

## State Rural Health Plan

The purpose of the state rural health plan (SRHP) is to provide a snapshot of the current climate of rural health in Iowa and illustrate how the Iowa Medicare Rural Hospital Flexibility program working within the State Office of Rural Health will engage in activities to improve access to healthcare in rural areas and strengthen the rural health infrastructure.

The SRHP will be constructed in a manner that provides a demographic background related to the rural population and address some of the current measures designed to improve access and develop a robust rural health system.

The rurality of Iowa will require a collaborative effort between the State Office of Rural Health and its many stakeholders. No one entity or group will be able to solve the issues related to rural health. The SRHP will provide a strong foundation to build upon and chart a course to keep all groups focused on the outcome of improving rural health. Stakeholders will be able to identify action areas their organization desires to engage and drive improvement. The initial SRHP will serve as a tool for staff to present the future of rural health in Iowa. Staff will facilitate focus groups to assist with connecting the activities of the SRHP based on interest and expertise of the stakeholders.

## Overview of Rural Health

### How Do We Define Rural in Iowa?

The term ‘rural’ has various definitions. Iowa utilizes several classification systems when designating a rural county, depending on which federal or state program the county wishes to participate. However, as a fundamental definition – and for a basic clarification of the term ‘rural’ throughout majority of this State Rural Health Plan, Iowa uses the U.S. Census Bureau’s definition of rural to designate 89 of 99 its counties as non-metropolitan statistical areas.

The U.S. Census Bureau defines an *urbanized area* (UA) as consisting of adjacent, densely settled census block groups (BGs) and census blocks that meet minimum population density requirements along with adjacent densely settled census blocks where together they encompass a population of at least 50,000 people. *Urban clusters* (UC) have a similar definition; however, the overall population can be 2,500 to less than 50,000. The Census Bureau defines all other areas as rural<sup>1</sup>.

The following 10 counties below are designated as Iowa’s urban counties:<sup>1</sup>

- Black Hawk
- Dallas
- Dubuque
- Johnson
- Linn
- Polk
- Pottawattamie
- Scott
- Warren
- Woodbury

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### Population and Economic Indicators

Iowa’s rural population is experiencing a slight stunt in growth as more people are moving out of rural communities and buying homes in larger, urban cities. Iowa’s rural population in 2006 was 1,580,552, which represented 53% of Iowa’s total population; a slight decrease of 2% since year 2000 when the rural population represented 55% of Iowa’s total population<sup>ii</sup>. However, between 2000 and 2006, Iowa’s total population growth increased by 2%. The state’s total population in 2006 was 2,982,085, and the national population during that year was 299,398,484 respectively<sup>iii</sup>.

### Geography

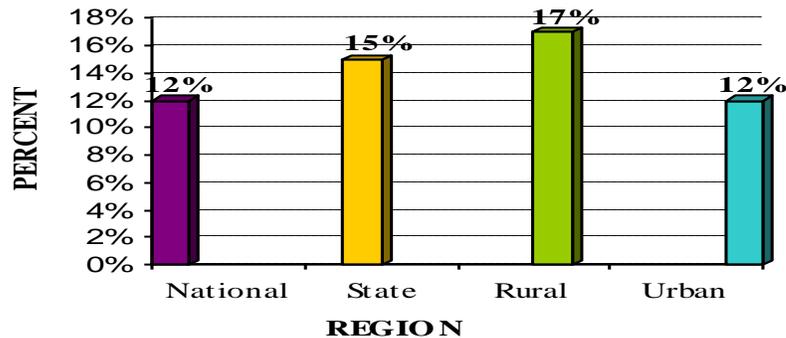
Iowa is bordered by Minnesota to the north, Wisconsin and Illinois to the east, South Dakota and Nebraska to the west, and Missouri to the south. These geographic features have all played a role in shaping Iowa’s economics, transportation, and growth.

### Age

In Iowa, the median age is 37.8 years – slightly higher than the national median age at 36.4 years<sup>iv</sup>.

Iowa’s 65 + years population is steadily increasing, and as of 2006, its rural counties had the highest percentage of elderly people (65 years of age and older) at 17%, in relation to the region’s total population, - higher than the state’s elderly population of 15%, in relation to the state’s total population. Iowa’s urban counties had an elderly population of 12%.

**POPULATION 65 YEARS OF AGE AND OLDER, IOWA, 2006**



Source: National - U.S. Census Bureau, 2006; State, etc. - Iowa Data Center, 2006.

When all 435,657 elderly Iowans were isolated into one group, it was found that majority of elders – 62% resided in rural communities. The remaining 38% of elders inhabited urban communities throughout Iowa.

### Race and Ethnicity

Iowa has a higher percentage of the non-Hispanic white-alone population and a lower percentage of Hispanics and blacks than the nation as a whole<sup>v</sup>.

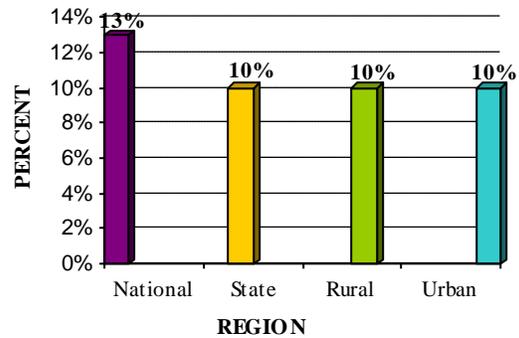
Yet Iowa’s diverse population is continuing to grow, becoming a state with an increasing variety of racial and ethnic backgrounds, and a selection of diverse languages. Statewide, in 2006, the African American population was 2%; the Asian/Pacific Islander population was 2%; and the Hispanic population was 4% - an increase of one percent since 2000<sup>vi</sup>. Those Iowans who identified themselves racially as “other”<sup>vii</sup> - comprised 1% of the statewide population.

Foreign born Iowans are continuing to increase as more immigrants move to the United States, and choose Iowa as their home. Currently, 3.8% of Iowans are foreign - born compared to 12.5% of the nation’s population<sup>viii</sup>.

**Employment and Workforce**

In 2000, Iowa’s rural unemployment rate was 4% mirroring the national, state, and urban Iowa average of 4%<sup>ix</sup>. As of 2006, Iowa’s statewide percentage remained at 4%, resulting in no change in the percent of unemployment<sup>x</sup>.

**POVERTY OF ALL AGES, IOWA, 2005**



Source: National - U.S. Census Bureau, 2005; State, etc. - Iowa Data Center, 2005.

**Poverty**

In 2005, 10% of Iowa’s rural population (inclusive of all ages) lived in poverty – slightly lower than the national poverty level during that time of 13%<sup>xi</sup>.

However, the United States Department of Agriculture points out higher poverty levels in rural regions may be due to lower rural educational attainment, less competition for workers, and limited availability of highly skilled jobs in the rural occupational mix<sup>xii</sup>. For Iowa, this trend may be realized as communities experience further losses in the rural employed population.

**Educational Attainment**

Education is very important to Iowans. Throughout the years, the percent of people attaining a bachelor’s degree or higher has been on the rise.

In 2006, 88.9% of Iowans reported being a high school graduate or higher<sup>xiii</sup> – about 3 percent higher than the national report of high school diploma attainment or higher<sup>xiv</sup>.

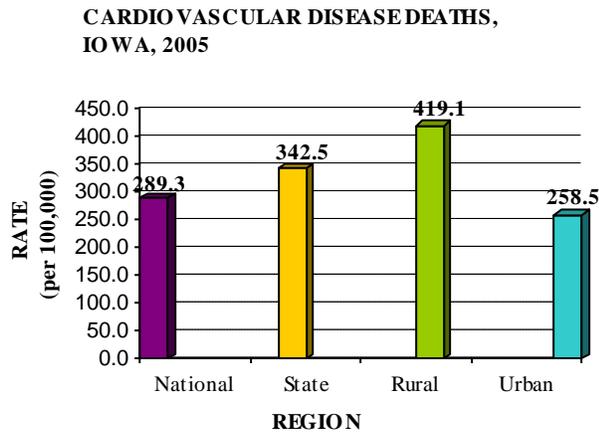
Iowa ranked 37<sup>th</sup> in the nation regarding states with people aged 25 years and over who have attained a bachelor’s degree or higher. At 24%, Iowa’s higher level degree attainment is slightly lower than the national percentage of 27%<sup>xv</sup>.

**Overall Health**

Iowa’s rural counties fare worse on many measures of health compared to the state average. Rural Iowans experience higher rates of chronic disease and mortality, and lower rates of physician availability.

**Cardiovascular Disease**

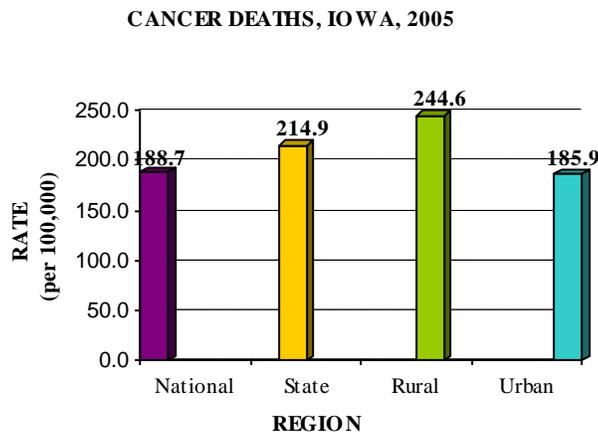
Cardiovascular disease (CVD) is among the top ten causes of death for Iowans.



Source: National – CDC, NCHS, 2005; State, etc. – IDPH, Vital Statistics, 2005.

**Cancer (Malignant Neoplasms)**

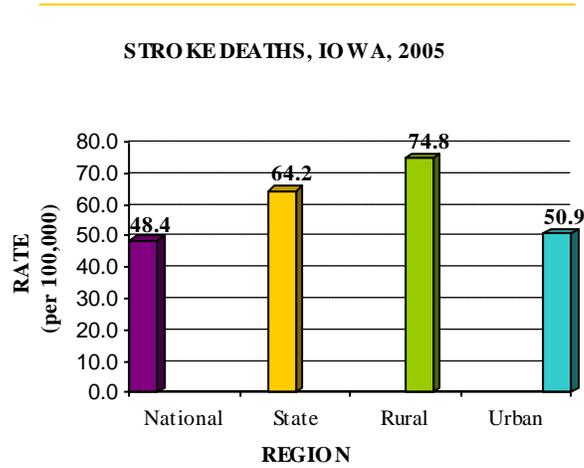
In 2005, Cancer was the second leading cause of death for Iowans<sup>xvi</sup>. Rural Iowans experienced a rate of cancer higher than the state and urban rate.



Source: National – CDC, NCHS, 2005; State, etc. – IDPH, Vital Statistics, 2005.

### Stroke (Cerebrovascular Disease)

In 2005, stroke was the 3<sup>rd</sup> leading cause of death for Iowans. Rural Iowans experienced a rate of stroke higher than the state and urban rate.



Source: National – CDC, NCHS, 2005; State, etc. – IDPH, Vital Statistics, 2005.

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### Oral Health - Dental Services

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program assures comprehensive health care services for children enrolled in Medicaid. The EPSDT Dental Services Reports provide annual county-by-county data for dental services provided to Medicaid-enrolled children<sup>xvii</sup>.

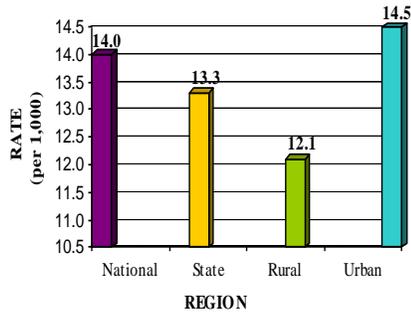
Almost half of rural Iowa’s Medicaid-enrolled children received either preventative dental services, or dental treatment (46%) matching the statewide percentage, and coming slightly under the percentage of urban Iowan counties (47%).

### Live Births

Iowa’s birthrate continues to increase annually. The raise in live births could be evidence of a combination of the following:

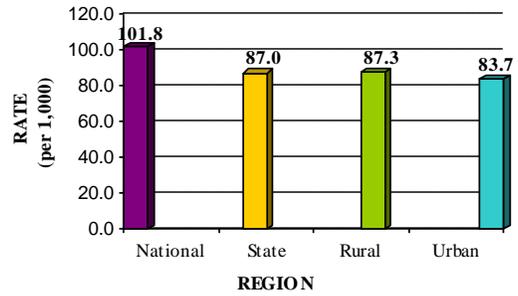
In 2005, the rural Iowa birth rate was lower than the Iowa urban rate, the statewide rate, and the national rate. The low rate of births for rural Iowans could be affected by the growing elderly population, economical changes, and/or the increasing trend of younger Iowans moving to urban areas to live and raise their families.

LIVE BIRTHS, IOWA, 2005



Source: National – CDC, NCHS, 2005; State, etc. – IDPH, Vital Statistics, 2005.

BIRTHS TO MOTHERS UNDER AGE 20 YRS., IOWA, 2005



Source: National – CDC, NCHS, 2005; State, etc. – IDPH, Vital Statistics, 2005.

### Mothers under the Age of 20 Years

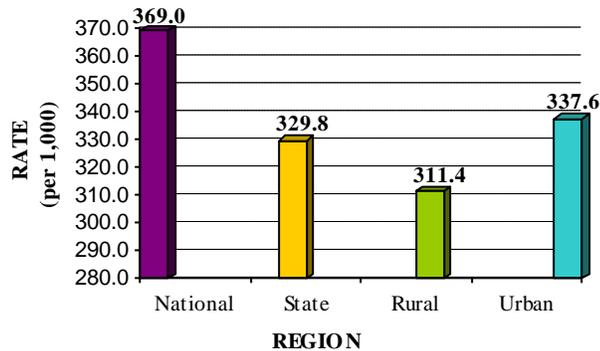
Live births in rural counties are noticeably lower than urban counties; the rate of live births to mothers under the age of 20 years is also noticed to be decreasing. Rural live births to mothers under the age of 20 years have decreased from a rate of 101.9 in 2000 to a rate of 87.3 in 2005<sup>xviii</sup>.

Rural births to mothers under the age of 20 still ranks as the highest region within the state, surpassing the urban counties by 3.6 and the statewide rate by .3.

### Births Out of Wedlock

Births to women out of wedlock have grown increasingly common throughout the nation. Iowans have followed this trend as the rate of live births to women out of wedlock has risen from 266.8 in 2000<sup>xix</sup>, to 329.8 in 2005.

BIRTHS TO WOMEN OUT OF WEDLOCK, IOWA, 2005



Source: National – CDC, NCHS, 2005; State, etc. – IDPH, Vital Statistics, 2005.

## **State Rural Health Efforts**

### **Bureau of Health Care Access**

The bureau of Health Care Access is located within the Iowa Department of Public Health, Division of Health Promotion and Chronic Disease Prevention.

#### **Mission**

Promoting and protecting the health of Iowans. Assuring the provision of essential public health services through assistance to internal and external customers, including both the private and public sector, and promoting collaborative programming and policy at both the state and local levels to assure access to health care.

#### **Vision Statement**

Iowa's community health, primary health care and rural health care needs will be met.

#### **Bureau Activities**

The Bureau of Health Care Access advocates for quality health care delivery systems for all Iowans and provides information, referrals, education, grant opportunities, technical assistance, and planning for Iowa communities. The bureau is designated the state entity for addressing rural health, primary care and health care workforce issues in Iowa, and works to improve access to health care for vulnerable populations.

The Bureau of Health Care Access is home to two centers. The first is the Center for Rural Health and Primary Care; programs within the center are State Office of Rural Health, Iowa Medicare Rural Hospital Flexibility Program, Small Hospital Improvement Program, and Primary Care Office. The second center, the Iowa Health Workforce Center includes the state loan repayment program and other workforce initiatives.

### **State Office of Rural Health**

The State Office of Rural Health (SORH) is a federal-state partnership to help rural communities and organizations identify and resolve issues and build rural health infrastructure. The office provides rural health advocacy and outreach, coordination of rural health resources and consultation to communities and health care providers to improve access to healthcare for Iowans in rural communities.

### **Primary Care Recruitment and Retention Endeavor (PRIMECARRE)**

The Primary Care Recruitment and Retention Endeavor (PRIMECARRE) was authorized by the Iowa Legislature in 1994 to strengthen the primary health care infrastructure in Iowa. PRIMECARRE allocations currently support the Iowa Loan Repayment Program, with matching federal and state funds.

#### Iowa Loan Repayment Program:

- Offers two-year grants to primary care medical practitioners for use in repayment of educational loans.
- Requires a two-year practice commitment in a public or non-profit hospital or clinic located in a health professional shortage area (HPSA). HPSAs are designed to identify communities with diminishing health care services and provide them with opportunities to improve access to and availability of care. By identifying health professional shortage areas, communities become eligible for state and federal assistance to recruit and retain health professionals, access additional reimbursement dollars, and eventually alleviate the shortage.
- Provides up to \$30,000 per year for primary care physicians, psychiatrists, and clinical psychologists; up to \$20,000 per year for dentists; and up to \$15,000 per year for physician assistants, registered advanced nurse practitioners, certified nurse midwives, dental hygienists, clinical social workers, and psychiatric nurse specialists.

#### **Small Rural Hospital Improvement Grant Program (SHIP)**

The Small Rural Hospital Improvement Grant Program (SHIP) is a federally funded program through the Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services. The federal grant provides additional resources to small rural hospitals to assist with:

- Implementation of prospective payment systems (PPS)
- Compliance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Reduce medical errors and support quality improvement (QI) strategies

#### **Iowa Health Workforce Center**

The center was created in 2002 as the Center for Health Workforce Planning to assess and forecast health workforce supply and demand, promote recruitment and retention, and assure a competent, diverse health workforce in Iowa.

The mission of the center at that time was to assess and forecast health workforce supply and demand; address barriers to recruitment and retention; support strategies developed at the local level that prevent shortages; and engage in activities that promote and assure a competent, diverse health workforce in Iowa. The center's initial emphasis on nursing and nursing assistive personnel has been expanded to other health workers in 2004.

In 2008, the state legislature provided funding that resulted in the transformation of the previous center through a new name and additional activities. The purpose of the change was to address the health and long term care infrastructure and workforce.

The Health Workforce Center shall coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, diverse, and sustainable health care workforce in this state. The health care delivery infrastructure and the health care workforce shall address the broad spectrum of health care needs of Iowans throughout their lifespan including long term care needs.

### **Iowa Medicare Rural Hospital Flexibility Program (FLEX)**

*The FLEX program goal is to work as partners in fostering an integrated, dynamic, yet sustainable rural healthcare system that provides the highest quality of care.*

The Balanced Budget Act of 1997 established the Medicare Rural Hospital Flexibility program (FLEX) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) reauthorized the FLEX program.

The FLEX program consists of five core components: rural health planning, Critical Access Hospitals (CAH), emergency medical services, quality improvement, and networking. The program is intended to preserve access to primary and emergency health care services, improve quality of rural health services, provide health services that meet community needs, and foster a health delivery system that is both efficient and effective.

### **Critical Access Hospital Designation Overview**

1. States may designate a facility as a CAH if it meets the conditions of participation as required by CMS. A hospital must meet the following criteria to be designated a CAH:
  - Located in a rural area
    - More than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or only secondary roads, (*No hospitals in Iowa meet this criteria*)
  - OR**
  - Certified by the state as being a “necessary provider” of health care services to residents in the area (*this provision’s sunset date was December 31, 2005*).
  - In Iowa, an interested hospital must first be recognized as a Necessary Provider by the Iowa Department of Public Health, Bureau of Health Care Access FLEX program. Next, the hospital is eligible to be surveyed to become a Critical Access Hospital.
- Provide 24-hour emergency care services
- Average length of stay of 96 hours or less
- Operate up to 25 beds for acute inpatient care, subject to the 96-hour length of stay

- For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services
2. Medicare pays CAHs for inpatient and outpatient services on the basis of their current Medicare allowable costs or “cost-based reimbursement” and are paid cost for ambulance services if they are the only ambulance supplier within 35 miles (*no Iowa ambulance services meet this criteria*).
    - CAHs are exempt from the inpatient and outpatient prospective payment systems
    - Capital improvement and equipment costs may be included in the Medicare cost report
    - Reimbursement is based on 101 percent of the CAH’s reasonable costs
  3. CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital; each unit may have up to 10 beds that do not count against the CAH inpatient bed limit. Distinct Part Units are paid under the prospective payment system.

Iowa utilized the following criteria to determine necessary provider’s status:

Applications need at least six points on the eleven-point scale to be designated as a necessary provider.

Applicants are required to score at least two points in the facility characteristic section. Successful applicants will demonstrate community involvement, a service to the community, and the isolation or vulnerability of the population in the hospital service area.

### **Population Characteristics Subtotal 4 Points**

1. Applicant must have a three-year average poverty rate equal to or greater than the three-year state average. *The hospital must have a three-year average county poverty rate greater than or equal to the state average.*
2. Applicant must have a two-year average unemployment rate greater than or equal to the state two-year average. *The hospital must have an unemployment two-year average greater than or equal to the state two-year average.*
3. Applicant must demonstrate an elderly population (65 years and older) percentage greater than or equal to the state average. *The hospital must have a county elder population (65 years and older) percentage greater than or equal to the state average.*

4. Applicant must demonstrate thirty percent of the hospital catchment's area is in a shortage area. *Thirty percent of the hospital catchment's area is within a health professional shortage area, governor's health professional shortage area, or medically underserved area.*

### **Geographic Characteristics Subtotal 2 Points**

1. Applicant must demonstrate a rural vulnerable population by reporting motor vehicle accident (MVA) rate or farm injury rate greater than or equal to the state average for the perspective category. *The hospital must have a MVA rate or a farm injury rate greater than or equal to the state average for the perspective category.*

2. Applicant must be located on roads that at times are inaccessible, thereby creating critical local service needs for the populations isolated at that location. *Does a level C or D road service the city/town where the hospital is located?*

### **Facility Characteristics Subtotal 5 Points**

1. Applicant must be an Essential Community Provider (ECP) as defined by the Iowa Department of Public Health, Office of The Director, Administrative Directive 95-25, April 20, 1995. *The hospital adequately proves that it is an ECP according to the Administrative Directive?*

2. Applicant must be a participant in the Medicare program and be Medicare Dependent or eligible. *The hospital clearly demonstrates the facility is designated or is eligible to be designated as a Medicare Dependent hospital?*

3. Applicant must be an emergency medical services (EMS) provider or demonstrate a cooperative and collaborative relationship with the local EMS provider. Hospitals must meet one or all of the following criteria:

1. A hospital representative is on the EMS Board or an EMS representative is on the hospital board.
2. The hospital provides medical control for the EMS provider.
3. The hospital shares financial responsibility for EMS.

*Is the hospital recognized as a provider of Emergency Medical Services or meet other listed criteria?*

4. Applicant must be an obstetric and/or prenatal services provider. *Does the hospital provide obstetric or prenatal services?*

5. Applicant is the only hospital in the county. *Is the applicant the only hospital in the county?*

### **Federal FLEX Grant Required Activities**

## 1. **Development and Implementation of Rural Health Networks**

Most Iowa hospitals, prior to the FLEX program, were networked in a hub and spoke system through management and affiliation agreement. The few independents quickly executed network agreements to comply with federal requirements. This networking provided a strong foundation since many of the critical stakeholders were engaged and had begun implementation of a network vision. The existing structure prompted the FLEX program to evaluate the structure and work with network hospitals to develop stronger networks. The network relationship between the urban, tertiary hospitals and the critical access hospitals has changed to retool their role within the network. The CAHs, now more financially stable, are in a position to request a different array of services. The FLEX program serves as a liaison to the network staff so *best practices* from other networks are incorporated into each network.

## 2. **Support of existing CAHs and Eligible Hospitals**

This section encompasses the majority of FLEX activities. The FLEX program has continued to expand efforts through sub-contracts and educational offerings. Stakeholders have become engaged to drive quality and patient safety improvement. Several of the FLEX stakeholders' funding has requirements stakeholders work more dependently with the State Office of Rural Health and the FLEX program. The improved working relationship enables all parties to expand educational offering without duplication.

## 3. **Improvement and Integration of Emergency Medical Services (EMS)**

The most prominent issue associated with EMS is the fact that initially most players in the healthcare system did not recognize EMS as a key piece of the system. EMS operated outside the healthcare system as group with a perceived role as transport only. This sentiment is changing as EMS is recognized as a key piece of the healthcare system. EMS has the ability to stabilize and initiate patient care that will improve patient outcomes.

The EMS role at the federal level is simply located in the various federal entities providing grants to state and local EMS entities. The lack of a true federal home has caused state EMS entities to attempt to serve in a leadership role with limited resources.

## 4. **Improving Quality of Care**

The FLEX program has been a significant player in driving quality and patient safety. The FLEX program works closely with the Iowa Foundation for Medical Care (state quality improvement organization) and the Iowa Healthcare Collaborative.

The Iowa Healthcare Collaborative (IHC) is a provider-led and patient-focused nonprofit organization dedicated to promoting a culture of continuous improvement in healthcare. IHC's goal is exceptional healthcare in Iowa. IHC plays a unique role in putting healthcare providers (doctors, nurses and hospital executives) in a leadership position to drive clinical improvements and accelerate change.

Created in 2004, the partnership between the Iowa Hospital Association (IHA) and the Iowa Medical Society (IMS) uses a "multi-stakeholder" approach to bring together and engage physicians, hospitals, insurers, employers, consumers and other community partners to share data and rapidly deploy best practices. Through IHC's efforts, healthcare providers gain access to nationally agreed on, evidence-based measures that improve the delivery of care. Insurers get information to facilitate performance improvements and employers are better equipped to educate employees about wellness and prevention resulting in healthier communities.

IHC's focus is to be supportive and complementary to the other national quality and patient safety initiatives and works closely with national organizations like the Institute for Healthcare Improvement (IHI), the National Patient Safety Foundation (NPSF), the American Hospital Association (AHA), the American Medical Association (AMA), the federal Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and others.

## **Additional Supportive Activities**

### **Economic Assessments**

The FLEX program in 2001, 2002, and 2004 provided funding to complete economic assessments of the health sector at the county level. The contractor utilized the *Rural Health Works* program to complete these analyses. The reports illustrated to the rural counties the economic value of the health sector. The information proved helpful in educating the local officials that the financial support through annual funding provided a positive return on investment. One prominent finding was the health sector was often the second highest employer with local school system having the highest employment.

Currently, the Iowa Hospital Association conducts the economic assessments on an annual basis for its member hospitals.

### **Community Health Assessments and Health Improvement Planning (CHNA-HIP)**

Every five years, each county is required to complete an assessment of the health needs in their perspective county. The local public health agency invites all stakeholders to meet and discuss current health needs for their county. The Iowa Department of Public Health provides data to assist the counties in identifying current and future health needs.

In March 2007, every county in Iowa submitted a CHNA-HIP Mid-Course Progress Report to the Iowa Department of Public Health. The CHNA-HIP Mid-Course Progress Report provides IDPH, partners and constituents with information regarding the progress local boards of health and local partners are making with their 2005 health improvement plans.

The report contains a narrative reporting the status and progress of each objective and the locally identified health issue included in the 2005 CHNA-HIP Report. The narrative identifies how community partners have been involved and how the action plans have been implemented.

Community health needs assessment and health improvement planning is an ongoing process. New objectives or locally identified health issues may have been addressed since submission of the 2005 CHNA-HIP. The Local Board of Health may have completed an objective or issue, if so, a brief narrative as to what was accomplished; involvement of partners and how the goals were met is included. For the objective or issues removed a narrative as to the rationale for doing so is included in the report.

### **Public Health Modernization**

In 2006, Iowa celebrated its 125th anniversary of the founding of organized public health in the state. Iowans have a rich tradition of sharing responsibility for addressing health problems and providing healthy communities. It is with this shared commitment to protect and promote the health of all Iowans that we prepare for the future of public health in the state.

Many challenges face public health in Iowa. Challenges include: new or re-emerging diseases, an aging population, an under-prepared public health workforce, decreased funding, an increasing immigrant population, health disparities, a new role in planning for and responding to public health emergencies, and inconsistent delivery of services statewide.

Recognizing the need for an integrated and fully funded public health system, the director of the Iowa Department of Public Health commissioned a work group in the summer of 2004. The charge for the work group was to assess the current structure of public health service delivery and to make recommendations for modernization of public health in the state.

The modernization efforts will likely result in the accreditation of the state health department and many local health departments.

In addition, the state bureau of Emergency Medical Services developed a set of standards to be implemented at the county level. The FLEX program has provided funding to initiate pilot implementation for three Iowa counties.

The above efforts further align the many aspects of the rural healthcare system to enable better communication and transfer of patients across the various segments. Standards simplify the process by assuring that each segment provides a certain level of care uniform for that particular segment (i.e. local public health agency) across the state.

## Health Reform

Iowa along with twenty-one other states have enacted legislation to implement health reform legislation. Below is the declaration of intent of the health reform legislation.

*It is the intent of the general assembly to progress toward achievement of the goal that all Iowans have health care coverage with the following priorities:*

*The goal that all children in the state have health care coverage which meets certain standards of quality and affordability*

*The goal that the Iowa comprehensive health insurance association, in consultation with the Iowa choice health care coverage advisory council, develop a comprehensive plan to first cover all children without health care coverage that utilizes and modifies existing public programs including the medical assistance program, the hawk=i program, and the hawk=i expansion program, and then to provide access to private unsubsidized, affordable, qualified health care coverage for children, adults, and families, who are not otherwise eligible for health care coverage through public programs, that is available for purchase by January 1, 2010.*

*The goal of decreasing health care costs and health care coverage costs by instituting health insurance reforms that assure the availability of private health insurance coverage for Iowans by addressing issues involving guaranteed availability and issuance to applicants, preexisting condition exclusions, portability, and allowable or required pooling and rating classifications.*

One critical element that is intertwined throughout the legislation is the concept of a medical home. The concept assures a patient receives the necessary preventative and acute care health services. The definition has shifted from previous definitions focusing on a particular segment (i.e. doctor's office) to a larger, integrated medical community approach.

**Goal: Improve Access to Healthcare for rural residents**

**Focus Area: Workforce**

Activities	Engaged Stakeholders	Outcomes	Measures
<p>Provide joint education activities related to recruitment and retention of healthcare workers</p> <p>Involve the private sector (i.e. business) in creating innovative changes to the current health workforce model.</p> <p>Develop referral networks promoting retention of Iowa trained healthcare workers</p> <p>Advocate funding be used to address short and long-term solutions</p>	<p><i>To be determined</i></p>	<p>Participants develop collegial relationships and understand the nuances of recruiting and retaining a diverse (i.e. ethnic, age) workforce</p> <p>Stakeholders will maximize education dollars by eliminating duplication and improving the caliber of speakers with pooled resources.</p> <p>Iowa trained providers will obtain employment within the state.</p> <p>Targeted efforts will have a more dramatic and long term impact.</p> <p>Additional private funding will provide opportunities for state and federal funding. Funding will be combined to reduce the number of individual scholarship programs by various stakeholders.</p>	<p>Multiple joint conferences are convened.</p> <p>Work benefits better reflect the demand of the workforce.</p> <p>Reduction in out-migration of Iowa trained providers.</p> <p>Fluctuations within specific health workforce sectors (i.e. nurse, lab technicians) will be stabilized.</p>

**Goal: Improve Access to Healthcare for rural residents**

**Focus Area: Information Technology**

Activities	Engaged Stakeholders	Outcomes	Measures
<p>Facilitate the continuous improvement of the state information technology infrastructure.</p> <p>Provide joint education activities related to utilization of information technology</p>	<p><i>To be determined</i></p>	<p>Solid, Safe, and Secure infrastructure promoting the transfer of health information between patient – provider, provider – specialist.</p> <p>Uniform patient identifiers and data sets to facilitate the highest level of care, regardless of rurality.</p> <p>All components of the rural health sector will understand the legal requirements of providing care and protecting the patient record using information technology.</p> <p>Telehealth activities will be expanded and enhanced. Funding for these activities will be appropriately distributed.</p>	<p>Improvement in connectivity and bandwidth to rural facilities and providers.</p> <p>Access to specialists within 35 miles of their home.</p> <p>New services will be provided via telehealth (i.e. mental health, E-icu)</p>

**Goal: Improve Access to Healthcare for rural residents**

**Focus Area: Facility/Services**

Activities	Engaged Stakeholders	Outcomes	Measures
<p>Assess the utilization of current healthcare facilities (i.e. clinics, hospitals, public health, FQHC)</p> <p>Target funding to greatest areas of need to improve infrastructure (i.e. buildings) and provide additional services.</p>	<p><i>To be determined</i></p>	<p>Rural residents receive the care they need and deserve</p> <p>Rural residents efficiently enter the healthcare system (i.e. clinic versus emergency room)</p> <p>Fewer residents forgo treatment or care due to transportation limitations</p> <p>Rural residents will have a medical home.</p> <p>Reliance as the sole provider of care on safety net providers is reduced; the patient load is more evenly distributed across all facilities. Payment structure is adjusted to compensate for low volumes.</p> <p>Additional private funding will provide opportunities for state and federal funding.</p> <p>Joint funding initiatives will maximize available dollars.</p> <p>Funding will be directed to areas of greatest need.</p>	<p>Reduced emergency room visits, improved patient outcomes.</p> <p>Residents fulfill treatment regimens and obtain increased preventative care.</p> <p>The entire rural health infrastructure will be improved, not specific segments.</p>



**Goal: Support rural health providers by eliminating barriers and improving consumer engagement.**

**Focus Area: Benchmarking**

Activities	Engaged Stakeholders	Outcomes	Measures
<p>Provide multiple training avenues to assure spread of information to front-line staff.</p> <p>Benchmarks are reported at the state level and within peer groups (i.e. critical access hospitals)</p>	<p><i>To be determined</i></p>	<p>Consumers readily have access to provider performance</p> <p>Provider staff becomes engaged on driving system-wide improvement</p> <p>Credible data repository is developed.</p> <p>Reporting tool is reflective of nuances associated with urban and rural providers.</p>	<p>Performance data included in provider annual report.</p> <p>Staff survey results reflect an increased knowledge of facility and staff benchmarks.</p> <p>Annual <i>dashboard-like</i> report is completed.</p>

**Goal: Support rural health providers by eliminating barriers and improving consumer engagement.**

**Focus Area: Grant Programs**

Activities	Engaged Stakeholders	Outcomes	Measures
<p>Develop a targeted approach of safety net funding to areas of most need.</p> <p>Develop joint grant scholarship programs combining public and private funding.</p>	<p><i>To be determined</i></p>	<p>Safety net funding will be used to provide services in areas that currently have no services.</p> <p>Safety net funding will alleviate some of the impact of current charity care.</p> <p>A certain level of services will be provided throughout the state.</p> <p>Efficiencies will be created by eliminating administrative waste associated with multiple scholarship programs.</p> <p>Assurance individual employers' scholarship assistance extends the joint scholarship program.</p> <p>The workforce need of the various job classifications will be uniformly reported.</p> <p>Increased funding from public and private sources based on the success of a joint scholarship program.</p>	<p>More Iowans will be in a medical home.</p> <p>Number of providers receiving scholarships will increase.</p>

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