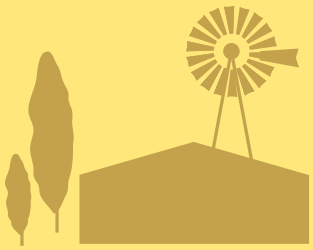
Forum 1: A Focus on Iowa Health Care Programs
November 15, 2006
Iowa Memorial Union, Iowa City, Iowa



Rebalancing Health Care IN THE HEARTLAND

FORUM 1 SUMMARY

Sponsors

Mercy Health Network
The University of Iowa

Co-sponsors

Delta Dental of Iowa
Iowa Hospital Association
Iowa Medical Society

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The University of Iowa Health Sciences Policy Council Forum Planning Committee

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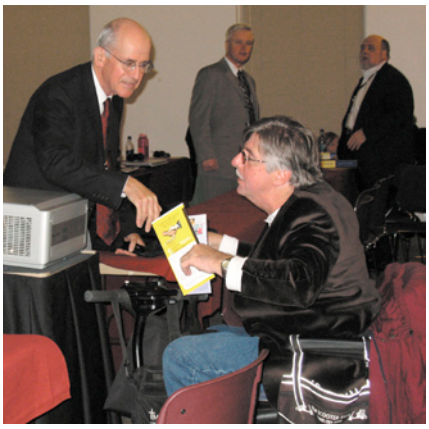

Forum rapporteur Steven Schroeder (left) and Randy Davis, Iowa Olmstead Consumer Taskforce

Rob Fernandez, Master of Public Health in Policy and Administration student, and Elena Dicus, Master of Health Administration student

Left to right: Jane Halliburton, Iowa Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury Commission; Robert Bacon, UI Center for Disabilities and Development; and Scott Lindgren, UI professor of pediatrics and Center for Disabilities and Development

Iowa Senator Amanda Ragan

Sharon Yearous, pediatric nurse practitioner, Xavier High School, Cedar Rapids

John Hale, Iowa CareGivers Association

Preface

Few subjects are as important to individuals and communities as health care and its guiding public policy. On a personal level, health care often dictates quality of life and financial security. On a policy level, the complexities and competing priorities brought about by rapid changes in health care science and technology combined with expectations for health care services by consumers and fragmented funding structures have presented a challenge that, to date, continues to strain the entire health care system from consumer to federal policy authorities.

The University of Iowa Health Sciences Policy Council convened the first of three forums on November 15, 2006. Rebalancing Health Care in the Heartland Forum 1 brought together experts in state health care issues to focus on Iowa's publicly funded health care programs and the overarching elements of cost, prevention, access, providers, and quality. The University of Iowa is well positioned to lead this critical and timely discussion. As a publicly supported academic institution, the University provides a non-partisan forum for the consideration of issues of public interest and concern. In addition, with its strong array of health professionals and researchers, The University of Iowa is well suited to provide the information and research that will inform this discussion.

This summary of Rebalancing Health Care in the Heartland Forum 1 sets the stage for Iowa to move forward in improving the health care delivery system. Using the issues surrounding aging, children, mental health, and disability services systems, Forum 1 presented Iowans with data, research, anecdotal evidence, policy analysis, and momentum on which to continue policy discussions and deliberation.

The University's second forum will examine health care reform initiatives and proposals adopted in other states. The day-long event in spring 2007 will consider those initiatives and any potential application to Iowa's health care reform. The third forum will occur in autumn 2007 to capitalize on the policy and media attention the presidential caucus process brings to Iowa. Hearing about health care reform proposals of aspiring presidential candidates will highlight this final forum.

The University of Iowa Health Sciences Policy Council encourages all stakeholders to consider the information provided through this and the succeeding forums in developing appropriate policy solutions for Iowa's health care services system that focus on the consumers of health services and provide balance in addressing the issues documented in this summary.

Additional information about the Rebalancing Health Care in the Heartland series can be found at www.rebalancinghealthcare.org.

Executive Summary

Health Care Policy Implications for Iowa's Future

This section presents a summary of the policy-related issues of access, cost, prevention, providers, and quality as applied by Iowa's publicly financed health care system serving the aged, children, those with disabilities, and those with mental illness. Information provided by the participants in the Rebalancing Health Care in the Heartland Forum 1, taken together, points policy discussion for Iowa toward certain themes highlighted in this document.

The time is right for these discussions. In Iowa's Capitol, shifts are taking place in the governor's office and the legislature. New and veteran policymakers will be seeking the latest information on health care issues. The rising costs and deficiencies in the health care system and publicly funded programs make it even more critical that these discussions occur now.

At the federal level, similar changes in congressional leadership offer greater opportunities to provide Iowa's federal representatives and key members of Congress with research and data to support their work. Federal reform, while necessary, is unlikely to occur quickly. Iowa cannot afford to wait years for federal-level reform; rather, its leaders must proceed in analyzing the issues and taking appropriate action. Iowa must ensure that comprehensive health care policy addresses key issues and ultimately improves the health and health care of all Iowans.

Emerging Themes and Policy Implications

Several common themes ran throughout the Forum 1 presentations. As these themes are examined in detail, it becomes evident that the fundamental issues and concerns about the current system for those with publicly funded health care and the uninsured apply to Iowa's general population. Overarching policy themes that emerged from two or more speakers across the topics of aging, children, disabilities, and mental health included:

- quality of life,
- choice,
- access,
- cost,
- prevention,
- providers, and
- quality.

These seven themes are detailed further in the following pages. However, their discussion at a policy level must be integrated. None of these themes can be addressed in health policy reform without addressing the others. The ultimate challenge to policymakers is to consider the vast impact of health policy reform and to truly "rebalance" the system in such a way that these seven themes are fairly considered in the result.

Quality of life for many Iowans is dictated by health care services.

Health care policy translates directly to quality of life policy for Iowans, particularly poor Iowans. While examples of the relationship between health care policy and quality of life can be seen in the lives of all Iowans, those who need specialized services and supports are bound by additional regulations and often-cumbersome programs.

- For elders, quality of life is provided through health care options that can allow increased consumer choice and better controlled costs if delivered through the Home and Community-Based Services waiver. The Iowa Person Directed Care Coalition is another example of an approach that seeks to provide balance in the delivery of long-term care services to individuals within a residential facility setting. Each of these approaches challenges the traditional institution-based health care system and improves individuals' quality of life through greater choice and control.
- Quality of life for children is influenced by the family environment, support systems, and financial status. The burden on the policy system to provide needed supports and services increases when children have special needs. There is evidence that policies that promote programs in early brain and child development prevent future health issues. This implies a need for early intervention and coordination of care initiatives. Educating and supporting parents is a critical strategy, with home visits and group well-child care both showing promising results.
- For people with disabilities who rely on public programs for supports, quality of life is largely a factor of what the system allows. Some who are able to work conclude it is unwise to have a job that pays more than is allowed by Medicaid because they cannot afford to be without the health care coverage. Iowa, with prodding by the Supreme Court Olmstead Decision, has made strides toward allowing improved quality of life for people with disabilities through the early implementation phase of the consumer choice (waiver) option. This option allows and expects its participants to make informed decisions in selecting supportive health care services and providers that best meet their needs.
- For people with mental illness quality of life is highly dependent on their health care services. People with serious mental illness (SMI) often rely on their personal support system and health professionals on a daily basis. Programs for Assertive Community Treatment (PACT), which are used in Iowa's managed mental health services, are among the evidence-based medicine receiving greater attention at the local, state, and federal level. There are still 5,000 residential care facility beds for people with mental illness in Iowa. It is a priority to shift many of those to community-based services.

Individual choice in health care is a fundamental value for Iowans, and across the United States.

Health care policy must address the value of individual choice because it makes sense as policy, but also because consumers will not support loss of choice in their care. Across the spectrum, forum speakers discussed consumer choice. One of the most difficult issues of balance in the health care system is to determine how much choice people "should be allowed" when the funds are coming from taxpayers.

- **Choice is often linked with quality of life for the aging populations.** If quality of life is increased by staying in one's own home, that choice may improve health accordingly, reducing need for more costly institutional health care services. Health care policy for elders needs to be flexible, easy to access, and provide information to consumers about quality and outcomes so they can make decisions in their best interests.
- The impact of choice for children is less obvious, particularly because children lack the decision-making acumen and the legal authority to make health decisions for themselves. But health care policy needs to give children a chance to succeed and develop into healthy adults. Policy that supports systems of multi-

disciplinary and coordinated care maximizes the options for many children in need. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits are one means to identify needs that require early intervention in order to give the child a chance for a healthier life. With this comes the need for requisite policy to maintain and reimburse health care providers for this service.

- People with disabilities have recently taken center stage in Iowa and across the nation on the issue of choice. Policy changes in the disability services system were given impetus by the U.S. Supreme Court's Olmstead Decision which, in essence, determined that people with disabilities have the right to live in the least restrictive setting and to choose services, including health care services, to support them in that setting. In its implementation, the consumer choice (waiver) option challenged traditional decision making that excluded the disabled consumer from the primary decision-making role. Increasing numbers of people with disabilities are eligible for Medicaid and Medicare. Policy opportunities abound in establishing a flexible, consumer-oriented system that may provide lessons for the health care system as a whole.
- People with mental illness need to receive appropriate treatment so they are well enough to make choices in their lives. An estimated 4.5 percent of the population has serious mental illness (SMI). Those with SMI are frequently unable to take care of their other medical conditions, such as heart conditions or diabetes, which further shortens their life span. Health care policy can support choice for people with SMI by addressing institutional bias and investing some of the funding in programs providing a continuum of care.

Access to health care in Iowa is dictated by internal and external forces that exacerbate the issue.

Access to health care means different things to different people, but it is clear that Iowans living in rural communities and the inner city experience significant difficulties with access. **Access is central among rebalancing health care issues.** The federal policy response in recent years has been increased support for Community Health Centers operating under specific designation as Federally Qualified Health Centers and receiving significant federal funding through Centers for Medicaid and Medicare Services (CMS). Yet forum presenters provided ample evidence that access issues remain in Iowa.

- Elders and their families are concerned that health conditions be managed well as aging occurs. Aging may also lead to disabling conditions, bringing the elder person's needs in close alignment with people with disabilities. Access to health care through Medicare and Medicaid programs provides acute services. Meeting long-term care needs of a growing older population should move the current health care system toward policy that supports livable communities with a full complement of flexible, community-based services. Fostering communication between service providers and addressing end-of-life care must also be included in policy considerations for the elderly.
- Access to health care for children through the children's state health insurance program ***hawk-i*** has improved in recent years. Iowa has significantly increased enrollment in Medicaid and is now one of only two states to reduce the number of uninsured. The work is far from done, with significant impacts on a child if access to services is limited by one or more factors. The enrollment process should be easier and more efficient to enroll even more children. A new Iowa program, Preparation for Adult Living (PAL), was launched in July 2006 to extend Medicaid services to children in the

foster care system who turn 18. Children's access into the health care system is multi-layered and dependent on the family, the providers, and the payers. Policy for children's health must address access to prevention, early childhood intervention, and continuity in treatment.

- People with disabilities are deeply involved in a services system that allows them to live with their disability and function on a daily basis; many of these services are not health related. In addition, people with disabilities need access to health care, whether or not the need is directly related to their disability. Within the current policy framework, Medicaid providers are the primary point of access to the health care system for many people with disabilities and should therefore focus on easier enrollment and greater efficiency. Few generalizations can be made about the individual needs of people with disabilities because of variations in conditions, attitudes, and experiences. Policy that supports access to health care services must therefore be flexible.

- Mental illness impacts people in each of the three populations already addressed, as well as the general population. Its reach is overarching. In Iowa, inpatient beds are being eliminated as the result of federal policy and low reimbursement rates, creating an access problem. In rural Iowa there are no psychiatrists, and in most parts of the state there is a waiting period to be seen by a psychiatrist, while crisis cases can usually be accommodated. Individuals often have to travel great lengths to access services. The Iowa Legislature eliminated the provision requiring that children receiving mental health services must come through the Child in Need of Assistance (CINA) process. Programs for Assertive Community Treatment (PACT) is a viable policy option, but at this time there is a shortage of these types of programs. Policy is needed to encourage mental health professionals to settle and work in Iowa's most rural areas.

Cost must be a key focus of health care policy reform.

Cost is considered by some as the primary reason that health care reform is needed. **Between 2005 and 2030 Medicaid costs are expected to grow by 330 percent in Iowa,** compared with a growth in gross domestic product of 72 percent. Health care expenses are increasing for many reasons. Our society relies more on health care than in the past, and with technology and treatment advances come higher costs. Throughout the forum, speakers addressed the trend toward increased individual responsibility for a greater share of health care costs. Any attempt to rebalance the system will result in cost shifts, and the positive and negative impacts of those shifts must be anticipated and addressed.

- Traditional facility-based care for elders is being reexamined across the country with clear implications for cost. Some traditional facilities are developing a more consumer-directed and flexible set of services that may have a further impact on cost control. Other efforts are examining whether costs are reduced when services are provided in a flexible system of coordinated care that allows individuals to remain in their communities. The concept of livable communities, which has been studied in Johnson County, may provide a model for Iowa's policy development.

- Costs to provide children's health care can be divided into acute care, anticipatory guidance, and preventive care. Data show the costs to provide children's health care is relatively low when compared to adults. Medicaid and ***hawk-i*** provide a mechanism to provide anticipatory guidance, but it is not a focus of current policy. Anticipatory guidance is described as primary care providers offering parents information and guidance in promoting their child's health, growth, development, and safety. Other elements to consider when addressing health care policy for children are

options for partnerships (e.g., training programs for anticipatory guidance), requiring a dental visit to enter school, and well-child care similar to the existing law requiring that all children receiving Medicaid services have a dental home by 2008.

- Services for people with disabilities are the cost drivers of Medicaid, yet this program may well be an effective way to provide services to other high-need individuals, particularly when compared to the cost of private insurance. Health care policy should recognize the importance of investing in the health and mobility of people with disabilities, which reduce the need for later, more costly services. Institutional bias also enters into the cost discussion. The institutional system still tends to turn to a facility to provide services when it may be neither necessary nor cost-effective to do so. Iowa's progress in reducing the number of facility beds and increasing access to the Home and Community-Based Waiver Services (HCBS) is a positive step in addressing institutional bias. The consumer choice (waiver) option, as shown by other states, provides better health outcomes and improved consumer satisfaction, but is not designed as a cost-savings initiative.
- **Providing services to people with mental illness costs Iowa $1 billion annually.** This presents a significant rebalancing challenge for Iowa's system that serves these people often most in need of health care services. In addition, aging baby boomers will result in a reduced health workforce and rising health care costs. Health care delivery for persons with mental illness may incorporate wider use of coordinated care that includes local mental health trained nurses, tele-health to access specialized services, a psychiatrist, and greater use of the Internet. A key challenge in this area is to identify what cost-effective programming options bring about the best health outcomes for this population and to incorporate those elements into health care policy for people with mental illness without making the policy decisions based primarily on issues of cost.

Prevention efforts have demonstrated positive health care results and should be included in health care policy and budgets.

In each of the four populations discussed by forum presenters, prevention was emphasized as an investment with a good return in the form of a healthier population and enhanced quality of life. Iowa has begun to seriously think about prevention and to enact policy reflecting prevention as a growing priority. Examples include the requirement for children receiving Medicaid services being required to have a dental home by 2008, and increases in use of home and community-based waivers that include a more flexible approach to delivery of prevention services. One might also argue that the Iowa Legislature's commitment to continue full funding of Iowa's Medicaid program is tantamount to an investment in prevention.

- It has been demonstrated that when evidence-based health promotion programs are implemented, health outcomes are improved. In Iowa, a chronic disease self-management program will be implemented to help individuals maintain their level of health. Policy addressing prevention needs for elders might include considerations such as maintaining mobility, ensuring livable communities, providing flexible services in the individual's home, and focusing on nutrition and self-care.
- **Prevention efforts for children are paramount and should be included in basic health care policy.** In early years, prevention involves promoting optimal brain development, which will have lifelong benefits for the child. Preventive services investment in children is the right thing to do, even if cost savings are not realized. Anticipatory guidance, home visits, group well-child care, office-based literacy programs, parent-held child health

records, and new models of pediatric care have potential for improving childhood health outcomes. Day care, schools, and training sessions for parents provide opportunities to engage in prevention activities. In Iowa, prevention efforts also include addressing food security and poverty within the state's borders.

- For people with disabilities, both primary and secondary prevention efforts are important. Primary prevention seeks to prevent the disability in the first place, while secondary prevention treats disabilities before they become too functionally limiting or severe. Policy to support prevention efforts might include addressing the key role of folic acid in the prenatal diet to prevent certain birth defects, providing prenatal care and information, addressing substance abuse in pregnant women, conducting surveillance and screening, health maintenance programs, and more fully implementing the consumer choice (waiver) option.

Prevention policy is an investment that ultimately can support individuals who want to contribute to society, work, live independently, and more fully participate in their communities.

- People with serious mental illness need intensive services to prevent recurring episodes that impact not only their mental health, but their overall health. Prevention programs for this population might also provide prevention opportunities for other health issues, such as smoking. Health care policy might also include investment in school-based mental health clinics and innovative cooperative care teams to leverage mental health provider expertise in health professional shortage areas.

Qualified providers need to deliver high-quality services through coordinated care that maximizes health improvement outcomes.

In some geographic areas of Iowa and some specialty areas, a shortage of professionals and gaps in service leave patients vulnerable. Even though the federal government classifies Iowa as a rural state, there is a wide variation of provider availability between rural, suburban, and urban areas of Iowa. Policy considerations in rebalancing the health care system must include recruitment and retention of qualified professionals to serve all areas of the state. Policy to retain professionals in their practices, e.g. loan repayment programs and reasonable reimbursement rates, will require policymaker attention. Further policy attention to team approaches in coordinated care delivery may also improve health outcomes for Iowans. Emphasis needs to be given to collaborative and coordinated care and policy that supports the education and training of health care professionals to provide coordinated care in a team environment.

- Medication management serves as a key example of how elders might achieve improved health outcomes. Side effects increase with the number of medications taken; the average Iowa elder takes 10 medications. Seniors commonly alter their dosage to either manage side effects or stretch the medication for financial reasons. Health outcomes suffer, primarily from undermedicating. Policy to promote a pharmaceutical care management collaborative care model suggested by the Institute of Medicine would address both problems. Another opportunity for provider service delivery is in the coordinated care effort of livable communities, supporting elders remaining in their homes with ample services available and with providers engaged in ongoing communication.

- Children needing health care services in all areas of the state often require specialist services. Case management and service coordination is not always locally available

or reimbursed, which creates a gap for some in their service delivery. Policy to support tele-medicine and tele-health can help fill these gaps. Iowa's children increasingly need services from primary care, behavioral, emotional, development, and mental health professionals. Domestic violence and substance abuse create additional needs for specialized children's services. Recruitment and retention of quality providers is an issue, and the aging of the current health workforce compounds the problems. Policy solutions are required as market forces are not meeting the need, particularly in rural communities. Those policy solutions may include such options as "circuit rider" specialists, incentives to recruit and retain qualified health professionals, increased use of cooperative teams, and use of communications technology.

- People with disabilities seek providers for their daily life services and support as well as health care. **In many health care professions and related disciplines, a workforce shortage is looming.** People needing daily personal assistance and other functional living services often experience the impacts of this shortage before other populations. Within medical professions, the 15-minute visit and relative value unit have more impact on people with disabilities than on the general population. Policy shifts to promote a team-based approach and emphasize prevention may provide a viable alternative to the traditional medical system.

- Providers for people with severe mental illness are scarce in many areas of Iowa. Access to psychiatric services cannot be assumed in rural areas. While recruitment and retention of providers should not be overlooked from a policy perspective, alternatives should be considered. More than a dozen of Iowa's mental health centers are closing because of low reimbursement rates. The newly created mental health authority in Iowa should mandate a recovery-based system of mental health care and implement evidence-based mental health care statewide. This is a significant policy step for the state. A team approach, including the Program for Assertive Community Treatment (PACT) with peer support specialists, may emerge as a policy priority for this population.

Quality in the health care system, including direct patient treatment, must continue to improve.

The first theme in this series notes that quality of life is directly related to quality of health care. Policy promoting health care quality is paramount; Iowans deserve nothing less than excellent quality care. Considerations of quality in the policy arena may vary by population or by discipline, but there was agreement across all presenters that quality health care delivers improved health outcomes for the individual. Further, there seems to be consensus that coordinated, interdisciplinary services that encourage consumer choice and active involvement in determining service needs are hallmarks of quality health care. Developing policy to balance these priorities and manage impacts of cost and other shifts is the ultimate challenge to Iowa's policymakers.

- For elderly populations, quality of care means the individual is successfully managing health conditions and enjoying quality of life. From a policy perspective, coordination of care, collaboration among providers, support in managing complicated programs like Medicare Part D, and promotion of a healthy lifestyle are areas of focus for the future. Technology may also be useful to elders in assuring quality of care, with Internet access to general health and wellness information and/or increased access through a primary care provider/specialist for improved care management approaches for chronic conditions. Policy to promote coordinated community-based health care for individuals as they age and need services for disability and mental health issues will be critical to assure quality care.

- **Quality health care for children often impacts their adult health.** Children's health and growth needs are aimed to promote later healthy development. From a policy perspective, children's health care does not fit neatly within the adult health care system. The challenge is to ensure that children receive quality health care, even though the system does not naturally support it. Policy is therefore needed to assure well-child care, increased individual attention by pediatricians at visits, inclusion of anticipatory guidance, developmental surveillance, improved detection of disabilities at a younger age, early dental care, and attention to mental health and development issues at an early age.

- Quality health care services for people with disabilities are determined on an individual basis and are directly related to quality of life. People with disabilities face a major policy hurdle in the form of stringent regulations on earnings of individuals and the low income threshold at which services are denied. Policy in support of quality services for those with disabilities might emphasize choice. However, managed care and choice seem to be policy contradictions. Policy that promotes access to affordable health care for people with disabilities at all income levels, increased options for community and home-based living arrangements, and peer support initiatives would significantly assist people with disabilities. Because people with disabilities are often unemployed and among the poorest Americans, they often lack the resources for a healthy diet and transportation to receive health care. The consumer choice option (and other waivers), "cash and counseling," and the Money Follows the Person concept are critical to health care policy for people with disabilities.

- Much summarized above also applies to people with mental illness. **Quality will not exist without access.** Models of collaborative care and the Programs for Assertive Community Teams (PACT) offer options to succeed. Policy support has recently come in the form of a small but significant amount of funding for research allowing development and implementation of a functional assessment tool and outcomes for some members of this population. A policy challenge remains in documenting the quality of mental health services, as Iowa currently lacks the information technology capacity to systematically capture and review these data.

Welcome

James Merchant, Dean, University of Iowa College of Public Health, and Senior Advisor to the President for Public Health Programs and Policy

- The goal of this forum is to focus on Iowans most in need: children, the aging/elderly, individuals with disabilities, and individuals suffering from mental illness. The forum will address the issues of cost and prevention, access, service providers, and quality as they relate to each group.
- Iowa's 2008 caucuses provide an opportunity for Iowans to identify issues of concern to them and their fellow Americans. Iowa can help set the tone for the national discussion on health care.
- The reasons have never been more apparent:
    - In 2004 it was estimated that health expenditures reached $1.9 trillion, or approximately $6,280 per person. Health expenses account for 16 percent of the gross domestic product, which is estimated to grow 20 percent to $4 trillion by 2015.
    - More than 90 million Americans live with chronic diseases such as cardiovascular disease, cancer, and diabetes. These and other chronic diseases account for 70 percent of all deaths in the United States, and their diagnosis and treatment represent nearly 75 percent of U.S. health expenditures including hospital spending, prescription drugs, physician services, home health care, and nursing home care. However, only one penny out of each dollar spent on U.S. health care is devoted to prevention.
- The 2006 mid-term election resulted in a marked shift in the electorate in Iowa and nationally. As recently noted by the Robert Wood Johnson Foundation, some of this shift can be attributed to concern over health care issues.
    - The Pew Research Center for People and the Press reported that not since 1994 have Americans identified health care as a very big problem: 55 percent in 2006, up from 17 percent only a year ago.
    - It has been widely reported that **more than 46 million U.S. children and adults lack health insurance**. The lessons from terrorism, Hurricane Katrina, and the avian influenza threat have focused national, state, and local attention on the need to strengthen the public health infrastructure to make communities healthier and safer.
    - Finally, the national epidemic of obesity is now recognized to include our nation's children. An estimated 20 million children and teens will be overweight or obese in the year 2010. Given all of these health care concerns, this is an opportune time to discuss needed changes in health care in Iowa and the nation.

Opening Remarks

Gary Fethke, University of Iowa Interim President

- Health care can be thought of as an economic issue. The U.S. health care system grew out of the price control structure of World War II. Companies offered health care and pensions as a way of attracting workers to critical-need industries.
- That system of funding health care worked well in the 1950s, 1960s, and 1970s. During those periods, the U.S. economy was the strongest on earth. Without competition in world markets, businesses could afford to provide benefits to workers without an extensive burden.
- This system is now unraveling due to the forces of globalization. U.S. rivals in Asia, Europe, and Latin America are becoming far more competitive in key U.S. industries. These countries are not burdened by health care and pension costs.
- The current U.S. health care system cannot be sustained in a global economy. Firms that have access to as good or better technology, lower labor costs, national health care systems, and inexpensive transportation will dominate key markets. The U.S. has been generous in the provision of health care and pension benefits, but is now burdened by generations of legacy costs.
- **Globalization will be the defining force in determining who pays for health care costs.** There is going to be realignment in who is responsible for health care costs among business, government, and individuals. Businesses will either stop paying legacy costs from the World War II era or disappear.
- Fethke believes the realignment will begin with a shift from business to government, and then to the individual. Economics are driving the health care system toward higher deductibles and health care savings accounts. Health care will move toward a system that will be based on ability to pay rather than an entitlement system.
- Another economic factor of note is intermediaries. Intermediaries are individuals or organizations who sit between a vendor or supplier of a service and the customer. Some intermediaries, such as travel agents, are being eliminated by technology. In other industries, such as health insurance, intermediaries are growing in force. Competition, once let loose in an industry, will shrink profit margins and will lead to changes in the way goods and services are delivered.
- As companies, businesses, and universities address these changes, the importance of promoting prevention and wellness will increase significantly.
- In a world of increasing competition and interconnectivity, competitive forces will affect the margins of all businesses. In that world the challenge will be to become more efficient, aggressive, and innovative or become obsolete.

Letter from Governor-elect Chet Culver

Governor-elect Culver sent the following letter, which was read aloud by Dean Merchant.

Dean Merchant and Forum Participants:

As Iowa's governor-elect, I am heartened and encouraged that the University of Iowa Health Sciences Policy Council has convened this first of three forums to address the very real issues of health care right here in the heartland. Though I am unable to be with you as you gather on Wednesday, I share your commitment to creating solutions so all Iowans have access to affordable, quality health care no matter where they live or what their personal circumstances.

Many of the topics you will discuss are those that people across the state talked with me about during my months of conversations with Iowans. Individuals with health problems face personal pain and, sometimes, financial hardship. **Together, the health issues of all Iowans create consequences for our workforce and the vitality of our communities.** Those conversations and your forum agenda affirm that the priorities contained in my Healthy Opportunities Plan for Every Iowan are more important than ever. Your deliberations on the difficult health care issues surrounding children, the aging, mental health, and disabilities will continue to be incorporated into the policy discussions as, together, we seek policy solutions for all Iowans.

I thank each of those attending the forum for investing the day in coming together to work toward those solutions. As we move ahead into the new Culver-Judge administration, I will count on you to work with me and the state's leaders in this commitment to continue the progress toward affordable, quality health care for all Iowans.

Thank you very much.

Sincerely,

Chet Culver
Governor-elect

Keynote Speaker

Kevin W. Concannon, Director, Iowa Department of Human Services

"Post Election 2006: Prospecting for System Opportunities in Iowa Healthcare"

- **Prevention and Public Health** - Four primary opportunities for health promotion and disease prevention exist in Iowa: 1) reduce tobacco use, 2) improve diet, 3) increase exercise, and 4) reduce poverty. The saliency and likelihood of these opportunities occurring has changed for the positive as a result of the November election.

  It is important for Iowa to aggressively pursue an increase in the tobacco tax. If increased, the tax will have a dramatic impact on reducing tobacco usage among young people and will also improve the health of nonsmokers. This would be a sound policy change from both a public health and fiscal standpoint. Starting January 1, 2007, the Iowa Medicaid program will begin offering smoking cessation support to Medicaid recipients.

  DHS is also working with the Iowa Department of Public Health (IDPH) to improve the diets of individuals and families participating in public programs. Iowa is ground zero in terms of growing food, and yet there are people who are food insecure within the state. DHS has been working very deliberately to increase access to food assistance for individuals with limited incomes. But coupled with this effort must be efforts to deal with nutrition and exercise.

- **Poverty** - Iowa also has an opportunity to begin to address poverty. Iowa has not adjusted Temporary Assistance to Needy Families (TANF) reimbursement rates for low-income individuals since 1993. There is no question that, from a health care point of view, poor people have more health issues than people of means.

  In addition to addressing health care needs, **Iowa must also try to lift people out of poverty through an increase in the minimum wage** and other supports for individuals in the workforce. DHS has made recommendations in the agency budget to help "make work pay" so that benefits of people in the workforce exceed the benefits of those who are not.

- **The Setting for Policy Change** - Iowa has significantly increased enrollment in Medicaid in the state. Iowa is one of only two states that have made gains in reducing the number of uninsured. While the reduction is modest, it is still a success. Iowa also has one of the highest rates of employer-related health insurance in the United States.

  Iowa has helped close the gap in the uninsured through Medicaid, ***hawk-i*** (the State Children's Health Insurance Program (SCHIP), and the IowaCare program. The expansion of Medicaid through IowaCare has achieved a much more equitable system than the previous State Papers Program in terms of regional access into which there are uniform applications of eligibility.

  Iowa is also in the midst of expanding the children's health insurance program. A number of uninsured children in Iowa are currently eligible for ***hawk-i*** or Medicaid. Governor-elect Culver has made insuring all children in Iowa a priority for his administration. Congress will also have an opportunity to revisit the State Children's Health Insurance Program through reauthorization in 2007.

  Iowa has received waivers from the Centers for Medicaid and Medicare Services (CMS) for the Medicaid program. Iowa had relied on intergovernmental transfers, using previously earned federal funds to match future funds. This

worked well for Iowa, but CMS has taken the position that intergovernmental transfers are no longer acceptable. Iowa negotiated with CMS, resulting in the creation of the IowaCare program to recover $65 million and create an additional $35 million in funds to implement health transformational initiatives.

Last year, Iowa made improvements in the behavioral health system, which had some weaknesses. Iowa has made steps to mitigate legal settlement for state payment cases. Several other innovations are also currently being reviewed by CMS including reimbursement to Community Mental Health Centers for costs rather than according to a payment schedule, and reimbursement for inpatient beds for hospital psychiatric units.

Iowa has one of the fastest growing aging populations in the country. **Iowa's current system of long-term care is overly dependent on an institutional model of care.**

Iowa has recently made changes to child welfare health-related programs. In order for children with serious mental illness to receive care, they were required to come through the Child in Need of Assistance (CINA) system. The CINA system reflects very primitive beliefs regarding the causes of mental problems for children. Last year the legislature eliminated the provision that required all children to come through the CINA system to receive care. DHS will propose further changes to children's mental health services in 2007.

- **Preparation for Adult Living (PAL) Program** - Each year about 550 children "age out" of the foster care system in Iowa when they turn 18. Last July in Iowa, the PAL program extended Medicaid services to these children through age 21 and will provide access to living arrangements and higher education. The PAL program is a small but very important step for these young people.

- **IowaCare** - The IowaCare program came about as a result of the impending loss of millions of dollars in federal funds. IowaCare is a limited health care benefit program with a limited health care network, which provides health care to individuals who are categorically not eligible for Medicaid. Since July, Iowa has seen a reduction in enrollment related to the Deficit Reduction Act (DRA). The DRA requires proof of citizenship status. Individuals dropping off coverage typically do not have these documents available. This is a burden on the poor and elderly that hopefully will be addressed legislatively.

- **Medicaid** - Medicaid in Iowa is experiencing an increase in enrollment related to increased child enrollment and the Medicaid for Employed Persons with Disabilities (MEPD) program. Disability numbers have not increased, but costs of services have increased. Elderly persons represent 10 percent of the Medicaid population and 25 percent of the costs; persons with disabilities represent 16 percent of the Medicaid population and 48 percent of the costs. The Medicaid program, by default, is the long-term care policy for the United States. In the case of persons with disabilities, especially those with behavioral disabilities, the Medicaid program is the primary support.

- **State Children's Health Insurance Program (SCHIP)** – This program is scheduled for reauthorization by Congress in 2007. States currently receive SCHIP funding using a formula based on population. Iowa spends more on SCHIP than is allocated to the state. Not only should Congress reauthorize SCHIP, they should address the inadequacies of the funding formula and overall federal investment.

- **Health Transformation Initiatives** - There are great opportunities in Iowa to move forward with a number of health transformation initiatives. Iowa has done a good job of reducing the number of individuals residing in state mental health institutes. While Iowa has four

such institutes, the collective number of beds and patients combined is approximately 200. Iowa ranks 45th in comparison to other states in terms of the number of state-operated psychiatric beds.

There is a long-standing prohibition in Medicaid policy against using funds to pay for the care of patients between the ages of 22 and 64. This prohibition is referred to as the Institute for Mental Disease (IMD) prohibition. As part of Iowa's agreement with CMS related to intergovernmental transfers, Iowa agreed to convert funds to serve individuals accessing services through the state mental health institutes to the community.

Iowa is in the midst of negotiating with IDPH to offer dietary counseling for select populations in Medicaid. Iowa is in the "beta testing phase" to implement a web-based program that will move Medicaid patients toward electronic medical records. This system is currently being tested in Iowa's Federally Qualified Health Centers and will be fully rolled out in January 2007. Iowa is currently working with Des Moines University and The University of Iowa to offer health assessments to all patients in the Medicaid system with mental retardation (MR) or developmental disability (DD) diagnoses.

- **Home and Community-Based Services** - **Iowa has the highest rate of institutionalization in the United States for individuals age 65 or older.** Iowa also has the highest rate of private pay and the lowest rate for Medicaid for individuals in long-term care settings. Individuals prefer to stay in their homes and communities as long as possible. Iowa is in the midst of efforts to support home and community-based services.

  The consumer choice option is currently being piloted in the Waterloo area. The idea behind the consumer choice option is to provide the consumer with the opportunity to use Medicaid funds to purchase care services in the community. This is not a cost-savings effort, as demonstrated by states that have already implemented this system, but produces better health outcomes and improved consumer satisfaction.

  Iowa is working with CMS to create a differential eligibility level and more stringent criteria for Medicaid admission to nursing facilities to help move toward more home and community-based services. Iowa is also overly dependent on intermediate care facilities for persons with developmental disabilities. The state must provide suitable residential alternatives for people with MR in the community. Iowa must move toward the values we express and provide more individual services.

- **Mental Health and Disability Services** - Iowa spends a collective $1 billion annually on care for individuals with behavioral disabilities. Iowa has a system with strengths and weaknesses. DHS will work with the next governor and legislature to find additional ways to finance the system while maintaining the community aspects. The National Alliance for the Mentally Ill gives Iowa very low marks due to how the system is financed.

  Iowa has received federal funds to implement a system of care for children with serious mental illness as a pilot program in the eastern side of the state. To the extent that Iowa faces challenges in the adult behavioral health system, the challenges are even greater for children.

- **Health Reform** - Massachusetts has recently enacted the most robust health reform in the country targeted at fully providing health insurance to all residents of the state. One of the elements of the Massachusetts system requires all employers to have an IRS Section 125 health plan, but employers are not required to fund the plan. This requirement ensures that employees are able to access the state health insurance program on a pre-tax basis. Between income tax and FICA, this requirement saves 30 to 35 percent, reducing the net cost to the individual. DHS will research such innovations further and hopes to make a recommendation to the governor.

Elected Officials

Forecasting the Legislative Session

Stacey Cyphert introduced Senator Amanda Ragan, who represents Senate District 7. She was recently elected as an assistant majority leader. While the committees have not yet been set, Senator Ragan has experience with health care issues, which would allow her to provide leadership in that area.

Senator Amanda Ragan

- **It is clear that people with lower and middle incomes have problems accessing affordable health care.** This is the biggest issue constituents wanted to talk about in the district that I serve, whether it had to do with pharmaceuticals or access to health care. It was not just the elderly, rather people representing every age group and every walk of life.
- One of the programs the legislature will look at this year is the SCHIP program, which includes ***hawk-i*** and Medicaid expansion. There is a hope that Congress will fully fund this program through its reauthorization in 2007, as this will make a difference in Iowa's budget.
- There is also a hope to increase the number of children served through Medicaid and SCHIP, as these programs are good ways to get families engaged in health care. According to the Robert Wood Johnson Foundation, this program has reduced the number of uninsured children in Iowa by 21 percent from 1997 to 2004. The only concern is that 40,000 children and families with incomes up to 200 percent of the federal poverty level still do not have access to health care because private insurance companies are not insuring as much as they had in the past. This trend is also being seen with employers, so that is a concern. One proposal is to increase the income eligibility for SCHIP above 200 percent of the federal poverty level in order to include more lower and middle income children.
- The legislature will also likely consider expanding SCHIP to parents. Last year there was a proposal that would have covered parents who are up to 50 percent of the poverty level. It looks like the cost would be less than $10 million and it would be an effective way to gradually insure some parents.
- Another area that needs to be addressed is the shortage of health care professionals. This is an issue particularly important in rural Iowa. The federal reimbursement rate has a huge impact on a provider's ability to recruit and retain staff. The legislature would like to work with the universities, colleges, and community colleges to boost the number of health care professionals in Iowa.
- Another issue is to make improvements in the IowaCare program. The University of Iowa, the Iowa Legislature, and Governor Vilsack created the program in 2005 and it has made great strides over the State Papers Program; however, across the state there is a need for services not covered under IowaCare.
- There is also a need to ensure that wellness and prevention programs and initiatives are fully funded, such as the Iowa Dental Home program that was authorized in the IowaCare legislation.
- Finally, the legislature will continue to fully fund the Iowa Medicaid program and work to expand the home and community-based services available to Iowa citizens.

Christopher Atchison introduced David Heaton, who represents House District 91. He became chair of the Joint Human Services Appropriations Subcommittee in 1999, and the State of Iowa has benefited from his leadership. He helped to develop IowaCare, the community empowerment legislation, and many of the concepts that have been discussed today.

Representative David Heaton

- Health care in Iowa is a three-legged stool made up of Medicare, Medicaid, and employment-based health care, which is how the majority of citizens access health care coverage. While nine out of ten Iowans have coverage, each of the three legs has serious issues that must be addressed for Iowans to have health care security.
- For Medicare in Iowa, there are two factors that apply pressure to the system; the first is that Iowa is an aging state. In 2005, over 14.7 percent of Iowa's population was age 65 or older. By the year 2030, the U.S. Census Bureau estimates this will grow to 22.4 percent. The other issue is Medicare reimbursement. The Iowa Medical Society reports that **Iowa ranks 80th out of 89 payment localities in Medicare reimbursement.** These two issues could be solved if there was sufficient funding in the Medicare Trust Fund.
- In 1985 Medicaid and Medicare accounted for 9 percent of federal spending. Today, it is almost 20 percent and is rising. This year also marks the first year that the Medicare Trust Fund is spending more than it is taking in. By 2018 the Trust Fund will be exhausted if the incoming revenue to the program will only pay for 80 percent of the expenditures.
- Medicaid has the largest impact on the state's budget. Over 300,000 Iowans receive health care through Medicaid. In 1999, the state spent a total of $389 million on the program. For the current fiscal year, the legislature appropriated $753 million and that might not be enough. While other states cut their Medicaid rolls and left thousands waiting to see if they could secure coverage, Iowa maintained its commitment to those who had signed up for Medicaid and ***hawk-i***.
- Sixty-eight percent of the people under 65 in this state get their health care coverage from their place of employment. Yet, there is great disparity in health care coverage between small and large private employers. The Kaiser Foundation found in 2003 that 97.4 percent of the firms with 50 or more employees provided health care coverage as part of their benefit package. The same survey found that just 37.4 percent of small businesses in Iowa with fewer than 50 employers provided coverage. For the public sector, the cost of employee health care is also a major issue. In 1999, the monthly premium for family coverage of state employees was $471. In 2006, the cost has risen to $1,212 per month.
- One of the major problems throughout our health care system is the fact that many believe there is no incentive for them to maintain health care coverage. This could be solved through a health care system similar to the new Massachusetts system.
- In 2005, Iowa made a commitment to provide a dental home for children in the Medicaid program, which could prevent 40 percent of the infectious diseases that that child would contract in a lifetime.
- Iowa's health care infrastructure is another critical issue. There is a need for more family practitioners and physician assistants, and the need to stretch the medical delivery system in Iowa. As far as psychiatric and mental health services are concerned, there is much promise through the use of tele-health and tele-medicine to assist in rural mental health service delivery.
- Iowa's new governor-elect has promised to provide health care coverage to parents of children enrolled in ***hawk-i***, which is a laudable goal, but not as simple as it would seem. Federal law says that states cannot provide benefits to SCHIP recipients who are not provided to a Medicaid recipient. That means parents with children on Medicaid must also receive the same services. Iowa's current effort covering children in ***hawk-i*** already consumes more than Iowa's share of SCHIP funding from the federal level.
- With Iowa's growing senior population, Iowa must commit to repaying the Senior Living Trust Fund. Iowa's mental health system is facing its own funding questions. Some advocates want to expand in-home services while downsizing Iowa's state institutions. Yet Iowa's senior population the issue of dementia is a growing concern. Individuals with dementia will live longer and longer and as they become older, they become more difficult.

Panel 1: Children

Moderated by *David Johnsen*, Dean, University of Iowa College of Dentistry

Dean Johnsen noted that children are the future and they do not vote, so it is our responsibility to ensure their health and well-being. Johnsen introduced Dr. Paul Dworkin, who has been a driving force in every major national initiative in developing and articulating science-based principles into protocols and programs for children. Johnsen ended his comments by asking, "What are the consequences of failure on both an individual and societal level?"

Keynote Speaker

Paul H. Dworkin, MD, Professor and Chair, Department of Pediatrics, School of Medicine, University of Connecticut, and Physician-in-Chief of Connecticut Children's Medical Center

"Fulfilling the Promise: Promoting Optimal Development Through Child Health Services"

- The goal of child health services is to promote child growth and development. The goal of the American Academy of Pediatrics (AAP) for child health services is to be "committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults."
- Recent advances in knowledge of early brain development and early child development can and should inform thinking about the redefinition of child health services.
- Recent research has provided extraordinary insights about child development and health. This knowledge must be embraced to inform planning and decision making. Researchers have a good understanding about early childhood and development, but there is still much to learn about adolescent brain development.
- **Promoting children's optimal development is not just a good thing to do, it is imperative that we do it.** In order to best accomplish this, it is important to take into account the way that the brain works.
    - First, a child's experiences and environment have a long-term impact on his or her emotional, social, cognitive, and physical development. Brain growth, both prenatal and during the first two years of life, is of extraordinary significance in determining the individual's health later in life. It outweighs all other aspects of development.
    - Second, the concept of neural plasticity has had profound implications for the clinical services offered. Neural plasticity is the ability of the brain to recover from insults and injury and this process is extraordinary. The critical concept in this finding is that a young brain takes less time to recover and is more efficient and effective in organizing the developing nervous system. It is more challenging for an older brain to reorganize a more developed nervous system. There is an opportunity in early childhood that is unparalleled and while the window never closes, the opportunity during early childhood to repair and recover is unmatched.
    - Third, there are critical periods in brain development and although it continues throughout life, the first three years are critically important in providing a strong foundation for growth.
    - Fourth, the brain develops sequentially. Therefore, experiences need to be sequential as well. In counseling parents, the experiences of the child must match the developmental needs of the child. Parenting is really about providing the "right" experiences in the "right" amounts at the "right" time in the life of the child.

- Fifth, development of the human brain can be and will always be shaped by experiences. Experience, in turn, leads to neural changes in the brain, which makes the brain more receptive to subsequent experiences. This cycle must be promoted as children's optimal development is promoted.

Based on the information provided above, there are several implications that lead to intervention and promotion of healthy development through child health services. Intervention is imperative and research shows that parents desire more information about how to best promote their child's learning and development. These include:

- The Commonwealth Fund released survey findings in 1998 that speak directly to expectations parents have in ensuring their children's healthy development. Parents desire expert guidance and information on a wide range of topics including: how to encourage learning, how to discipline, toilet training, sleep patterns, crying, and newborn care.
- As the traditional content of child health services is considered, the services typically include: health history; physical examination; measurements; sensory screening; developmental/behavioral assessment; immunizations and procedures; and anticipatory guidance. The two items that have special relevance in this discussion include developmental/behavioral assessments and anticipatory guidance, which includes developmentally oriented counseling.
- Anticipatory guidance is defined as the provision of information to parents with the expected outcome being a change in parent attitude, knowledge, or behavior. **Anticipatory guidance should be emphasized as a means to promote children's development.** There is a need to individualize the content and to discuss matters at the level of parents' cognitive, cultural, and psychological readiness. The information provided needs to be more than a simple list of age-appropriate topics.
- There has been a great deal of research regarding the effectiveness of developmentally oriented counseling. In developmental monitoring the goals are to support health supervision through the early detection of developmental and behavioral disabilities, particularly for children who are identified to be high-risk. Developmental monitoring also supports the provision of appropriate services and support to children facilitated through the unique access that is available to young children and families. Unfortunately, interactions with parents are not always based on the research and findings that exist and the health care system is still unsure how best to perform detection and intervention.
- Consideration of developmental monitoring, specifically developmental surveillance and screening, leads to four key components which include: eliciting/attending to parents' concerns; obtaining a relevant developmental history; making accurate observations of children; and sharing opinions with other professionals.
- Developmental monitoring is a flexible, longitudinal, and continuous process and knowledgeable practitioners perform skilled observations during each encounter they have with a child. Each child must be viewed within the context of their overall well-being and tools need to be used to enhance parental communications, including sharing opinions with other services providers such as visiting nurses, child care providers, among many others.

Dworkin also discussed five evidence-based strategies and noted the importance of viewing children in their overall environment and circumstances. The five strategies below have been shown to improve the effectiveness of children's health and development.

1) **Home Visiting**: this strategy includes the promotion of children's optimal growth and development and is proven to improve the effectiveness of children's health and development. Promotion and implementation of home visits must be continued and there must be documentation of the quality of these programs.

2) **Group Well-Child Care**: this strategy allows groups of parents that have similarly aged children to come together to discuss issues affecting their children. Studies have been conducted that show the efficacy of these programs. Mothers were found to be more assertive and ask more questions, parents were more likely to initiate discussions on more topics, there was greater coverage of recommended content for the issues discussed, and there was a decrease in amount of advice sought by parents between health care visits.
3) **Office-Based Literacy Programs**: this strategy is in response to the promotion of the importance of school readiness as a national concern. Many individuals may be familiar with the Reach Out and Read program, which provides books to pediatric waiting rooms, anticipatory guidance on literacy development, and gifts of books at well-child visits. Outcome-based studies have shown positive results, including changes in parents' behavior, children being more likely to report reading as a favorite activity, gains in children's language, and later gains in academic performance and development (i.e. vocabulary scores). **These programs are particularly important for disadvantaged populations.**
4) **Parent-Held (Electronic) Child Health Records**: this strategy is shown to be efficient, but has not been widely embraced in the U.S. It promotes parents as partners; enhances communication and cooperation between parents and health professionals; provides a basis for discussing development, behavioral, and common health care issues; serves as a resource for useful health promotion and educational materials; and has proven and extensive international experience behind it.
5) **New Models of Pediatric Care**: strategies can include intra-office and intra-clinic efforts as well as statewide initiatives. Examples include:
    a. Healthy Steps for Young Children: this program is promoted by the Commonwealth Fund and has the goals of strengthening parents' knowledge, attitudes, and behavior; promoting child health and development; and improving child outcomes. The content includes child health specialists within the clinical setting and includes many provisions that link parents to the community. This program has shown remarkable gains in parent behaviors and outcomes for children.
    b. Help Me Grow: this is a statewide effort in Connecticut, which was implemented in 2002 and has four components.
        i. Child Development Infoline
        ii. Child Development Community Liaison
        iii. Education and Training of Child Health Providers
        iv. Evaluation

- There are formidable obstacles to implementation of these strategies, including funding and necessary knowledge and skills of care providers. However, there is a need for well-designed, prospective studies of promising innovations and new models, and there is a role for advocacy.
- Dworkin concluded with the imperative that the new knowledge of early brain/child development demands that the content and process of child health services be redefined.

Cost/Prevention

Peter C. Damiano, DDS, MPH, Professor, Public Policy Center and College of Dentistry, The University of Iowa

- Damiano encouraged the notion that preventive care is the right thing to do even if there is no monetary savings. He emphasized:
    - What is spent on children in health care is relatively low compared to adults. Prevention costs for children are also relatively low.
    - Providers are not paid enough to do good prevention and the current prevention programs are not designed to be provided on a large scale.

- Twenty-eight percent of parents statewide report receiving anticipatory guidance in the last year. The system does not facilitate this to happen very often or effectively.

- Damiano noted that as this forum focuses on public insurance programs, it will be important to recognize the need to change the Medicaid and SCHIP programs to include more anticipatory care.
  - Damiano referenced a recent report about Medicaid and ***hawk-i***, which is included in the forum packet. He noted that Iowa was one of two states that increased health care coverage for children.
  - Medicaid and SCHIP provide a mechanism for providing anticipatory care, but there is a need to assist and support providers in becoming more effective in the way that services are being offered.
  - It is estimated that anywhere from two-thirds to three-fourths of uninsured children would be eligible for Medicaid or ***hawk-i***, so there is an opportunity to cover more children.

Anything that the health care system can do to reduce the stigma of having children in state-funded health insurance programs is important.

- In discussing anticipatory care, Damiano noted the possibility of including schools as a partner. There is some discussion about requiring public school children to again require a sign-off by a dentist before they would be allowed to attend school. The problem with re-implementing this type of program is the lack of providers and more specifically a lack of providers willing to serve children covered by Medicaid or ***hawk-i***. Legislation is now in place that requires all children in Medicaid to have a dental home by 2008. This strategy might also work for ensuring children receive well-child visits.

Access

Robert F. Anderson, MD, FAAP, Community-Based Pediatrician, Genesis Health Group, Bettendorf, IA

- Access to health care is not just entry into the health care system. Access is multi-dimensional in demands and accountability.
- Approximately 30 percent of children in Iowa are enrolled in Medicaid and ***hawk-i***. It is projected that 221,000 children will be provided access to health care coverage through Medicaid and ***hawk-i*** in 2008.
- Medicaid through the Early and Periodic Screening Diagnosis and Treatment (EPSDT) promotes a gold standard for children's treatment and health care in Iowa. Both Medicaid and ***hawk-i*** face challenges in what services are provided under the programs. ***Hawk-i***, because it is provided through private insurance companies, provides less access to services as compared to Medicaid. Both programs are threatened by spiraling health care costs.
- Curtailing eligibility, limiting outreach, restricting or limiting benefits, reducing provider payments, among many other strategies, will result in a net impact that is like any other attempt to control costs. It will result in shifting costs to another system and will negatively affect children. The need for service delivery does not change and if a child is denied care, the cost of the denied health may be more than society can bear.
- Eligibility, outreach, enrollment, retention, benefits, cost sharing, and layers of access are all components of the publicly funded health insurance programs.
  - The eligibility police are not needed, but what are needed are eligibility enablers such as presumptive and continuous eligibility. A loss of employment should be enough for presumptive eligibility. Children and adolescents should not be dropped from programs once they reach a certain age. Often their poverty remains and premium payments are not in their piggybanks.

    - The ill and handicapped waivers for children with special health care needs should not be limited by a first-come, first-served basis.
    - Outreach needs to be put out of business only when there is no more business.
    - The enrollment sites should be expanded and **the process needs to be as seamless as possible between Medicaid and *hawk-i***. Application forms should be short and easily understood.
    - Cost-sharing hampers benefits, particularly for the soft and preventive services. Behavioral benefits should have parity with medical health benefits.
    - The Medicaid graduate should have an opportunity to purchase COBRA-like insurance instead of becoming uninsured.
- The benefits of EPSDT have been well-outlined. The private insurance sector has little insight as to the power of this strategy in promoting the health of children. For the private sector, preventive care treatment options only are covered if they fall into the benefit package of medically necessary treatment.
- To commit to treatment after diagnosis seems logical, but the definitions are elusive and can be contrary to specialist recommendations.
- The inability to see a pediatric specialist just because the adult specialist is on a provider panel that does not include a pediatric specialist may impair health outcomes and may be more costly.
- Managed care may not only limit provider access but may also hurt access to pharmaceuticals and immunizations. This should not be governed by whim or fancy, but through evidence-based decisions that take into account the specific needs of the child.
- The Medicaid provider relationship must be mentioned. By law, Medicaid must guarantee access to providers. Providers have to be accessible and care should not be interrupted. Framing this contract with individual providers has been problematic. Many providers are now under a system and these systems still need to provide access to providers. This contract might even take on a pay-for-performance model and the more accessible the systems policy, the better reimbursement to the system.
- As for reimbursement to providers, the minimal should be a cost of living adjustment.
- Children's access into the health care system is multi-layered and dependent on all systems involved – the family, the providers, and the payers. Medicaid and ***hawk-i*** are the conduits for the economically less fortunate to have health care parity.

Provider

Cheryll Jones, ARNP, CPNP, Health Services Coordinator, University of Iowa Child Health Specialty Clinics, Ottumwa, IA

- Jones commented that the delivery of services requires a team effort and that her comments are from the perspective of a rural provider. The center she works at in Ottumwa provides services to 10 counties and includes a child health specialty clinic. The patients are from primarily rural areas and most are low income. Jones has been a pediatric practitioner for over 30 years and noted that her response will focus on emerging issues that she has experienced and observed.
- There has been a significant increase in the primary care, behavioral, emotional, developmental, and mental health care needed. **There is a huge problem with illicit drugs and drug-affected children.** Other issues include children living in foster care placements and the social pathology in terms of domestic violence.
- There are also real issues with recruitment and retention of providers at all levels. The global economy is an issue for health care as well as business, as there is competition to recruit providers on a state and national level.

- The aging health care workforce also affects the ability to provide services. The issue of replacing providers that are aging will have a huge effect on access to services.
- The health care industry is a major economic development issue as it is usually the first or second largest employer in rural settings.
- Ottumwa serves pediatric patients on a regional level, and is currently serving approximately 6,000 children. Forty percent of these children ranging from birth to age five have Medicaid as the primary payer for their health care services. Thirty-eight percent of children age six to eighteen have Medicaid as their primary payer, and these statistics do not take into account that Medicaid can be a secondary payer. When calculations include children that have Medicaid as a secondary payer, the percentages increase to about 50 percent. Medicaid typically only reimburses about 50 percent of what a provider bills.
- Jones discussed the work of the Ottumwa Regional Heath Care Board, which analyzed a number of different issues that affect the health care system in the Ottumwa area.
    - The payer mix, specifically private payer insurance, is problematic in how they reimburse. This is a problem statewide and the high percentage of individuals on Medicaid makes it difficult for providers to sustain themselves.
- Jones reminded the group that the individuals impacted by these issues are not numbers on paper–they are real children with real faces and real families with real faces.
- The Assuring Better Child Health and Development (ABCD II) grant and task force has made recommendations about mental health services for children. Most services start in primary care settings, so there is a need for education and training and reimbursement for services for primary care providers.
- Case management and care/service coordination is a crucial part of delivering services appropriately, and this is not reimbursed by any of the payers. Jones noted that the Ottumwa system would benefit from a full-time social worker to help coordinate all of the psychosocial services needed by children and adults.
- **The use of tele-health and tele-medicine is growing, particularly in rural areas** and has been very helpful, especially in mental and behavioral health cases. This helps the primary care providers access the collaboration that is required to deliver appropriate services and can enable individual providers to access specialists for children in need.
- The passage of the Deficit Reduction Act (DRA) at the federal level did not change a lot, but it gave the Iowa Legislature some opportunities and options to change service delivery. Iowa needs to carefully weigh the pros and cons of those options to ensure quality and access of care for children and equity for providers.

Quality

Jody R. Murph, MD, MS, Associate Professor, Department of Pediatrics, Division of General Pediatrics and Adolescent Medicine, Carver College of Medicine, The University of Iowa

- Early childhood experiences are inextricably linked to later health outcomes and play a role in determining development, success in school, health status throughout life, and even the development of chronic diseases. Many of the diseases that kill adults – heart disease, diabetes, hypertension, and even some cancers – have their beginnings in childhood.
- Children are different than adults and yet our system of health care was designed for adults. Children are often an add-on to the current adult system. Children need to have their health developed and nurtured so that their later health and development can be optimized.
- The current health market does not account for the important component of children's health expenses. The benefits in terms of positive health outcomes may not accrue for decades and they may be more apparent to the

juvenile justice system or to the educational system instead of the health system. A new conceptual framework is needed to provide health care for children.

- Well-child care is an important part of the children's health care system. These visits were originally linked to the childhood vaccination schedule, and it may be time to unlink these services so that primary care providers can focus more on the recognition and prevention of the new morbidities that have already been mentioned – obesity, behavioral and development issues, mental health issues, and oral health concerns in young children.
- Time is a considerable barrier to quality care. Well-child visits average 17 minutes in length, and in that time period pediatricians are charged with counseling parents and children on over 162 different verbal health directives that include everything from growth, development, and immunizations to injury prevention, literacy, nutrition, and the use of child care. This anticipatory guidance is in addition to the screenings that have been mentioned, the physical exam, and the diagnosis or treatment of any disorders. Pediatricians have to make choices about anticipatory guidance and the use of structured screenings.
- Although developmental surveillance is recommended at all well-child visits, only 50 percent of families report their child has ever received such an assessment.
- Approximately 16 percent of children and 30 percent of low-income children have some kind of disability, but only 20 to 30 percent of these disabilities are detected prior to school-age entry when early intervention would be most effective.
- Although standardized screening instruments have proven efficiency, less than one-fourth of pediatricians use them routinely, instead relying on clinical assessment alone. This leads to inconsistent diagnoses and referrals and missed opportunities for intervention.
- The reasons for low rates of screening for development, behavior, maternal depression, and family risk factors include those already mentioned – lack of education and training of the provider, lack of time, lack of reimbursement, and lack of referral sources.
- **Behavioral and mental health issues among children have lasting repercussions.** When aggressive and anti-social behavior progress to age nine, further intervention is unlikely to be successful. Children who are hard to manage at age three to four are likely to have continued difficulties into adolescence. Young children with challenging behaviors are rejected by peers, have fewer positive interactions with adults, and are less likely to be successful in school, yet fewer than 10 percent of these children receive effective treatment.
- As many as 13 percent of children between 9 and 17 have serious emotional or behavioral disorders. These children miss more days of schools than all other disability categories. More than 50 percent drop out of high school and three-fourths of those children are arrested within five years of leaving school. The juvenile justice system or the out-of-home placement facility is often the end-of-the-line for a failed system of development and mental health care for children. Instead of ensuring positive outcomes, the lack of quality, community-based services has created a culture of disposable children.
- Because of the severe shortage of trained mental health professionals, primary care providers are assuming greater responsibility for care. Barriers to quality and behavioral care by primary care providers include: lack of training, lack of time, lack of support, and lack of reimbursement. Longer visits must be allowed if primary care providers are to fill this gap. Alternatives include the use of tele-medicine that involves educators and improved access to specialists.

- Six to 13 percent of mothers experience maternal depression. The effects of maternal depression on children are profound and have been shown to have persistent effects on child development. Primary care providers are in a unique position to address the issue because of the frequency of well-child visits; however, only 8 percent of providers ask mothers about maternal depression.
- **The lack of oral health screening and services is a very big concern.** A shortage of available dentists that will serve children under the age of three is very prohibitive to providing proper care. Primary care providers could provide dental screenings and refer as necessary, but health care leaders must be willing to redefine roles, incorporate evidence-based practices, partner with parents, take a close look at how services are paid for, manage children's health care, and invest resources early when there is the most chance for success.

Children Question and Answer Session

Q: Dr. Dworkin, can you expand on the environment of health care and how that affects redesigning the system? Please respond to the panelists based on the content of the keynote provided.

A: (Dworkin) I agree with the notion that the proof of a cost reduction cannot drive decisions made to improve health care outcomes for children. Identifying children early is cost-effective. Even given the challenges of the current environment, promoting children's optimal outcomes is critical. The resounding solution is to strengthen care coordination, which could involve placing social workers in doctor's offices, and relieving providers from coordinating all of these services. Help Me Grow was initially piloted at the city level and has as one goal to successfully identify children at risk and identify service providers. On average, it took 7.5 contacts to link the child to the appropriate service and necessary programs.

Q: Based on its efforts to increase enrollment of children on Medicaid and ***hawk-i***, Iowa is well-positioned to go further in implementing universal health care, but what about children of undocumented workers? How do we deal with this issue, because it seems to be a stopping point for implementation of universal health care coverage for children?

A: (Damiano) This is a tough question. It may be difficult to create a new program for undocumented workers and their children because of the DRA. Unless you want to create an entire program for undocumented people, unfortunately, there is little opportunity for that happening at this time.

Comment from conference participant: Nobody has mentioned school nurses and how important they can be in prevention. Twenty-six percent of school districts in Iowa do not have a school nurse. In the school districts where a nurse is on-site, often they are overworked and do not have time to work on prevention. There are only two states that require a school nurse, and Iowa should require this.

Panel 2: Aging/Elders

Moderated by *Jordan Cohen*, Dean, University of Iowa College of Pharmacy

Dean Cohen stressed the importance of reviewing the long-term care system and referred to Director Concannon's remarks regarding the preponderance of people who are currently in nursing facilities who may be able to receive services in the community. A change in the long-term care system would demand coordination of care and collaboration among providers that currently does not exist. This has implications for the University in terms of talking with students about being part of interdisciplinary teams.

Keynote Speaker

Rosalie A. Kane, PhD, Professor, Division of Health Policy and Management, School of Public Health, University of Minnesota

"Building Blocks of a More Balanced Long-Term Care System"

- The goal of long-term care is to support individuals in living meaningful lives. Institutions are changing dramatically based on the demands and desires of the aging population. Older people want their health conditions to be managed well, and they care about their living environment. They prefer to remain in their home or a home-like setting. Families desire the same things for their loved ones.
- Kane has completed a study of eight states regarding the rebalancing of long-term care and related supports. The study looked at the management approaches of these states to determine what strategies contribute to successful rebalancing, which refers to changing the balance of utilization and Medicaid expenditures from institutions to community care. The challenges in rebalancing include being conscious of expenditures and ensuring that quality of care is maintained in the home and community-based service system.
- The rebalancing idea is not new. In Oregon, Richard Ladd has been a pioneer in identifying barriers to rebalancing, including logistical, political, and philosophical barriers. **The philosophical barriers can be the most challenging**. Many people believe that older people need the protections provided by nursing facilities; ageist sentiments exist and must be addressed.
- The eight states reviewed in the study include: Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington. All of these states have different strategies to achieve rebalancing but also have commonalities. The states vary in the number and organization of home and community-based waivers, use of a state plan, state agency organization, local entry points, and levels of consistency across consumer subgroups, budgeting mechanisms, and plans for using managed care.
- Management features that were reviewed include:
    - Approaches to improve access to services – such as financial and functional eligibility, case management, consumer information, single-entry points, and web sites.
    - Approaches to improve the array of services available – such as independent provider models, consumer direction, and a range of community residential care.
    - Budgetary approaches – such as consolidation in single state agencies, reimbursement strategies and incentives, Money Follows the Person, and capitation strategies.

    - Approaches to link services more effectively – such as acute care, mental health, rehabilitation, housing, and education.
- The building blocks for a successful rebalancing initiative include:
    - Attention to state government organization, usually toward integration instead of cabinet-level programs related to specific disabilities or age groups.
    - Strong vision statements in state statute and consistency among government documents and websites.
    - Leadership consistency at the executive and legislative levels.
    - Consumer and provider stakeholder involvement. It is more difficult to involve older people in the same way that persons with disabilities have provided leadership in rebalancing.
    - Broadened array of services
    - Consumer directed services
    - Strategic use of grants
    - Use of the web through development of user-friendly information systems.
    - Data systems
    - Active relocation of consumers from institutions
- **Arkansas** was one of the first states to implement cash and counseling and is currently working to cash out nursing homes. A provision has been implemented for nurse delegation to allow nurses to teach and delegate nursing tasks to unlicensed assistive personnel, which works very well for the provision of home and community-based services.
- **Florida** has invested much energy in private managed care organizations to do some of the coordination. Florida has also developed quality standards for nursing homes, allocating funds for higher staff ratios.
- **Minnesota** has used a lot of systematic approaches to downsize nursing homes. Minnesota uses the term "long-term care consultations" rather than "case management." Aging services are separated in concept and management from disability.
- **New Mexico** has developed an expanded personal care option under Medicaid in their state plan, which included a living wage for workers.
- **Pennsylvania** uses the Governor's Office of Health Care Reform as a catalyst for system change. The state is working to downsize nursing homes and is currently piloting a fast-track eligibility process.
- **Texas** has massively reorganized its state government. The state is applying a Money Follows the Person approach and is providing targeted relocation assistance.
- **Vermont** has developed an approach similar to Iowa's in terms of nursing home eligibility and admission standards. This requires a 1115 demonstration waiver, which creates several tiers of eligibility. Vermont's population size has allowed it to achieve full rebalancing for the mentally retarded and developmentally disabled populations. Vermont is now trying to address rebalancing related to seniors.
- **Washington** has developed an effective assessment tool that encompasses all populations. **The independent provider model is the strength of the Washington system.** The Medicaid nursing home caseload in Washington is decreasing and the home and community-based service caseload is rapidly increasing. In another five years Iowa's numbers could look this good.
- States are also working to address issues such as labor force efforts, information technology capacity, quality indicators appropriate for home and community-based services, practical housing initiatives, streamlined access, managed care initiatives, consumer direction, chronic disease management, and mental health initiatives at the community level.

- Kane will be developing topic papers examining the impact of the following issues on rebalancing efforts. Topic papers may include:
    - State strategies to support and involve consumer advocates
    - State organizational structures to promote rebalancing
    - Making choice operational: case management and other vehicles
    - Managed care and chronic disease management
    - Community-based residential services
    - Multiple perspectives on quality
    - Total costs of Medicaid services (acute care plus long-term care) for Home and Community-based Services (HCBS) users compared to institutional users
    - Characteristics of HCBS users and institutional care users in a subset of states
- Rebalancing efforts have been spurred by the Olmsted Supreme Court Decision. The disability community has helped to inform the thinking related to rebalancing for the aging population. The aging community has typically approached advocacy by framing issues in terms of meeting their health care needs, while the disability community frames issues in terms of civil rights.
- Rebalancing issues remain; **states must determine how severe problems will be managed in the home and community-based service system** and if case management is effective. Rebalancing within populations must also be addressed. The ratio of developmentally disabled to aging spending should be a concern in all states. The Money Follows the Person system can be used for both the disabled and aging populations. Finally, the nursing home of the future may start looking like some of the better assisted living options of today.

Cost/Prevention

Charlene Teed, Quality Improvement Advisor, Iowa Foundation for Medical Care

- The Iowa Foundation for Medical Care (IFMC) is the quality improvement organization for Iowa. The goal of IFMC is to protect and improve the quality of health care services provided to Medicare beneficiaries. IFMC works to improve care through four primary strategies: 1) increasing effectiveness and efficiency of care, 2) using information technology effectively, 3) measuring and reporting data, and 4) helping organizations move toward a culture of quality.
- The Pioneer Network, formed in 2004, is a grassroots movement aimed at creating a new culture of aging. The network defines culture as an ongoing transformation anchored in person-directed-care values that return control to elders and those who work closest with them.
- Iowa has a new coalition, the Iowa Person Directed Care Coalition, dedicated to assuring that Iowans can direct their care and their lives wherever they live. The coalition is comprised of representatives from the Iowa Department of Inspections and Appeals, trade associations, the Ombudsmen, Iowa care givers, IFMC, and providers.
- The coalition is organized into three groups addressing interventions, definitions and applications, and regulations. The coalition defines culture change as an ongoing transformation of the physical, organizational, and psycho/social spiritual environments that is based on person-centered values. Long-term care is defined as a continuum of care regardless of setting or age. Person-directed care is defined as individual choice directing lifestyle, care, systems, and daily routine. The definitions were chosen to align with the Pioneer Network.

- The regulatory group reviewed Iowa code chapters 58 and 61 and made recommendations to:
    - Permit nursing facilities to establish person-directed care environments in which the care and services provided promote decision making and choice by the resident.
    - Minimize regulatory barriers inserting resident choice in various provisions including those dealing with resident clothing, bathing, living arrangements, care and treatment plan, medication administration, and meal planning.
    - The next step for these regulations will be public comment and then hopefully they will be enacted by the legislature in 2007.
- Advancing Excellence in America's Nursing Homes is a national campaign. This is a two-year program and campaign that seeks excellence in the quality of life and the quality of care for America's nursing home residents. The program will track eight key indicators and set goals to improve the quality of nursing home care while acknowledging the critical role of nursing home staff in providing care. Nursing homes can participate in the quality program by visiting www.nhqualitycampaign.org.

Access

Brian P. Kaskie, PhD, Assistant Professor, Department of Health Management and Policy, College of Public Health, The University of Iowa

- Discussing livable communities for older adults moves the conversation upstream to a point that precedes the need for long-term care.
- A livable community should offer the following: home and community-based services that are portable and accessible; pharmaceutical management programs; nursing homes that support culture change; and quality initiatives.
- **The elements of a livable community include health care, day care, end-of-life care, behavioral programs, housing options, leisure, education, mobility, and work and volunteer opportunities.**
- Data indicate that older adults are moving from other parts of Iowa to retire in Johnson County, which has been rated as a top place for seniors to retire.
- The Johnson County Consortium on Successful Aging surveyed older adults in the county and conducted focus groups to ask what makes Johnson County a great place to live. The goal was to support what was already working and identify shortcomings that could be addressed and improved through research of best practices in other communities and states.
- The findings confirmed that health care and hospitals in Johnson County are very good, and that leisure and recreational opportunities are widely available. The research uncovered inadequacies in health promotion and prevention, housing, end-of-life care, day care services, and connections between services and the faith-based community. The survey uncovered a difference between seniors' desire to live at home for as long as possible and their belief that remaining at home is an option.
- A county-wide campaign was conducted to inform service providers that there is a growing community of adults that will be demanding the availability of services and supports.
- A community forum found that individuals want improved access to information resources, financial or tax incentives for home modifications, and more health promotion behavior information.

Provider

Elizabeth A. Chrischilles, PhD, Professor, Department of Epidemiology, College of Public Health, University of Iowa

- The Institute of Medicine (IOM) and other authorities are calling for better medication management through the use of technology, multi-disciplinary teams, and research on medication error prevention.
- The more medications taken, the more side effects an individual will experience. **The average Iowa senior takes 10 medications, including prescription, non-prescription, and herbal supplements.**
- About 10 percent of Iowa seniors and 25 percent of Iowans with a disability report having a side effect from their medications in the past year. Among Iowa seniors who experienced a side effect, approximately 75 percent saw a doctor and about half stopped the medication. Side effects are expensive; nationally they cost $3.5 billion annually in hospitals and $1 billion annually for outpatient care.
- The most common drug-related problem is under-use. Under-use comes in two forms, either not receiving medication or not receiving enough medication. In one study, two-thirds of preventable drug-related episodes that resulted in urgent care were due to under-treatment, whereas only one-third were related to overdosage or side effects.
- The July IOM report suggests multi-disciplinary team care as a new form of primary care to manage medication use. This can help health systems as well as patients receive value for the dollars they are spending. Four controlled trials have shown that pharmacists working together with physicians can improve medication regimens for the elderly.
- In Iowa, 114 pharmacies collaborated with physicians to recommend and implement action plans to resolve medication-related problems among Medicaid beneficiaries. The rate of use of medications that are inappropriate and should never be used among the elderly was quite high in this population and was reduced substantially by the collaborative-care model.
- Iowa also has large scale experience with medication review through the Iowa Priority Prescription Drug Program. A medication review is a face-to-face discussion between the patient and health care practitioner to review prescription and non-prescription medications and herbal supplements. An annual medication review is a health plan quality indicator that is proposed as part of a pay-for-performance policy through Medicare.
- There are about 24,000 people enrolled in the Iowa Priority Program, one-eighth of whom availed themselves of the medication review from community pharmacists. Those who participated in the medication review were the ones who needed it most–20 percent were found to be taking medication that should not be used by elders.
- Also in Iowa, one successful firm is reimbursing pharmacists for identifying and resolving drug therapy problems. In one year this program demonstrated an average of 3.4 medication errors per 100 patients. Under-use was again found to be the most prevalent problem followed by medication side effects.
- A lot of money is being spent on medications that do not work or cause ill effects. No one is managing the multiple medication needs of seniors. **In Iowa, practitioners know how to provide the multidisciplinary team care to transform the medication use system.** If there is an incentive to do so, providers can redirect their daily work load to make it happen.

Quality

Carlene Russell, MS, RD, LD, FADA, Nutritionist, Iowa Department of Elder Affairs

- Several Iowa Department of Elder Affairs (DEA) services are available in the community to support rebalancing efforts.
- The Older American Act (OAA) programs provided 30 or more services and served approximately 109,000 older adults in Iowa last year. These services are often provided by Iowa's Area Agencies on Aging.
- The largest service is the congregate and home delivered meal program, which has proven to be cost effective and supports independent living. Other services provided under the OAA include case management, information and assistance, chores, homemaker, transportation, senior employment, and the family caregiver program.
- DEA is working with the Aging and Disability Resource Center, which serves as a single point of entry for both the aging and disability populations to access community services.
- The Medicaid Elderly Waiver is also helpful in supporting community-based living. In 2006, approximately $536 a month was the average cost to keep a person in their home compared to over $3,000 a month if they were in a nursing home. Iowa was able to support about 13,000 individuals under this waiver.
- The Elderly Waiver includes two meals a day plus nutrition counseling, which makes Iowa unique in comparison to other states. Of the individuals on the Elderly Waiver, 60 percent are at high nutrition risk, but only 1 percent are receiving the counseling service.
- The Senior Living program provides 25 services including case management, home-delivered meals, and chores. This program served 16,000 individuals in Iowa last year.
- Home and community-based services help compress morbidity and keep people healthier longer. Preventative and health promotion services are essential.
- Nutrition and physical activity have been shown to impact the effects of aging. For example, as health starts to decline, unintended weight loss occurs often in the form of muscle, not fat, resulting in a downward spiral of disability and often death.
- The Oxford Health Plan, in dealing with Medicare in New York, found that for every $1 spent, $10 were saved when individuals were provided nutritional counseling.
- **When evidence-based health promotion programs are implemented, health outcomes are improved.** In Iowa, DEA and the Department of Public Health will be implementing the Stanford Chronic Disease Self-management Program as the result of a grant from the U.S. Administration on Aging.
- The rebalancing effort must include: 1) empowering consumers to make informed choices for long-term care, 2) targeting high-risk, nursing-home-appropriate individuals and delaying institutionalization, and 3) building prevention into community living through health promotion and disease prevention programs.

Aging Question and Answer Session

Q: There has been an explosion of medications; it is difficult for practitioners to keep up. How can we move what is known about research and technology into the private physician's office?

A: (Chrischilles) We know little about how drugs work among older adults who take many medications. Additionally, technology is a knee-jerk response to trying to help providers, but in Iowa and many other places we are far from being able to use technology as the solution. Many drug-related problems could not be solved through electronic medical records and other technology innovations.

Q: Could you describe the multi-disciplinary model you are developing?

A: (Chrischilles) There is uniformity in the literature that medication reviews by pharmacists are effective. Iowa has tested some models that utilize collaboration that result in actionable plans.

Panel 3: Disabilities

Moderated by *Jean Robillard*, Dean, University of Iowa Roy J. and Lucille A. Carver College of Medicine

Dean Robillard noted that individuals with disabilities want to contribute to the success of society, work, live independently and be full members of their communities, which are the same aspirations that all individuals have. Robillard introduced Mr. Crowley and his presentation on Medicaid and Medicare policies as they impact individuals with disabilities and those with chronic conditions.

Keynote Speaker

Jeffrey S. Crowley, MPH, Senior Research Scholar, Health Policy Institute, Georgetown University, Washington, DC

"Health and Long-Term Services Coverage for People with Disabilities: The State of the Current Policy and Potential Opportunities for Iowa"

Crowley reported that he would address two key issues in his presentation. The first was how best to address the challenges faced by this nation and to provide a way to think differently about these issues. The second was to give a brief overview about what is going on at the federal level, with a specific focus on some opportunities for Iowa.

- There is not consensus on many health care policy issues and there is a split among the parties and stakeholders about which issues are key. Universal health care coverage, raising taxes to pay for health insurance coverage, and health savings accounts are some current topics of debate.
- Money matters, and there is concern about whether or not entitlement programs are sustainable. However, the sustainability question is not as clear cut as many people commonly perceive. Crowley believes that radically changing the entitlement programs isn't necessary, and that the perception that these programs are totally unsustainable may be inaccurate.
- **An estimated 6.8 million more Americans have become uninsured since 2000, and 5.4 million more people are now living in poverty as compared to 2000.** Additionally, there are also increasing wealth disparities. Between 2000 and 2005, for every wealthy family that benefited from the tax cuts that were enacted in 2001 and 2003, there are 160 new uninsured Americans.
- Money frames everything, and there are some very serious issues in this regard. Five years ago, Federal Reserve Chairman Greenspan supported tax cuts because he was worried that the tax surpluses would distort the national economy. Just five years later there are projected record deficits, which account for the roughly $9 trillion difference between what was projected for a surplus versus what the deficit is projected to be right now. This issue colors everything that can be done in health policy.
- Another issue is the legislation at the federal level that led to the current deficits. Forty-nine percent of the deficit was caused by the tax cuts, and 35 percent of the current deficit can be attributed to defense, homeland security, and other international spending. Only 10 percent of the change from projected huge surpluses to the huge deficits has been entitlement spending such as programs like Medicare, Medicaid, Social Security, and food assistance, among others.
- Medicaid is not perfect and there are challenges to address, but it should not be considered the "Bogeyman." People frame the debate about Medicaid and health care policy to drive a radical agenda. Medicaid is a lifesaver for the individuals with disabilities and children who access the program.

- The following incorrect claims are often made about Medicaid: Medicaid is broken; Medicaid spending is out of control; Medicaid is crowding out other state priorities, such as education; and Medicaid in its current form is unsustainable. Data exists that can refute all of these statements. For example, data show that on a per person basis, spending is growing more slowly in Medicaid than in the private insurance sector even thought it serves a sicker population.
- Other broad problems include controlling health costs across all payers, financing access to new medical technology, establishing a national system for financing long-term service, and adapting to changing demographics needs.
- The changes that need to be made in Medicaid would be much more solvable if there really was a national long-term services policy. People are never told, in any stage of life, what the expectations are in planning for long-term service needs or ensuring they have health care coverage. There may be a need for expanded private health insurance coverage so that Medicaid could get back to serving the low-income segment of the population. Medicaid has not failed; instead, policymakers have failed to enact broad policies to deal with these issues.
- It needs to be acknowledged that persons with disabilities are the cost drivers of Medicaid. There is not a reason to apologize for this, but as a country there has been a conscious decision that Medicaid is where really high-cost cases should be financed. Imagine what would happen if the private system was forced to meet the needs of persons with disabilities, if it was expected to pay for long-term services. There is some data to show that Medicaid is more efficient than these other programs.
- It is not just individuals with disabilities that are the cost drivers, but also people over the age of 65 who have disabilities. Seven percent of people in Medicaid use long-term services, but they account for 52 percent of the spending. It has a disproportional impact. If the highest-cost Medicaid beneficiaries are considered, which make up 2 percent of the Medicaid population, these individuals are responsible for one-quarter of the spending. This fact makes it difficult to say that cuts can be made to services that do not impact the individuals who are the most disabled.
- **Institutional bias, the idea that people can only access the services they need in an institutional setting, is really is a civil rights issue.** In light of budget pressures this issue needs to be clearly communicated to policymakers. Right now the message is that if an individual needs assistance going to the bathroom or dressing each day, the service is only guaranteed in a nursing or other long-term care facility. The only promise made to individuals is that they will be able to receive the services they need in an institution, and that should embarrass everyone.
- Waiting lists for Medicaid services in the community have been growing since the passage of the Supreme Court Olmstead Decision. From 2002 to 2004, waiting lists for Medicaid community-based services grew by more than 50,000 people.
- Challenges related to ending institutional bias tomorrow include the following:
    - Financing
    - Political Pressure
    - Affordable Housing
    - Labor Shortages
- Congress recently made changes to Medicaid, which affect issues of financing, expanding access to community services, overcoming political pressure, and addressing affordable housing and labor shortages,
- The Deficit Reduction Act (DRA) made significant changes to Medicaid and other programs, saves a tremendous amount of money ($4.7 billion), and impacts several beneficiary-related changes, including premiums, cost-sharing, flexible benefits, documentation requirements, health opportunity accounts, and long-term services.

- There are several major areas of long-term services reform: Asset Transfers; Long-term Care Partnership Program; Family Opportunity Act; Money Follows the Person Demonstration; New State Options to Provide Home and Community-based Services; and Cash and Counseling.
- Crowley commented on several consumer reactions to the DRA, none of which resulted in improvements to the four challenges discussed above (financing; political pressure; affordable housing; or labor shortages). It also did not decrease the deficit; rather it increased it.
- Senator Grassley put together a great legislative package that would have achieved the same level of Medicaid savings as what eventually passed, but it did not pass after reaching the full Senate because of powerful interests. The drug companies and managed care companies came in to reduce the size of their cuts, so these cuts had to come from beneficiaries, which was unfortunate.
- Crowley next addressed several opportunities for Iowa, which included:
    - Family Opportunity Act
    - Money Follows the Person
    - Managed Long-term Care
- Key themes in recent federal and state Medicaid policy changes include greater personal responsibility; "tailored" benefits; increased role of private marketplace; increased spending predictability; and a more challenging policy environment. There has also been a loss of state legislative input. State legislative involvement always results in better policies being developed at the federal level.

Cost/Prevention

Scott D. Lindgren, PhD, Professor, Department of Pediatrics, Carver College of Medicine, and Center for Disabilities and Development, The University of Iowa

- In prevention there is discussion about both primary and secondary prevention. Even when disabilities cannot be prevented, there is a need to treat them before they become too severe or functionally limiting.
- **It is critical to invest in research to find out the causes of disabilities and make the crucial links to public health practice.**
- Women need access to quality prenatal care and information about their own health to ensure the health of their children. Information about drug abuse is particularly important since this is an increasing problem in Iowa.
- In order to identify developmental disabilities as soon as possible, there must be surveillance and screening in the primary care setting.
- Iowa has a health promotion program called Living Well with a Disability, and a new research grant has added a medication component to this program. This program has been shown to reduce secondary conditions, improve overall health, reduce limitations to mobility, reduce pain and fatigue, improve mood, and reduce hospitalizations. Research is being conducted to compare the cost of the program with the savings to Medicaid. It costs $225 for one individual to attend the eight-week program with weekly group meetings, and over a six-month period the net savings in Medicaid could add up to $300,000 per 100 participants. These data would make a strong case for promoting health promotion programs to persons with disabilities.
- Self-direction and personal choice are important philosophies. There is an institutional bias in Iowa and there are clearly market forces and lobbying groups that try to keep the system this way. Fortunately, there are competing forces that are working on eliminating the

institutional bias by allowing for access to home and community-based services. Unfortunately, there are still large barriers to achieving this goal, which include:
    - Obtaining adequate medical care for those complex medical needs
    - Obtaining intensive supervision and support for those with severe behavioral needs
    - Locating high-quality community-based services even if the money is available
- Most individuals with disabilities rely on publicly funded programs as their medical safety net. To maintain that safety net, those individuals have severe asset limitations and there is a need to de-couple health care coverage and employment so persons with disabilities can build assets and wealth. Society should not ask people with disabilities to remain poor to access health care coverage. Universal health care coverage should be provided to all Americans and would allow persons with disabilities to pursue employment and to live more independently, which are values everyone strives toward.

Access

Jane E. Halliburton, Vice Chair, Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury Commission, and Chair, Story County Board of Health, Nevada, IA

- Members of the disability community have not only seen increased access but also increased inclusion in many activities, which is an important change. Iowa needs to be careful not to make policy changes that reverse the many positive gains.
- One key development has been the state-county management committee, which really created a specific partnership between governmental levels. This committee allowed the state to work on Medicaid with the federal government as well. Halliburton cautioned the participants that Medicaid cannot be viewed in isolation, whether it is the funding or the services that are accessed.
- In 2002, the legislature changed the role and charge of the Mental Health/Mental Retardation/Developmental Disability/Brain Injury (MH/MR/DD/BI) Commission. One component of the system created along the way was the central point of coordination, which allows for a single point of entry into the system, resulting in significant differences for Iowa's citizens. With these partnerships have come new opportunities. To keep this momentum going, it is important for Iowa to expand those partnerships and to find new ways to work together to ensure that Iowans of all ages have access to appropriate and quality services.
- There has also been a discussion of how individuals access services through a particular diagnosis, indicating that people have become accustomed to talking about different groups of people or particular funding streams while forgetting the individual. Building partnerships through collaboration will return our focus to the person so they can grow and thrive.
- Everyone is used to hearing about the dramatic split between rural and urban areas. When Iowa is considered from a national or international perspective, the entire state is rural. Iowa has less than three million people living in the state, compared with the county where Phoenix, Arizona is located, which has a population of over five million people. To provide services and access to Iowa's citizens, a critical mass must be achieved because from a national perspective, Iowa is not there. This calls for creativity and building partnerships.
- **The Iowa Legislature created the empowerment system, which is a wonderful example of a program full of partnerships that benefits children ages zero to five.** Empowerment does not define what the local programs cover necessarily, other than that children ages zero to five must be served with funding. Empowerment provides an opportunity to collaborate. De-categorization is another program Iowa has in place, which is an opportunity to collaborate for young people.

- Story County was able to implement a community dental clinic because of leadership and collaborations. One of the local pediatricians spearheaded this effort because he saw a tremendous need that was not being met in the dental services area.
- At the state level, there is a need for these same kinds of partnerships. There is legislation that is bringing together the Departments of Human Services, Public Health, Education, and Corrections, among others.
- The MH/MR/DD/BI Commission will be meeting to make a recommendation about the allowable growth formula for FY09. That funding has not been there in recent years. That is what has not only stopped the momentum toward greater access, but it has been reversing the progress that has been made. In this last year, the Commission has heard from a number of counties that have had to amend their plans to reduce their services. The waiting lists are getting longer. While Iowa has made great strides in providing that access and inclusion across the state, progress can only continue with partnerships, collaborations, and appropriate funding.

Provider

Jeffrey G. Lobas, MD, EdD, MPA, Professor, Department of Pediatrics, Carver College of Medicine, and Director, Child Health Specialty Clinics, The University of Iowa

- The system of care that exists right now is broken: costs are rising, quality is questionable when compared to other industrialized countries, medical errors are a problem, complexity, especially around disabilities, is increasing, and there is more dissatisfaction around patients and providers. The 15-minute visit and the relative value unit seem to be what is driving the care provided to consumers. These issues are more exacerbated for those with disabilities.
- In our society, a disease treatment system has been developed, which is sub-specialty oriented, rather than a primary care system that is wellness-oriented. Other countries have shown that this system does not work. It drives up costs, and it probably delivers poorer care, in general.
- **Patients and families deserve and desire high-quality care that is affordable.** This care has to be compassionate, coordinated, continuous, competent, and culturally sensitive. The present system makes it difficult to deliver this type of care.
- Physicians really want to deliver this type of high-quality care. At heart, physicians are altruistic. They want to do the right thing. They tend to be data driven, but the systems they work within do not support delivering this type of care. In a state like Iowa, primary care is asked to serve families and patients with disabilities.
- It is important to develop a new paradigm for thinking about the health care system. A new care model has been described. Some call it the chronic care model, others the medical home model, but at its core, it is team-based and planned care.
- Data support the value of moving to a new paradigm of care that is team-based and planned. This is characterized by having primary care in the central role, by patients interacting with a well-prepared practice team using a holistic approach, community resources, and care coordination. It is evidence-based and it engages the entire system.
- The hallmark of this approach is allowing patients to manage their health with the aid of effective self-management support strategies. This delivery system design identifies the team with planned interactions, case management, and regular follow ups, not an episodic type of care. It engages the entire community and gets people out of their silos and working together to look at community partnerships.
- These types of solutions come out of the Institute for Health Care Improvement. There is presently a Leadership Council for Chronic Disease, which the Health Department has put into place. Supporting wrap-around services, care coordination, and a systems level approach

will take new educational expectations, a new way of training providers, and new financial expectations and innovative reimbursements. It will also take an infrastructure to encourage these movements and spread this type of innovation.

- Finally, Iowa has an opportunity to use tele-health. Within the child health specialty clinics, tele-health has been used to provide child psychiatry services, metabolic clinics, genetic counseling, pediatric diagnostic clinics, and feeding clinics. All of the efforts have been very successful, providing a way to get needed care out into rural communities. It is still important for the sub-specialist services to involve primary care.

Quality

Cherie Clark, Coordinator, Linn County Office, Evert Conner Center for Independent Living

- One in five people nationally has a disability. Persons with disabilities are just now being invited to the leadership table, stating what is needed in order to have a good quality of life.
- Quality of services and quality of health care impact the quality of life for persons with disabilities.
- There is a need for choice in doctors, hospitals, and specialists, and there are serious concerns about managed care and persons with disabilities. Clark noted she did not see the two going hand-in-hand.
- Persons with disabilities need to have access to affordable health care. **The long-term care system must be moved from an institutional system to a community-based system.** Persons with disabilities need to be able to live, work, and play in the communities of their choice. That means giving access, and if access and choice are provided, quality of life can be achieved.
- The vast majority of people with disabilities fall into the poorest group of Americans. Medicare and Medicaid are not adequate if individuals do not have access to transportation. Individuals on Supplemental Security Income (SSI) get $603 per month at the most. The SSI income qualifications level must be increased from well below poverty level to at least the poverty level.
- There are many individuals with disabilities who have to choose between food and medicine, and heat and a trip to the doctor. All too often, food and heat win out. The State of Iowa must come together if quality of life is to be extended to every citizen. Support is needed as the disability community approaches potential funders, decision makers, and planners.
- Iowa needs a Money Follows the Person system, where cash and counseling is available, the institutional bias is eliminated, and quality services are available to persons with disabilities.
- Peer support services for individuals with disabilities are critical to mental, physical, and financial health.

Disabilities Question and Answer Session

Q: Can you identify any particular hurdle that is jump-able for those of us with visible and invisible disabilities now that there are identified allies in positions of representation?

A: (Clark) One of the easiest issues to work on is to push for full implementation of Money Follows the Person as it provides a lot of momentum for moving the system forward. Cash and counseling should also become the norm in Iowa and across the nation. The vast majority of people with disabilities are very able, willing, and capable of making decisions about their own care so policies need to be designed to support the individual in receiving the least restrictive option.

Q: When the federal government allowed Medicaid buy-in for parents with children with disabilities, once again there is a frustration on my part when I see health care offered to children with disabilities, but when the person becomes an adult, a lot of the access to health care and the services that previously had been provided for

the person before the age of 22 are gone. If they are going to allow parents of a child with disabilities to purchase Medicaid for their child on a sliding scale, why would they not allow that to continue as that person becomes an adult and is still dependent on the parent and needs the health care so desperately that they received before age 22?

A: (Crowley) I agree and share your frustrations. One of the comments I tried to make was that everything comes down to money, and even earlier iterations of the Family Opportunity Act were much more generous. It was all about what was politically doable with a small amount of money. What you are saying is that it does not make sense to be doing all these piecemeal approaches to solving problems, as we need something more comprehensive. But, the issue you raise, and forgetting about the Family Opportunity Act, this whole idea that we make this important investment in kids through EPSDT and then the child ages out, gets nothing, and it just makes no sense. We are investing in kids so they can have great lives and then we take away that great life when they are adults. We need to do something better.

Q: If I understood correctly, you mentioned that 7 percent of Medicaid beneficiaries are responsible for 52 percent of the costs of the program. From your perspective, are there alternatives to dealing with that fundamental fact of such a small percentage of the beneficiary population relating to such a high percentage of the cost? Is there a different way of dealing with that population to free up some monies to do some other things?

A: (Crowley) I could answer that question different ways. The point I was trying to make about the concentration of costs is somewhat neutral. Certainly, if we had universal coverage those costs would be spread, but I am not necessarily convinced it is a bad thing that all of those individuals are in the Medicaid program. I think Medicaid tends to be more efficient than a lot of private coverage and we have built up a lot of expertise. But, the point I was trying to make is that when we make policy decisions, just like we saw in the Deficit Reduction Act, we talked about giving states new flexibilities to charge more cost sharing or to tailor benefits. Do people really think that that will be cost effective in the long run, denying benefits to people that need them? Or do we really think that people with really high needs are using too many services and the way to cut it is to make it so they cannot afford it? **Denying individuals benefits does not result in a savings in the long run.** Our policymakers need to understand we have those high-cost cases and need to look at cost-saving solutions in the context of the individuals being served as they really do need those services.

A: (Schroeder) I think there is an answer, and the private sector has found it. They had the same cost concentration. Case management works because if you have a patient at home with heart failure, you want to make sure they are taking their medications and are not experiencing additional heart failure, that they are stepping on a scale each morning, and that the weight is recorded and viewed by a nurse each day at the home. If the weight goes up, changes can be made to the medications and to other treatments, to keep them out of the hospital and out of the Intensive Care Unit. I really differ a little bit in the sense that all that money being spent to serve the highest needs clients in Medicaid is not really the best way to use it. I think there are huge savings there and they could be done by practicing smarter and you get better quality too.

Panel 4: Mental Health

Moderated by *Patricia Clinton*, Clinical Professor, University of Iowa College of Nursing

Professor Clinton introduced the topic of mental health, noting that this population is among the most vulnerable and the most hidden.

Keynote Speaker

Gerard P. Clancy, MD, President, The University of Oklahoma-Tulsa, and Dean, College of Medicine, Tulsa, OK

"Rebalancing Health Care in the Heartland: Panel and Discussion on Mental Illness"

- Dr. Clancy's discussion focused primarily on individuals with serious mental illness (SMI), which includes schizophrenia, schizoaffective disorder, bipolar affective disorder, and major depression. **The seriously mentally ill encompass approximately 4 to 5 percent of the population.**
- Over time, there have been varying ideas and successes in treating individuals with serious mental illness. Up until about 500 years ago, these individuals were cared for in the homes and communities in which they lived. Thinking then shifted to a belief that it may be better if these individuals were given asylum, resulting in the creation of special facilities far removed from communities.
- Changes started to occur in the 1960s with more effective medications and attention to civil rights, and institutions were down-sized. Under the leadership of President Kennedy, the Community Mental Health Centers Act was passed, providing funding and creating a network of mental health centers across the country. At this time, Iowa had a companion program that provided financial assistance to young psychiatry residency graduates to get them into smaller communities in Iowa.
- Between 1970 and 1990, some mental health centers across the nation lost focus, resulting in increased homelessness, dual diagnoses, and HIV among those with SMI. This was a period of dramatic increases in the cost of care and the first for-profit psychiatric hospitals were formed.
- In 1990, new insurance plans were created with no mental health coverage at all. The National Alliance for the Mentally Ill (NAMI) went on the march and pushed hard for mental health parity. In 1995, Massachusetts and Iowa were the first states to create managed behavioral health care in the Medicaid program.
- In 1998, a study called Schizophrenia Patient Outcomes Research Team found that:
    - 70 percent of patients received inadequate doses of medication
    - Less than 50 percent had coexisting depression, anxiety, and hostility treated
    - Only 50 percent had side effects treated
    - Only 10 percent of families were receiving support
    - 90 percent of patients were unemployed, with only 23 percent receiving unemployment assistance
    - 2 to 10 percent participated in an emerging program called PACT (programs for assertive community treatment)
- PACT is a mobile interdisciplinary team of mental health professionals led by a psychiatrist that brings care out to the community on a daily basis. PACT has been shown to decrease costs, increase patient outcomes, and increase satisfaction.
- Theses studies also showed that **inadequate treatment for persons with serious mental illness results in increased suicide rates, violence, substance abuse, HIV infection, homelessness, and shorter life expectancy.**

- In 1998, NAMI and the Patient Outcomes Research Team made recommendations for individuals with schizophrenia that focused on ensuring adequate medication dosages, treatment of coexisting conditions, availability of electroconvulsive therapy, appropriate family and psychological interventions, vocational rehabilitation, and greater availability of PACT teams.
- The president's New Freedom Commission stated that the mental health system was not working and needed redesign. Since then the federal government has given states transformation grants, which are in process to redesign the mental health service delivery system. Also during this time period, there has been greater attention to evidence-based medicine.
- The PACT Across America Campaign sponsored by NAMI has done wonders to bring PACT programs to every state in the nation. The University of Iowa and Magellan Health Services were pioneers in this area. Iowa was the first state to have managed Medicaid pay for PACT services.
- **PACT programs continue to be the gold standard for persons with serious mental illness.** In Oklahoma, the results from the PACT program are clear. Before participating in the PACT program individuals had an average annual hospital stay of 50 days, after participating the average annual hospital stay was reduced to 19 days. Before participating in the PACT program individuals had average annual jail time of 10 days, after participating it was reduced to 3 days.
- More psychiatrists are needed to deliver the PACT model of care.
- Right now in the field of psychiatry new technologies are being developed and will soon move into the clinical setting, such as rapid genetic screening and neuro-imaging of brain function. These tools will guide providers to the best treatment options for each individual rather than trial and error. New treatments hold hope for patients that have not responded to existing treatment options.
- The field of psychiatry will be facing a "perfect storm": a significant increase in the cost of diagnostic treatment and delivery of care advances, the baby boomers' increased age-related mental health needs, and a psychiatrist shortage among the larger national physician shortage.
- Clancy recommended a new type of psychiatrist practicing in a new type of environment, similar to an air traffic controller. In this model a psychiatrist would partner with nurse practitioners, physician assistants, pediatricians, and internists to guide care, but not "fly the jet." The University of Oklahoma has effectively used school-based clinics in elementary schools.
- **Iowa must create financial and other incentives for medical practitioners to stay in the state.**

Cost/Prevention

Joan M. Discher, General Manager, Magellan Health Services

- Over the next two to eighteen years baby boomers will pose a tremendous challenge to Iowa. Fewer people will be in the workforce, the aging population will drive up health care costs, and increased health care costs will increase expenditures of programs like Social Security and Medicare.
- There will be increased self-responsibility for everyone, such as consumer choice, health savings accounts, and new health reimbursement arrangements as in Medicare Part D. Consumers will have to spend dollars more wisely.
- Globalization will impact health care in ways such as increased use of tele-health, allowing individuals to access specialized health care services. Iowa has had great success with tele-health in the child health specialty clinics. The Internet creates a new way of doing business and will change health care delivery.

- **Outcomes will be improved and money will be saved by doing what is right the first time.** Magellan, with the help of DHS and the Community Reinvestment Fund, has started school-based programs, intensive psych rehab, tele-health, assertive community treatment, and many others. Now it must be determined which of these programs achieve results, and which do not.

Access

Craig E. Wood, Director, Linn County Mental Health and Development Disability Services

- Acute care is a problem in Iowa because hospitals are closing units due to low reimbursement rates and high numbers of uninsured patients. In the past, uninsured patients were transferred to state institutions. State institutions are reducing their capacity, which puts more pressure on private hospitals to serve the uninsured.
- Since 1999, the number of total acute care beds in private hospital psychiatric units has dropped by 60; between 2004 and 2005 the total dropped from 752 to 733 beds. Since 1999, the total number of beds at the state mental health institutions has dropped by 181. Iowa's four state mental health institutions have a combined 269 beds.
- The problem is being exacerbated by increasing numbers of people with mental retardation who develop severe behavior disorders as they age and who are being housed in acute care psychiatric units. This phenomenon is a result of the reduced capacity of state institutions.
- Outpatient mental health access is limited also by geography. In most areas of the state, there is a minimal wait for psychotherapy but there is a longer wait for adult psychiatric services. For critical cases, most patients are able to be seen on an emergency basis.
- A March 2006 study on the psychiatric workforce shortage in Iowa indicated that this shortage is great even in comparison to other health practitioner shortages. It has been suggested that the problem of attracting psychiatrists to Iowa is due to the Medicaid rate.
- The idea in rebalancing is to improve the relationship between the amount of money spent on services provided in institutions and services provided in people's homes.
- In terms of accessing community supports, there is shortage of PACT (programs for assertive community treatment) programs due to a lack of a consistent funding stream, as it is not included in the state Medicaid program. PACT is currently a pilot program and there is little incentive for expansion. Many of the people who would benefit from PACT are Medicare patients.
- Maintaining qualified staff is an additional challenge for PACT programs. Rural Iowa poses unique challenges, particularly related to transportation and developing a complete PACT team.
- The adult rehabilitation option is a Medicaid service that states can offer in the state Medicaid plan. Iowa added the adult rehab option in 2001. Medicaid recipients with mental illness could receive supportive community living services, job training, and placement services. Therefore, Medicaid was paying over $10 million for rehab option services. Centers for Medicaid and Medicare Services (CMS) uncovered documentation errors and as a result of what was determined to be fraudulent practices, Iowa was forced to pay back $6.5 million. Iowa discontinued the rehab option effective June 30, 2006.
- There is planning being completed to develop other Medicaid funded services to replace the rehab option but CMS must approve the plan. Community supports for non-Medicaid individuals are funded primarily by counties, which are unlikely to find funding to continue the rehab option without state support.
- **Rebalancing services requires building community capacity, not just closing the doors to institutions**. Community

capacity is hanging by a thread and at the same time institutions and private hospitals are becoming less of a resource. The solution to these problems is money, and it will take more money to serve people properly.

Provider

Patrick N. Smith, Med, Executive Director, Northeast Iowa Behavioral Health, Inc., Decorah, IA

- Mental health centers provide a safety net for individuals with serious mental illness. Approximately 13 mental health centers have closed in Iowa over the last 10 years due to reimbursement issues. The mental health system is unraveling as funding of mental health services has moved away from a locally funded and controlled system to a Medicaid funded system. Iowa must re-vision its mental health system.
- At the federal level, in 1999 Surgeon General Dr. David Satcher released an epic review of the state of mental health in the country. President Bush's New Freedom Commission also looked at the delivery of mental health services. Both concluded that the system needed transformation.
- Charles Curie, former director of the Substance Abuse and Mental Health Services Administration (SAMHSA), believes that **a mental health system should ensure that people with serious mental illness have a decent job, a decent place to live, and a date on Saturday night.**
- Smith and his colleagues have been working on the development of a recovery-based system of care in the Northeast Center, and further development of the system throughout the state. A recovery-based system of care means that consumers are empowered to demand quality of care and quality of life.
- The passage of HF 2780 established a mental health authority in Iowa within the Department of Human Services (DHS). Iowa needs this authority to mandate a recovery-based system of mental health care and implement evidence-based practices across the state.
- Regarding institutional bias, Iowa has a disproportionate number of people with serious mental illness residing in residential care facilities because a community-based continuum of care does not exist.
- Iowa compares well in term of expenditures related to mental health services, but the dollars are largely spent for institutional services. Iowa must move toward more community-based services; it will be a long but an important process. Iowa must address Medicaid reimbursement rates, which cover about 60 percent of actual costs.

Quality

Michael A. Flaum, MD, Associate Professor and Director, Iowa Consortium for Mental Health, Department of Psychiatry, Carver College of Medicine, The University of Iowa

- There are currently 60 full-time unfilled psychiatric jobs, and another 20 part-time unfilled positions in Iowa. These jobs will not be filled with better advertising or student loan repayment incentives; Iowa must find another model. If Community Mental Health Centers are reimbursed at cost, Iowa may be able to attract graduating residents.
- There are 650 physician assistants in Iowa, 25 of whom specialize in psychiatry. There are 750 nurse practitioners in Iowa, with approximately 10 percent specializing in psychiatry. The University is working to enhance the competencies of these and other health professionals to expand mental health services.

- By Iowa Code, the Mental Health and Developmental Disabilities Commission is required to report every two years on access to and quality of mental health services in Iowa. Iowa does not have the information technology capacity to systematically look at the match or mismatch between needs and services provided. Last year, the legislature directed a small but significant amount of funding to move forward with the implementation of a standardized functional assessment tool and outcome measures.
- Only about 12 percent of individuals that might benefit from PACT (programs for assertive community treatment) services are getting those services. **Unless PACT services are incorporated into the Medicaid State Plan, many individuals will not receive those services.**
- Regarding rebalancing, there are 5,000 residential care facility beds in Iowa. While Iowa is reducing beds in the state mental health institutions, many individuals with chronic mental illness reside in residential care facilities.
- Flaum spends time every week at a residential care facility with about 125 beds. About 95 percent of the residents have chronic mental illness. For years the municipal bus stopped about a half mile from the facility. As of September 1, the municipal bus stops at the facility. This event is more of a community integration activity than tearing facilities down to build apartments. Those 125 residents now are able to live, work, and participate in their community. This took persistence, but not a lot of money. This demonstrated that targeted action can have a tremendous impact on rebalancing.

Mental Health Question and Answer Session

Q: The psychiatric shortage in Iowa is severe. I would like to see The University of Iowa increase enrollment in the College of Medicine to meet the shortages.

A: (Clancy) The key is looking at the provider mix to address the shortages through interdisciplinary teams.

Rapporteur

Steven A. Schroeder, MD, Distinguished Professor of Health and Health Care, Department of Medicine, University of California, San Francisco, and President Emeritus, Robert Wood Johnson Foundation, San Francisco, CA

- There is really a need to focus on the cost. We can do it with reorganization and rebalancing. Clearly there is a lot of money being spent in this country for health care that does not result in good health. Health care is a big part of the economy in this state, and thus rebalancing and shifting patient care out of the hospitals and nursing homes and into the communities becomes challenging as people who are at risk to lose money will say, "Not so fast."
- Iowa is a unique state because it is small and its policymakers are able to work in a bipartisan fashion. Director Concannon indicated that the political balance in the state might open the door to reorganization of the health care system and the consideration that must be given to raising the cigarette tax.
- There may be more opportunities for health promotion and disease prevention, and Iowa should certainly consider raising taxes for cigarettes. Iowa and Vermont were the only two states that increased Medicaid coverage and the state legislature may consider expanding coverage to parents. **Iowa is also a state with one of the highest institutionalization rates and is most definitely facing a workforce shortage.**
- As the discussion turned to children, developmental health was the focus in order to find children at risk early to minimize the costs of health care in the long-run. There is a need to educate parents, individualize services, and perhaps prevent disabilities that may develop later in life. New models of pediatric care were highlighted and Iowa was complimented for being committed to insuring its children. There were arguments made that quality should trump costs and that full benefits are not always actualized.
- The coordination of care was a theme among all of the panels, which often runs against the grain of the health professions and incentive structure, particularly in the mental health system. The medical system and medical training is biased against the coordination of care. Young medical students want to do shift work, they want a life, they have big debts, and they do not want to do this interesting, challenging, coordination of care. Incentives must be designed to counter these issues.
- The issue of how to get doctors to go to rural areas is a challenge as medical professionals have high debts. Iowa might consider having medical professionals serve rural areas on a rotating basis to assist in providing better coverage.
- On the issues of the large aging population, Schroeder mentioned that many people want a quiet death at home rather than receiving services in a hospital or ICU. It is hard to keep people home when they have severe diseases, and states must be encouraged to support hospice programs as they are a wonderful substitute to expensive hospital care.
- Schroeder indicated he would raise a caution flag regarding the epidemic of Alzheimer's disease. It is very challenging to care for these types of patients at home as they often become violent, incontinent, and susceptible to pressure sores. To be able to provide these types of services in an individual's home may not save money and will require appropriate care and a very supportive family.

- The panelists mentioned generic case management several times within their presentations. Generic case management is the one system where improvements can be made to quality and there can be a cost savings, but it requires going against the grain so this type of rebalancing is not easy.
- Both of the state legislators indicated the importance of continuing to work in a bi-partisan fashion and mentioned that health care will be one of the top issues for policy-maker discussion. There is a need to focus on cost and the legislators were interested in finding out more about how the Massachusetts plan is working.
- Much care provided to persons with disabilities is funded under Medicaid and many issues were discussed that should lead Iowa and other states to place a particular emphasis on improving the system for persons with disabilities. **The institutional bias in Medicaid must change and experimenting with new Medicaid options is an important thing to do.** Many of the panelists commented on the importance of expanding home and community-based services and many states are exploring new programs under Medicaid to address special needs populations. How Iowa manages the profits is an important issue.
- Health promotion in the disability community was mentioned several times. The chronic care model was continually mentioned along with choice as a function of quality of care and quality of life. Individual panelists also highlighted the need for providing incentives to individuals with disabilities to work without the fear of losing their Medicaid benefits.
- There was a fascinating history provided about the mental health system and the PACT model. The panelists also talked about new ways to do business, the lack of resources available to implement the PACT model, the unraveling of the mental health safety net, the idea of trying to preserve personal income for consumers so they can have a decent life, the optimism about the new state health authority on mental health, the importance of school-based clinics for mental health care, and the advisability to include other health care providers involved in mental health services treatment through incentives. Schroeder added that smoking is a huge health care issue for persons with mental illness, indicating that **smoking is the single largest reason that persons with mental illness die.** There is a need to continue to help smokers quit within the mental health system.
- Reconfiguring the chronic care model of case management is a key part of rebalancing and reconfiguring the way that care is provided. Iowa starts at an enviable place in terms of the current health data, the quality of life, income, and with its current political harmony.
- Forum participants should prioritize goals, interact with state and local policymakers about them, and time the priorities out to track progress. Iowa can be a state to show the rest of the country that the health care system is broken and how to fix it.

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http://www.kff.org/medicaid/7569.cfm

A Medicaid Perspective on Part D Implementation and The Medicare Prescription Drug Program: Findings from a Focus Group Discussion with Medicaid Directors, Kaiser Family Foundation
http://www.kff.org/medicaid/upload/7447.pdf

The Number of Uninsured Americans is at an All-Time High, Center for Budget and Policy Priorities
http://www.cbpp.org/8-29-06health.htm

SCHIP Financing Update: In 2007, 17 States Will Face Federal Funding Shortfalls of $890 Million in Their SCHIP Programs, Center for Budget and Policy Priorities
http://www.cbpp.org/6-5-06health2.htm

State Medicaid Budget Survey State Fiscal Years 2006 and 2007, Kaiser Family Foundation.
http://www.kff.org/medicaid/7569.cfm

State Medical Factsheet for Iowa and the United States, Kaiser Family Foundation
http://www.kff.org/mfs/medicaid.jsp?r1=IA&r2=US

Why Not the Best? Results from a National Scorecard on U.S. Health System Performance, The Commonwealth Fund
http://www.cmwf.org/usr_doc/Commission_whynotthebest_execsumm_951.pdf

General Resources

The American Association for Retired Persons (AARP)
http://www.aarp.org

The Center on Budget and Policy Priorities
http://www.cbpp.org/

The Centers for Medicare and Medicaid Services
http://www.cms.hhs.gov/

Families USA
http://www.familiesusa.org/index.html

The Federal Administration on Aging (AoA)
http://www.aoa.gov/

The Iowa Coalition on Mental Health and Aging
http://www.public-health.uiowa.edu/icmha/

The Iowa Department of Elder Affairs
http://www.state.ia.us/elderaffairs

The Iowa Department of Human Services
http://www.dhs.state.ia.us

The Iowa Foundation for Medical Care
http://www.ifmc.org/

The Iowa Legislative General Assembly
https://www.legis.state.ia.us

The Iowa Medicaid Enterprise
http://www.ime.state.ia.us/

The Kaiser Family Foundation
http://www.kff.org

The National Conference on State Legislatures
http://www.ncsl.org/

The National Governor's Association
https://www.nga.org

The Northwest Area Foundation
http://www.nwaf.org/

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