12 weeks, depending on the preferences of students and sponsors. The statewide nature of this educational program is shown on *Exhibit D*, which accounts for 25 years of medical student activity in the MECO Program. Note that the regional centers participate, but rural sites are also a popular choice for MECO participants.

The Department of Family Medicine has a required four-week student clerkship — a preceptorship based in private family medicine offices. Students consistently rate this clinical experience at a high level. A relatively stable roster of community-based faculty do the teaching. Students also have an opportunity for a preceptorship in their senior year. *Exhibit E* shows the location of last year's family medicine clerkships and fourth-year family medicine preceptorships, and *Exhibit F* accounts for 22 years of student rotations to family medicine offices across Iowa.

In 1996, the Carver College of Medicine introduced a required community-based primary care clerkship into the school's clinical curriculum. Third-year students spend four weeks in the vicinity of a University-affiliated Regional Medical Education Center. The entire course is coordinated through the regional centers. The number of students going to each regional center last year is reported in *Figure 3*.

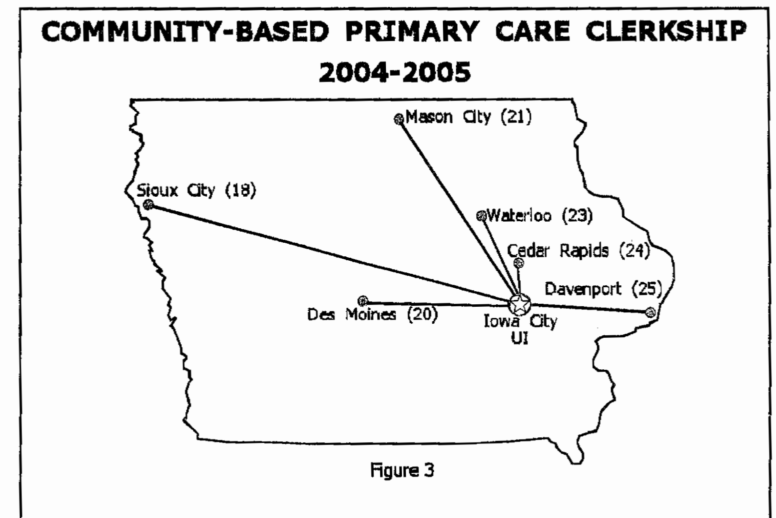


Figure 3

The clinical curriculum of the College offers other opportunities for medical students to gain experience in community-based settings. *Exhibit G* specifies the number of students participating in additional third and fourth-year experiences in community settings. The affiliated regional centers are involved directly or administratively in most of these course offerings.

Residents (i.e., house staff) in some of the University's residency programs have required rotations of four weeks or longer in community-based clinical settings. Much of this graduate training activity is coordinated through the University's regional centers *(Exhibit H)*.

Similarly, the College's Physician Assistant Training Program is dependent on community-based medical practices for much of the clinical training of physician assistant students. They leave Iowa City for rotations in several medical specialties. Again, the regional center communities are well-represented in last year's record of activity *(Exhibit I)*.

To help augment the didactic teaching effort that is so generously contributed by community-based faculty across the state, the College of Medicine sends visiting faculty to the regional centers through the College's Visiting Professor Program. The sites vary in their use of the visiting professors, who give teaching conferences and participate in other educational activities during their visits to the training sites *(Figure 4)*.

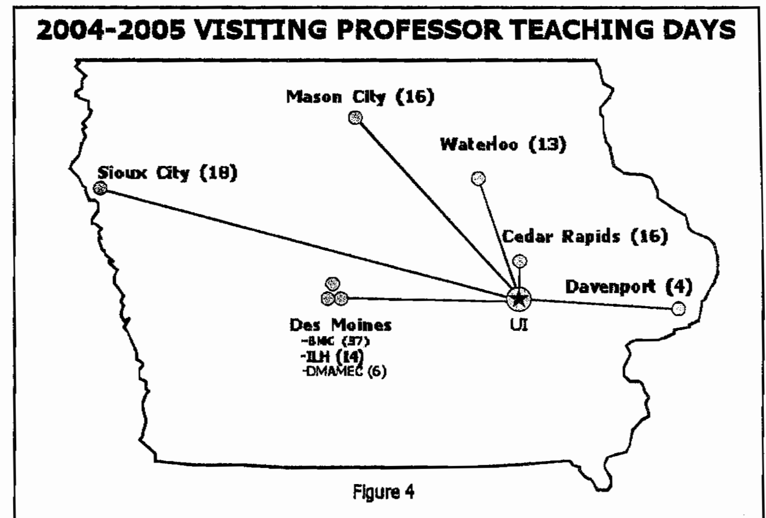
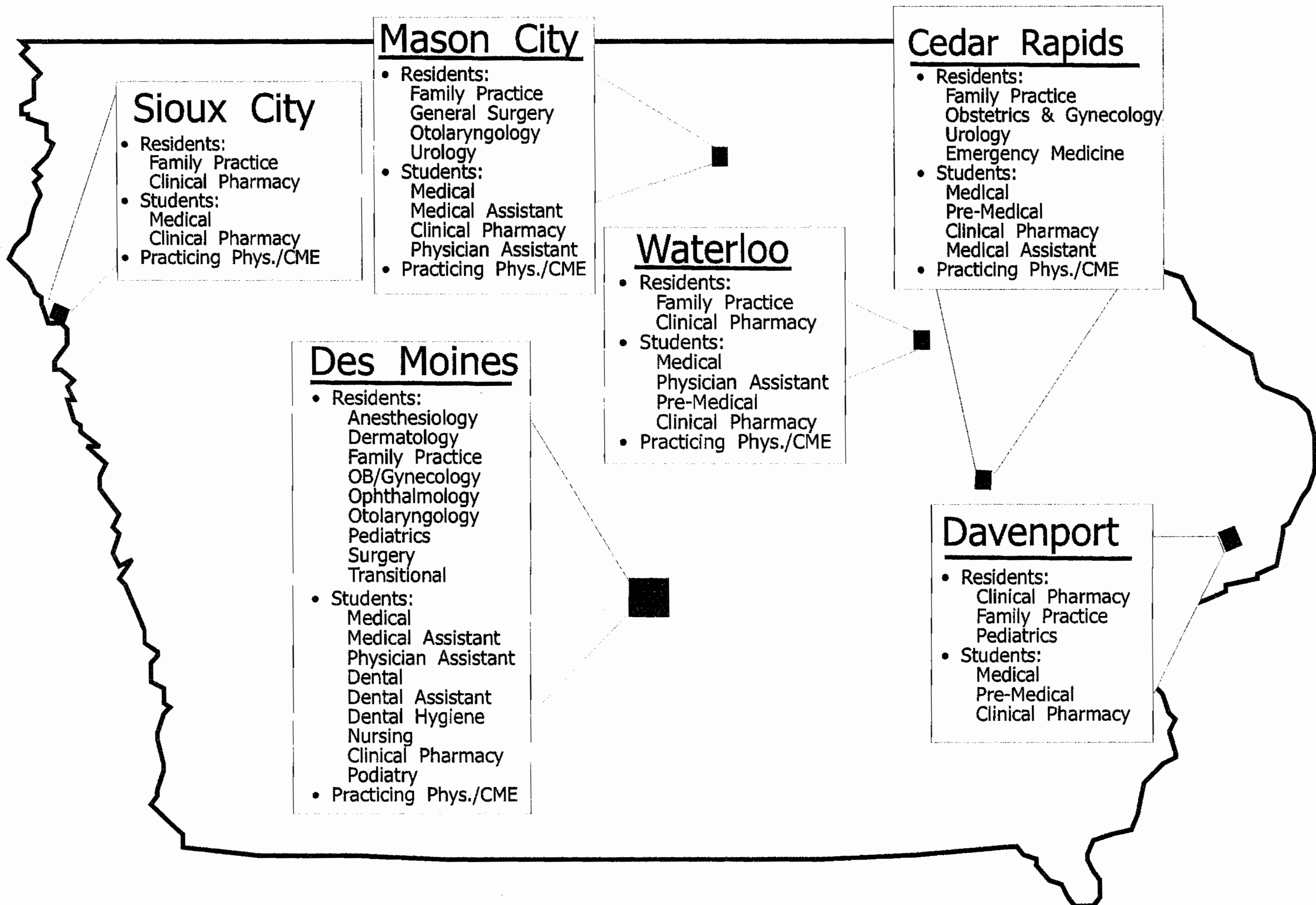


Figure 4

All of the community-based clinical education activity covered by this report can be integrated on a single graphic using symbols to stand for each category of activity. *Exhibit J* depicts the geographic breadth and programmatic depth of the University's Statewide Medical Education System.

Exhibit A

HEALTH PROFESSIONS EDUCATION in Community-Based Training Centers 2004-05



Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

UI Carver College of Medicine
Community-Based Faculty Development Program

Exhibit B

Regional Workshops	Cedar Rapids	Des Moines	Iowa City	Mason City	Quad Cities	Sioux City	Waterloo	Totals
One-Minute Preceptor (1997-98)	27	77	13	22	27	17	30	213
Evidence-Based Medicine (1997-98)	20	55	8	12	18	12	32	157
Feedback (1998-99)	9	74	8	14	10	5	25	145
Evaluation (1999-00)	13	***	19	13	22	*	18	85
Time Management (1999-00)	15	50	*	12	18	24	14	133
Giving Bad News (2000-01)	*	23	*	*	12	*	26	61
Teaching Medical Ethics (2001-02)	*	31	*	16	16	28	27	118
One-Minute Preceptor (2001-02)	18	44	+	20	14	10	20	126
Cultural Competency (2002-03)	24	12	+	15	10	31	22	114
Presentation Skills (2002-03)	29	27	+	4	12	31	20	123
Bioterrorism (2003-04)	36	11	+	12	11	23	10	103
Complementary Medicine (2003-04)	35	19	+	9	9	32	26	130
Feedback (2003-04)	3	23	+	9	10	25	26	96
One-on-One Teaching (2003-04)	7	22	+	6	15	27	24	101
Teaching Geriatrics Assessment (2003-04)	26	7	+	8	*	26	+	67
Teaching Presence of the Patient (2004-05)	10	15	+	9	10	26	24	94
Instructional Quality (2004-05)	9	17	+	10	9	23	16	84
Evaluating Learners (2004-05)	*	10	+	7	9	25	6	57
Domestic Violence (2004-05)	25	10	+	*	9	28	13	85
Latino Cultural Competence (2005-06)	9	12	+	29	11	22	10	93
Talking to Teens (2005-06)		9	+			26		
Subtotals	**315**	**548**	**48**	**227**	**252**	**441**	**389**	**2,220**

UI-Based Workshops	All Sites		
Resident in Difficulty** (1999)	17		
Teaching Ethics** (2001)	11		
Community Teaching Scholars I** (2003)	12		
Community Teaching Scholars II** (2004)	13		
Community Teaching Scholars III** (2004)	13		
Community Teaching Scholars IV** (2004)	11		
Community Teaching Scholars V** (2005)	11		
Community Teaching Scholars VI** (2005)	9		
Subtotals	97	**(Subtotal)**	**97**
Total Faculty Attendance			***2,317***

* Cancelled due to low registration.
** Train the Trainer
*** In Des Moines, Feedback and Evaluation were combined.

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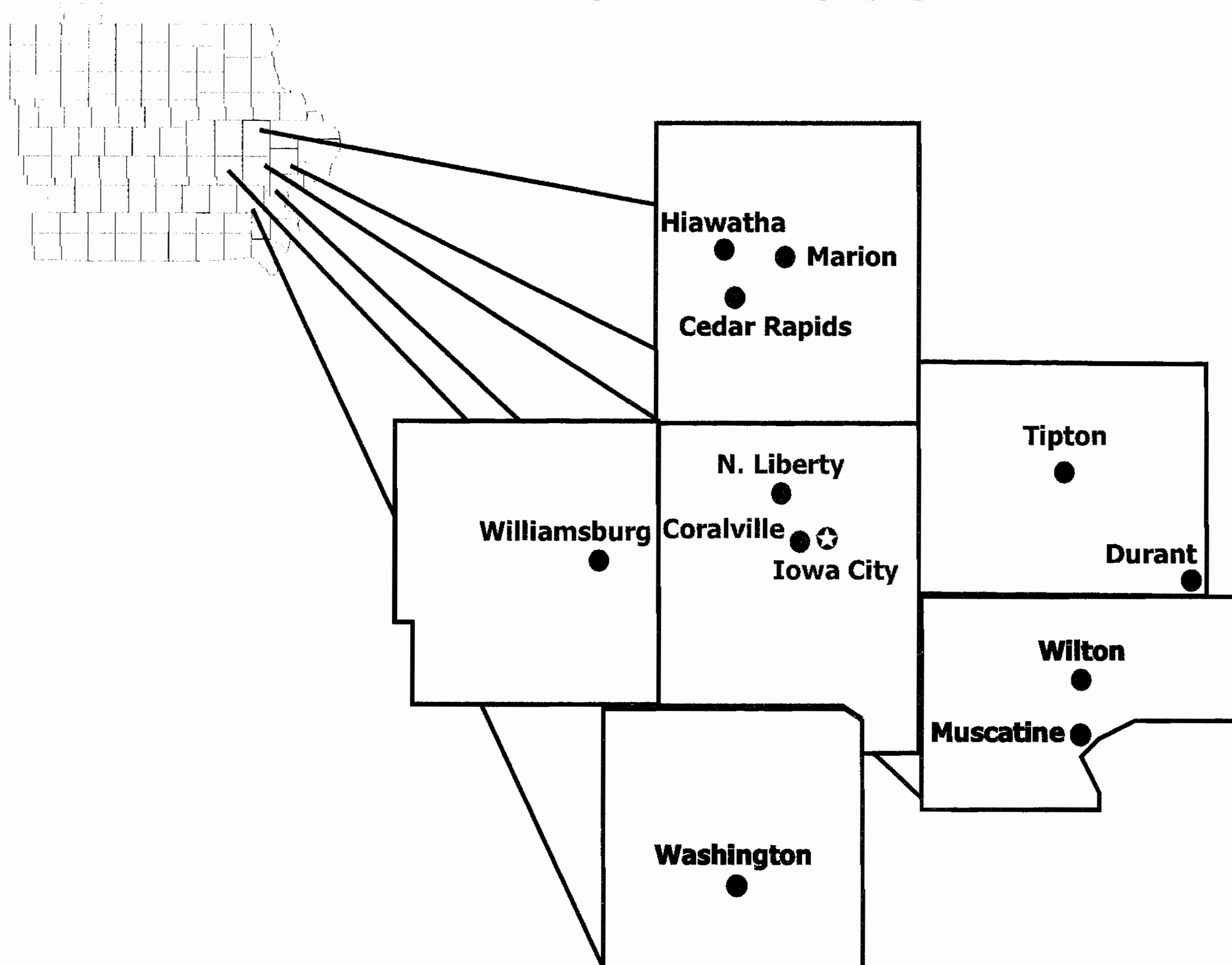
Clinical Shadowing Program*
2004-2005

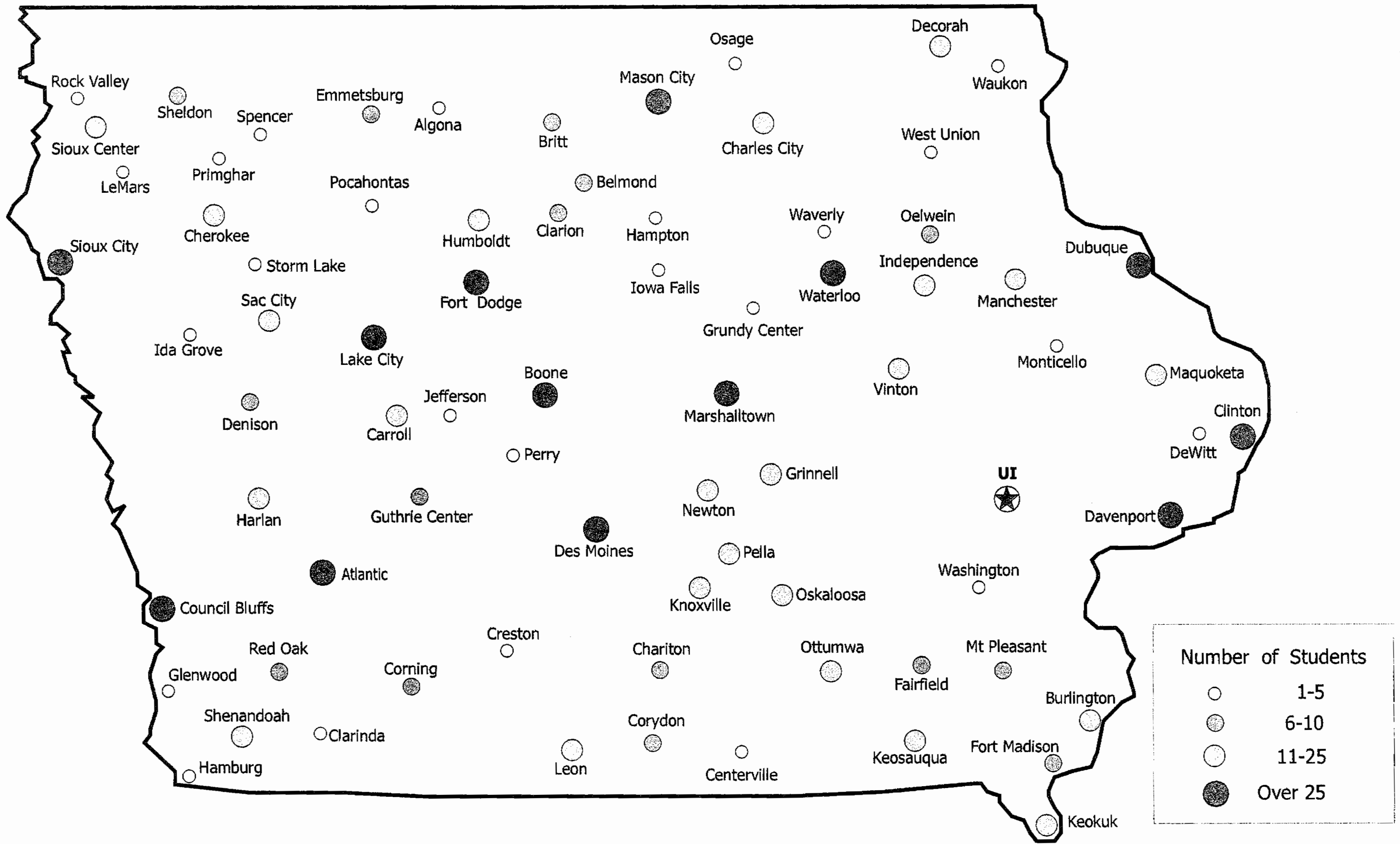


***First-year medical students**

With 135 M1s, a total of 402 slots were needed to place each student in 3 clinical settings.

Exhibit I

MEDICAL EDUCATION AND COMMUNITY ORIENTATION PROGRAM SITES 1980-2005*



***Does not include 1984 MECO activities.**

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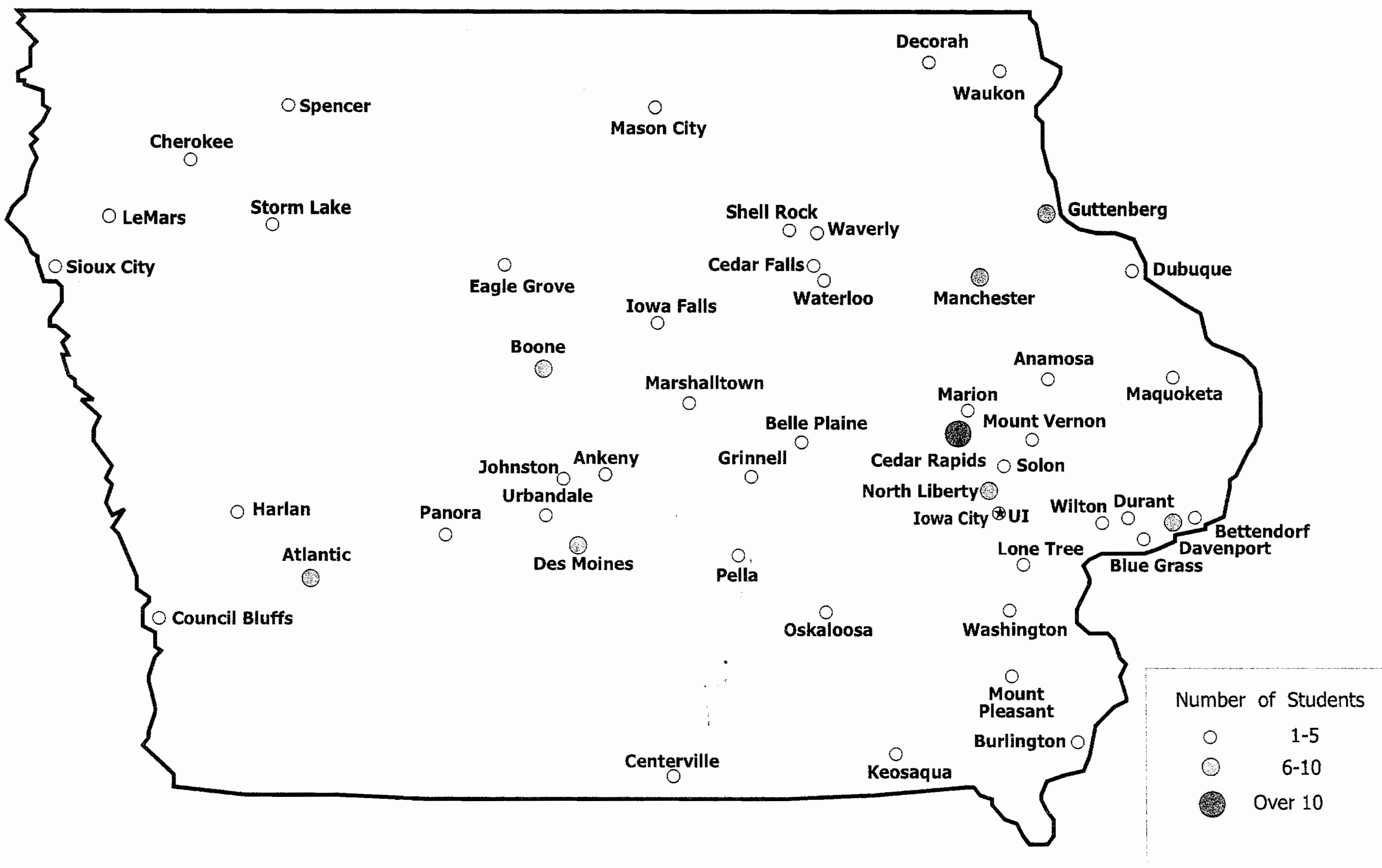
Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

FAMILY MEDICINE STUDENT PRECEPTORSHIPS 2004-2005



Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

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Exhibit F

FAMILY MEDICINE STUDENT PRECEPTORSHIPS
1984-2005

Rock Rapids
Estherville
Spirt Lake
Sibley
Sheldon
Northwood
St. Ansgar
Cresco
Waukon
Decorah
Forest City
Osage
Clear Lake
Emmetsburg
Mason City
Charles City
West Union
Spencer
Orange City
Sioux Center
Algona
Rockford
Elkader
Belmond
Waverly
Greene
Oelwein
Guttenberg
Cherokee
Humboldt
Clarion
Aplington
Shell Rock
Cedar Falls
LeMars
Eagle Grove
Iowa Falls
Edgewood
Kingsley
Storm Lake
Parkersburg
Dubuque
Sioux City
Fort Dodge
Independence
Dyersville
Sac City
Webster City
Waterloo
Manchester
Grundy Center
Gowrie
Bellevue
Story City
Traer
Center Point
Lake City
Anamosa
Onawa
Marshalltown
Marion
Denison
Ogden
Vinton
Maquoketa
Boone
Mount Vernon
Carroll
Nevada
Belle Plaine
Cedar Rapids
Manilla
Perry
Amana
DeWitt
Clinton
Grinnell
Marengo
Solon
Tipton
Johnston
Ankeny
Durant
Panora
Newton
North Liberty
UI
Iowa City
Logan
Urbandale
Bettendorf
Harlan
Coralville
Wilton
Des Moines
West Liberty
Atlantic
Pella
Kalona
Davenport
West Des Moines
Buffalo
Carlisle
Lone Tree
Blue Grass
Clive
Pleasantville
Sigourney
Muscatine
Indianola
Oskaloosa
Washington
Council Bluffs
Wapello
Red Oak
Creston
Chariton
Fairfield
Winfield
Ottumwa
Burlington
Shenandoah
Mount Pleasant
Leon
Centerville
Hamburg
Clarinda
Corydon
Keosauqua
Lamoni
Fort Madison
Keokuk

Number of Students
- 1-10
- 11-25
- 26-50
- Over 50

Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

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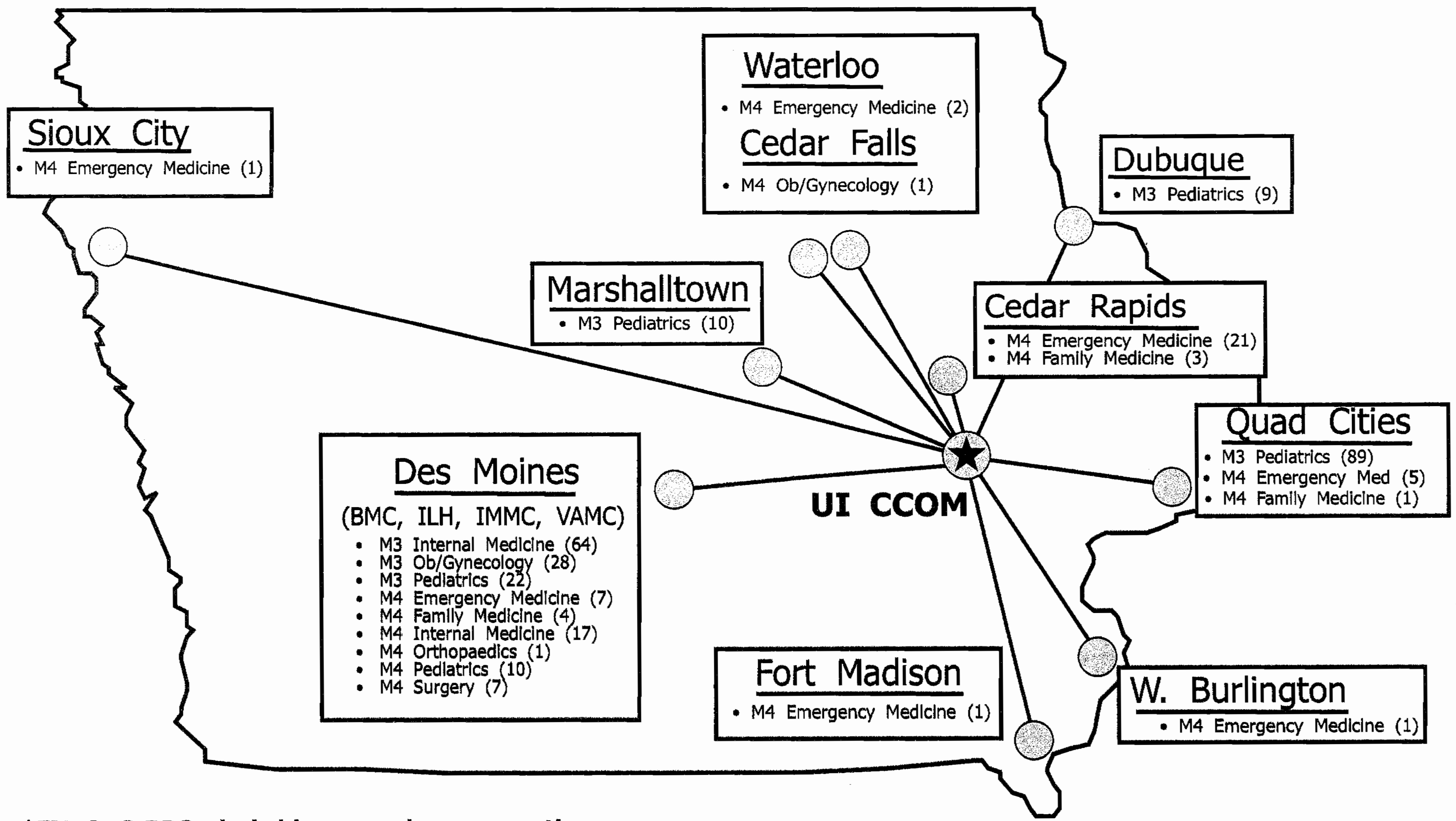
OTHER* CLERKSHIP AND ELECTIVE SITES 2004-2005



***FM & C-BPC clerkships are shown on other maps**

Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

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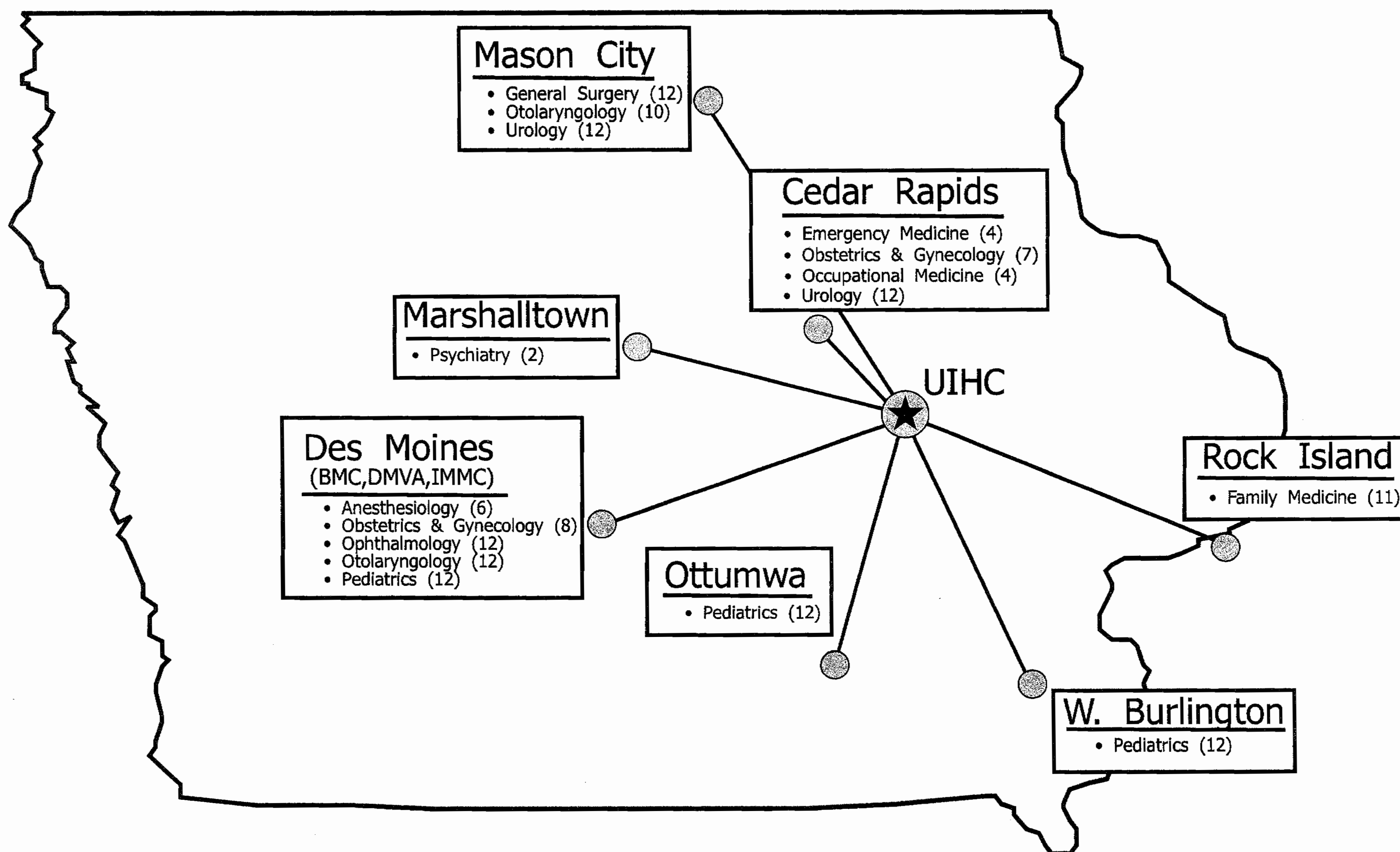
COMMUNITY-BASED HOUSE STAFF ROTATIONS*
UIHC/CM
2004-2005



***These are required rotations totaling X months of clinical training.**

Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

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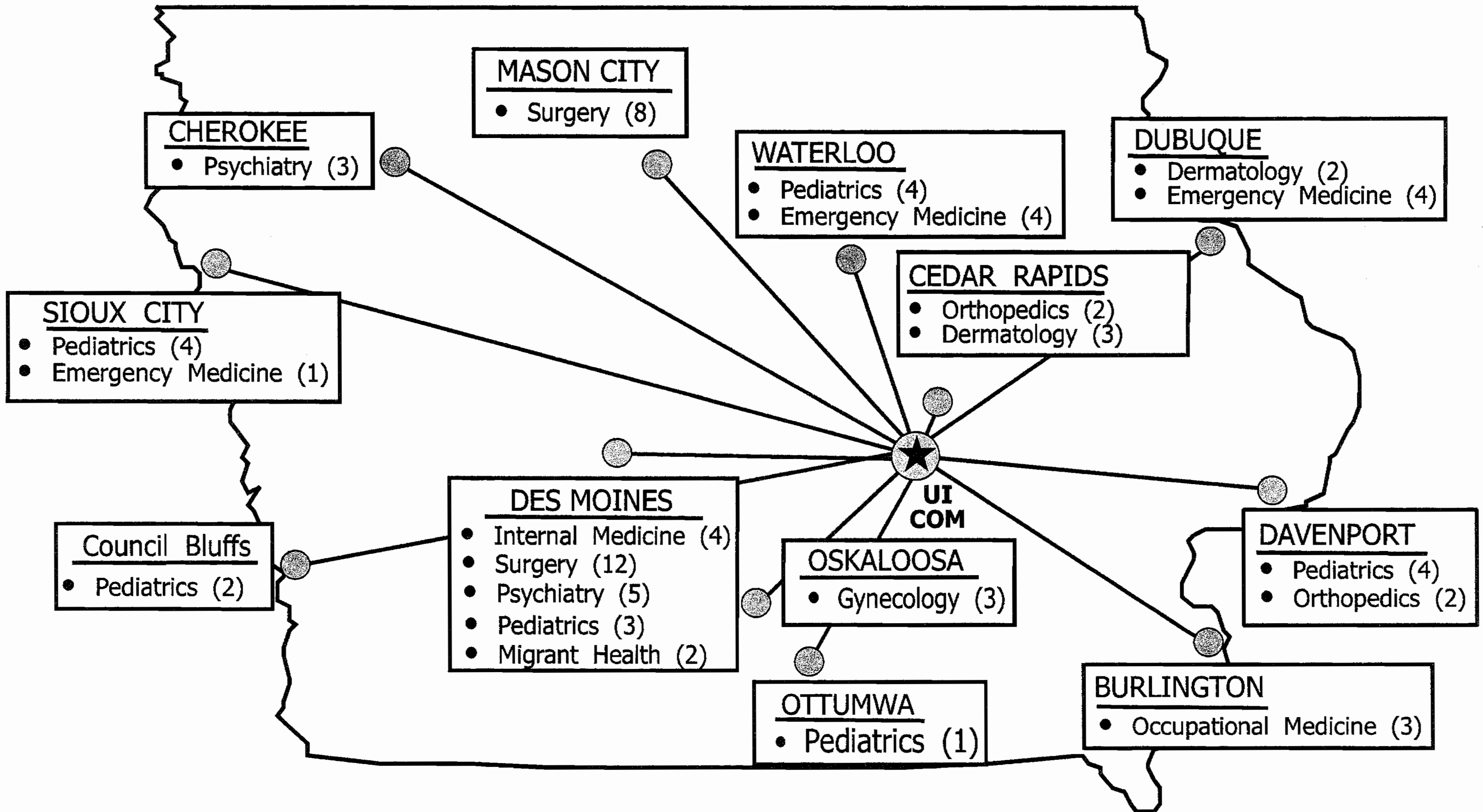
Exhibit I

PHYSICIAN ASSISTANT PROGRAM
Community-Based Training Sites*
2004-2005



***Not Including FM Rotations**

Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

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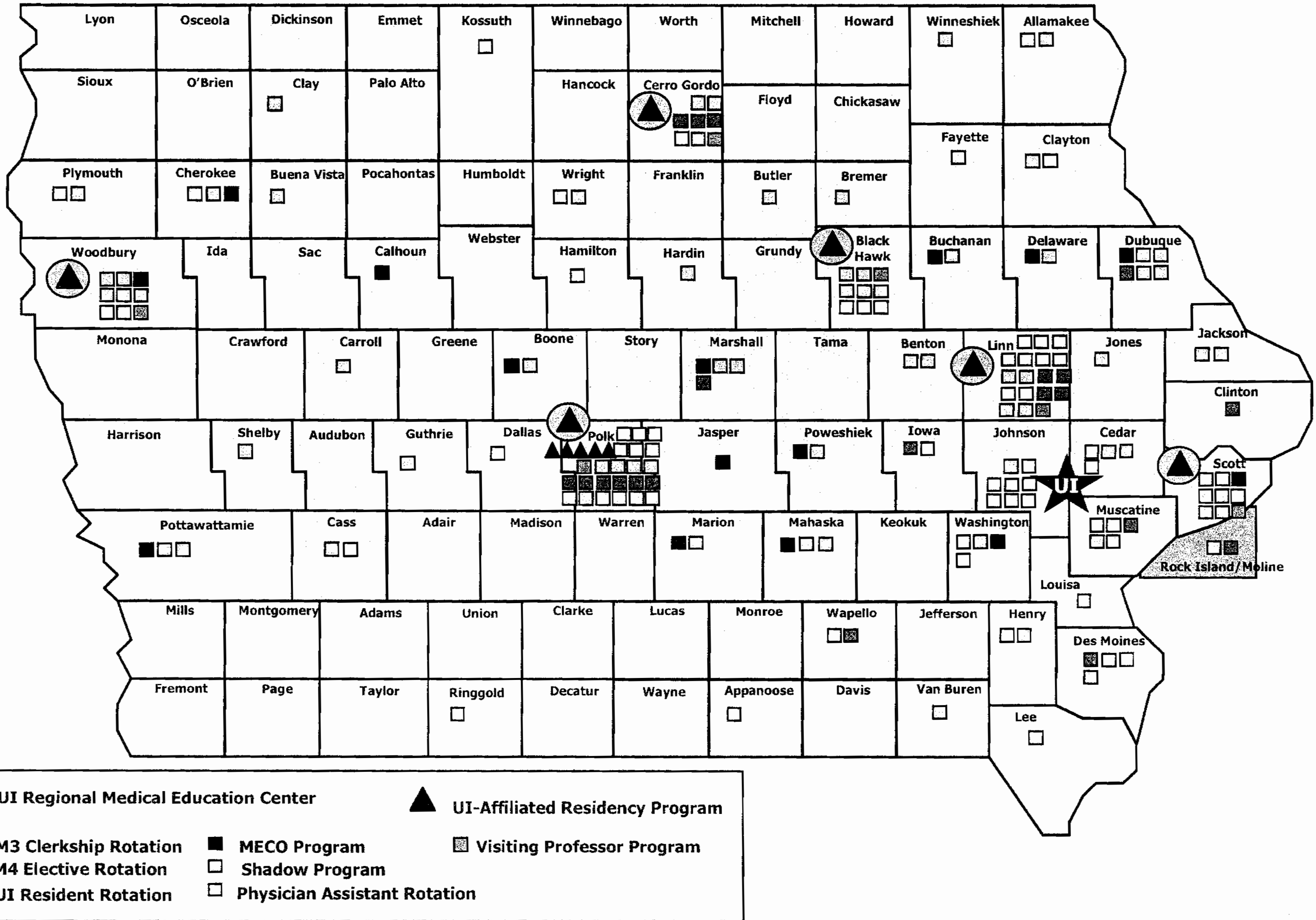
Exhibit J

STATEWIDE MEDICAL EDUCATION SYSTEM
Location of Educational Activities
2004-2005



Source: Office of Statewide Clinical Education Programs, UI Carver College of Medicine, October 2005

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