

**Existing Recommendations
Health and Long-Term Care Workforce in Iowa**

August 21, 2009

Repeated Recommendations and Common Themes

1. Increased Medicare/Medicaid reimbursement
2. Need for data and analysis of data
 - a. So we know areas (professions, geography) of greatest need
 - b. To help project/predict and plan for and address needs
3. Need for definitions of shortages among various professions
4. Need for a lead entity to be point of coordination among efforts; knowledge of efforts; point of contact (i.e., a “center”)
5. Technical assistance to local areas/communities about recruitment, retention, planning, etc.
6. Loan repayment and loan forgiveness programs and other incentive programs that work
7. Recruitment strategies – Web sites, promotion of Iowa, etc.
8. Training capacity – mostly post-educational practicums, residencies, clinical, etc.

Title	Organization	Link and URL/Date Produced			
A Strategic Plan to Increase Minorities in the Health Professions in Iowa	Iowa EXPORT Center of Excellence on Health Disparities	http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/strategic_plan_minorities.pdf August 31, 2005 Recommendations:			
		Strategy	Lead Agency(s)	Timeline	Cost Estimate
		8A.1 Review admissions criteria for more individualized screening	Post-Secondary Health Training Institutions	Year 1	Minimal or No Cost
8A.2 Reduce dependence on standardized tests as allowable	Post-Secondary Health Training Institutions; Exam Vendors	Year 1	Minimal or No Cost		

		8A.3 Increase financial assistance for minorities in health	Post-Secondary Health Training Institutions; Private Foundations	Year 1	\$1,000,000
		8A.4 Implement ethnic- and career-specific health training programs	Post-Secondary Health Training Institutions	Years 2-3	\$250,000
		8A.5 Provide mentoring, minority role models, and social services	Post-Secondary Health Training Institutions	Years 2-3	Minimal or No Cost
		8A.6 Increase leadership and mentoring training programs for minorities	K-12 Schools; Post-Secondary Health Training Institutions	Years 2-3	\$300,000
		8A.7 Explore new and nontraditional paths to the health professions	K-12 Schools; Post-Secondary Health Training Institutions	Years 2-3	Minimal or No Cost
		8A.8 Provide bridging programs between two and four year colleges	Post-Secondary Health Training Institutions	Years 2-3	Minimal or No Cost
		8A.9 Require cultural competency training and increased MHP percentages for accreditation and graduation	Post-Secondary Health Training Institutions; Licensure Boards	Years 2-3	\$500,000
		8A.10 Provide innovative programs to learn second career	Post-Secondary Health Training Institutions	Years 4+	\$800,000
		Strategy	Lead Agency(s)	Timeline	Cost Estimate
		8B.1 Increase experiential learning partnerships	Post-Secondary Health Training Institutions	Year 1	Minimal or No Cost
		8B.2 Develop partnerships with external mentors and organizations	K-12 Schools; Post-Secondary Health Training Institutions	Year 1	Minimal or No Cost
		8B.3 Conduct public awareness campaigns specifically with minority businesses, newspapers, radios, faith institutions, etc.	Iowa Department of Public Health	Year 1	\$200,000
		8B.4 Develop comprehensive academic pipeline partnership programs between K-12 and post-secondary institutions to recruit minorities into health fields.	K-12 Schools; Post-Secondary Health Training Institutions	Year 1	\$500,000

		especially at younger ages			
		8B.5 Utilize face-to-face and word-of-mouth referrals and recruiting	K-12 Schools; Post-Secondary Health Training Institutions	Year 1	Minimal or No Cost
		8B.6 Develop recruiting partnerships with minority serving organizations out of the state or nation where possible	Post-Secondary Health Training Institutions	Year 1	\$200,000
		8B.7 Utilize minorities in training, recruiting, and retaining other minorities in health workforce	K-12 Schools; Post-Secondary Health Training Institutions; Private and Non-Profit Health Providers, NGOs	Years 2-3	Minimal or No Cost
		8B.8 Offer training programs on-site where minorities are	Post-Secondary Health Training Institutions	Years 2-3	\$400,000
SECTION 9.					
RECOMMENDED CORE CURRICULA AND CULTURAL COMPETENCY OFFERINGS					
<p>Increasing minorities in the health professions has been promoted as a primary strategy to improve the cultural competency of the workforce in meeting the special needs of diverse and underserved populations, so that health disparities can ultimately be reduced. As such, improving cultural competency and increasing minorities in the health professions are often cited as twin goals that should be addressed simultaneously to be most effective.</p> <p>Providing culturally competent health care means that a provider or organization is sensitive to the cultural differences between patients; understands the influence of these differences on their health practices and status; and can modify programs from a practical standpoint to meet the specific needs of diverse clients. Assuring that patients receive culturally appropriate care is increasingly necessary</p>					

		<p>with the country’s rapidly changing demographics. However, some health training schools have only recently implemented curricular changes so that their students are educated in working with diverse clients, while other schools still have relatively few offerings in the multicultural health field. In order to address the simultaneous and highly correlated issues of increasing minorities in the health professions and improving the cultural competency of providers, the following recommendations are offered for workforce planners:</p> <p>9.1 <i>Require at least basic cultural competency training for all health professions in order to graduate or receive licensure.</i></p> <p>9.2 <i>Require that health training schools offer cultural competency education programs for their students in order to pass accreditation.</i></p> <p>9.3 <i>Provide cultural competency training for all staff in health care organizations, including top management, health providers, support workers, and clerical staff.</i></p> <p>9.4 <i>Utilize cultural competency training programs that incorporate conceptual and theoretical information with extensive hands-on learning and experiential activities.</i></p> <p>9.5 <i>Provide first-hand opportunities for minorities in the local community to speak to health care workers and trainees about issues specific to their culture.</i></p> <p>9.6 <i>Emphasize face-to-face, personal learning when teaching cultural competency skills, and allow for ample time to practice and apply knowledge learned.</i></p> <p>9.7 <i>Include training on the traditional health beliefs and practices of minority populations, in addition to standard cultural competency training, so that health providers understand alternative and complementary forms of medicine practiced by others around the world.</i></p> <p>9.8 <i>Incorporate training on working effectively as providers with medical Interpreters.</i></p> <p>9.9 <i>Teach skills to work effectively with low-literacy and limited English proficiency clients, and emphasize health literacy and visual literacy skills when conducted cultural competency</i></p>
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<p>The Future of Iowa’s Health and Long-Term Care</p>	<p>Iowa Department of Public Health</p>	<p>http://www.idph.state.ia.us/hpcdp/common/pdf/health_care_access/hltcw_jan08.pdf December 2007</p>

<p>Workforce: The Health and Long-Term Care Workforce Review and Recommendations</p>		<p>Recommendations:</p> <p>Short Term (1 to 2 years)</p> <ol style="list-style-type: none"> 1. Establishment of the Iowa Health Workforce Center: Summit participants agreed that the current system of tracking health workforce is fragmented, and without coordination improvements cannot be achieved. Multiple entities collect varying data regarding health professions. There is a lack of clear lines of communication and a need for increased collaboration to assure resources are leveraged at maximum benefit for Iowans. An aggressive, targeted and comprehensive approach at the state level is needed. An Iowa Health Workforce Center will conduct and coordinate recruitment and retention of health professionals, increase local capacity for recruitment and retention, and prepare for the future by guiding data-driven decision making on priority needs and efforts. 2. Expansion of loan repayment programs: Sustain recruitment/retention/training programs that are working. Recruitment and retention needs were among those most frequently mentioned during summit discussions. Expansion of loan repayment availability in Iowa would strengthen communities’ ability to attract quality health professionals to serve Iowans. Increase recruitment, retention, and training/education efforts through known existing tools such as: <ol style="list-style-type: none"> a. Developing or expanding loan forgiveness and loan repayment programs b. Increasing the number of available Iowa residencies/internships c. Providing technical assistance to communities trying to recruit and/or plan d. Creating mentoring programs, preceptorships, team-based approaches and other similar strategies to prevent turnover/increase retention 3. Continue efforts to increase Medicare/Medicaid reimbursement for Iowa so that providers are able to pay health professionals at rates that are competitive with other states 4. Raise public awareness of the shortages and impact – expanded public awareness of the shortages and impacts will expand the conversations around the state on these issues, and get more people involved in addressing them <p>Long Term (3 to 5 years)</p> <p>[Note: At the summit, the long-term timeframe discussed was 3 to 10 years. This is reflected in Appendix D. Following the summit, based on discussion with stakeholders, the long-term time frame for this report was shortened to 3 to 5 years to more accurately reflect the urgency of health and long-term care workforce needs.]</p> <ol style="list-style-type: none"> 1. Continue efforts to increase Medicare/Medicaid reimbursement for Iowa so that providers are able to pay health professionals at rates that are competitive with other states (short and long term strategy) 2. Maintain infrastructure (a center) established for coordination of health and long-term care workforce efforts (as established in number 2 above) 3. Maintain and improve data collection/tracking/accessibility 4. Continue to sustain recruitment/retention/training programs that are working, adjust those that need changes, and develop new programs to address emerging workforce needs. 5. Align licensure scope of practice with scope of practice taught in education programs – so that “mid-level” aka “physician extender” professions are allowed/expected to maximize use of their training/skills. In
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		<p>conjunction with health and long-term care providers, workers, licensing boards and others, review the opportunities to enhance the efficiency and effectiveness of the workforce via changes to scope of practice. Any changes to scope of practice will require appropriate training and appropriate compensation for the responsibilities possessed.</p> <ol style="list-style-type: none"> 6. Continue and expand efforts toward wellness and prevention, a health care system rather than a sick care system, to reduce demand 7. Maximize best practices and efficiencies in how professionals deliver services – communicate/share
<p>Report of the Iowa Governor and Lt. Governor’s Nursing Task Force</p>	<p>Office of the Governor</p>	<p>http://www.governor.iowa.gov/news/2008/03/attachments/080303-Nursing-Task-Force-Report.pdf March 3, 2008</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Develop a Health Workforce Center to be a focal point for nurse workforce data and measures. • Expand programs in public and private sectors to provide forgivable loans and scholarships for nursing education at all levels. • Increase the number of nursing faculty through innovative employment, strengthening recruitment efforts and increasing salaries. • Increase efficiency and effectiveness of education programs and improve their ability to provide easy transitions from community colleges to the private nursing colleges and state universities. • Build a strategy for private investment in nursing, encouraging endowed chairs and program endowments to foster more nurses seeking advanced detgrees. • Foster Iowa’s rural voice to assure that those unique challenges and health situations are recognized and addressed as part of each health strategy. • Encourage public sector health facilities employing nurses to increase nursing wages to meet national salary averages. <p><i>Subcommittee I – Education</i> The four focus areas identified to address nursing shortage challenges in education are:</p> <ol style="list-style-type: none"> 1. Faculty Shortage 2. Student Recruitment 3. Accessibility and Affordability of Education 4. Changing Health Care Needs <p><i>Subcommittee II – Rural</i> The Rural Nursing Shortage Work Group recommends the development and ongoing funding of a Health Workforce Center to be charged with the following functions:</p> <ul style="list-style-type: none"> ○ Measure the professional and paraprofessional nurse workforce supply, identify and designate shortages areas and trends and define the need.

		<ul style="list-style-type: none"> ○ Help rural areas grow their own health care providers by developing strategies designed to fit their circumstances and needs and by providing technical assistance for local planning. ○ Make education/training/credentialing accessible in a number of ways and particularly through distance learning. By expanding and coordinating distance learning opportunities the educational needs of local health providers are met for the entry into professional practice and for continuing education to maintain licensure and skills. Provide incentives to enhance collaborative use of existing or newly developing information technology (IT) systems and technologies. ○ Explore ways to increase Medicare and Medicaid reimbursements rates into rural Iowa areas. The workgroup also notes that issues of recruitment and retention should be addressed by public/private partnerships in collaboration. The workgroup supports the efforts of the Nurse/Nurse Aide Task Force appointed by Iowa's Governor (2005-2006) as well as the Direct Care Worker Task Force (2006) and endorses the recommendations of the Health and Long term Care Workforce Summit that met in November of 2007. (Reports available at: http://www.idph.state.ia.us/hpcdp/workforce_planning.asp). <p><i>Subcommittee III – Shortage</i></p> <p>Goals for the Iowa Healthcare Workforce Center:</p> <ul style="list-style-type: none"> ○ Engage in activities to sustain a competent and diverse healthcare workforce ○ Assess and forecast healthcare workforce supply and demand ○ Promote recruitment and retention of healthcare workforce ○ Support strategies that prevent shortages at the local level. <p>Goals for the Nursing Workforce Center/Leadership Council:</p> <ul style="list-style-type: none"> ○ Improve image and marketing of nursing as a profession and career choice ○ Health Professions Tracking, Research, and Data Sharing ○ Implement strategies that result in recruitment and retention of Iowa's nursing workforce ○ Support education/ training of nursing workforce ○ Address financing of health and long term care in Iowa ○ Review opportunities to enhance the efficiency and effectiveness of the nursing workforce <p>Nursing Workforce Leadership Council Membership:</p> <ul style="list-style-type: none"> ○ Practicing Nurses and ARNPs ○ Educators ○ Employers ○ Board of NurSing Professional Associations <p>The Leadership Council Responsibilities:</p> <ul style="list-style-type: none"> ○ Build and promote infrastructure assets ○ Assist in identifying funding to support the work of the Center ○ Set Guiding Principles ○ Provide overarching direction for the Center ○ Approve strategic and operational plans for the Center ○ Support Policy Change ○ Endorse projects and activities of the Center
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<p>Iowa's Mental Health Workforce</p>	<p>Iowa Department of Public Health</p>	<p>http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/mentalhealth_0306.pdf March 2006</p> <p>Recommendations: Based on the information found while completing this study, the following recommendations are put forth:</p> <ol style="list-style-type: none"> 1. That the Bureau of Professional Licensure and the Office of Statewide Clinical Education Programs combine efforts to gather and report detailed employment information about mental health professionals working in Iowa. 2. That the Bureau of Professional Licensure continues their efforts to activate an on-line licensure renewal process in order to facilitate collection and reporting of employment and education information. 3. That education programs and professional organizations determine ways and means to recruit and retain more students into mental health professions. 4. That education programs provide to as many students as possible, ease of access to mental health curriculums and continuing education updates through the use of e-learning. 5. That legislators determine ways to provide incentives such as loan repayments to graduates and new hire assistance to potential employers of Iowa mental health graduates who practice in the state.

		<ol style="list-style-type: none"> 6. That professional associations assist in developing a working definition of what constitutes a “shortage” in their profession that includes, but is not limited to, budgeted vacancies. 7. That licensure boards review the scope of practice, educational requirements including internships, licensure procurement processes, and procedures for endorsement of out-of-state licensees in order to facilitate timely entry into practice. 8. That citizen groups use the data to inform their constituents and make recommendations to legislators. 9. That practice and education develop collaboratives that expand local opportunities for clinical experiences leading to licensure and/or certification. 10. That health professionals and associations promote awareness among employers regarding competencies, prescribing authority and reimbursement issues impacting advanced registered nurse practitioners, physician assistants, and other mental health professionals 11. That health professions explore practice models that improve the quality and efficiency of mental health services. <p>Numerous publications, agencies, and speech makers have indicated that there is a shortage of mental health professionals in Iowa yet little research has been conducted to quantify or define what constitutes a “shortage.” There are several sources of data that provide information about a potential shortage concerning the mental health workforce in Iowa but no studies or groups have assumed the task of matching the workforce supply with demands or needs of the population. The purpose of this study was to add to the growing body of knowledge about the current licensed mental health professionals in Iowa. It details the characteristics of psychiatrists, psychologists, health service workers (licensed psychologists with additional training in the clinical area), marital and family therapists, mental health counselors, physician assistants, and advanced registered nurse practitioners and social workers specializing in psychiatric care. Data relevant to reimbursement, substance abuse, and primary care physician service to the mentally ill were not considered in this report.</p>
<p>A New Day Coming? A Productive Discussion on Dental Workforce Change</p>	<p>Bob Russell, DDS, MPH, Iowa Department of Public Health</p>	<p>http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/a_new_day_coming.pdf</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Consider new dental workforce models • Implement well-designed evaluations of a prospective new workforce model • A new mid-level dental provider type prepared to focus on needs of high-risk underserved populations • Partnerships to address access to needed services required by high-risk underserved populations
<p>Planning and Training for a Telehealth Workforce for Rural Iowa</p>	<p>Child Health Specialty Clinics</p>	<p>http://www.idph.state.ia.us/hpcdp/common/pdf/workforce/plan_train_telehealth.pdf August 2006</p> <p>Recommendations: <u>A Plan to Move Telehealth Forward</u></p>

		<p>In order to move the telehealth system forward in the state of Iowa, several strategic steps are necessary. First, there are a set of general recommendations for the state:</p> <ol style="list-style-type: none"> 1. It would be useful to undertake a surveillance effort to determine the current use of telemedicine and the numbers and types of patients being seen in this way should be implemented and monitored over time to see where these efforts are working and being sustained. This will be challenging, since we could find no evidence that this is currently being tracked, but it is necessary to determine capacity for expansion into additional areas. 2. There could also be a surveillance effort to determine the capacity across the state for telecommunications infrastructure that could support telemedicine, i.e. availability of ICN sites, availability of adequate high-speed internet access or T-1 lines. 3. Continued monitoring of the distribution of medical providers across the state is critical. The areas in the state where there are shortages of medical specialties should be assisted in exploring ways in which telehealth systems might be used to address those needs. 4. State policy makers should be given information about the uses of telehealth and given opportunities to talk with providers and consumers who are using it. They should be encouraged to consider policies that provide incentives for physicians willing to learn and practice in this modality as a way of expanding services to children with special physical and behavioral healthcare needs in the rural areas of the state. 5. Medical schools should be encouraged and assisted in developing training and practice opportunities for students who have an interest in using telemedicine in their practices. <p>In addition to these general recommendations, several strategic steps are necessary in order to advance telehealth and, specifically, to create a statewide system of specialty services available to rural populations through telecommunications technology. We are recommending a regional pilot approach, which could then lead, region by region, to the development of a statewide system:</p> <ol style="list-style-type: none"> 1. Using a variety of population data, including the data included in this report, regarding location of pediatricians and child psychiatrists relative to child population, we would suggest the identification of a group of counties where there is an obvious need, an identified region to use as a pilot universe for the development of a telehealth system. Need would be based on the population and provider data, and on the distance from specialty providers. Geo-mapping of child population and physicians would be particularly helpful in this process. 2. Within that region information would be gathered in more specific ways, by interviews or focus groups with local providers to identify priority needs. This information should include data about the incidence of special health needs, with behavioral health being one of those. It would be important to get information from local schools and other human service providers, as well as the medical community. 3. Because most areas of the state have a Child Health Specialty Clinic, and because these clinics have some experience with telehealth and have relationships with local providers, CHSC would be the logical entity to provide technical assistance, training and support in enhancing current systems and adding new telehealth systems. 4. From the data gathered in the region, one could project whether there is a critical need for pediatric services
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		<p>and/or child psychiatry services and/or other specialties, and approximately how much of each.</p> <ol style="list-style-type: none"> 5. An assessment could then be made of the technology capability in the region. It is worth noting that not every community has access to internet bandwidth adequate for this type of use. On the other hand, hospitals already have T-1 lines in place and may be willing to collaborate with other entities in the use of these. 6. There are then several possibilities for expanding telehealth locations in the region. The CHSC clinic may be able and willing to increase the number of telehealth sessions. There may be a pediatric or family practice office that is able and willing to create a telehealth “studio” where their patients and their office staff could participate in specialty consultations. This would enable the rural practitioners to participate directly in the consultations they request for their patients. There may be a hospital that already has the necessary equipment and would be willing to partner in providing telehealth consultations for the community. 7. Obviously, the other necessary step is the recruitment and hiring of the required specialty providers who now reside and practice in urban settings and in tertiary facilities. They would have to be encouraged to practice in this new way and would need opportunities for training and practice, as well as time to build these new relationships across the state. <p>Hopefully, one part of their telehealth practice would be providing education to the local practitioners who are caring for these patients with special health care needs, through modeling and through professional development, which will ultimately build the capacity of the local providers to deal with these issues.</p>
<p>The Iowa Medical Society: Report of the Task Force on Iowa’s Health Care Infrastructure</p>	<p>Iowa Medical Society</p>	<p>http://www.iowamedical.org/documents/Comm/IMSTaskForceReport.pdf April 2008</p> <p>Recommendations: The 40-plus recommendations of the Task Force vary from general encouragement toward a particular course of action to specific ideas for change. The recommendations fall under four topic areas: 1) Iowa’s physician workforce; 2) medical education and training in Iowa; 3) caring for Iowa’s uninsured; and 4) Iowa’s public health system.</p> <p>1. Iowa’s physician workforce To strengthen the security of Iowa’s physician workforce and to assure that Iowans will have adequate access to primary and specialty health care, the Task Force recommends:</p> <p><i>Enhancing physician recruitment and retention.</i> 1) Iowa’s medical education institutions should assist in recruitment of new physicians to practice in the state. This requires entities other than educational institutions to partner and fund programming that will provide</p>

		<p>opportunities and incentives for new physicians to remain in Iowa.</p> <ol style="list-style-type: none"> 2) Collaborative and coordinated recruitment programs should be pursued to identify potential physicians who may be attracted to practicing in Iowa. 3) Medical practices and health care organizations should recognize and develop a diverse set of employment options enabling physicians with differing work/life balance needs to find appropriate practice opportunities, thereby assuring a higher level of professional satisfaction. 4) Noting the issues discussed in this report, IMS, through research and study, should help its members develop new and innovative solutions to bring additional physicians to Iowa. 5) IMS and other organizations should facilitate and support further study of Iowa physician retention and develop strategies to curtail physician migration from Iowa. 6) To support a patient-centered medical home model of care delivery, mechanisms should be identified to assure ongoing and effective primary care physician recruitment and retention. <p><i>Encouraging medical liability reform.</i> Iowa lawmakers should pass a Certificate of Merit law to ensure that only cases with merit move through the court system. As a result, cases would only advance if there was a legitimate possibility that medical standards of care had not been followed.</p> <p><i>Improving funding mechanisms.</i> A variety of financial strategies could affect physician workforce levels in Iowa, including issues outlined below:</p> <ol style="list-style-type: none"> 1) Funding streams for graduate medical education should be expanded in those specialties that are experiencing a physician shortage to create more residency opportunities. 2) Private entities and federal, state, and local governments should provide greater financial support to assist new physicians with loan repayment in exchange for practicing in the state. 3) IMS members and health care organizations should support efforts to improve fairness in physician reimbursement by payers that currently limit Iowa physician salaries. 4) Efforts to reduce or eliminate indirect medical education funding should be closely monitored and appropriately addressed. <p><i>Improving quality of care.</i></p> <ol style="list-style-type: none"> 1) Iowa's health care community and Iowa's policymakers should maintain their support of the Iowa Healthcare Collaborative. 2) Close ties should be promoted between research and practice. The Task Force believes that there is a great need to close the time gap between a research discovery and the implementation of new patient care practices leading to proven higher quality care. New systems that disseminate and implement evidence-based medicine are needed. <p><i>Advancing patient education.</i> A system should be developed to better educate the public on factors that impact the quality of their health. This includes emphasizing preventive care (including dental care for children), medication education, and family or support group education to help patients understand how best to experience and pursue quality care. Health</p>
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		<p>literacy is an important aspect in effective patient education. Promotion of patient responsibility helps assure better patient outcomes. Strategies for assisting physicians in educating their patients should be promoted.</p> <p><i>Providing consistent coverage.</i> Insurance programs should provide appropriate benefits so patients will be able to focus on their <i>health</i> rather than their <i>coverage</i>.</p> <p><i>Disseminating new technology.</i> Technology, which includes data management, quality measures, and coordinated records management, should be expanded and coordinated to better link health providers with patients to create a more seamless and complete system of providing care to patients. This enables higher quality care provided in a more efficient manner – both reducing workload and creating a practice environment that is more attractive to potential physicians. Electronic health records should be expanded with an eye toward developing a true patient-centered medical home.</p> <p><i>Fixing inadequate reimbursement systems.</i> Medicare payment inequity is an impediment to recruiting physicians to Iowa. This creates problems in health care access and quality of care. The governor and state legislature should join IMS in advocacy efforts on this issue. To remedy the current inequity, Congress should take the following steps: 1) Fix or repeal the flawed Sustainable Growth Rate formula. 2) Change the current RBRVS funding formula to remove geographic inequities. • <i>Avoiding waste.</i> Policymakers and health care providers should continue identifying and reducing waste within the health care system. This should include waste in health care delivery and health care financing.</p> <p><i>Increasing public awareness.</i> The Task Force encourages IMS and other health care organizations to educate the public about today’s health care challenges and their impact on patient care. Providers should help the public understand the impact of Iowa’s low physician reimbursement on health care access in the state. •</p> <p><i>Supporting physician-directed collaboration.</i> To better effectuate patient health care goals, physicians should continue to lead their teams of providers toward delivery of coordinated, efficient care.</p> <p>2) medical education and training in Iowa To maximize Iowa’s ability to retain its Iowa-trained medical students and to effectively build partnerships with our state’s medical academic centers and other available programs, the Task Force recommends:</p> <p><i>Encouraging Iowa residents.</i> Iowa’s medical and residency programs should expand and pursue policies that will further support growth in highly qualified residents of Iowa being accepted into medical school programs. The federal government should approve funding for these expansions. Furthermore, Iowa must be innovative and develop state-specific solutions.</p>
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		<p><i>Addressing shortage areas.</i> Iowa’s physician shortage areas should be designated and emphasized in Iowa’s medical schools and residency programs. Furthermore, Iowa’s residency programs should seek funding to expand capacity for those specialties experiencing a shortage.</p> <p><i>Supporting Area Health Education Centers.</i> Iowa’s health care system must support Iowa’s new AHECs. Additionally, Iowa’s medical education institutions should consider greater use and support of AHECs to expand community-based learning and thus create an expanded presence across the state. Support for the University of Iowa’s regional health education system should continue.</p> <p><i>Developing new models of delivery.</i> Along with better linkages between medical student practice experiences in identified shortage areas, new models of delivering care in areas with scarce resources should be developed and tested.</p> <p><i>Meeting the employment needs of a new generation.</i> Iowa’s medical education institutions should further recognize and support changes to their programs that will assist physicians in making necessary changes in their practices to better match the needs of new physicians, more of whom are women and/or who represent increasing diversity. If Iowa is to compete for those new physicians, Iowa’s medical practices must adapt to the needs of today’s graduates.</p> <p><i>Expanding support for women entering practice.</i> Mentoring programs for women should be expanded to encourage opportunities for women to practice in Iowa.</p> <p><i>Enhancing mentoring programs.</i> Mentoring programs for students should be further developed and pursued so students will experience a maximum opportunity for academic success and be educated to the benefits of practicing in Iowa. Joint efforts among Iowa’s medical schools, IMS, and practicing physicians could develop such a program. Additional mentoring programs should be developed for physicians already in practice to enhance retention and improve colleague interaction.</p> <p><i>Valuing international students.</i> Iowa’s communities and our medical education institutions should invest in programs that encourage international medical graduates to practice in Iowa. Efforts should be made to develop retention efforts for international physicians.</p> <p><i>Monitoring enrollment.</i> Expanded medical school class sizes alone is not a solution to Iowa’s current physician workforce needs, and a national increase in physicians will not alleviate geographic maldistribution of physicians. Because factors might change, Iowa’s medical schools and residency programs should continue to evaluate the impact of increasing</p>
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		<p>enrollment on Iowa’s physician supply. Future consideration of increased medical school enrollment must be supported by valid research, which now suggests a weak link between increasing enrollment and addressing physician shortages in particular areas.</p> <p><i>Linking health systems and medical clinics.</i> Iowa’s medical education institutions should further pursue relationships with health systems and medical clinics to create more opportunities for study and understanding of the day-to-day functions of today’s practice environment. These relationships can foster greater understanding of issues related to advocacy, policy, regulations, infrastructure, and bylaws.</p> <p><i>Linking practicing physicians to education.</i> Iowa’s practicing physicians should be offered mentoring opportunities by Iowa’s medical education institutions which will encourage intergenerational learning.</p> <p><i>Developing alternative education formats.</i> Iowa’s medical schools are encouraged to further explore the possibility of creating alternative formats for physician education. This could involve reducing by one year the time required to complete a program, for example, through a 3 + 4 (three years of undergraduate work followed by four years of medical school) program or through alternative scheduling for existing academic program designs.</p> <p><i>Expanding input for curriculum development.</i> Iowa’s medical education institutions are asked to further develop and pursue curriculum development, with the input of medical students and those physicians practicing in Iowa, that emphasizes Iowa specific needs as well as the ability of graduates to work successfully with people and teams.</p> <p><i>Increasing financial support of education.</i> Iowa’s medical education institutions should work with organizations that will develop public/private partnerships with local sources to financially support medical education for students who will commit to practicing in Iowa. The growth level of loan burdens is not sustainable. Schools and organizations such as IMS must work to further discover and develop methods to increase tuition assistance for medical students.</p> <p>3) caring for Iowa’s uninsured To assure that all Iowans can access health care services regardless of their income, the Task Force recommends:</p> <p><i>Increasing access to health care.</i> In keeping with IMS policy, the Task Force believes that all Iowans should be able to access affordable, high quality health care.</p> <p><i>Providing universal coverage for children.</i> Recognizing that universal health care access for children is supported by AMA policy, discussions around access to care for all children should include:</p>
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		<p>incubate health care coverage programs that best serve their populations.</p> <p><i>Improving the IowaCare program.</i> IowaCare needs restructuring and an improved reimbursement structure. To adequately treat individuals in the IowaCare program and to potentially expand this program, it is necessary to ensure that physicians are reimbursed fairly. Additionally, the program must be reduced in complexity. Finally, consideration should be given to expanding the IowaCare program to allow for coverage in additional settings throughout the state. Physicians at the University of Iowa Hospitals and Clinics and Broadlawns Medical Center should necessarily have a seat at the table to help determine program features and reimbursement rates. IMS, on behalf of Iowa physicians with patients served by this program, should also be involved in discussions, particularly to address program design and funding support.</p> <p><i>Acknowledging problems facing the underinsured.</i> As health care coverage becomes more expensive, we must take note of the growing number of “underinsured.” Employers that offer health care coverage are shifting costs to their employees as health insurance premiums rise. Employees may then only be able to afford less expensive insurance plans that offer less coverage. While these Iowans will continue to have health insurance, their less comprehensive insurance coverage may fail to adequately prepare them for the financial repercussions of seeking certain forms of health care. This may, in turn, have an adverse impact on the quality of health care they receive.</p> <p>4) Iowa’s public health system. To better assure that Iowans’ health is improved in areas indicating challenge, the Task Force recommends:</p> <p><i>Implementing interventions.</i> Early life interventions should be emphasized to combat obesity in the state. Other interventions should be targeted toward promotion of:</p> <ul style="list-style-type: none"> o Diet, exercise, and nutrition; o Tobacco prevention and control; o Education in juvenile risk behaviors such as drug use and sexual behaviors; o Improved prenatal care for pregnant teenagers; o Education and prevention of substance abuse; o Pediatric developmental and behavioral assessments to advance primary prevention efforts; and o Oral health. <p><i>Utilizing established benchmarks.</i></p>
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		<p>who otherwise do not have access. The Task Force supports:</p> <ol style="list-style-type: none"> 1) A greater link between community and critical access hospitals and community health centers; 2) Greater collaboration between specialists and community health centers; and 3) Recognition of CHCs as an integral part of Iowa’s health care system. <p><i>Using schools as a public health access point.</i> Schools are serving an expanded role in public health delivery. Schools are a natural avenue to disseminate public health information and provide preventive and public health services. The Task Force supports increased efforts to expand these initiatives.</p> <p>Additional Considerations The Task Force understands the importance of public health and prevention activities and believes that this sentiment is shared throughout the physician community. Despite this, physician reimbursement and education do not reflect its importance. Any solution to improve the health of Iowans must include a paradigm shift of compensation for a new manner of care that fosters physician/patient dialogue of preventive care. Students in undergraduate and graduate medical education programs, as well as practicing physicians, are often taught the importance of prevention and public health. However, educational systems emphasize the treatment of acute and chronic conditions. Public health matters receive only passing coverage, despite the enormous impact on the health care system. Enhanced focus on educational programs can lead to a greater appreciation and recognition of public and preventive health issues in practice.</p> <p>Recommendations: To improve awareness and to reinforce the importance of public health activities among Iowa physicians, the Task Force recommends:</p> <p><i>Improving physician reimbursement.</i> Current reimbursement systems do not value public health and prevention activities. This works against public health and prevention goals and should be restructured to reflect their importance.</p> <p><i>Enhancing physician education.</i> The Task Force recommends that physician education emphasize the value of a public health system and its strengths in preventing illness and disease.</p> <p><i>Increasing emergency preparedness.</i> Emergency preparedness is an essential component of public health and medical care delivery. Existing, well developed structures, such as Iowa’s trauma system of care, should continue to play a coordinated role in Iowa’s system for emergency preparedness.</p>
Report of the Task Force on The Iowa	UI Carver College of Medicine,	http://www.healthcare.uiowa.edu/CCOM/Administration/IowaPhysicianWorkforce.pdf 7 MB lengthy download time

<p>Physician Workforce</p>	<p>University of Iowa Hospitals and Clinics</p>	<p>January 2007</p> <p>Recommendations:</p> <p>Physician Education / Training Capacity</p> <ul style="list-style-type: none"> ○ Increase the class size of the UI Carver College of Medicine modestly (~10%) and increase the proportion of medical school graduates who remain in Iowa for residency training. ○ Increase the enrollment in select Iowa residencies and fellowships based on physician demand data. To that end: promote Iowa’s practice opportunities among medical students, residents and fellows, seek state and private funds for additional graduate training positions, energize student interest groups in the specialties for which demand is high, initiate early recruitment programs at the pre-medical school level. ○ Consider adding residency slots in psychiatry and general surgery (rural track) using the community-based family medicine residency model. ○ Develop and validate a national index to prospectively identify specialties in which a supply shortage might develop due to downward trends in medical student and resident career choice. (This will require new financial support.) <p>Physician Retention</p> <ul style="list-style-type: none"> ○ Identify the specific reasons for attrition associated with physician relocation and help in developing strategies aimed at stemming the outflow of physicians. (This will require new financial support.) ○ Establish favorable state, regional and local loan repayment programs for specific specialties using the primary care model of years-of-service in exchange for specified amounts of loan repayment. ○ Publicize Iowa practice opportunities throughout the University’s GME system and promote contacts between prospective employers and UI GME program directors and trainees. ○ Establish programs for early pipeline collaborations/connections between students and residents, and specific communities. ○ Work with the IMS, IHA and other stakeholder organizations in developing programs that promote Iowa as a place to practice and live. ○ Set a minimum target for the number of University of Iowa students training in select allopathic residency programs in Iowa. ○ Provide technical assistance to medical groups, health systems and hospitals in designing their recruitment packages, including recommended incentives, contract advice, and recruitment strategies. (This will require new financial support.) ○ Continue to monitor age and gender trends within the Iowa physician community. <p>Recruitment of Physicians from Other States</p> <ul style="list-style-type: none"> ○ Systematically contact Iowa medical graduates training in other states and promote information concerning Iowa opportunities. (This will require new financial support.) <p>Public Policy Initiatives</p>
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<p>Direct Care Worker Compensation Advisory Committee</p>	<p>Iowa Department of Human Services</p>	<p>http://www.dhs.state.ia.us/docs/2008-12%20Direct%20Care%20Worker%20Compensation%20Advisory%20Committee%20Report.pdf</p> <p>December 11, 2008</p> <p>Recommendations:</p> <ol style="list-style-type: none"> 1. Fully Fund the Current Modified Price-Based Case Mix Reimbursement System 2. Modify Current Reimbursement Methodology to Include an Inflation Update in Non-Rebase Year: 3. Modify Calculation of Direct Care Median Component: 4. Modify Information Reported by Nursing Facilities on the Medicaid Cost Report: <p>Options for Funding the Recommendations</p> <ol style="list-style-type: none"> 1. General Fund: Policymakers could fund the recommendations from the General Fund and make an investment in the direct care workers, increase the supply of the direct care workers, promote greater workforce stability through increased compensation and reduce costs associated with high staff turnover. 2. State Fines: Under Iowa Code section I 35C.36, the Iowa Department of Inspections and Appeals (DIA) has the authority to issue a fine for violation of state regulations. This money is deposited into the general fund. Policymakers could use a portion of this money to bolster nursing facility quality by investing in a stable workforce. 3. Accountability Measures: The 2001 Iowa Acts (HF 740) created intent by the General Assembly to initiate a system to measure a variety of elements to determine a nursing facility's capacity to provide quality of life and appropriate access to Medicaid in a cost-effective manner. During the 2008 legislative session, Senate File 2425, section 33 made changes to the Accountability Measures including the establishment of a workgroup that is to develop recommendations to redesign the accountability measure program. The Direct Care Worker Compensation Advisory Committee recommends that consideration be given to using some of these funds to increase the compensation to direct care workers. 4. Provider Tax: In accordance with the legislation that created the Direct Care Worker Advisory Committee, the group recognizes the importance of utilizing additional federal funds to offset the continued growth in overall Medicaid costs. More specifically, portions of increased funding from this source can be directed to wages and other costs of employment for employees in long-term care. This method of drawing down additional federal funding is used by 31 other states. In 2003, House File 619 gave the Department of Human Services (DHS) authorization to assess nursing facilities a quality assurance assessment (provider

		<p>tax). The DHS submitted a state plan amendment (SPA) to the Secretary of the US Department of Health and Human Services, Centers for Medicaid and Medicare, to implement the provider tax. In 2005, CMS and the federal government were no longer allowing intergovernmental transfers. In Iowa, the intergovernmental transfer was the mechanism used to fund the Senior Living Trust. Iowa agreed to end the intergovernmental transfers, as a condition of approval for an 1115 Demonstration Waiver, which allowed the state to implement the IowaCare Initiative. As a special term and condition of the 1115 IowaCare Demonstration, DHS agreed to not implement a nursing facility provider tax and was required to withdraw the pending SPA. As a result, the state was not able to implement the nursing facility quality assurance assessment (provider tax) created in HF 619. Advocates for the concept of a provider tax believe that Iowa's recent economic challenges imposed by natural disasters and the economy may be cause for this IowaCare agreement to be renegotiated. The IowaCare Demonstration Waiver is scheduled for renewal effective July 1, 2010. The Direct Care Worker Compensation Advisory Committee believes that effectively utilizing these additional resources could provide gains in wage and benefit planning and assuring the workforce of compensation growth to keep pace with statewide economic changes.</p> <p>5. Expanded Medicaid Appropriations: At the time this report was in final drafting, conversations were occurring at the federal level to increase the amount of Medicaid dollars flowing to the states as part of a broadened economic stimulus package. The advisory committee recommends that if additional federal Medicaid funds are made available, and if the funds could be used for the purpose of increasing direct care wages or other forms of compensation, that consideration be given to do so.</p>
IDPH Response and Direct Care Worker Advisory Council Recommendations	Iowa Department of Public Health	<p>http://www.idph.state.ia.us/hcr_committees/common/pdf/direct_care_workers/report_response_nov08.pdf May 1, 2009</p> <p>Recommendations: At this time I am requesting the Direct Care Worker Advisory Council address the following during the balance of FY2009 and in the first half of FY2010:</p> <ol style="list-style-type: none"> 1. Identify the DCW contribution to rebalancing health and long term care 2. Gather more comprehensive stakeholder input regarding the council's existing recommendations including input from the disability community 3. Research similar credentialing efforts to demonstrate such efforts have decreased direct care worker turnover and improved quality of care in other states. 4. Thoroughly review existing regulations governing training of direct care workers in all settings and an analysis of consistency and variance among current requirements. 5. Develop a strategic plan that addresses outreach/education regarding the importance of DCW
Direct Care Worker Advisory Council Recommendations	Iowa Department of Public Health	<p>http://www.idph.state.ia.us/hcr_committees/common/pdf/direct_care_workers/report_nov08.pdf November 2008</p>

		<p>Recommendations:</p> <p>Grandfathering Recommendations</p> <ul style="list-style-type: none"> ○ Implement a Process to Certify the Existing Direct Care Workforce ○ Adopt a Regional Phased-In Approach to Grandfathering <p>Communication and Outreach Recommendations</p> <ul style="list-style-type: none"> ○ Establish a Phased Plan of Communication and Outreach to Support Implementation <p>Supplemental Recommendations</p> <ul style="list-style-type: none"> ○ Expand Membership on the Direct Care Worker Advisory Council ○ Conduct an Assessment of Existing Technology Resources and Capabilities ○ Complete Estimates of Resources Needed for Technology, Personnel, and Partners to Continue Implementation ○ Support Legislation Establishing the Iowa Board of Direct Care Workers
<p>Senate File 389</p>	<p>2009 Legislative Session</p>	<p>Division V.</p> <p>Established but did not fund new programs related to health care workforce, including</p> <ul style="list-style-type: none"> ● medical residency grants, ● health care provider incentives, ● nurse and nurse educator incentives, ● safety net provider network incentives, and ● a physician assistant mental health fellowship program. <p>Requires annual report on use of funds. Implements this division to the extent that funding is available. (Not funded in 2009.)</p>