

Minutes
 Health & Long-Term Care Access Advisory Council
 August 26, 2010
 10:30 a.m. – 3:00 p.m.
 Urbandale Public Library: Urbandale, Iowa

<u>Members Present</u>	<u>Members Absent</u>	<u>Others Present</u>
Roy Bardole	Cindy Baddeloo	M.J. Venteicher, Iowa Health Care Association (rep for Cindy Baddeloo)
Bobbretta Brewton	Betsy Chrischilles	Conway Chin, Iowa Osteopathic Medical Association (rep for Leah McWilliams)
Shelly Chandler	Libby Coyte	Francisco Olalde, The University of Iowa (rep for Roger Tracy)
Ryan Hopkins	Michele Devlin	Nicole Schultz, Iowa Pharmacy Association (rep for Betsy Chrischilles)
Steve Johnson	Brian Ferrell	Greg Boattenhamer, Iowa Hospital Association (rep for Laura Malone)
Jill Scott-Cawiezell	Brian Kaskie	Anne Wright, Mercy Medical Center (rep for Brian Farrell)
Catherine Simmons	Laura Malone	Wendy Gray, Des Moines University AHEC (rep for David Plundo)
	Leah McWilliams	
	Daniel Otto	Gloria Vermie, Iowa Department of Public Health
	David A. Plundo	Kevin Wooddell, Iowa Department of Public Health
	Julie Stauch	Michelle Holst, Iowa Department of Public Health
	Roger Tracy	Doreen Chamberlin, Iowa Department of Public Health
		Phil Wise, Planned Parenthood of the Heartland
		Sandy Nelson, Iowa Medical Society
		Bobbi Buckner-Bentz, Iowa Department of Public Health
		Anne Kinzel, Iowa Legislative Health Care Commission
		Todd McGee, Iowa Workforce Development
		Michele Greiner, Iowa Psychological Association

*Health and Long-Term Care Access Advisory Council Web site http://www.idph.state.ia.us/hcr_committees/care_access.asp

Topic	Discussion
Introductions and Welcome	Michelle Holst welcomed the attendees to the meeting.
Brief Review of May Meeting and Update on Overall Strategic Planning Progress	Michelle Holst provided an overview of the minutes from the May 2010 meeting. Michelle is meeting with individual members to gather information about different organizations and their areas of interests and how we move the committee forward.
Michelle Holst, IDPH	Michelle is open to suggestions regarding subcommittees/workgroups. The department can conduct conference calls and/or web meetings such as GoToMeeting. Submit any ideas for subcommittees/workgroups to Michelle. The committee's last meeting was in conjunction with the Center for Rural Health and Primary Care Advisory Committee. The committee's next meeting is September 9, 2010. Additional information on the committee is available at http://www.idph.state.ia.us/hpcdp/rural_health_primary_care.asp .

It is anticipated that Louis Lex will be presenting on Community Health Needs

Assessment and Health Improvement Plan (CHNA & HIP) at the October meeting. Additional information on CHNA & HIP is available at <http://www.idph.state.ia.us/chnahip/default.asp>.

Certificate of Need 101 Barb Nervig, Iowa Department of Public Health, provided the committee with a basic primer and history of the Certificate of Need program. Ms. Nervig has been with the program for 21 years; administering the program for 18 of those years.

Barb Nervig, IDPH

Presentation available at http://www.idph.state.ia.us/hcr_committees/common/pdf/care_access/20100826_certificate.pdf

Certificate of Need (CON) is a regulatory review process that requires application to the Department of Public Health for, and receipt of, a certificate of need prior to the offering or development of a new or changed institutional health service.

Projects proposed by providers are reviewed by department staff and the State Health Facilities Council, a five-member, governor-appointed body. Council members serve a six year term and they cannot serve consecutive terms. There are currently two members whose term expires in April 2011.

The federal government enacted two separate hospital capital expenditure review programs in the early 1970's; one of these was the National Health Planning and Resources Development Act which contained the provisions of CON programs. This established a system of state and local health planning agencies to conduct CON review of capital expenditures, major medical equipment, new institutional services; develop state health plans; health care data collection; and perform other functions related to the provision, availability, and cost of health care.

Although the federal mandate was repealed in 1987, there are still about 36 states that operate some form of a CON program. Iowa enacted its version of CON in 1977 with the passage of House File 354, now codified at [Code of Iowa sections 135.61 through 135.83](#).

What kind of authority does the CON have?

CON has sanctioning authority (e.g. monetary, licensure) if an entity does not get a required CON.

CON has been studied and changed several times including by the Governor's Health Regulation Task Force in 1996 which resulted in several modifications to the program that were adopted by the Iowa General Assembly in 1997. The 1997 Iowa General Assembly also directed the department to complete a comprehensive review of the CON program and submit a written report of the findings and recommendations. As a result, the 1999 Task Force recommended that Iowa's CON program be maintained with no changes to existing law or regulation. Upon making this recommendation, the Task Force members concluded that the CON program in Iowa continues to be relevant.

Minority Report: The Iowa Medical Society (IMS) voted for repeal. IMS also offered some amendments as an alternative to repeal. The Iowa Association of Homes and Services for the Aging supported keeping the CON law, but did offer options for amending the law.

A new institutional health service or changed institutional health service shall not be offered or developed in this state without prior application to the department for and receipt of a certificate of need. See Iowa Code section [135.61\(18\)](#) for complete list of "New institutional health service" or "changed institutional health service".

"Institutional health facility" means any of the following: a. a hospital, b. a health care facility, c. an organized outpatient health facility, d. an outpatient surgical facility, e. a community mental health facility, or f. a birth center.

There are certain criteria the council considers when evaluating applications. See Iowa

Code section [135.64\(1\)](#). In addition to the findings required with respect to any those criteria, the council shall grant a certificate of need **only** if it finds in writing, on the basis of data submitted to it by the department, that:

- a. Less costly, more efficient, or more appropriate alternatives to the proposed institutional health service are not available and the development of such alternatives is not practicable;
- b. Any existing facilities providing institutional health services similar to those proposed are being used in an appropriate and efficient manner;
- c. In the case of new construction, alternatives including but not limited to modernization or sharing arrangements have been considered and have been implemented to the maximum extent practicable;
- d. Patients will experience serious problems in obtaining care of the type which will be furnished by the proposed new institutional health service or changed institutional health service, in the absence of that proposed new service. (see Iowa Code section [135.64\(2\)](#)).

A major advantage of the CON process is to allow opportunity for public comment and notice regarding health care expenditures and programs that will impact all Iowa citizens. A Public Hearing is held for each application giving applicants and affected parties an opportunity to present oral testimony to the Council.

Once a project is approved there is some follow-up. There is a six month written progress report that is required. This report does not go to the council but is submitted to the department.

A CON is only valid for one year. Projects not completed within one year after approval must request an extension. Extensions may be granted for up to one year and some projects may require more than one extension.

There are sections in the CON statute regarding data collection and reports from facilities that are relevant to the HLTCA Advisory Strategic Plan. Due to lack of resources and because most of this information is filed in hard copy, it cannot be queried easily. The data collection requirements in the CON statute indicate that they are not to duplicate the efforts of other state agencies. Other types of data/reports we receive are from the hospital association's annual surveys, capital expenditure reports from the hospitals, and 990 Tax Forms from nursing homes and hospitals.

Questions:

Is there an appeals process?

Yes, there is an appeals process. Applicants or affected parties may request a rehearing with the council and/or a judicial review.

There is also no restriction on reapplying for CON.

Specifically, what facilities have to have CON?

That is a really difficult question because of all the requirements and different exclusions. In general we see applications from nursing homes, hospitals, and surgery centers with the occasional physician's office.

What happens when a project is $\frac{3}{4}$ completed and is way over budget and when they come back to you, you say no? Then what?

Generally, they don't halt the project but they can issue fines for exceeding the approved amount.

You mentioned 36 states have an active CON, do you know of any movement with health care reform legislation for CONs to become more active. Are there any states that have taken a recent interest in CON process?

We haven't heard of any. The network of CON has somewhat of a listserv which hasn't mentioned anything. They do however; produce a national directory every year. One of the questions asked is if they had any legislation that impacted CON in your state.

You said that RCFs are excluded and assisted living is excluded but there has been a big explosion of assisted living growth in Iowa. Do you see or have you heard about the potential for a CON for assisted living or RCF?

When I started in 1989 a study was conducted to get RCF out of the program. They weren't being denied and there were few new applications so they were taken out of the program. Assisted living was never put in the program. However, the original code for assisted living along stated that as you got certified by Elder Affairs, which was voluntary, you did not need a CON. But if you didn't seek voluntary certification then you needed to complete the CON process.

What is the cost of applying for a CON?

The application fee is three tenths of one percent of the capitol cost of the project. The application fee minimum is \$600 and the maximum is \$21,000.

Where does your budget come from?

The application fees go into the general fund. The program budget is 100 percent state funded.

What happens when you have a facility that is being underutilized but the reason is not need but the outcomes of the facility people are not utilizing the facility fully? Is that taken into account when looking at the approval of CON?

We have heard that argument a lot especially with nursing homes. The council still needs to look at those beds because they exist.

Because Medicare is shifting to reimbursement based off your outcomes, not necessary the quality or newness of the facility, if you have a facility where the quality of care and outcomes are not as high or there are deficiencies with DIA and such so people do not refer to or use that facility as much. Are those arguments written into the plans and if so is that something that is taken into consideration?

One of the questions on the application form, especially for nursing facilities, asks the results of the last two or three surveys from DIA. The council considers that information in addition to other information submitted when evaluating an application against the criteria in the code.

– CON implications for 2012 strategic plan

Michelle Holst, IDPH

Michelle Holst led discussion on the implications of CON and the 2012 strategic plan. The council reviewed the section of the code that encompasses the strategic plan and CON. Iowa Code section [135.163](#) and [135.164](#).

After review Michelle open it up for council discussion.

When you start talking about regions, it didn't say count but geographic regions. Since the needs vary throughout a county will the division of counties be considered?

It will be on how the boundaries are drawn and whether the same boundaries can be used for different health care facilities and services. We will look first at what already exists in terms of regions/boundaries and hope to use something that already exists if possible.

How many regions do we want?

Staff will work to keep it at a manageable number.

Is there any prevailing template that already exists for dividing the state into geographic regions?

Pretty much every entity and/or program has a template that is pertinent to their program needs.

Michelle anticipates that staff will gather different existing maps that divide the state into regional boundaries and analyze them in order to meet the requirement for the strategic plan.

Service delivery should be looked at as one of the descriptors for the criteria. Rural Iowa usually falls/clusters into service delivery areas that mainly located around hospitals.

Looking at the health care cost would be to look at Medicare payment clusters and the different Medicare reimbursement levels within clusters.

An idea is to look at health needs assessments that entities have already completed instead of inventing a new assessment. However, existing health needs assessments are completed from the perspective of the entity completing the assessment (e.g. AHEC regions with needs assessment tailored toward the recruitment and retention of workforce).

We need to remember to pay attention to high growth areas.

It is appreciated that the data collection piece is in the code because from provider perspective we provide tons-and-tons of data to different state agencies and we do not get a lot of data back. Much like the different regions, if you are working public health, DHS, and Medicaid you are providing them information but receive limited information back.

As we look at the data requirement we should not just say what we know/want to know but how the data will be utilized. When looking at data collection and the overall charge of helping to reduce health care costs, whenever data collections are mandated it adds to the cost. This leads to “Why collect the data if it will not be utilized.” If the data already exists elsewhere, do not mandate that providers report data they already provide in other mediums.

What does the stability of health care look like, how is it defined, and how do you address it?

What was the intent when the legislation written?

What is health care stability? What are the criteria?

Does it mean supply of workers, maintained facilities, quality, and cost stability?

One of the things, as a long-term care provider, that Iowa could see in the next 10-15 years, and is presenting itself in Iowa in some form is “age in place”. Iowa is not an “age in place” state but at some point someone will want to have that conversation. What are consumers going to expect in the next 10 – 20 years and how does this impact what we deliver in the state. How do we decide that? Do we let regulators, consumers, or payers decide that?

Michelle asked the council what concerns they have regarding the strategic plan requirements.

From a hospital perspective there are some issues around the data collection requirements and what we are trying to accomplish. This referred to the language about health planning or health infrastructure. Certain things to question are: Do we have enough hospitals? Not enough hospitals?

For different programs there are completely different rules and regulations that sometimes conflict with each other and as new programs enter Iowa providers must meet certain regulations for that program that are in conflict with a different program under the same umbrella. This makes it very difficult. Need to look at standardization of the health care system and with the provider systems.

Michelle asked the council if they have different ideas, perspectives, or connections they are seeing related to the strategic plan as a whole.

The health needs of rural Iowa are changing. Especially the health facility needs. There are different levels of facilities and services provided. It would be beneficial to look ahead 10-15 years when developing the plan. and is there going to be an increase in aging

needs/facilities.

A projective view is a good idea. How do we look/move forward? What is the region of a community and how far does it reach? But keep in mind the long-term version and that people do not want to reside in huge institution and that they want to stay in their community.

In the mental health and disability realm, the economic drive is the opposite of incentives for movement away from institutional care. All of the incentives are at the facility/institutional level of care.

Long-term care is struggling with looking at reasonable regulations that ensure quality care and that go after bad providers yet is not punitive to everybody or impacts the workforce. Currently, there are workers facing criminal charges for simple mistakes that happen.

The activities of the VA should be reflected in the plan along with the work of the Regional Resource Center.

Conduct a review of current data accessible. Conduct a survey of what data exists. The data will need to be integrated.

Members Sharing
Information and
Awareness

Stategic Plan

Michelle Holst

Members

Workforce Development
Grant
Todd McGee, IWD

Presentation available at

http://www.idph.state.ia.us/hcr_committees/commo_n/pdf/care_access/20100826_planning.pdf

Todd McGee, Iowa Workforce Development presented on the Health Care Workforce Planning Grant application that Iowa Workforce Development submitted on behalf of the Iowa Workforce Development Board. The grant is part of the Affordable Care Act and is intended to gather information on the health care workforce and better coordinate and implement workforce planning and analysis. Award announcements are expected September 30, 2010, with an award of \$150K.

Eligibility for the planning grant was limited to State Workforce Investment Boards. All awardees will be expected to analyze state labor market information data; identify high demand and projected high demand occupations; identify current resources to train, recruit, and retain workers; describe academic standards for credentialing and licensure; describe state policy on health career information and school counselor guidance; and identify policies or regulations to develop this plan strategy.

The grant work plan includes: submit request to codify the Iowa Health Workforce Center for consideration during 2011 legislative session; establish metrics, methodology, HRSA expectations to demonstrate planning success; conduct meetings between health care, workforce, and other stakeholders; write planning proposal for 15% growth of primary care workforce in new personnel, and replacement of personnel through attrition, by 2020.

Other activities in the work plan are: planning starter data sets, establish MOUs and data sharing agreements, expand information gathering to other data sets through gap analysis, identify emerging and high-demand occupations in Iowa's primary care workforce, and identify state and federal policies and/or regulation requiring clarifications or modification to help grow the primary care workforce. Make data-based recommendations on the projected attrition rate of the aging workforce, predictions on the pipeline of available workers, and give priority recommendations.

Develop cultural competency education recommendations and coordinate with New Iowans Center, the Iowa Bureau of Refugee Services, Iowa Department of Human Rights, and other subject matter experts. Individuals from different cultures have different expectations of the health care system and health care workforce. Health care does a lot of H1B visas and IWD is required to check H1B visa and identify training programs for U.S. workers to lessen the need for H1B visas.

As part of the plan, IWD is to identify state and federal policies or regulations that need clarification or modification to increase the primary care workforce by 15 percent over

the next decade.

Why so light on a plan for recruiting and education metrics?

IWD concentrated on gathering the data first and incorporating it, where possible, into one data warehouse. The warehouse will contain the various data components to describe the health care workforce. This will allow analysts to help IWD with recruiting and education metrics planning.

Questions:

Assuming you get the grant, at what point do you achieve what you have described to us?

The grant period is for one year. We feel with the other processes going on that it is a six month process if we get everyone's cooperation and assistance. With your help, if we identify the right datasets needed, the right interoperability standards, the right questions to ask the system, and all the MOUs and data sharing agreements it should go fairly quickly.

But in terms of public policy, you should be positioned to utilize this during the 2012 legislative session?

Actually, we already have some of the data that can be utilized. If we knew what data queries to run to extract the data you require, we could do some stuff now.

The Iowa Needs Nurses Now legislation requires IWD to collect nursing data from different entities for aggregation and analysis. IWD wants all state agencies to have access to data. There will be controls on the data to protect confidentiality.

Within the 1.4 million dollar request for the data warehouse there is a database manager and two positions for reporting. These are fulltime positions that will make sure of the validity, cleanliness, and security of the data. This will help the legislature make better database decisions.

The department applied for direct care workforce training program. It is a three-year pilot focused on curriculum development and piloting of curriculum for direct care workers. The goal of the department's grant is to allow the DCW Advisory Committee to continue to develop and pilot the curriculum and standards. The grant also provides for development and piloting of technology for certification of direct care workers. One of the biggest issues of the advisory committee is data. The data committee is looking at the different datasets to pull together some estimates and make recommendations for gaps within the data.

Grant for TANF and other low income individuals to get into health carriers. Michelle believes that IWD, Mercy, and Bureau of Refugee Services were involved in submission of the grant application.

Other related grants include nurse managed health clinics, nurse faculty, and residency programs for physicians. IDPH has not received official information about whether eligible entities in Iowa applied.

Steve Johnson spoke about lessons learned on certification of alcohol and drug counselor. The board decided not to collect data on ages resulting in no data on age groups. Steve Johnson is trying to get the board to reconsider their position.

Strategic Plan
"Sub-Plans"
Progress
Michelle Holst

Erin Drinnin, IDPH, provided an overview of new and upcoming health care workforce resources and opportunities. The resources and opportunities are Federal loan repayment, bi-annual recruitment and retention workshops, and health workforce fact sheets.

New and Upcoming
Health Care Workforce
Resources
Erin Drinnin

Presentation available at

http://www.idph.state.ia.us/hcr_committees/commo/pdf/care_access/20100826_resources.pdf

Iowa applied for and received two-year grant with match support from Iowa Health System, Mercy Des Moines, University of Iowa Health Care, and Des Moines University for a total of \$150,000. Additionally, the National Health Service Corp received an increase of \$300 million in funding and will be conducting a half-time pilot program.

Can you receive both PRIMECARRE and NHSC?

Not simultaneously but you can receive one or the other as long as you have no obligation/commitment.

Have you heard anything about expanding the definition of primary care provider?

Erin Drinnin indicated that she has not heard anything regarding expanding the definition of primary care provider. Some states have state funded loan repayment programs which gives them the flexibility to fund providers outside of the primary care provider as defined by federal program.

In February 2010, the department held a recruitment and retention workshop. The meeting was an opportunity to meet and discuss ways to support statewide recruitment and retention. The meeting had approximately 60 attendees which included health professional recruiters, human resources staff, and others involved in recruitment and retention of health professionals. It was identified that most providers offer some type of recruitment incentive while only some have retention incentives. Other issues and barriers identified include community size and location; perceptions; rural; salary; call schedules; difficulty getting them there to be able to sell community; housing, lifestyle; and expectation of loan repayment.

Additional roles of the department were also identified by the group. These roles include outreach to residency programs; career/residency fairs; ongoing communications with recruiters; recruitment and retention workshops; social networking with employers and recruiters; direct recruitment support to employers and candidates; media activities; Partner with AHECs; and mentor program.

Another workshop is being planned for either October or November 2010 [UPDATE: December 1, 2010]. Topics could include networking with other recruiters, successful recruitment tips/techniques, successful retention tips/techniques, working with IMGs, J-1 Visa Waiver Physicians, and updates/information sharing from IDPH.

The Iowa Health Workforce Center is developing fact sheets on health care professions. The fact sheets will include demographic information, geographic distribution, projected demand and workforce shortage, and projected exits such as retirements. The initial fact sheet being developed is for primary care physicians. Other professions to be developed include RN, PA, NP, DDS, RDH, direct care workers, and mental health professionals. If there are any additional suggestions, please send them to Erin Drinnin.

Discussion:

The Affordable Health Care Act formed a Committee to Review Criteria for the Designation of Medically Underserved Areas and Health Professional Shortage Areas. The committee comprises 28 members who are key stakeholders representing programs that are most affected by these designations. The meeting schedule will be published in the Federal Register with a target date for a draft final proposal.

For recruitment and retention, specifically psychiatric, discuss how telehealth can be used as an incentive. Telehealth could be used as a selling point to new graduates and residents. Currently there are 70+ counties covered under telehealth which includes other health areas besides psychiatric. Iowa Health Systems received a substantial grant for the development of telehealth.

Strategic Plan

The legislation to codify the Iowa Health Workforce Center is drafted with the department’s legislative liaison. Michelle believe the draft legislation is moving forward through the department. Preliminary indications indicate the legislation is fine and that it will continue through the executive branch process.

The department is working on the sub-plans and getting things organized. Michelle met with Gloria Vermie, State Office of Rural Health director, regarding the rural health resources plan. Internally we are establishing deadlines for sub-plan drafts. The drafts will be brought to the council for review and additional ideas. The assessment of technology and trends will be pulled from the e-health initiative efforts and assessments.

How will gathering the different data allow us to anticipate who might be retiring and who will need replaced. Can we really tell from the data how to ask the right questions? We could end up totally relying on testimonial data anyway. Is there any input from the council regarding this?

There is a field of study on projections of data. A series of criteria is used to make projections.

Different professions could have different retirement ages and changing circumstances (e.g. economic, social, personal) could alter the retirement ages.

OSCEP conducted a physician location study to determine the circumstances as to why physicians are relocating from Iowa.

Magellan released a crisis stabilization RFP. This is a pilot to investigate alternatives to court ordered mental health hospitalizations by providing community-based centers.

Public Comments

Appreciative of the data collection efforts that are so difficult for psychology in the state. There are some states that collect the data. OSCEP does not collect data on psychology but I would love to have that data collected.

Michelle Holst, IDPH

Public Attendees

Next Steps

Plans for future meetings

Presentations requested at future meetings:

- CHNA-HIP – Louis Lex, IDPH
- Personal Health Information\Records.
A clinic organization in Virginia is giving all their patients a flash drive with their personal health information\recrods.
- There have been significant grants made available the past few months with the e-Health Initiative. Have e-Health present again at a future meeting because of the numerous developments since they presented in January 2010.
- When the Rural Health Resources Plan (Rural Health Safety Plan) is ready to be reported, the RHPC Advisory Committee and the HLTCA Advisory Council could hold another joint session.
- Have a presentation on Safety Net

Conclusions/directions from today

Michelle Holst, IDPH

Members

Future meetings formats could be online meetings/webinars and small workgroups to complete specific tasks/projects.

Next meeting: Thursday, October 28, 10:30 a.m. to 3:00 p.m.
Location: Urbandale Public Library, Room B