

Minutes  
 Health & Long-Term Care Access Advisory Council  
 March 25, 2010  
 10:30 a.m. – 3:00 p.m.  
 West Des Moines Community Schools: Learning Resource Center

**Members Present**

Cindy Baddeloo  
 Roy Bardole  
 Ryan Hopkins  
 Laura Malone  
 Julie Stauch

**Members Absent**

Shelly Chandler  
 Bobbretta Brewton  
 Conway Chin  
 Betsy Chrischilles  
 Sue Curry  
 Libby Coyte  
 Michele Devlin  
 Molly Guard  
 Angela Johnson  
 Steve Johnson  
 Daniel Otto  
 David A. Plundo  
 Sabra Rosener  
 Roger Tracy

**Others Present**

Wendy Gray, Des Moines University AHEC (rep for David Plundo)  
 Carol Alexander, The University of Iowa (rep for Roger Tracy)  
 MJ Venteicher, Iowa Health Care Association  
 Julie McMahon, Iowa Department of Public Health  
 Michelle Holst, Iowa Department of Public Health  
 Kevin Wooddell, Iowa Department of Public Health  
 Sandy Nelson, Iowa Medical Society  
 Jonathan Hellenback, Iowa Pharmacy Association  
 Gloria Vermie, Iowa Department of Public Health  
 Julie McMahon, Iowa Department of Public Health  
 Doreen Chamberlin, Iowa Department of Public Health

\*Health and Long-Term Care Advisory Council Web site [http://www.idph.state.ia.us/hcr\\_committees/care\\_access.asp](http://www.idph.state.ia.us/hcr_committees/care_access.asp)

Topic	Discussion
Call to Order  Introductions and Welcome	Michelle Holst <ul style="list-style-type: none"> <li>▪ Members and guests introduced themselves</li> </ul>
Update on SF 2092 and IowaCare  Anne Kinzel, Coordinator, Legislative Health Care Coverage Commission	<p>Anne Kinzel with the <a href="#">Iowa Legislative Health Care Coverage Commission</a> presented an update on IowaCare program legislation.</p> <p>The <a href="#">presentation is available</a> on the Health and Long-term Care Advisory Council's Web site.</p> <p>The commission was created by legislature in 2008 and began work in September 2009. The commission consists of 11 citizens, 4 legislators, and 3 department heads. The commission is to provide recommendations to increase access for low-income adults.</p> <p>Issues in adult coverage include affordability (premiums and co-pays) and coverage availability (preexisting condition exclusions and lifetime maximums).</p> <p>Affordability is about wages. A family's premiums in Iowa have increased by 95 percent from 2000 to 2009.</p> <p>State Reform <a href="#">SF 2356</a> (Formerly <a href="#">SF 2092</a>) includes expansion of IowaCare, development of a statewide diabetic registry, and the creation of an Iowa insurance exchange.</p> <p>Current eligibility for IowaCare is between ages 19-64, income less than 200 percent of federal poverty level, no insurance, and not eligible for Medicaid.</p> <p>Proposed enhancements to existing IowaCare includes:</p>

- Regional care network
  - Utilize the 14 Federal Qualified Health Centers
- Other primary providers
  - Authorize DHS to designate other private providers and hospitals as participants in regional network
- Emergency care
- Expand to include less than 300 percent of federal poverty level

Creation of a Diabetic Care Coordinator:

Requires IDPH to develop a plan to coordinate diabetes care for patients at community health centers, rural health clinics, free clinics, & other collaborative safety net provider network members. Also, enhance prescription medication access through the Iowa Prescription Drug Donation Repository.

Recommendations for an Iowa Insurance Exchange:

- Begin to design an insurance exchange. State government should facilitate the creation and provide oversight. Expand transparency on cost and quality and develop definition for health care quality and pricing.
- Provide readily available & reliable information.
- Organize existing or reformed market.
- Exchange established in the Insurance Division.
- Provide information regarding all coverage available in the state.
- Statutory options that improve seamlessness in the health care system in the state.
- Establish methodologies to provide uniform & consistent side-by-side comparisons of coverage options.
- The Commission & Insurance Commissioner will have 180 days to construct a plan.

There have been some amendments to the bill. One of which is to improve the workings between Broadlawns and their tax picture with respect to IowaCare.

**Questions:**

Would existing programs such as DHS offers would be on the exchange?

- The exchange would include public and private source for insurance information.

Are you anticipating any difficulty in getting apples-to-apples comparison information from insurance companies?

- I would assume the companies would follow the law. The law is encouraging and the Insurance Commissioner is charge with moving this forward.
- If the definitions are there and clear enough, they would have to provide the information that fit into those definitions.

Can you explain the implications of the Broadlawns amendment?

- The intent of language in the bill is designed to ensure that Broadlawns is the primary provider for IowaCare in Polk County until they are made whole.
  - This is because Broadlawns is putting up the money that allows the state to draw down federal funds.
  - Broadlawns agrees the language now proposed adequately protects their exposure.

How do anticipate getting information to small business owners about the exchange?

- I think this is going to be a significant challenge.

It seems that from the beginning of arguments over health insurance we missed the point. The point is health care is very expensive. How can we maintain quality and reduce the cost.

- What we have defined as quality, in the U.S. health care, largely by quantity.

	<p>Therefore, we have defined quality by what we make available, but is it really quality in terms of what is being returned to us?</p> <ul style="list-style-type: none"> <li>○ We will need to redefine what quality is and how we think and operate.</li> </ul> <p>Another issue is litigation protection. A portion of our society is litigation prone but when they win a claim, it could be devastating to the physician and hospital/facility. What part of the tests the doctor prescribes is defensive medicine related?</p> <ul style="list-style-type: none"> <li>• There probably a certain number of tests are being ordered to protect oneself. <ul style="list-style-type: none"> <li>○ The estimates I have seen, in terms of cost it adds to the national health care bill, are approximately 1.8 percent.</li> </ul> </li> <li>• We need to think about physicians and testing is to think about outcomes not the test itself.</li> </ul>
<p>Members Sharing Information &amp; Awareness</p> <p>Michelle Holst</p>	<p>Iowa Needs Nurses Now Bill - <a href="#">SF 2384</a> - Relating to the nursing workforce including the establishment of an Iowa needs nurses now initiative. Included in the bill is the establishment of a nursing workforce data clearinghouse; develop recommendations to determine options for additional data collection; funding sources for financial assistance; frame work/infrastructure for financial assistance program; and lab simulation. If the bill passes, the next step is to promulgate the rules.</p> <p>AHEC Bill – <a href="#">SF 2170</a> - An Act providing an appropriation for matching funds for area health education centers. This act contains an appropriation from the general fund of the state to the department of public health for the fiscal year beginning July 1, 2010, and ending June 30, 2011.</p>
<p>Integration of Related Activities</p> <p><i>Direct Care Worker Advisory Council</i></p> <p>Jennifer Furler, State Public Policy Group</p>	<p>Jennifer Furler, State Public Policy Group, presented an overview of activities related to the Direct Care Worker Advisory Council.</p> <p>Legislation from 2008, HF 2539, directed Iowa Department of Public Health to establish an advisory council. The council’s responsibilities include advising the director regarding regulation and certification of direct care workers, based on the work of the direct care workers task force established pursuant to 2005 Iowa Acts, Chapter 88.</p> <p>The advisory council has very broad representation. It is made up of representatives of direct care workers, educators of direct care workers, other health professionals, employers of direct care workers, and appropriate state agencies.</p> <p>The council defines a direct care worker as an individual who provides supportive services and care to people experiencing illnesses or disabilities and does not included nurses, case managers, social workers, and other professionals licensed or certified by a board.</p> <p>The board continues to learn more about the size and diversity of the workforce. The group believes there are around 100,000 direct care workers (including CNAs, home health aides, and others) that fall within their definition. There is varied functionality in the workplace of direct care workers.</p> <p>Direct care occupations include 3 of the 10 fastest growing jobs next decade and Iowa is anticipated a need for 10,000 new direct care workers by 2016. Most direct care occupations do not have state or national recognized educational standards and education has lagged with demand for service and changing preferences by consumers.</p> <p>The way the council is approaching this is as a need for a comprehensive solution. Their recommendations include quality and portability of education of education training; the need for career pathways; recruitment and retention; job satisfaction; professionalism; and wages and benefits. Education pathways and requirements could include specialty endorsements (e.g. brain injury, Alzheimer’s and dementia, medication, assistance, and others). This would allow for unique packages of skill for direct care workers.</p>

The council is recommending the creation of a professional board. The board would provide coordination and oversight of the workforce. The board would issue state recognized certification and be administered within the Iowa Department of Public Health.

Another element of the council's recommendations is continuing education. They are recommending a two-year cycle for completion of continuing education. Any advanced education or training towards any specialty endorsements the worker would undertake, the worker would receive credit towards their continuing education requirements.

The council has recommended a train-the-trainer infrastructure. This would increase training capacity and foster an assortment of training entities (e.g. employers, community colleges, non-profit or private entities). There would be numerous opportunities for choice for workers and employers on how training would be offered. In addition, they have recommendation for instructional requirements along with considered alignment with federal regulations related to CNA training.

The council recommended a reporting process for grandfathering direct care workers. Direct care workers would need to meet certain criteria for grandfathering. This would allow workers to report their skills and the functions they perform and be recognized under this system.

Technology recommendation by the council is an education management system. The system would be utilized for administration, documentation, reporting, delivery of online education, and reporting of grandfathering. The council is looking at existing system where possible (IDPH learning management system, DIA registry).

Next steps for the council are to develop a plan, evaluation recommendations, locate resources, and partners for a pilot program. Additionally, the council is integrating input from stakeholders to further curriculum development.

This will be something new for workers and employers - kind of a cultural change. Right now, employers are responsible for training workers whereas this shift responsibility onto the worker, like other professions, to maintain their training.

More information on the Direct Care Worker Advisory Council and their reports are available at [http://www.idph.state.ia.us/hcr\\_committees/direct\\_care\\_workers.asp](http://www.idph.state.ia.us/hcr_committees/direct_care_workers.asp).

**Questions:**

How do you see this functioning in rural areas with limited population and need for direct care workers?

- The way the system is structured addresses the needs in rural Iowa particularly well. With this system, a direct care worker would be able to have a package of skills to provide a variety of services in the community. This would allow workers to be more flexible with their skills.
- This system would create diversity among direct care workers and flexibility for providers that have workers that address a variety of different needs.

Would it be a lot more like any other professional who is licensed? A direct care worker would be a direct care worker who could work in a number of settings.

- Direct care worker personnel are trained by their employer to work specifically with that population. The idea is this would be broader. They would be introduced to services through the continuum and be able to provide some of those services.
- A direct care worker or an agency could encourage their workforce to have a number of these training modules so they could provide a whole host of services to individuals.
- This would create many opportunities in rural Iowa. There is a lot of opportunity exploration into the role of a direct care worker.

Which community colleges are participating in the pilot?

	<ul style="list-style-type: none"> <li>• The council wants to include one rural community college and one urban. Since a number of community colleges have expressed interest, there will be some sort of application or letter of interest.</li> </ul> <p>My hope would be that this would eventually stabilize the workforce. Many of my nursing home workers are nursing students and use direct care worker positions as a stepping-stone to further their career.</p> <p>Thought was expressed about type of penalty with direct care workers for poor decision-making. As a nurse, physician, or any licensed profession, you can have your career and your profession taken away from you if you do not make that. If I walk in and say I am quitting today and I abandon my patient I am reported to the board of nursing, I could lose my license or have it put on probation. A home care aide or CNA they can walk in and quit, they could go down the road and hired on almost immediately.</p> <ul style="list-style-type: none"> <li>• This has been discussed and some options for addressing poor behavior, including issuing warning letters.</li> <li>• You would have to teach people what it means to have a credential. The council has talked about this.</li> </ul> <p>Another thing that would be helpful from a federal level would be a standard level/competency.</p> <ul style="list-style-type: none"> <li>• It appears federally they are driving towards demonstration projects that could indicate something like this could work.</li> <li>• If you could make something like this work at the state level, you might help eliminate or fragmentation of federal regulation. Also, there are state regulations that are conflicting by setting.</li> </ul> <p>Not knowing how the health care bill will affect direct care workers, there are many respite providers and organizations that employ 200-300 people and they will be considered employers. Therefore, will they be required to provide health insurance or penalized? How will this impact the home and community based respite providers?</p> <p>Somehow, we have to reward people that do a good job and the job they do. And, not have them think they have to move to administration.</p> <ul style="list-style-type: none"> <li>• They need to be able to make a living and to be able to support their families.</li> <li>• It is not just a monetary value but also the general value of the work.</li> </ul>
<p>Strategic Plan Discussion</p> <p>Michelle Holst</p>	<p>Michelle Holst led discussion on the sub plans within the council’s strategic plan specifically regarding Anne Kinzel’s and Jennifer Furler’s presentations. This information can impart the upcoming strategic plan and how the council moves forward in the future.</p> <p>Michelle asked the council what stood out in Anne’s presentation as it applies to health care delivery infrastructure and health care workforce resources?</p> <p>As an employer, we received notice that our employee health plans are increasing 31 percent. Therefore, as an employer that will have an impact because our family plan will rise \$2,200 and a single will be over \$700. That will really impact the number of individuals I employ.</p> <p>Health care reform impact on employers and health care workers in ways we cannot believe.</p> <p>What do we have to take into account that happened this session at both the state level and federal level. What do we need to change and/or remove from our strategic plan?</p> <p>From an AHEC perspective, I wonder about if there is enough workforce to see all the newly insured. Incentives for workforce to enter and stay into fields still have to be a central and core component moving forward. Included in the incentives include reimbursement rates, earnings/earning potential, pathway programs, scholarships, loan</p>

	<p>forgiveness, etc...can be utilized to increase the workforce to address the new demand for health care services.</p> <p>How are we going to educate and assist the tens of thousands people on where to access the new health care delivery system and what services are they eligible? Patient education and patient navigation are going to be huge challenges.</p> <p>In family planning, the family planning agencies/programs do the enrollment not DHS. We have staff that do enrollment of the clients.</p> <p>Assuring access for all Iowans could include “Assure that all Iowans know how to enroll or access health care programs and plans.” Council agreed that this may be key for the strategic plan.</p>
<p>Intro to the Center for Rural Health and Primary Care 2010 Annual Report</p> <p>Gloria Vermie, State Office of Rural Health, IDPH</p>	<p>Gloria Vermie, director of the <a href="#">State Office of Rural Health</a> presented an introduction to the Center for Rural Health and Primary Care.</p> <p>The <a href="#">presentation is available</a> on the Health and Long-term Care Advisory Council’s Web site.</p> <p>Why Rural Health?</p> <ul style="list-style-type: none"> <li>• 45 percent of Iowans live in rural areas</li> <li>• 82 percent of the land in Iowa is agricultural/farms</li> <li>• Agriculture is the most hazardous industry in the U.S. with rates of 27.3 per 100,000 workers</li> <li>• There is disparity in health and medical care for rural communities</li> <li>• Access to care is the overriding problem in rural America</li> </ul> <p>Beginning in 1989, rural Americans mortality rate increase compared to Americans in urban areas. Nobody knows why. Additional information can be found at <a href="#">Tracing Rural America’s Mortality Penalty</a>.</p> <p>Challenges in rural health include health care workforce, reimbursement rate federal and state, decreased rural economy base, health insurance, age, poverty levels, and access to facilities and preventative medicine.</p> <p>When you talk about self-insured, you are talking about less insurance. The farmers in the lowest income bracket (&lt; \$30,000) pay over 30 percent of their income for health insurance. Overall, one-fourth of all farmers in Iowa pay more than 25 percent of their income on insurance.</p> <p>Solutions include celebration of the culture of rural; advocate and support policy that addresses rural health issues; monitor federal &amp; state guidelines; utilize grants and programs offered to rural communities and providers; collaborate to enhance workforce; improve information &amp; communication within rural areas.</p> <p>Gloria provided the council with an overview of the Center for Rural Health and Primary Care 2010 Annual Report that is available at <a href="http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/2010_rhpc_annualreport.pdf">http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/2010_rhpc_annualreport.pdf</a>.</p> <p>A CD of the report was distributed to those in attendance. Additional CDs are available on request and printed copies should available mid-April. Contact Kevin Wooddell at <a href="mailto:kwooddel@idph.state.ia.us">kwooddel@idph.state.ia.us</a> or 515-281-6765.</p>
<p>Standing Agenda Item, Member Sharing, Information and Awareness</p>	<p>Julie Stauch described the Iowa Needs Nurses Now initiative. The Iowa Needs Nurses Now website address is <a href="http://www.ianeedsnursesnow.org">http://www.ianeedsnursesnow.org</a>.</p> <p>There is an Iowa Needs Nurses Now bill that will create the infrastructure needed for the</p>

	<p>initiative. What needs to happen first is 1) create a data-clearing house, 2) funding for financial assistance specifically to nurse educators. Another part of it is clinical experience lab simulators. The goal is to create four regional lab simulator opportunities that can be shared by nursing schools across the state.</p> <p>Iowa Needs Nurses Now will be holding a series of forums in 11 different communities with nurses. Each forum will have a panel of speakers to discuss what Iowa Needs Nurses Now has learned and discuss what the initiative is trying to achieve. The forums will also address what needs nurses see along with what is happening within the nursing profession. The forum schedule is available at <a href="http://www.ianeedsnursesnow.org">http://www.ianeedsnursesnow.org</a>.</p> <p>When did the hospitals close their schools of nursing?</p> <ul style="list-style-type: none"> <li>• The hospitals have not closed them. It is the clinical experience opportunities because of the reduced bed days for patients. This reduction has been a trend for a number of years. This reduces opportunities to get clinical experience needed.</li> </ul> <p>Should the council advocate for interdisciplinary clinical programs/experiences?</p> <ul style="list-style-type: none"> <li>• In rural areas, it is an interdisciplinary team in the community.</li> <li>• There is a push to promote more interdisciplinary clinical training at the student level, which prepares them for collaborative relationships.</li> </ul>
<p>Next Steps <i>Plans for future meetings</i></p> <p><i>Conclusions/directions from today</i></p>	<p>The next council meeting will include a joint session with the Rural Health and Primary Care Advisory Committee. In terms of our plans within our plan is rural health care resources and we will be relying on Gloria Vermie and other staff within the Department of Public Health.</p> <p>Things that stand out during the meeting:</p> <ul style="list-style-type: none"> <li>• Continue to build the workforce because of a pending need for health care providers.</li> <li>• Access equals location and availability</li> <li>• Affordability equals health care and insurance costs</li> </ul> <p>Did Iowa Legislature use any part of our report for legislation this year?</p> <ul style="list-style-type: none"> <li>• Not directly</li> <li>• Some of our recommendations would not have opportunities until at least next year (i.e. codifying the Iowa Health Workforce Center).</li> </ul> <p>Access is a function of availability and affordability. Availability is a function of workforce and location. Affordability is a function of cost and insurance. Therefore, as a council what parts can we truly affect. This may need to be included within the strategic plan and what parts are the most important.</p> <ul style="list-style-type: none"> <li>• As a council/state has more ability to affect availability.</li> </ul>

**Next meeting:** Thursday, May 27, 10:30 a.m. to 3:00 p.m.

Location: West Des Moines Community Schools: Learning Resource Center, West Des Moines, IA