

# COMMUNITY HEALTH

NEEDS ASSESSMENT 2015



## CENTRAL IOWA

**CAPITAL CROSSROADS**   
*A VISION FORWARD*

Dear Community Health Advocate:

On behalf of the Steering Committee, we are pleased to share Central Iowa's first regional Community Health Needs Assessment. This assessment outlines the top health priorities within three Central Iowa counties: Dallas, Polk, and Warren.

Central Iowa business and community leaders have a history of collaboration; the health and wellness industry is no different. We know we are stronger when we work together, and we have no doubt that this effort will move the needle on our region's health – if we continue working together to address the priorities laid out here.

We would like to extend our gratitude to all who participated in the development of the Assessment. We also would like to thank in advance all those who will be involved in taking up the priorities outlined in this Assessment.

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## Executive Summary

Every five years, the Iowa Department of Public Health expects local health departments to conduct a Community Health Needs Assessment (CHNA). At the same time, the Patient Protection and Affordable Care Act requires nonprofit hospitals to conduct a CHNA every three years. Both of those calendars and requirements coincide this year, allowing for the creation of a single multi-county, multi-hospital regional CHNA.

In alignment with the Capital Crossroads Regional Vision Plan, the Greater Des Moines Partnership facilitated the development of this CHNA along with a Steering Committee comprised of representatives from hospitals, health departments, philanthropic organizations, service providers, academic institutions and the private sector. The group identified five areas to address in the CHNA: Access to Care, Youth, Physical Environment, Workforce, and Mental Health.

Work groups were created to assess each focus area and to identify current conditions, targets, challenges, needed resources, and priority areas. Upon completion of this work, the Steering Committee reconvened to capture the overall vision for a healthy community environment that supports and enables all Central Iowans to live healthy lives and encourages everyone to take responsibility for their own health.

## Background

### *Community Health Needs Assessment*

The Patient Protection and Affordable Care Act, signed into law in March 2010, requires nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) at least once every three years beginning in March 2012. The Iowa Department of Public Health requires local public health agencies to conduct a CHNA at least every five years.

These requirements present the opportunity for local community health leaders to join forces and identify priorities that can serve as a guide for programs, policies and investments. Working together often creates efficiencies, new partnerships and increased collaboration. Ultimately, Central Iowans benefit when data, resources and expertise are shared to attain the common goal of a healthier community.

### *Care Facilities*

**Broadlawns Medical Center** is an acute care, community hospital supported by several specialty clinics that serve the medical, surgical, mental health, and primary healthcare needs of Polk County residents. The system is comprised of 66 physicians, 1,000 employees, and 20 specialty clinics.

**Mercy Medical Center** is an 802-bed acute care, not-for-profit Catholic hospital situated on three campuses. Founded by the Sisters of Mercy in 1893, Mercy is the longest continually operating hospital in Des Moines. It also is one of the largest employers in the state, with more than 7,100 employees and a medical staff of more than 800 physicians and allied health associates.

**UnityPoint Health Des Moines** provides coordinated clinic, hospital, and home-based care for patients in Central Iowa. UnityPoint Health Des Moines is led by nearly 290 physicians and providers working in more than 50 UnityPoint clinic locations. They are supported by four state-of-the-art UnityPoint Health Des Moines hospitals – Iowa

Methodist Medical Center, Iowa Lutheran Hospital, Blank Children's Hospital, and Methodist West Hospital – and a cancer center along with home healthcare services.

### ***Local Public Health Agencies***

The **Dallas County Public Health Department's** mission is to promote, protect, and improve the public's health through surveillance, education, care coordination, disease prevention, mobilization of community resources, and enforcement of public health policies and regulations.

The **Polk County Public Health Department's** mission is to create the conditions for all people to live healthy lives by engaging residents, reducing health disparities, and attending to the needs of the most vulnerable families.

**Warren County Health Services'** mission is to improve and contribute to the health of the total population of Warren County through health promotion, prevention, teaching, and caring.

### ***The Process***

The Central Iowa CHNA was completed using a three step process:

1. Establish the Assessment Infrastructure
  - Convene a Steering Committee
  - Review 2012 CHNA
  - Identify timeline, process, necessary working groups, and other stakeholders
2. Establish Working Groups
  - Identify which, if any, parties are missing from the table
  - Determine which metrics to study
  - Assess the current state of affairs in each work group area
  - Establish targets
  - Determine challenges in reaching these targets
  - Ascertain what resources are needed to reach these targets (data access, collaboration, funding, policy changes, etc.)
  - Pinpoint the top three to five priorities for each work group
3. Define Significant Community Health Needs
  - Capture community vision
  - Define resources, Best Management Practices (BMPs), existing gaps, and what policies could be implemented
  - Rank the work group priorities

It is envisioned that the Capital Crossroads and Greater Des Moines Partnership staff in collaboration with the Wellness Capital Committee will continue facilitation with the CHNA Steering Committee to ensure progress in implementing the priorities laid out in the CHNA.

### ***Input***

The Work Groups were comprised of a broad range of individuals representing various organizations and constituencies across the community. These individuals were recruited to provide their expertise in regards to the work group focus and the populations they serve.

## Priorities

The 2015 Central Iowa Community Health Needs Assessment is a collaboration of hospital and health department representatives along with other community stakeholders. A Steering Committee identified five areas to address, including access to care, mental health, physical environment, workforce, and youth. The final report addresses six priorities, based on the potential for implementation and depth of impact. Those priorities include:

- A. Increase opportunities for expanded and alternative means of healthcare delivery to address issues limiting access to care
- B. Establish more vibrant communities and neighborhoods characterized by mixed- and joint-use spaces and facilities that are accessible and available to everyone, including public gathering places for diverse and integrated engagement, and designs that promote healthy lifestyles
- C. Expand statewide training efforts for all professionals working with children across the various health and child-serving systems in Trauma Informed Care, cultural competency, and mental health first aid
- D. Identify additional sources of funding to create new and expand existing training programs in Psychiatry and Psychology and improve the mental health and disabilities training of primary care doctors and other primary care providers
- E. Ensure access to high-quality pre-K and K-12 education for Central Iowa children
- F. Ensure access to health care services and education for Central Iowa's newcomer population

The priorities are detailed as follows:

### **A. Increase opportunities for expanded and alternative means of healthcare delivery to address issues limiting access to care**

While Central Iowa has relatively low rates of uninsured individuals, access to health care is a multi-faceted issue, touching all areas of care, provider options, payment systems, geography, and cultural considerations. Challenges remain with service and provider shortages throughout certain areas of care.

The State of Iowa has undertaken a redesign of its mental health system in recent years, but a shortage of physicians in emergency medicine, obstetrics and gynecology, psychiatry, and child and adolescent psychiatry are still an issue. Many rural communities are seeing an aging population, thus magnifying the shortage. It also is difficult to find providers willing to relocate outside of urban areas or Iowa in general.

With advances in technology, there are opportunities to explore care options outside of traditional settings. Considering alternative services, such as urgent care, may allow for fewer emergency room visits and allow for access throughout a broader region.

As the community at large continues to address access through a more holistic approach to address the basic needs of the community, one of the top priorities in increasing access is increasing the opportunity for expanded and alternative delivery of services.

The concept of exploring various means to provide care outside of traditional scenarios, such as in the clinic with a physician, may lead to helping address access issues, including provider shortages. Technology is quickly making it more realistic to provide remote forms of healthcare in a broader region and in a more efficient manner. Further,

possibly expanding the provision of services such as urgent care may help to reduce unnecessary emergency room (ER) visits and provide added convenience for many trying to access healthcare outside of regular business hours.

**Potential Strategies:**

- Expand web-based physician consultations
- Explore use of smartphones as a tool for physicians and providers
- Expand telemedicine
- Study expanded urgent care locations & hours
- Use other primary care providers

**Suggested Target Indicators**

**Table A-1**

Indicator	Baseline		
	Polk	Dallas	Warren
Increase the ratio of PCPs	1,015:1	2,399:1	1,675:1
Increase the ratio of other primary care providers	1,068:1	5,742:1	4,734:1
Increase web-based physician provider access services			
Increase availability to Urgent Care services	Benchmarking figures are unavailable.	Benchmarking figures are unavailable.	Benchmarking figures are unavailable.

**Best Management Practices**

A number of best management practices (BMPs) exist to increase opportunities for expanded and alternative services. They include:

- Conduct an environmental scan to assess the services available regarding telemedicine and online types of provider access
- Conduct an environmental scan to assess hours of operation and locations of urgent care facilities

**Funding**

- Opportunities to supporting development of creative means to address health needs through telemedicine and web-based provider access

**Policies**

- Explore transportation policies as a means to address access based on proximity to physical services

**B. Establish more vibrant communities and neighborhoods characterized by mixed- and joint-use spaces and facilities that are accessible and available to everyone, including public gathering places for diverse and integrated engagement, and designs that promote healthy lifestyles**

Central Iowa has recognized the need to create an active, vibrant community in plans and vision strategies such as Capital Crossroads, The Tomorrow Plan, Housing Tomorrow, and Healthy Polk. The need for an active, vibrant community also has been recognized in a number of current health-related initiatives, including but not limited to Age-Friendly Community, Healthy People Healthy Places, and Healthy Homes East Bank. The previous Community Health Needs Assessment focused on obesity as a priority, which continues to be recognized as an issue in the community. Combating obesity is part of a larger effort to build a culture of active and healthy lifestyles.

For over a century, physical activity has been engineered out of people’s daily routine in Central Iowa, resulting in more sedentary lifestyles that can lead to obesity. Creating a mixed-use community with a variety of shops and services provides a robust antidote to obesity and a long list of other negative health, economic, and environmental outcomes. Adding several steps will not solve this epidemic, but engineering activity in multiple times will. Here the dose-response rule is that some is good; more is better.

Clustering public services and retail within close proximity to one another, along with residential areas, decreases reliance on automobiles, which reduces emissions, encourages walking and using public transportation, and leads to a more vibrant community. Building walking into daily routines and commuting patterns makes it easier to achieve recommended levels of physical activity. It follows that decreased usage of automobiles and lower volumes of auto traffic are correlated with fewer instances of auto-pedestrian accidents resulting in injuries and fatalities.

In recent years, multiple walkability assessments have been conducted in the region, and the Des Moines Area Metropolitan Planning Organization has launched an initiative to increase the number of jurisdictions that adopt a Complete Streets policy. While much attention is focused on inner cities, an active, vibrant community is not an urban-only phenomenon; smaller communities have gathering places like schools, places of worship, and town squares.

Multiple metrics will be used to track the progress in creating an active, vibrant community, as shown in the following table:

**Table B-1**

Indicator	Baseline	Data Source	2020 Target
B-Cycle check outs	3,025	Des Moines Bicycle Club	6,000
Number of walk trips per household per day	Polk: .79 Dallas: .69 Warren: .67	AARP Livability Index	2
Number of jurisdictions with Complete Street policies	4	Des Moines Area MPO	20
Miles of on-street bike facilities	26	Des Moines Area MPO	125

Percentage of people who always feel safe and secure	85.69%	Well-Being Index	90%
Percentage of people living with severe housing problems	Polk 13 Dallas 9 Warren 9	Community Health Rankings	0
Percent average resident spends on housing + transportation (housing burden)	47%	Des Moines Area MPO	33%

**Best Management Practices**

A number of best management practices (BMPs) to support the creation of an active, vibrant community can be drawn directly from The Tomorrow Plan:

- Develop a system of vibrant, walkable employment and residential nodes dispersed throughout Central Iowa and connected to one another by multimodal transportation corridors
- Provide multimodal transportation access throughout the region
- Make walking, biking, and using public transportation a normal part of daily life
- Encourage and celebrate placemaking and community building opportunities

A number of other BMPs exist as well. They can be found at:

- Center for Neighborhood Technology – Location Efficiency Hub (<http://www.cnt.org/projects/location-efficiency-hub>)
- Center for Neighborhood Technology – Priority Development Areas (<http://www.cnt.org/projects/priority-development-areas>)
- Center for Neighborhood Technology – Transportation + Community Development (<http://www.cnt.org/transportation-and-community-development>)
- Center for Transit-Oriented Development (<http://www.ctod.org/ctod-research.php>)

**Funding**

- ArtPlace America (<http://www.artplaceamerica.org/our-work/national-grants-program/introduction>)
- Federal Transit Administration ([http://www.fta.dot.gov/12347\\_6932.html](http://www.fta.dot.gov/12347_6932.html))
- Our Town (<http://arts.gov/grants-organizations/our-town/introduction>)
- Placemaking Micro-Grants (<http://www.realtoractioncenter.com/for-associations/smartgrowth/placemaking/placemaking-micro-grant.html>)
- Project for Public Spaces (<http://www.pps.org/reference/artfunding/>)
- Reconnecting America Inventory of TOD Programs (<http://reconnectingamerica.org/inventory/index.php>)

**Policies**

- Center for Neighborhood Technology – Policy (<http://www.cnt.org/policy>)
- Center for Neighborhood Technology – Transportation + Community Development (<http://www.cnt.org/transportation-and-community-development>)

- Complete Streets (<http://dmampo.org/complete-streets/>)
- Reconnecting America Inventory of TOD Programs (<http://reconnectingamerica.org/inventory/index.php>)
- Updated comprehensive plans and zoning ordinances

**C. Expand statewide training efforts for all professionals working with children across the various health and child-serving systems in Trauma Informed Care, cultural competency and mental health first aid**

Central Iowa leaders have conducted an Iowa-specific analysis on Behavioral Risk Factor Surveillance System data to assess the health effects of childhood trauma for Iowans. The study showed that 55 percent of Iowa adults experienced at least one Adverse Childhood Experience (ACE), or incidents that can dramatically impact, or upset, the safe, supportive environment needed. In Central Iowa, 43 percent of adults in Polk County, 37 percent in Dallas County, and 41 percent in Warren County experienced two or more adverse childhood experiences as follows.

Research has shown that an increase in the number of ACEs reported by adults is correlated with an increased risk for some of our most serious health and social issues, including alcoholism, chronic obstructive pulmonary disease, depression, illicit drug use, ischemic heart disease, liver disease, smoking, adolescent pregnancy, sexually transmitted diseases, intimate partner violence and health-related quality of life.

This research points to a significant need for Central Iowa health providers, educators, social service professionals, to understand childhood trauma as a significant driver of poor health outcomes and to work to prevent its occurrence and mitigate its impact.

An estimated 20 percent of children in the United States have a diagnosable mental health condition. These conditions impact children of all ages, every racial and ethnic background, and every socioeconomic status. Mental health conditions in children are typically complex, involving multiple problems and multiple diagnoses and impact children in different ways throughout their development. There are devastating consequences, including poor academic achievement, dropping out of school, substance abuse, involvement with the correctional system, lack of vocational success, inability to live independently, and suicide.

Mental health disorders are the most expensive conditions in childhood. Children and youth who receive mental health and substance abuse services paid for by Medicaid, while less than 10 percent of the overall Medicaid population, represent approximately 38 percent of total Medicaid child expenditures (Pires, [et.al.](#), 2013). These health sector costs are only a portion of the total cost; children with serious and complex mental health needs are often involved in other child-serving systems such as child welfare, juvenile justice, special education and early childhood services. High-end care such as hospitalization and residential services are by far the largest percentage of these total costs.

***Potential Strategies:***

- Increase knowledge of healthcare systems on the impact of trauma on patient health by providing training for providers and staff, creating environments that do not retraumatize patients, and increasing prevention strategies such as trauma assessments and multi-generational supports in pediatric and family practice health care.
- Provide schools with the necessary training and resources to build awareness, understanding and knowledge about how to address children who have experienced toxic levels of stress and/or have mental health concerns and when to refer to additional services, including mental health providers. Almost one half of children ages 10 to 17 in the United States have experienced one or more Adverse Childhood

Experiences. National statistics show that 70 percent of youth in state and local juvenile justice systems have a mental illness and that 50 percent of youth in the child welfare system have a mental illness. These child-serving systems should have the tools and training available to better understand how to respond and build resiliency for the children in their care.

- The region's opportunities also include the need to specifically identify funds to train correctional staff on mental health issues and trauma informed care and to cross train mental health providers and corrections staff. It is important for corrections staff to receive ongoing training on systems navigation and resources while mental health providers would benefit from training on criminal thinking and safety issues. Standardization of curriculum in local criminal justice colleges to include mental health issues and its impact upon the criminal justice system would be key to this integration of training along with expanding Crisis Intervention Team (CIT) training for law enforcement officers.

**D. Identify additional sources of funding to create new and expand existing training programs in Psychiatry and Psychology, and improve the mental health and disabilities training of primary care doctors and other primary care providers**

Iowans have become increasingly aware of the insufficiency of mental health care services over the last several years. There have been numerous efforts across the state to educate residents about the importance of mental health services and the need for an adequately funded and staffed adult and children's mental health system. The Adult Mental Health System Redesign is one clear effort that has begun with goals and objectives spanning a five to seven year period. Progress has been made, yet questions remain about the adequacy of funding and long term support.

Moving forward, action steps to address the mental health crisis in Central Iowa and the state must include childhood trauma prevention and early intervention strategies. The focus on mental health across the lifespan will be essential. There exists a need to increase the number of mental health service providers while also reducing the barriers to access to mental health care in order to meet the growing need in Central Iowa. This begins by supporting and fully funding the Adult Mental Health Redesign and also launching a Children's Mental Health System Redesign to complement it. An estimated 20 percent of children in the US have a diagnosable mental health condition.

There have been recent efforts to work collaboratively in the region to strategize ways to increase training opportunities in mental health. One such effort, called the Des Moines University (DMU) Clinical Collaborative, was formed in 2012 and includes representatives from UnityPoint, Mercy, Broadlawns, The Iowa Clinic, and the Veterans Administration Hospital. The original focus of the Collaborative was to address clinical training needs of DMU students but it evolved to include very fruitful conversations about the need to work collaboratively in support of growing Graduate Medical Education opportunities. The entire group has identified a need to work together to benefit the community in supporting psychiatry training and other mental health and behavioral health training efforts. Whereas funding is the major barrier in advancing this effort, there has clearly been an eagerness to work collaboratively across systems to further this effort.

Currently, the State of Iowa has one psychiatric residency training program at the University of Iowa. The psychiatry department at the University of Iowa is outstanding, known nationwide as a leader in academic research and teaching. Many local provider organizations are working together to start a second residency training program for psychiatry that would include rotations with several regional community partners. This program would ultimately graduate four new psychiatrists per year that have had training in community and clinical psychiatry. The program would be structured to encourage graduates to consider rural practice.

The primary barrier to starting a second residency program is funding. Once fully operational, the program would have up to sixteen residents at a time with a projected annual cost of \$2.88 million. While there have been grants available to provide startup funds for such a program, there is no assurance of future funding.

Central Iowa has several opportunities to increase training opportunities and identify financial resources to aid in addressing many of the identified needs. This Community Health Needs Assessment Steering Committee will continue to build collaborations and partnerships in Central Iowa to develop new opportunities for training across systems and disciplines and identify new sources of revenue to support training efforts. Additionally, the work will focus on providing better preparation of primary care physicians and other providers in behavioral health through continuing medical education and/or certificate programs in Primary Care Behavioral Health.

With the passage of the Mental Health Parity and Addiction Equity Act and the Affordable Care Act, millions of Americans who have not had, or could not afford, access to care before will have comprehensive benefits. These steps will require that insurance reform and reimbursements be addressed in order to maximize these benefits. It also will require the provision of education to the public on health insurance products.

Multiple metrics will be used to track the progress in enhancing mental health service delivery and accessibility, as shown in the following table:

**Table D-1**

Indicator	Baseline	Data Source
Number of Mental Health Prescribers In Private Practice	316	Amos MH and Disability Workforce Report (2014) – after consultation with Iowa Bd of Medicine and IDPH, Iowa Nurses Association, and Iowa Physician Assistant Society
Ranking for overall mental health workforce availability	44/50	2015 Mental Health America report: The State of Mental Health in America – page 40 – <a href="http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf">http://www.mentalhealthamerica.net/sites/default/files/Parity%20or%20Disparity%202015%20Report.pdf</a> 1144:1
Percentage of Iowans with medical insurance	92%	<a href="http://www.desmoinesregister.com/.../19/iowans-lack-health-insurance/9270235">www.desmoinesregister.com/.../19/iowans-lack-health-insurance/9270235</a> Dm Register article 5-19-14 230,000/3,046,000 = 8% uninsured Also – pg. 48 of the 2015 Mental Health America report: The State of Mental Health in America supports 230,000
Shortage of slots for offenders who need mental health services	862	Sally Kreamer, former Director of Fifth Judicial District
Shortage of ISP or high risk officers to provide intensive services and supervision in a correctional setting	29	Sally Kreamer, former Director of Fifth Judicial District
Number of psychiatric beds available	711	2016-17 DHS proposed budget <a href="http://dhs.iowa.gov/sites/default/files/4_Promote_Behavioral_Health_Status.pdf">http://dhs.iowa.gov/sites/default/files/4_Promote_Behavioral_Health_Status.pdf</a>
Number of suicides	71 (2013)	Federation for American Immigration Reform <a href="http://www.fairus.org/states/iowa">http://www.fairus.org/states/iowa</a>

**E. Ensure access to high-quality pre-K and K-12 education for Central Iowa children**

Despite Iowa’s low unemployment rate and the highest graduation rates in the US, poverty and unemployment persist. The unemployment rate often is a reflection of a skills gap, which contributes to provider shortages and access issues for Central Iowans. As Baby Boomers retire, data indicates that a substantial portion of the working-age population lacks a sufficient level of literacy and numeracy skills to fully participate in the current work environment.

Half of all job openings in Iowa are considered middle-skilled jobs. These jobs require more than a high school diploma but not a four-year degree. Many of these jobs are found in Science, Technology, Engineering and Math (STEM) related fields. It is imperative to provide the future workforce with a high quality early childhood and secondary education. This will prepare students for high school graduation, postsecondary education, and career opportunities in high-demand jobs.

A number of initiatives centered on education currently exist in Central Iowa. Those include the United Way of Central Iowa Income Goal, Bridges to Success, Education Drives Our Great Economy (EDGE), and Central Iowa Works. All focus on using education to grow the workforce and the incomes of Central Iowans.

**Potential Strategies:**

- Increase access to quality early learning environments that promote school readiness
- Increase K-12 students’ proficiency in literacy, reading, and math
- Identify and engage at-risk students and improve school success by addressing barriers for students and families
- Support public-private partnerships to expose young people to careers (i.e., Wellmark job training partnership with Des Moines Public Schools and the Waukee Aspiring Professionals Exchange (APEX) program that partners with several local employers)

**Suggested Targets**

**Table E-1**

Indicator	Goal
High School Equivalency Diploma	<b>6,000 additional</b> Central Iowans will receive a high school equivalency diploma
Graduation Rate	<b>94 percent</b> graduation rate by 2018
Increased opportunities for individuals to enter career pathways	Benchmarking figures are currently unavailable; therefore, a goal has not been formalized.

**F. Ensure access to health care services and education for Central Iowa’s newcomer population**

Central Iowa is experiencing dramatic growth in its immigrant and refugee population, with about 2,500 refugees directly resettled in Polk County in the last five years. The growth is reflected in public school demographics: in Perry, 19.4 percent of students are English Language Learners (ELLs); in Des Moines, it is 17 percent, and Urbandale has 10 percent. With more than 6,000 students, the Des Moines Independent Community School District has the largest

ELL program in the State of Iowa. These students and their families help make Iowa a more diverse state and contribute to the economic base as workers, taxpayers and entrepreneurs helping to fill the skills gap.

**Table F-1**

Indicator	Baseline
PK-12 English Language Learners (ELL)	8,192
PK-12 Total Enrollment	100,637
Percent ELL Enrollment	8.10%

Refugees and immigrants face barriers to accessing culturally and linguistically appropriate healthcare services. Language remains a substantial barrier in understanding healthcare systems, including health insurance and accessing appropriate care and treatment. Cultural norms and stigmas may prevent some newcomers from seeking the help they need to deal with behavioral or substance abuse issues. Healthcare providers struggle to deliver high-quality care to patients who do not speak English well. The use of interpretation services varies across healthcare settings, with some facilities less willing or capable to provide language access through the use of interpreters. These barriers result in a lack of proper care and services that ultimately affect the health and well-being of Iowa’s refugee and immigrant families.

A 2011 survey of Des Moines area service providers conducted by Lutheran Services in Iowa found that:

- 100 percent of respondents reported that language was a barrier to serving refugee families;
- 100 percent reported that if those barriers to service were reduced that they would be receptive to serving refugee families; and,
- 78 percent of providers reported feeling overwhelmed by the needs of refugee families they had served.

***Potential strategies for the health and medical community to undertake include:***

- Increase screening for behavioral health concerns, including mental health issues related to trauma or abuse, substance abuse, and domestic violence
- Educate Iowa’s health care providers on their responsibilities vis-à-vis language access under Title VI of the Civil Rights Act of 1964, which prohibits recipients of federal funding from discriminating based on national origin by failing to provide meaningful access to individuals who are Limited English Proficient (LEP)
- Provide resources to providers on local refugee- and immigrant-serving providers that are able to provide culturally and linguistically appropriate support, especially through the use of the community health navigator model
- Provide support to organizations, including hospitals and clinics, that assist refugees and immigrants to maintain appropriate health insurance coverage
- Liaise with local organizations that provide enrollment support, especially during the transition to Managed Care

**Suggested Targets****Table G-1**

<b>Indicator</b>	<b>Baseline</b>	<b>Target</b>	<b>Data Source</b>
Increase screening for behavioral health concerns, including mental health issues related to trauma or abuse, substance abuse, and domestic violence	Benchmarking figures are currently unavailable.	Once benchmarking figures become available, a target can be established.	US Committee on Refugees and Immigrants
Increase screening of new arrivals for mental health concerns	< 1%	75%	US Committee on Refugees and Immigrants
Patients reporting the person(s) who met them spoke in a way they could understand	Benchmarking figures are currently unavailable.	Once benchmarking figures become available, a target can be established.	N/A
Patients reporting the words on signs and forms were understandable	Benchmarking figures are currently unavailable.	Once benchmarking figures become available, a target can be established.	N/A
Patients reporting the people who met with them were respectful of who they are, what they look like, and what they believe	Benchmarking figures are currently unavailable.	Once benchmarking figures become available, a target can be established.	N/A

**Conclusion**

The 2015 Community Health Needs Assessment represents the strength of collaboration in Central Iowa, specifically Dallas, Polk and Warren Counties, in partnership with Broadlawns, Mercy Medical Center and UnityPoint Health Des Moines. This assessment is Central Iowa's first regional Community Health Needs Assessment, providing a broad vision spanning a depth of impact areas. The success of the outlined priorities will require a comprehensive and centralized database to support the efforts of the community. The Central Iowa community is committed to the vision of the Steering Committee, whose members include representatives from the health care industry, the broader business community, policymakers and other partners.

## Appendix A: 2015 Meeting Dates

### Steering Committee Meetings

January 29  
March 25  
April 27  
May 29  
July 22  
September 15  
November 16  
December 17

### Access Work Group

March 19  
April 9  
May 7  
June 23  
July 20  
July 27

### Mental Health Work Group

March 20  
April 10  
May 1  
May 15  
June 12

### Physical Environment Work Group

March 23  
April 23  
May 4  
July 14  
July 30

### Workforce Work Group

March 25  
April 14  
June 29

### Youth Work Group

April 20  
May 11  
June 12  
July 29  
August 12

## Appendix B: Work Group Members

### Access Work Group

*Team Leader:* Chris McCarthy, Center for Healthy Communities Project Manager, UnityPoint Health

- Jackie Easley, Director of Community & Diversity Services, Mercy Des Moines
- Chris Esperson, Quality Director, Primary Healthcare, Inc.
- Leah Gabriel, Psychiatric Advanced Registered Nurse Practitioner, Polk County Health Department
- Shelley Horak, Public Health Director, Dallas County
- Tom Newton, Vice President – Network Engagement, Wellmark Blue Cross and Blue Shield
- Elizabeth Presutti, General Manager, Des Moines Area Regional Transit Authority
- Mikki Stier, Vice President of Government & External Relations, Broadlawns Medical Center
- Tray Wade, Senior Vice President and Chief Operating Officer, HCI-VNS Care Services
- Laura Wenman, Vice President – Mission Integration, Mercy Des Moines

### Mental Health Work Group

*Team Leader:* Dr. Angela L. Walker Franklin, President, Des Moines University

- Dr. Fred Bahls, Chief of Staff, Veterans Affairs Central Iowa Health Care System
- Teresa Bomhoff, President, NAMI Greater Des Moines
- Kevin Carroll, Ed.D, Behavioral Health Executive Director, UnityPoint Health
- Dr. Michael Demand, Vice President, Health & Care Management, Wellmark Blue Cross and Blue Shield
- Erin Drinnin, Community Impact Officer – Health, United Way of Central Iowa
- Dr. Deborah Edelman-Blank, Staff Psychologist – Student Counseling Center, Des Moines University
- Greg Febbraro, Ph.D., NAMI Iowa Board Member & Psychologist, Counseling for Growth & Change
- Chris Frantsvog, Public Health Planner, Polk County Health Department
- Sally Kreamer, Director, Fifth Judicial District Department of Correctional Services
- Dr. Jan Landy, Section Chief – Psychiatry Department, Broadlawns Medical Center
- Eric Lothe, Vice President of Operations – UnityPoint Health & Chief Administrative Officer – Iowa Lutheran Hospital
- Suzanne Mineck, President, Mid Iowa Health Foundation
- Anne Starr, Chief Executive Officer, Orchard Place
- Cynthia Steidl Bishop, Chief Executive Officer, Eyerly Ball
- Jen Stout, Director, Manager – Strong Foundations: Therapy & Solutions, HCI-VNS Care Services
- Dr. Lisa Streyffeler, Assistant Professor – Behavioral Medicine, Des Moines University
- Karen Walters-Crammond, Executive Director, Polk County Health Services

### Physical Environment Work Group

*Team Leader:* Rick Kozin, Director, Polk County Health Department

- Pat Boddy, Partner, RDG Planning & Design
- Teva Dawson, Senior Transportation Planner, Des Moines Area Metropolitan Planning Organization
- Jami Haberl, Executive Director, Iowa Healthiest State Initiative
- Tim Lane, Health Consultant
- Beth Turner, Senior Manager – Tobacco Control & Lung Health, American Lung Association

- Tray Wade, Senior Vice President and Chief Operating Officer, HCI-VNS Care Services
- Becky Wampler, Director of Healthcare Sustainability, Wellmark Blue Cross and Blue Shield

### **Workforce Work Group**

*Team Leader:* Erin Drinnin, Community Impact Officer – Health, United Way of Central Iowa

- Rona Berinobis, Director of Workforce Inclusion, Wellmark Blue Cross and Blue Shield
- Kevin Elsberry, Chief Human Resources Officer, Mercy Des Moines
- Di Findley, Executive Director, Iowa Caregivers Association
- Sherry Gomis, Human Resources Director, Primary Health Care, Inc.
- Linda Hildreth, Director of Human Resources, Eyerly Ball
- Shelley Horak, Public Health Director, Dallas County
- Sue Huppert, Vice President – External and Government Affairs, Des Moines University
- Beth Jones, Public Benefit Manager, Delta Dental of Iowa Foundation
- Chris McCarthy, Center for Healthy Communities Project Manager, UnityPoint Health
- Norene Mostkoff, President and Chief Executive Officer, HCI-VNS Care Services
- Braxton Pulley, Chiropractor, Pulley Chiropractic Health Center
- Mikki Stier, Vice President of Government & External Relations, Broadlawns Medical Center

### **Youth Work Group**

*Team Leader:* Vernon Delpesce, President & Chief Executive Officer, YMCA of Greater Des Moines

- Kathy Leggett, Director – Center for Advocacy & Outreach, Blank Children’s Hospital
- Darby Taylor, Healthy Start Director, HCI-VNS Care Services
- Jenny Weber, Community Health Consultant, Wellmark Blue Cross and Blue Shield

## Appendix C: Data Sources

Child & Family Policy Center. *Iowa Kids Count: Trends In The Well-Being Of Iowa Children*. Rep. Child & Family Policy Center, n.d. Web. 19 Mar. 2015.

"Des Moines Regional Research, Stats, & Data Hub." Des Moines Regional Research Stats Data Hub. Greater Des Moines Partnership, n.d. Web. 19 Mar. 2015.

## Appendix D: Work Group Resources

- Workforce: United Way of Central Iowa Community Report Card
- Workforce: EDGE Goals and Metrics
- Workforce: Refugee Planning Group Employment Subcommittee Goals
- Workforce: Community Partners addressing workforce needs through basic skills and career preparedness and retention

## Appendix E: Impact of Actions Taken Since 2012 CHNA

The 2012 Central Iowa CHNA identified two significant health needs: Healthy weight (healthy eating and activity) and access to health insurance/care.

### Access

The Affordable Care Act has impacted the ability of Central Iowans to gain access to medical insurance. At the close of season two of open enrollment (2014-2015) for the health insurance marketplace/exchange, over 45,000 Iowans had chosen a health insurance plan through the marketplace ([www.healthcare.gov](http://www.healthcare.gov)). This is about double the number of enrollees during the first season of open enrollment.

The ability to find affordable health insurance has increased access to healthcare for many lower income Iowa consumers. Many consumers qualify for advanced premium tax credits and subsidies that make insurance more affordable. The State of Iowa has three Navigator Grantees that employ licensed navigators to provide one-on-one assistance to consumers who are shopping for health insurance in the marketplace.

Since the first open enrollment period during the fall of 2013, the Polk County Health Department held five health insurance enrollment fairs in collaboration with AMOS, Primary Health Care, Inc., Proteus, HCI-VNS, Planned Parenthood, Mercy Medical Center, Broadlawns Medical Center, and UnityPoint Health.

Additionally, UnityPoint Health has increased its efforts to address access to care through a number of tactics. It has worked to increase care facilitation and care coordination in its hospitals and clinics to effectively connect patients and resources needed for increased health outcomes. UnityPoint Health also has provided staff to assist individuals seeking healthcare coverage on the marketplace.

Mercy Medical Center – Des Moines recognizes the importance of establishing relationships with residents where they live and work before the need for acute health care arises. By delivering education and assessment opportunities in community centers, places of worship and outlying clinics, Mercy staff were able to converse with participants about their overall health and the opportunities for coverage available to them through the Affordable Care Act. These culturally-sensitive events complemented community enrollment fairs and the assistance provided in Mercy's expanding clinic settings and within their acute care facilities.

Since the last iteration of their CHINA HIP, Dallas County has created an innovative Health Navigation Program. The goal of this program is to ensure that residents of Dallas County will have access to available health resources in the county through one point of contact, with fewer steps to receipt of care, increased options, and improved outcomes.

Through a single point of entry, the Health Navigation program connects residents to resources and social supports to enable them to live long, healthy lives, regardless of their level of income, education, or ethnicity. The Program is implemented by a bi-lingual Community Health Worker who is trusted in the community and able to bridge cultural and language barriers, and a Master's level Social Worker. The Health Navigators serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate health care and social services. The United Way, the Iowa Primary Care Association, and other local foundation sources provide funding for staff salaries and projects within the program that specifically addresses the social determinants of health such as outreach to Iowa Health and Wellness Plan members, transportation vouchers, and food system improvements including fresh produce distribution.

## **Obesity**

UnityPoint Health has increased its efforts to support healthy eating, including support for farmers markets, school gardens, and nutrition education with the Science Center of Iowa. Efforts to address and promote active living have included Yoga In the Park, Do More Outdoors, enhanced workplace wellness programs and support, and support for local recreation trail maps and active living efforts such as Bike to Work Month and Open Streets events.

The MCH Title V program at HCI-VNS employs a full-time licensed dietician who promotes healthy behaviors for children by working one-on-one with children and families through a home visitation model. Referrals for dietician services are received from WIC, primary care providers, Des Moines Public Schools, and community agencies in Polk County. The dietician provides in-home education and nutritional counseling that promotes healthy eating, physical activity, and weight management.

Mercy Medical Center – Des Moines clinicians partnered with community residents to manage obesity and the chronic diseases that often accompany this condition. In dozens of workshops held across the three-county area, Mercy offered the Better Choices, Better Health Program at no charge to participants. The program, initially developed by experts at Stanford University, empowered individuals with chronic health conditions complicated by obesity to better advocate for their own healthcare and become active members in their healthcare team.

Evaluations conducted at the conclusion of each six-week session provided Mercy instructors with specific feedback. The outcomes most commonly recognized by participants included:

- Weight loss
- An increase in the amount of physical activity/daily exercise
- An increase in knowledge of what healthy food choices look like, how to select them, and what a “healthy plate” should look like at each meal
- A better idea what it means to be a partner on your own healthcare team
- Setting goals for themselves and being more confident in their ability to achieve them
- Overall, a better understanding of what it takes on their part to manage their chronic health condition

Participants reported many symptoms of chronic health conditions were improved from weight loss and healthy eating/moving more. As a result of this, the management of the chronic health conditions became less tasking as physical health improved.

Dallas County Public Health used the CDC’s Community Transformation Grant to address physical inactivity and nutrition. IWALK walkability assessments were completed and active living infrastructure was placed in six local communities. As a result, Perry Elementary began a Walking School Bus program funded through the Wellmark Foundation.

The grant activities also included building supports for a healthier food system and addressing food insecurity. Out of this work, the Hunger Free Dallas County workgroup has been created. Current priorities include raising awareness about hunger and poverty and increasing awareness and utilization of community resources in collaboration with local food pantries.

Separately, a Healthy Corner Store project addressed healthy options sold in tiendas located in Perry. This project included education for consumers and tienda owners and required collaboration between local store owners, Dallas County Public Health, Iowa State Extension, and the Iowa Department of Public Health. The successes were increased knowledge related to health and food choices, increased fruit and vegetable options across the community, and have increased trust across partners and the community.

## Appendix F: Regional Profile

### *The Community*

The community served by this CHNA was determined by the Steering Committee. It encompasses the majority of the region's labor shed and includes the hospitals and health departments that work together on a regular basis. More details on the community are contained in the following sections.

### *Residents*

The Central Iowa CHNA encompasses three counties: Dallas, Polk, and Warren. These three contiguous counties are home to the majority of the metropolitan's labor shed. In 2013, Dallas County's population was 74,641, while Polk and Warren counties had 451,677 and 46,971 residents, respectively. Collectively, these three counties represent approximately 19 percent of the State of Iowa's population, yet cover just three percent of the state's land area; Central Iowa has the highest population density in the state.

Over the last decade, Dallas County has experienced a 67 percent increase in its population. During the same period, Polk County's population grew just over 17 percent, and Warren County's population increased around 15 percent. These numbers outpaced the state growth rate of just over five percent for the same timeframe.

The median ages for Dallas, Polk, and Warren are 34.6, 35.0, and 38.8 years, respectively. All three counties are predominantly Caucasian, though the racial make-up of the three counties continues to evolve. The following table depicts 2013 racial composition data from the U.S. Census Bureau.

Race	Dallas County	Polk County	Warren County
White	93.90%	87.50%	98.70%
Black or African American	2.30%	7.70%	1.00%
American Indian and Alaska Native	0.80%	0.60%	0.70%
Asian	3.40%	4.40%	0.80%
Other Race	1.50%	2.20%	0.40%

The Hispanic or Latino populations continue to increase in the three counties as well. As of 2013, the Hispanic or Latino populations were 6.30 percent, 8.00 percent, and 2.20 percent for Dallas, Polk, and Warren counties, respectively.

The three counties have a total of 222,871 households. Of these households, approximately two-thirds are familial households. Around 35 percent of all households have one or more people under the age of 18, while just over 32 percent of households include one or more person aged 65 and over.

The adult population in Central Iowa is highly educated. In the three counties, over 93 percent of all residents have graduated from high school. Around 36 percent of residents have earned a bachelor's degree, and ten percent have a graduate or professional degree.

Other demographic measurements of note to this assessment include:

- A veteran population of nearly eight percent of the adult population in the three counties (32,683 residents)

- Approximately ten percent of the population has a disability, with about one-third of these individuals being age 65 or over
- Nine percent of Polk County residents, five percent of Warren County residents, and four percent of Dallas County residents had incomes that fell below the poverty line in the last year
- Nearly eight percent of Greater Des Moines residents lack health insurance

### **Employment**

In the three counties, over 307,000 residents are employed. Nearly 40 percent of residents work in management, business, science, and arts occupations. Approximately 27 percent are in sales and office occupations, around 16 percent are in service occupations, and almost 11 percent are in production, transportation, and material moving occupations. The remaining seven percent of workers are in natural resources, construction, and maintenance occupations.

Nearly 80 percent of workers are in the private sector in the three counties. Almost 14 percent of workers are employed by the government, and the remaining six percent are self-employed. Driving alone continues to be the dominant mode of choice in commuting to work. Carpooling in the three counties is in the eight to nine percent range, while public transportation is less than one percent of commutes. One to two percent of workers in each county walk to work, while three to five percent of workers work from home. The average commute time in Dallas County is 19.2 minutes. Polk County follows at 19.7 minutes, while Warren County workers generally commute for 24.7 minutes.

The median household incomes vary in each county, with Dallas County leading the way at \$78,837. Warren County follows with a median household income of \$62,386, while Polk County has a median household income of \$59,328. This pattern holds true for median earnings for workers: Dallas County workers bring in \$37,333, Warren County \$33,261, and Polk County \$32,921.

### **Areas of Need**

The Iowa Kids Count data book examines trends in the well-being of Iowa children. It includes 20 indicators that reflect child and family well-being, including health, welfare, education, and economic status. A look at data from the 2013 report is provided in the following table:

<b>Category</b>	<b>Dallas County</b>	<b>Polk County</b>	<b>Warren County</b>	<b>Total Count</b>
Child Abuse and Neglect	139	1,956	151	2,246
Child Poverty	1,591	19,167	1,074	21,832
Children Receiving WIC	631	7,094	640	8,365
Individual Income Tax Filers Receiving the Earned Income Tax Credit	3,056	30,040	2,501	35,597
Individuals Receiving Assistance from the Family Investment Program	227	6,242	280	6,749
Individuals Receiving Food Assistance	4,413	72,074	4,095	80,582
Free or Reduced-Price Lunch Eligibility	3,540	32,941	2,379	38,860

Low Birth Weight	78	476	34	588
Teen Births	29	363	31	423

## Appendix G: Work Group Reports

### Access to Care Work Group Report

#### ***Current State of Affairs***

Accessing healthcare can be a daunting challenge for even the most educated and prepared. A multitude of providers, payments systems, facilities and logistical challenges such as cost, language, transportation and culture can create a disjointed system that can be difficult to access and navigate. Further, these challenges cross various sectors of health care provision that include physical care, mental health, oral health, and home health for example, none of which are mutually exclusive.

Among the first challenges that generally come to mind when considering access to health care is the issue of insurance or payment. Health care services can be expensive and this is often one of the first considerations individuals entertain before seeking healthcare. Generally, people depend on insurance as a means of covering the majority of these costs. However, insurance costs can be a deterrent for many and even having insurance does not always equate to adequate health care access.

Even when accessing the health care system of providers, services, payments and everything else, it is often disjointed and difficult to navigate, let alone allowing one to understand the inner workings and relationships. Many opportunities do exist for case management, health navigation and care coordination. These services are often available through providers and community services to assist patients in seeking the best care and outcomes. Despite these efforts, availability still can vary across social and economic strata. Medicare/Medicaid, hospitals and clinics and some social services provide these services but there are generally qualifying restrictions to gain access to these services. Many individuals are forced to fend for themselves in regards to gaining the appropriate care for them in the most convenient means.

Finding the right type of provider to meet health needs can also be challenging for many. While our service area has a realistic ratio of providers to the population in many areas, there are some that still fall short of meeting the need. Further, there can be challenges in finding providers based on factors such as cultural competency, language provision, geographic locations, area of specialty and cost. Too often these challenges can lead to patients seeking care in more inefficient and costly locations, such as emergency departments.

Although the passage of the Affordable Care Act (ACA) in 2010 worked to address issues such as insurance access and affordability, care coordination and more accountable outcomes, challenges still remain. Insurance premiums are still unaffordable to many and unavailable to some such as undocumented immigrants. Further, previously uninsured individuals are now seeking care they may not have had before. This can lead to increases in the need for varied providers and care coordinators. It can also lead to pent up need for various services, thereby increasing costs to patients and providers.

#### ***Background on the Issue***

Central Iowa, which includes Polk, Warren and Dallas counties, is home to 585,227 people collectively (Polk=459,863, Dallas=77,409, Warren=47,956). Still, the area has relatively low rates of uninsured individuals. Rates for uninsured (defined as individual less than 65 years of age with no form of coverage) in the area are as follows: Polk=9 percent, Dallas=7 percent, Warren=7 percent.

Efforts such as the State Children's Health Insurance Program (SCHIP or hawki) and the Affordable Care Act have helped to contribute to this in a positive sense. However, this does not allow for certain members of the community to gain insurance coverage due to cost or immigration status. Costs also contribute to inability to see providers for many regardless of coverage. Individuals who reported that they could not see a doctor due to cost in the past 12 months were represented as follows: Polk=7 percent (sample size of 5,263), Dallas=6 percent (sample size of 849), Warren=6 percent (sample size of 522).

Central Iowa also has reasonable coverage for the provision of primary care. Primary Care Provider rates are as follows: Polk=1,015:1, Dallas=2,399:1, Warren=1,675:1. "Other Direct Care Providers", include nurse practitioners (NPs), physician assistants (PAs), and clinical nurse specialists show the following rates: Polk=1,068:1, Dallas=5,742:1, Warren=4,734:1.

The Robert Wood Johnson County Ranking has identified persons reporting poor or fair health status and poor physical health days as potential measures of the impact of health care access. For the area this breaks down as follows for Fair and Poor Health: Polk=11 percent, Dallas=11 percent, Warren=13 percent. Reports of Poor Physical Health Days were: Polk=2.8, Dallas=2.8, Warren=3.3.

Mental Health providers in the area are represented as follows: Polk=554:1, Dallas=2,333:1, Warren=4,303:1. Mental health providers include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care. Individuals reporting Poor Mental Health Days were: Polk=2.8, Dallas=2.5, Warren=2.6.

Dental providers for the area are represented in the following ratios: Polk=1,542:1, Dallas=3,732:1, Warren=3,156:1. However, the number of providers that accept Medicaid as identified on the Iowa Department of Human Services website is: Polk=171, Dallas=12, Warren=9. This is important in that dental health can have a critical role in providing prevention to numerous other health conditions such as infections.

### ***Discussion***

Considering the issue of access to care has proven to be a somewhat challenging process. The issue is multifaceted and difficult to assess in a short time without a much deeper investigation.

While we were able to find a variety of data to help us identify some of the higher level issues that can be actionable by our community, the following issues may be worth exploring deeper (and possibly help formulate strategies):

- While we identify coverage as an issue for many, it might be advisable to research the issue of affordability much more. This is no doubt a barrier for many but at which levels is difficult to establish.
- It might be advisable for our area to conduct an Environmental Scan of the various services available. This could include identifying various types of health facilities and availability. For example; understanding what exists in terms of Urgent Care coverage (geographically and hours of operation) could help in planning for expanded access. Similar efforts have been done recently in projects such as LAUNCH (Linking Actions for Unmet Needs in Children's Health) which identified the continuum of services available to children's health needs.
- In order to ensure successful outcomes, patients will often require pharmaceuticals. This is another area of access that presents certain challenges for many patients as well as providers. While it might be considered a second phase of access (after initial access to providers) it is still critical to compliance and success and remains out of reach of many.

- In considering strategies, tactics and indicators for Access to Health, the issue of transportation needs to be considered. In the 2014 DART Satisfaction Survey, only 5 percent reported Health/Medical appointments as the most important purpose of their ride. However, results showed that of the polled riders, 45 percent had a valid driver's license and 49 percent had no access to a working vehicle. Transportation should be considered in a broader context as to how it fits into larger systemic community-wide solutions as it crosses many other aspects of our lives in addition to health needs.
- Cultural competencies in dealing with a variety of ethnicities should be considered as an important part of health care access. Central Iowa has seen an increase in the number of immigrants and refugees locating here. Along with this there has been an increase in the need for a wider variety of language interpretation and cultural sensitivity. This also should be considered in a broader context as to how the fit into larger systemic community-wide solutions as they cross many other aspects of our lives and health needs.
- Some access issues in regards to long term care may in actuality be more appropriately considered a workforce strategy in order meet the need for direct care workers. The availability of an available workforce can have a direct impact on capacity and access.

These issues will all need to be considered in their relationship to other focus areas of community improvement. It may warrant a strategy such as that carried out by the United Way of Central Iowa in producing the ***Behavioral Health in Central Iowa*** report to fully explore the complex issues associated with the varied levels of health access.

#### ***Identified Priorities***

1. Address Issues that Limit Access to Post Acute and Aftercare Services
2. Address Provider Shortages
3. Increase Opportunities for Expanded/Alternative Services

#### ***Priorities Expanded***

1. Address Issues that Limit Access to Post Acute and Aftercare Services

It might be argued that having health care coverage would qualify an individual to access for services. Central Iowa's uninsured rates are relatively low yet need is still evident. Efforts to fully support the operations of aftercare services (such as staffing for example) should be explored as well as policy measures to increase support. Expanded care coordination between providers may also help to relieve various roadblocks to these services.

#### Potential Strategies:

- Address Mental Health services capacity
  - Expanded and integrated care coordination and Integrated Health Homes
  - Explore new MH Registry as a possible model
  - Explore and address the Direct Care shortage worker impact
2. Address Provider Shortages

The shortage of various providers directly impacts the ability of people to access health care that they need. This is true in regards to all health sectors and while some areas show little urgency for need, there are some

services that remain under represented. This is also true in a provider's ability to meet a specific need such as those presented by diverse and new cultures.

Potential Strategies:

- Expanded use of "Other Primary Care Providers"
- Work to increase Dentists that accept Medicaid and provide pro-bono services
- Explore and address the Direct Care worker impact
- Expand recruitment of diverse providers to mirror the need of the population

### 3. Increase Opportunities for Expanded/Alternative Services

The concept of exploring various means to provide care outside of traditional scenarios, such as in the clinic with a physician, may lead to helping address access issues including provider shortages. Technology is quickly making it more realistic to provide remote forms of health care in a broader region and more efficient manner. Further, possibly expanding the provision of services such as Urgent Care may help to reduce unnecessary ER visits and provide added convenience for many trying to access health care outside of regular business hours.

Potential Strategies:

- Expand web-based physician consultations
- Explore use of Smart/Cell Phones as a tool for physicians and providers
- Expand Telemedicine
- Study Expanded Urgent Care (Locations & hours)
- Using "Other Primary Care Providers"

### ***Suggested Target Indicators***

- Increase the dental providers that accept Medicaid by XXX percent  
Baseline: Polk=171, Dallas=12, Warren=9.
- Reduce Preventable Hospital Stays by XX percent /1000  
Baseline: Polk=49/1000, Dallas=47/1000, Warren=49/1000.
- Reduce the number of people who could not see a doctor due to cost during the past 12 months by XX percent  
Baseline: Polk=7 percent (sample size of 5,263), Dallas=6 percent (sample size of 849), Warren=6 percent (sample size of 522).
- Increase the ratio of PCP ratio by XX percent  
Baseline: Polk=1,015:1, Dallas=2,399:1, Warren=1,675:1.
- Increase the ratio of "Other primary Care Providers" by XX percent  
Baseline: Polk=1,068:1, Dallas=5,742:1, Warren=4,734:1.

### ***References***

- *Robert Wood-Johnson Foundation County Rankings & Roadmaps*
- *United States Census Bureau*

- *DART Customer Satisfaction Survey (2014)*
- *Iowa Department of Human Services*

## Mental Health Work Group Report

### **Background and Approach**

Nationwide, there has been a growing sense of urgency in the need to identify, treat, and support individuals with mental illness. The alarms have been sounded repeatedly as we hear of the many challenges faced by individuals and families and the mostly tragic consequences of failed efforts to identify and treat such individuals.

In the State of Iowa, we have also become increasingly more aware of the insufficiency of mental health care services. There have been numerous efforts across the state to educate Iowans about the importance of mental health services and the need for an adequately funded and staffed adult and children's mental health system. The Adult Mental Health System Redesign is one clear effort that has begun with goals and objectives spanning a five to seven year period. There has been progress documented to date, yet there remains questioned adequacy of funding and long term support. All of these efforts are to be applauded as we are gaining traction now which hopefully will lead to greater support in the future.

On the other hand, research has repeatedly shown that toxic levels of stress and adversity can derail the brain development process and can significantly increase the risk of mental health problems in adulthood. Therefore, moving forward, action steps to address the mental health crisis in our community and state must include childhood trauma prevention and early intervention strategies. Therefore, the focus on mental health across the life-span will be essential.

As the 2015 Community Health Needs Assessment (CHNA) was launched, it became clear to members of the Steering Committee that a focused effort on Mental Health was imperative. The creation of the Mental Health workgroup was intentional with a desire to cast a wide-net of engagement across hospital systems, health departments, community agencies, private/non-profits, insurance industry, and educational institutions. As this group convened, it became clear that there has been considerable effort across the region already with well-researched plans of action with clearly articulated recommendations for improved services and workforce improvements. Yet, the most often discussed barrier was adequacy of resources, both fiscal and human.

Individuals with a passion, coming together for mental health and getting on one accord, was the first step. The most important next step is to find a way to implement change that is sustainable.

The efforts of the members of the **Mental Health Work Group (Appendix I)** are compiled below. The primary focus of this effort was to compile and centralize the many documents and reports across a vast spectrum of services and organizations that have been working to raise awareness for years. We hope this concerted effort to work collaboratively in conjunction with the CHNA 2015 will move the agenda forward.

### **Current State of Affairs**

According to recent statistics from the **National Alliance on Mental Health, A Public Health Crisis (Appendix II)**:

- 1 in 4 Americans experience mental health issues
- 1 in 10 children experience a period of major depression

- Approximately 123,000 (4.1 percent) people in Iowa live with a serious mental illness such as schizophrenia, bipolar disorder or major depression
- There are approximately 80,000 youth in Iowa with Severe Emotional Disorders
- In 2013, Iowa recorded the largest number of suicides in our state's history:445
- Iowa should have at least 1,500 psychiatric beds for the severely mentally ill; we only have 750
- Based on our population, Iowa is:
  - 47<sup>th</sup> in the nation for number of acute care beds based on our population
  - 44<sup>th</sup> in the nation for mental health workforce availability
  - 47<sup>th</sup> in the nation for number of psychiatrists
  - 46<sup>th</sup> in the nation for number of psychologists

And to further elucidate the magnitude of the problem:

- Approximately 21 percent of Iowa children four months to five years of age are at moderate or high risk of developmental, behavioral or social delays
- One-half of all chronic mental illness begins by the age of 14; three-quarters by age 24
- Seventy percent of youth in juvenile justice systems have at least one mental health condition and at least 20 percent live with a severe mental illness
- In Iowa, suicide is the second leading cause of death in 15-42 year olds (Iowa Dept. of Public Health)

A recent report on **Adverse Childhood Experiences (ACE's) (Appendix III)** provides additional insight on the magnitude of the problem and long term implications for children's mental health.

Thanks to the collaborative effort of The United Way of Central Iowa, Mid-Iowa Health Foundation, and The Community Foundation of Greater Des Moines, a comprehensive survey was conducted by the Technical Assistance Collaborative, Inc. to study behavioral health services in Central Iowa. The focus of this survey was to assess community needs, and identify gaps and opportunities to improve service delivery, funding, and coordination of mental health in the region. The results of the **United Way Survey of Behavioral Health in Central Iowa (Appendix IV)** reflect interviews with more than 60 stakeholders. The strengths of the behavioral health system in Central Iowa were noted along with gaps and barriers, followed by a listing of recommendations to improve Behavioral Health Service Delivery, funding and coordination.

Federal designations for **Mental Health Care Shortage** areas, **Primary Care Shortage**, as well as **Medically Underserved Areas** in the state of Iowa are reflected in tables found in **Appendix V**. Polk, Dallas, and Warren Counties, however, are not designated shortage areas which create an added disadvantage in terms of access to Federal and State incentives to recruit and retain health care providers.

### **Priorities**

- A.** Fully fund and support the Adult Mental Health System Redesign and work toward eliminating the threats to its success.

#### *Redesign of the Iowa Adult Mental Health System (Appendix VI)*

The long awaited redesign of the Iowa adult mental health system began in 2010 and is still in process today. The system was in danger of collapsing and significant change needed to be made. With considerable stakeholder involvement, the redesigned system is envisioned to provide holistic treatment, state oversight and standards, regional management and local services.

The redesign has put into action the following major components:

- The State assumptions of the payment of Medicaid match in 2012.
- A long term funding formula expressed as \$47.28 per capita county levy.
  - Based on 1996 county levy dollars frozen by the state legislature.
  - Maximum dollars to be raised by counties are based on 1996 levels re-computed by determining the average levy dollars per capita statewide.
  - If a county has less than \$47.28 per capita, equalization dollars are to be paid to the county by the state to bring it up to \$47.28 per capita. Equalization dollars are an estimated \$30 million.
  - If a county has more than \$47.28 per capita, the county has to reduce the county levy to \$47.28. A reduction of approximately \$10 million.
- Statewide implementation of Medicaid integrated health homes for adults and children with severe mental illness.
- In the determination of which county pays for a person's mental health services - legal settlement was changed to county of residence.
- Core service domains were identified in state code which is required statewide.
- Additional (or core plus) service domains were identified in state code which could be provided if money is available.
- Medicaid expansion was enacted along with the Iowa Health and Wellness Plan (92,000), the Marketplace Choice Plan (31,000) and the Insurance Exchange (45,000 – 20 percent of total possible)
- 15 Regions were formed and began operations 7-1-14.
- Regions are in the process of building the required core services as well as building core plus services.

The Mental Health group applauds the efforts to date. However, considerable work has yet to be accomplished for long term sufficiency and system sustainability.

Because of the prevalence of mental illness (1 in 4 annual prevalence, 1 in 2 lifetime prevalence), a solid public health approach is needed. A public health approach is concern for the health of a population in its entirety and awareness of the linkage between health and the physical and psychosocial environment.

Opportunities for an Adequate Adult Mental Health System in Iowa are as follows:

- Increase funding and Maximize Resources
  - Equalization dollars promised in the long term funding formula have been withdrawn by the State – so no long term funding formula is in place for system sustainability.
  - There is no mechanism in place to move the funding formula to cover growth needs. Funds are now frozen at less than 1996 dollar levels (\$40 million less).
  - We are trying to create and grow an adequate adult mental health system with less than 20 year old dollar levels. We need long term funding identified and cemented firmly in Iowa Code.
  - There should be a consistent set of outcomes proposed so that clinical quality and quality of life variables are consistent across providers, regions, and managed care.
- Increase workforce (see section D on workforce for more details)
  - Without adequate workforce, there is no mental health system; there are no services or beds. Iowa has only 316 prescribers (psychiatrists, ARNP's and PA's in private practice seeing patients).
  - National rankings on workforce availability are dismal – 44<sup>th</sup> for overall mental health workforce availability, 47<sup>th</sup> for number of psychiatrists, and 46<sup>th</sup> for number of psychologists.
  - There is a dire need for all levels of mental health professionals including direct care professionals, peers, and home aides.

- Address entrenched stigma – lack of knowledge, prejudice and discrimination
  - Mental illness is a medical illness. Treatment is needed not punishment.
  - Mental health and mental illness education (across the life span) is needed in our communities and schools.
  - Heavy reliance on the criminal justice system has given a second label to these medically ill persons - criminals. Having a mental illness is not a criminal offense. This creates a double dose of public and personal stigma which interferes with access to care and recovery.
- Improve access to evidence-based home and community services and follow best practices.
  - Wrap-a-round services are not available in private health insurance policies.

Examples of wrap-a-round services are as follows: in-home supports, early intervention programs, Assertive Community Treatment, employment support, peer support, etc.

- There are differences in determining “medical necessity”.
- More mental health and substance abuse services are available in Medicaid than any private insurance policy; leading to the unnerving assumption by many that you must become poor in order to have a chance at adequate services.

In addition to applauding the steps already taken in the adult mental health system redesign, we support and advocate for the steps necessary to overcome the threats to a stable and adequate adult mental health system in Iowa. Access to mental health services should be as easy to obtain as access to other physical health services. Unfortunately, mental health is often an afterthought and illnesses of the mind remain shrouded in fear and misunderstanding.

As Surgeon General Dr. David Satcher said in the first report on Mental Health in 1999, “Considering health and illness as points along a continuum helps one appreciate that neither state exists in pure isolation from the other. In another but related context, everyday language tends to encourage a misperception that ‘mental health’ or ‘mental illness’ is unrelated to ‘physical health’ or ‘physical illness.’ In fact, the two are inseparable.”

## B. Launch a Children’s Mental Health System redesign

### *Children’s Mental Health Redesign: Build a Comprehensive System of Care for Iowa’s Youth The Case for Change*

An estimated 20 percent of children in the United States have a diagnosable mental health condition impacting children of all ages, every racial and ethnic background and socioeconomic status. Mental health conditions in children are typically complex, involving multiple problems and multiple diagnoses and impact children in different ways throughout their development. There are devastating consequences including poor academic achievement, dropping out of school, substance abuse, involvement with the correctional system, lack of vocational success, inability to live independently, and suicide.

Mental health disorders are the most expensive conditions in childhood. Children and youth who received mental health and substance abuse services in Medicaid, while less than 10 percent of the overall Medicaid population, represent approximately 38 percent of total Medicaid child expenditures (Pires, et.al., 2013). These health sector costs are only a portion of the total cost; children with serious and complex mental health needs are often involved in other child-serving systems such as child welfare, juvenile justice, special education and early childhood services. High-end care such as hospitalization and residential services are by far the largest percentage of these total costs.

### *Why System of Care?*

System of Care, an evidence-based approach to serving youth with mental illness, has more than twenty years of success in reducing costs and improving outcomes for youth (Stroul, et. al., 2012). The System of Care approach, when fully implemented includes a broad array of effective services and supports including early childhood and adolescent to adulthood transition services. Treatment planning is highly individualized and “wraps around” the child and family, and is built on their strengths and needs. It includes care coordination, navigation and collaboration across agencies. There have been System of Care projects in Iowa for six years. These four Iowa System of Care projects have replicated the same positive outcomes as those in other states: improved functioning of youth and significant cost savings.

Iowa implemented the Pediatric Integrated Health Homes (PIHH) in July of 2013. The PIHH model of care coordination is based upon System of Care. The PIHH care coordination team serves as a single point of contact for families as they navigate complex health care and child-serving systems. The PIHH teams assist families in access to critical resources such as safe housing and food. Iowa’s first and second year PIHH data demonstrates that these youth are experiencing functional improvement and increased stability. The PIHH, based on System of Care principles, is a major stride toward more coordinated community based care for Iowa’s youth.

Unfortunately, PIHH is only available for Medicaid eligible youth. Hawk-I and private insurance plans don’t provide for care coordination or home and community based services and supports. Another option for parents searching for help for their seriously emotionally disturbed child is to sign up for the Home and Community Based Children’s Mental Health (CMH) Waiver program. The CMH Waiver currently actively serves 740 youth (Children’s Mental Health Waiver Data, IDHS website May 7<sup>th</sup>, 2015).

Once enrolled in the CMH waiver youth can access intensive care coordination, wraparound supports, and home and community based services. Tragically, children wait more than 30 months before becoming enrolled in the CMH waiver, and, there are more than 2100 youth on the waiver wait list (Children’s Mental Health Waiver Data, IDHS website May 7<sup>th</sup>, 2015). Waiting 30 months for access to appropriate health care has a major negative impact on the health and development of the child, on the family, and on the community. Iowa needs to invest in state-wide expansion of System of Care for non-Medicaid youth.

There are significant service gaps in the Medicaid funded children’s mental health continuum, a set of services that should support our most vulnerable youth. These gaps include: crisis stabilization and mobile crisis services, intensive in-home therapies, respite, psychiatrists, and prevention services. These gaps have been identified in several children’s mental health work groups over the past several years (Children’s Disability Services Workgroup Final Report(s) 2012, 2013). Of all the prior recommendations, only the Pediatric Integrated Health Homes for Medicaid eligible youth has been implemented.

### *Opportunities for Establishment of a Children’s Mental Health System:*

1. Create and fund evidence-based “Core” and “Core Plus” services for Medicaid eligible children similar to the adult mental health redesign. Priority service gaps should be for services that have greatest potential to keep youth in their homes and communities. One such service is intensive in-home family therapy.
2. Fully fund “System of Care” for non-Medicaid youth state-wide, leveraging SAMHSA System of Care Expansion grants.
3. Develop and implement solutions across child welfare, juvenile justice, educational, and mental health to ensure “whole child” strengths, needs, and progress are addressed and expressed uniformly.

4. Implement developmentally appropriate mental health screening tools for primary care and family physicians to utilize during well child checks. Create connections for physicians to access children's mental health professionals to assist with referrals and/or treatment planning.
5. Continue state-wide Trauma Informed Care training efforts for all professionals working with children across the various health and child-serving systems. Other key training topics should include cultural competency and mental health first aid.
6. Support expansion of prevention services such as "First Five" which promote resiliency and enhance family protective factors.

### C. Address Insurance reform and reimbursements

#### *Payment for Services*

Most mental health and substance abuse services are paid for by health insurance companies and government programs (Medicaid and Medicare). Approximately 92 percent of Iowans have medical insurance. The number of uninsured Iowans has gone down the past two years since the State expanded Medicaid. While ACA compliant products are readily available in Iowa, there has been limited participation by insurers in the federally-facilitated health care exchange that makes premium subsidies available to consumers. Increased insurer participation in the exchange may prove to be the difference in closing the remaining uninsured gap in the state.

#### *Federal Level*

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act. In short, the law mandates that insurance coverage for mental health and substance abuse conditions be treated on par with medical conditions. CMS published final regulations of the law in 2013 and CMS gave additional details in 2015 that explain how the law applies to Medicaid programs. By 2017 millions of Americans will have comprehensive benefits that did not exist a decade earlier.

#### *Payment Reform*

The Affordable Care Act (aka Obamacare) has ushered in new payment methodologies for provider organizations. Focused on the Triple Aim (Better Care, Improving Health, Lower Cost) providers have entered into a new array of financial arrangements with commercial and governmental payers. In Iowa one new payment methodology - accountable care organizations (ACOs) - has been implemented by Medicare, Medicaid and commercial health insurers.

#### *Accountable Care Organizations*

ACOs are designed to improve quality of care and slow increases in health care costs by offering payment incentives to health care providers for effectively managing the total cost of patient care. As opposed to fee-for-service reimbursement approaches that pay health care providers on a per service basis, ACOs attribute a patient to a specific provider who receives financial incentives for meeting pre-specified clinical quality requirements and managing total cost of care.

Individuals with mental health and substance abuse issues are likely to benefit substantially from these new arrangements. ACOs require providers to coordinate care in a more active and timely manner, to avoid unnecessary duplication of services, and to consistently consider how to offer the highest quality care at the most appropriate cost. In doing so, ACOs address the misaligned financial incentives and system fragmentation that limit the availability of

mental health and substance abuse services, and fosters a higher level of care coordination between providers treating the same patient.

In Iowa ACOs have the potential to create greater uniformity in care delivery across insurance types. Iowa Medicaid Enterprise has recently established accountable care incentives for providers and initiated additional innovation programming through a State Innovations Model cooperative agreement (a.k.a., SIM grant) with the Centers for Medicare and Medicaid Services. The SIM grants focuses on whether new payment and service delivery models can produce superior results when implemented in the context of a state-sponsored health care plan. This work bolsters the efforts of commercial health insurers who have been working for several years with health systems, multi-specialty clinics, and primary care providers to improve the financial incentives to coordinate care and manage commercial and Medicare service quality and costs more actively.

One potential risk to the evolution of a well-functioning accountable care environment that can benefit those with mental health and substance abuse issues in Iowa is the introduction of managed Medicaid. It will be important to ensure that the introduction of managed Medicaid does not undermine the transformative efforts underway in Iowa.

#### *Opportunities:*

- Given that payment systems are highly complex and nuanced, provider and payor organizations should continue to find ways to educate the public about health insurance products and services.
- Provider and payor organizations should continue to embrace transparency. The public should easily be able to find relevant coverage and cost information for needed services.

#### **D.** Support adequate Training and Build an Adequate Mental Health Workforce

In the recently released **AMOS study on the Mental Health Workforce, (Appendix VII)** statistics and training locations were compiled reflecting the challenges in Iowa and the need to increase the number of providers as well as ensure adequate training of providers to better meet the health care needs of individuals with mental illness. The table reflecting workforce statistics is included in this AMOS study.

#### *Collaborative Efforts*

There have been efforts recently to work collaboratively in the Des Moines metropolitan area in strategizing ways to increase training opportunities in Mental Health. One such effort, called the Des Moines University Clinical Collaborative, was formed in 2012 and includes representatives from UnityPoint, Mercy, Broadlawns, The Iowa Clinic, and The Veterans Administration Hospital. The original focus of this Collaborative was to address clinical training needs of DMU students but evolved to very fruitful conversations about the need to work collaboratively in support of growing Graduate Medical Education opportunities. The one conversation which resonated with the entire group was the need to work together to benefit the community in supporting Psychiatry training and other mental health/behavioral health training efforts.

Whereas, funding is the major barrier in advancing this effort, there has clearly been an eagerness to work collaboratively across systems. This group has been aware of the effort local providers have made in trying to create a new Psychiatry residency program which is described below.

#### *Proposed New Psychiatric Residency Training Program*

Currently, the State of Iowa has one psychiatric residency training program, at the University of Iowa. The psychiatry department at the University of Iowa is outstanding, known nationwide as a leader in academic research and

teaching. Several local provider organizations have considered working together to start a second residency training program for psychiatry that would include rotations with several of our community partners. It is felt that this program would ultimately graduate four new psychiatrists per year who have had excellent training in community and clinical psychiatry. The program could be structured to encourage graduates to consider rural practice.

The primary barrier to starting a second residency program is funding. Once fully operational, the program would have up to sixteen residents at a time with a projected annual cost of 2.88 million dollars. While there have been grants available to provide startup funds for such a program, there is no assurance of future funding.

*Opportunities to build the mental health workforce and enhance training in behavioral health:*

- Continue to build collaborations and partnerships in Central Iowa to develop new opportunities for training across systems and disciplines
- Identify new sources of revenue to support training efforts (external/private support, state, federal, etc)
- Reduce barriers to recruit mental health and disabilities workforce
- Review licensing and credentialing eligibility criteria for adequate and efficient production of a workforce that meets Iowa's provider needs (incentives, licensure/credentialing, loan forgiveness, etc.)
- Develop loan forgiveness/repayment programming for mental health providers
- Explore possibilities of additional incentives to recruit and retain mental health providers
- Provide better preparation of primary care physicians and other providers in behavioral health through continuing medical education and/or certificate programs in Primary Care Behavioral Health

**E.** Provide adequate funding and staffing for the 5<sup>th</sup> Judicial District to reduce recidivism to our jails and prisons and continue to build mental health and substance abuse services outside of the criminal justice system.

The Fifth Judicial District Department of Correctional Services:

- Supervises approximately 9260 adult offenders on probation and parole and
- Another 350 or so adults in residential services and
- Covers 16 counties in the central, southcentral part of Iowa.

Based on a survey completed by the Dept. of Corrections in 2008, it is believed:

- 26.9 percent (**2585** adult offenders) are in need of mental health services
- 64.4 percent (**5963** adult offenders) need co-occurring disorders treatment. There is conjecture this estimate is too low.

Based on this information, the Mental Health unit (created in 1998) which provides supervision for offenders with severe and chronic mental health issues was tweaked to add clinically trained staff and began working with the FACT (Forensic Assertive Community Treatment) team doing jail diversion.

In FY 14, the Mental Health Unit had 122 new admissions, and as of 6-30-14 was actively supervising **210**. Only the most chronically ill are on specialized caseloads. Due to the offender's complex needs and need for direct community involvement by the Probation/Parole Office (PO), the Unit is made up of specially trained PO's with advanced degrees in a variety of mental health fields. The Unit is currently made up of **4 PPOs**. This past year two of the four specially trained PO's were unavailable for a significant portion of the year impacting the number of clients served.

The number of Offenders served decreased because supervision of all female offenders (**150**) with severe and persistent mental illnesses was transitioned to officers housed at the Fresh Start Women's Center. The transition was

done to better meet the specific mental health and criminogenic needs for the female offenders. This unit did have a licensed psychologist but due to budget constraints that position is currently being held open due to **lack of funding**.

While all probation/parole officers receive some training in dealing with offenders with mental health issues, they are not well versed in the other obstacles related to medication management, finding funding for services and the size of caseload. **Many times, we find there are inadequate services and providers outside of the criminal justice system for our clients to see or be referred to.** Long waiting times to see specialists can also interfere with timely treatment.

Last year, the department served:

- **17,592** people on probation, parole and pretrial services, and
- Had **131** probation/parole and community treatment coordinators available to provide services.

While the department utilizes risk assessment tools to provide services to the highest risk offenders, 16 percent (**2815**) of our population fit this category. According to Evidence Based Practices, the ideal caseload size for high risk special needs offenders is 1 to 30. As a result:

- We are **short 862 slots** for offenders who need services, many having co-occurring disorders.
- We are in **need of 29 ISP or high risk officers** to provide intensive services and supervision.

We have found that with proper treatment and supervision the annual revocation rate has not only been reduced but also the 3 year recidivism rate. Another positive development is the demonstration program between Medicaid and the Department of Corrections. The re-entry program for offenders includes signing up for Medicaid for immediate coverage of health services and medications needed.

*Opportunities:*

1. Additional funding for staffing for the Mental Health Unit, Fresh Start Women's Center, Fort Des Moines and high risk officers.
2. Additional funds to train correctional staff on mental health issues and trauma informed care.
3. Cross training for mental health providers and corrections staff. Corrections staff to receive on-going training on systems navigation and resources. Mental health providers to receive training on criminal thinking and safety issues.
4. Continue to build the capacity of the mental health system outside of the corrections system so there are services for our clients to access.
5. Standardization of curriculum in local criminal justice colleges to include mental health issues and its impact upon the criminal justice system.
6. Additional funding for a staff person at the Polk County jail to implement a Deferred Prosecution program. An officer would be located at Polk County jail to identify, screen and advocate for deferred prosecutions for eligible clients. Coordination with Jail Diversion program.
7. Create a joint office space that would include case managers, probation officers, medical personnel and other providers.
8. Expand CIT training for law enforcement officers.

*Listing of Overarching Priorities and Recommendations:*

- Fully fund and support the Adult Mental Health Re-design
- Establish a Children's Mental Health system of care
- Improve the mental health and disabilities training of primary care doctors and other primary care providers
- Identify additional sources of funding to create new and expand existing training programs in Psychiatry and Psychology as well as other mental health and substance abuse providers
- Address the lack of parity related to high premiums, co-pays, and deductibles that pose barriers for low income central lowans to access behavioral health care
- Continue state-wide training efforts for all professionals working with children across the various health and child-serving systems in Trauma Informed Care, cultural competency, and mental health first aid.
- Provide additional funding for staffing for training of correctional staff on mental health issues and trauma informed care
- Continue to build the capacity of the mental health system outside of the corrections system so there are more services for clients to access

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## Physical Environment Work Group Report

### **Background**

The Physical Environment is comprised of the built environment (facilities, streets and infrastructure), the natural environment (air, water, green space) and the social environment (engagement). "...People's health is profoundly shaped by their immediate environments, the places and things we as communities build, and where we house people." (Designing Healthy Communities, Richard J. Jackson with Stacy Sinclair, p X) According to the World Health Organization, 2008, and Commission on Social Determinants of Health, 2008, 55 percent of what contributes to our health comes from "social and environmental conditions" (compared to only 10 percent from the delivery of health care services).

"Rising rates of chronic disease and obesity nationwide have drawn local, state and federal-level attention and funding to the linkages between community design, land use decision-making, transportation patterns and the impacts these physical and environmental determinants have on public health. A well-established and growing body of research identifies associations between the built environment and different aspects of physical fitness, mental health, cardiovascular and respiratory diseases, fatal and non fatal injuries and nutrition" (Philadelphia2035: Planning and Zoning for a Healthier City, December 2010, p9).

**Current state of Affairs**

There are a number of current health-related initiatives (including but not limited to Age Friendly Community, Healthy People Healthy Places, and Healthy Homes East Bank) that have identified strategies to address the physical environment as a way to improve health. Capital Crossroads, The Tomorrow Plan, Housing Tomorrow and Healthy Polk include priorities related to the physical environment. The Metropolitan Planning Organization has an initiative to increase the number of jurisdictions that adopt a Complete Streets Policy. (Currently, only the cities of Carlisle, Des Moines Norwalk and Windsor Heights have adopted complete streets policies.)

In recent years multiple walkability assessments have been conducted (including in the MLK Jr. neighborhood, downtown Des Moines and Carlisle) by nationally known consultants and experts Dan Burden, Mark Fenton and Jeff Speck.

The Community Health Rankings includes scores on the physical environment. The scores for Dallas, Polk and Warren Counties are below. All counties are ranked from 1-99 with 1 being the best.

County	2010	2011	2012	2013	2014	2015
Dallas	50	32	96	9	93	96
Polk	93	9	48	43	72	98
Warren	55	48	59	51	35	37

**Priorities**

1. Establish more "vibrant" communities and neighborhoods characterized by mixed/joint use of space and facilities, access/available to everyone, public spaces as gathering places for diverse, integrated engagement.
2. Promote more active transportation (not just as exercise and recreation)
3. Good Air and Water Quality (including nature-based watershed-based planning)
4. Safe and Affordable Housing
5. Data Collection

**Vibrant Communities**

For over a century physical activity was engineered out of people's daily routine of Polk County. . Creating a mixed-use community with a variety of shops and services provides a robust antidote to obesity and a long list of other negative health, economic and environmental outcomes. Adding several steps will not solve this epidemic; but engineering activity in multiple times will. Here the dose/response rule is that some is good more is better.

Clustering public services and retail within close proximity to one another and to residential areas decreases reliance on automobiles, which reduces emissions and encourages walking and public transit as part of daily routines and leads to a more vibrant community. Building walking into daily routines and commuting patterns makes it easier to

achieve recommended levels of physical activity. It follows that decreased usage of automobiles and lower volumes of auto traffic are correlated with fewer instances of auto-pedestrian accidents resulting in injuries and/or fatalities.

While much attention and energy is focused on inner cities this is not limited to urban areas. Smaller communities may not have a "downtown" or distinct neighborhoods but they have they have gathering places like schools, places of workshop or town squares.

"An integral ecology is also made up of simple daily gestures....We should...consider taking public transit, car-pooling, planting trees, turning off the lights and recycling." – *Pope Francis*

### ***Active Transportation***

In addition to the land use and design of our communities, providing authentic healthy transportation options is essential to community and public health. Walking, bicycling, riding transit and any other mode that gets people up and moving improves the health outcomes of the community. The sedentary, environmentally harmful, and socially isolating dependence on automobile travel has negatively impacted the ability of cities, small towns, rural communities and neighborhoods to promote healthy choices.

In *Mobilizing Tomorrow*, the long-range transportation plan for Greater Des Moines, the region set a goal for 25 percent of all trips would be active transportation trips by 2050. Currently, 11 percent are active transportation trips. Significant changes in mindset and action are needed to increase the levels of healthy and active transportation behaviors in the region while elevating the safety of the transportation network. Walking and bicycling must be considered transportation options rather than simply recreation options. Robust transit must be seen as a key component for regional health and prosperity rather than as supplemental amenity.

Changing the built environment and improving active transportation is accomplished through engineering, education, encouragement, enforcement, and evaluation. The built environment needs to be engineered for people and their needs rather than just the needs of automobiles. Reducing automobile speeds, narrowing streets, and designing infrastructure on a human scale are essential for removing barriers to the safety and comfort of active transportation. Programming events, incentives, and outreach can educate and encourage people to shift to healthier behaviors. Enforcing laws that keep streets safer such as speeding and yielding laws makes streets more welcoming to people. Finally, continually monitoring and evaluating outcomes to determine the effectiveness of changes leads to more successful strategies.

Transportation choices are directly influenced by convenience, cost and experience. Active transportation is already the least expensive option, but it is rarely convenient or a pleasant experience due to the built environment. The healthy choice, the active choice must be easy, safe and pleasant in order to change daily behavior.

"The good news is that smaller, rural communities are actually closer to a healthy style of design than larger cities that have suffered the urban sprawl and downtown demise common across America. Smaller and even rural settings may be the best ones for healthy and active lifestyle...but there are battles to be fought for locally grown food, community gardens, sane (not "faux rural") subdivisions, complete streets, downtown housing density, and downtown vitality." – *Mark Fenton*

For example, schools are usually within walking distance of in-town students.

### **Safe Air/Safe Water**

Why should good water and Air Quality and Nature-Based watershed planning be priorities in building a healthy community?

Healthy communities require healthy natural resources. Public health outcomes erode in communities where natural resources pollution and depletion go unchecked.

Some of these impacts are immediate and toxic – the relationship between high nitrates in drinking water and methemoglobinemia (“Blue Baby Syndrome”). Others might prove less immediately toxic but create long-term health impacts (such as the links between particulate matter and asthma).

Federal and state regulations work to address those more obvious links between the environment and health but a series of more subtle connections must be made and considered. Increasingly, the public recognizes the value of outdoor experiences to personal and public health. Recent work in Iowa has shown that 74 percent of Iowans recognize parks and trails as “very important” or “important” for health, for example (Iowa Parks Foundation 2012 Citizen Attitude and Interest Survey). When park beaches are closed due to bacteria, or woodlands are dominated by invasives, these outdoor experiences – and their potential to promote physical and mental health – are seriously undermined.

It is no coincidence that a series of nature based strategies (e.g., the Iowa Parks Foundation’s “Parks to People” strategic plan) directly link public health to the health of the environment. New research (much inspired by Richard Louv’s *Last Child in the Woods: Saving our children from nature deficit disorder*) continues to surface, uncovering some additional aspect in the value of natural places and greenspace. Research has uncovered links to immune systems, patient recovery, and student learning – just to name a few.

Traditionally, planning efforts for communities have been rooted in transportation and/or economic development strategies – often treating communities as though they exist on a flat grid, unrelated to water flow, topography, and the need to link people to the outdoors. Thankfully, this method is changing. As we face degrading water quality, increased flooding, more invasive species in our fragments of natural spaces, we must recognize these factors first. When treated as afterthought and not part of the community plans, their degradation continues. When part of the plan up front, stewardship becomes the easier choice, our natural areas can be restored – and with them, the many public health benefits that link directly to healthy air, water, and habitat.

This is true regardless of where you live- city-suburban rural, regardless of your income or regardless of your zip code.

### **Safe and Affordable Housing**

From *Housing Tomorrow*:

"Housing is a human right, and a fundamental human need. Along with food and water, it is one of the core necessities of human life. And though its most important purpose is to provide shelter, housing is a lot more than a place to rest your head. Experts from various fields recognize that safe, stable, and affordable housing is essential to our region's health, education, and economic development.

Affordability affects health as well. When households pay too much for housing, they often enter into a vicious cycle of poverty that makes it all but impossible to build a better life. To pay their rent, families make

sacrifices on basic necessities like food and health care. Without access to health care, they may be too sick to work, or their children may miss school. Children often have to change schools as their parents move from place to place, searching for housing they can afford. Sometimes they run out of options, and end up sleeping on friends' couches, or in a shelter. Missing school and moving between schools hurts children's grades, keeping them from reaching their educational goals and hindering their ability to get the skilled jobs needed to support our local economy.

A greater challenge still will be ensuring affordable options throughout our region. Employers of low-income workers are spread far and wide across our area, and this will only continue as our region continues to expand outward. A 2015 Brookings Institute study indicates that between 2000 and 2012, there were 6 percent fewer jobs within a typical commute distance of central Des Moines and 15 percent fewer in areas of high poverty, but 9 percent more jobs in the area's suburbs. However, affordable housing remains concentrated within the urban core of Des Moines, far from these new job opportunities. Without reliable transportation, many workers spend hours each day commuting. For many low-income workers juggling jobs and family, these are hours they cannot waste.

The uncertainty of not having safe, affordable, stable housing is quite stressful and can negatively impact people's mental health."

The US Department of Housing and Urban Development (HUD) has identified 29 potential health hazards which can be found in the home. Lead-based paint poisoning can cause permanent developmental damage. Multiple triggers for asthma (dust, pets, pests, mold) are in the home. Almost all homes in Iowa are at risk for radon (Radon is the 2nd leading cause of lung cancer in Iowa -after tobacco).

### **Data Collection**

We were unable to identify good measures for two indicators (number of mixed used developments/ projects and water quality in streams and rivers for water and swimming) that are key elements for a healthy physical environment. Identifying good measures for these indicators of "vibrant community" and "safe water" should be a priority.

## **Youth Work Group Report**

### **Purpose**

The purpose of this document is to list the top health priorities of youth within the Central Iowa region (Polk, Dallas and Warren Counties)

### **Key Areas**

#### **1. Newcomer Population**

Areas of Need: The community is experiencing dramatic growth in the immigrant and refugee population. These newcomers struggle to navigate the system and find needed health care for their children. This often results in lack of proper care or unnecessary visits to the emergency room.

- a. Increase access to health and dental care through education and interpretive services.
- b. Define and engage key stake holders in reaching the families needing services.
- c. Educate healthcare providers to work with the immigrant and refugee population.

2. Obesity/Healthy Weight

Goal: Reduce overweight and obesity amongst youth in Central Iowa. 1 out of 4 youth in Iowa are overweight or obese.

Recommendations to Encourage Better Nutrition:

- **Restrict Availability of Less Healthy Foods and Beverages in Schools and Public Venues**  
Strategy: Develop and implement policies for healthier vending, vending machine access during the school day, encourage healthier classroom snacks and encourage celebrating holidays and birthdays with non-food related activity.
- **Discourage Consumption of Sugar-Sweetened Beverages in Schools and Public Venues**  
Strategy: Develop and implement policies that minimize marketing of sugar sweetened beverages in schools and public venues. Implement healthier vending policies in municipal venues with concession stands.
- **Increase Support for Breastfeeding**  
Strategy: Promote breastfeeding programs that aim to increase breastfeeding initiation, exclusive breastfeeding, and duration of breastfeeding.
- **Increase School-based nutrition education programs throughout Central Iowa**  
Strategy: School-based nutrition programs have educational components (e.g. nutrition education) environmental components (e.g. school menus, classroom snacks) and/or other components.
- **Increase Access to Fresh, Local Foods**  
Strategy: Work with Iowa Farm to School Program to educate schools and parents on connecting youth with fruits and vegetables grown in Central Iowa.

Recommendations to Encourage Physical Activity or Limit Sedentary Activity:

- **Enhance and Improve Infrastructure Supporting Walking/Biking**  
Strategy: Support communities in developing bicycle and pedestrian master plans that establish a framework to increase walking and biking, trails, and improve connectivity of non-auto paths in a particular locality.
- **Educate Schools and City Officials on Safe Routes to School programs**  
Strategy: Safe Routes to Schools is a federally supported program that promotes walking and biking to school through education and incentives
- **Encourage Schools to Incorporate More Physical Activity in Daily Lesson Plans**  
Strategy: Develop and implement policies that ensure children get regular active ('brain breaks') throughout the school day. Physically active classrooms incorporate physical activity breaks, classroom energizers, or moving activities into academic lessons. These can be implemented with existing curriculum.

*\*For children, overweight is defined as BMI percent between 85-94 percent; obese is defined as BMI percent greater than or equal to 95 percent*

Health Indicator			
Percentage of 6 <sup>th</sup> , 8 <sup>th</sup> , and 11 <sup>th</sup> graders who eat 3 or more servings of vegetables per day			
Percentage of 6 <sup>th</sup> , 8 <sup>th</sup> , and 11 <sup>th</sup> graders who were physically active for 60 or more minutes 5 or more days a week			

Percentage of 5 <sup>th</sup> graders in Central Iowa overweight or obese			
Percentage of 6 <sup>th</sup> , 8 <sup>th</sup> and 11 <sup>th</sup> graders who have smoked cigarettes in the past 30 days			

3. Nicotine/Tobacco

Goal Statement: Decrease usage of alcohol, tobacco and other drugs amongst youth in Central Iowa.

Recommendations:

- Identify organizations and community partners providing prevention services to caregivers of youth and type of services
- Determine best methods of providing prevention outreach and overcoming language barriers
- Work with community policy leaders and school policy leaders to implement best practices in tobacco/nicotine free sustainable policies

4. Environment

*Single Parent Families*

Marital status is important because it is an indicator of family income (i.e., couples usually have more family income than single parents). Single status may be an indicator of stress or lack of social support and marital status can affect eligibility for social services programs. Studies have repeatedly shown that marriage or long-term partnership is associated with better health status (Schoenborn, 2004). Polk, Dallas, and Warren all experienced an increase in single parent households between 2000-2008-2012. Below is a table highlighting the data from the 2013 Kids Count Report:

County	Single Parent Homes, 2000	Single Parent Homes, 2008-2012	2000 – 2008-2012 Change:
Dallas	1,256 (21.0%)	2,120 (21.9%)	4.1%
Polk	14,025 (27.6%)	19,049 (31.9%)	15.2%
Warren	1,243 (21.5%)	1,675 (27.5%)	28.3%

*Child Abuse and Neglect*

Child abuse is a complex problem rooted in unhealthy relationships and environments. Safe, stable, and nurturing relationships and environments for all children and families can prevent child abuse. However, the solutions are as complex as the problem. Increasing factors that protect children can reduce the occurrence of abuse. Preventing child maltreatment means influencing individual behaviors, relationships among families and neighbors, community involvement, and the culture of a society. Prevention strategies include effective programs that focus on attitude change and on modifying policies and societal norms to create safe, stable, and nurturing environments (CDC, 2015).

In comparing 2000 to 2013 data, Dallas experienced a slight decrease in the rate of children age 0-17 who are confirmed to have been abused or neglected, while Polk and Warren experienced increased rates. Below is a table highlighting the data from the 2013 Kids Count Report:

County	Confirmed Children, Rate per 1,000 Children, 2000	Confirmed Children, Rate per 1,000 Children, 2013	2000-2013 Change
Dallas	93 (8.1)	139 (6.5)	-19.8%
Polk	1,438 (14.9)	1,956 (17.1)	14.7%
Warren	72 (6.6)	151 (12.6)	92.1%

*Feeling Safe in the Home*

According to [www.countyhealthrankings.org](http://www.countyhealthrankings.org) (University of Wisconsin, Robert Wood Johnson Foundation) | 2013, Polk County ranked 64 of 99 counties in Iowa in social and economic factors (which includes education, unemployment, children in poverty, single parent households, inadequate social support, and violent crime). Dallas ranked 1 and Warren 11 for the same category. The number of reported violent crimes per 100,000 population were Polk: 358, Dallas: 154, and Warren: 163.

A recent University of Iowa study conducted at a Des Moines Planned Parenthood clinic reported that overall, physical and sexual intimate partner violence prevalence was 9.9 percent and 2.5 percent respectively; 8.4 percent of those in a current relationship reported battering (Saftas, et al., 2010).

*Poverty*

Poverty can impede children’s ability to learn and contribute to social, emotional, and behavioral problems. Poverty also can contribute to poor health and mental health. Risks are greatest for children who experience poverty when they are young and/or experience deep and persistent poverty.

Research is clear that poverty is the single greatest threat to children’s well-being. But effective public policies – to make work pay for low-income parents and to provide high-quality early care and learning experiences for their children – can make a difference. Investments in the most vulnerable children are also critical (National Center for Children in Poverty, Columbia University, 2015).

In comparing 2000 to 2013 data, all three counties demonstrated an increase in the rate of children living below the poverty level and the rate of individual income tax filers who received the Earned Income Tax Credit. Below is a table highlighting the data from the 2013 Kids Count Report:

County	Child Poverty, 2012 Rate	2000-2013 Change	Earned Income Tax Credit, 2012 Rate	2000-2013 Change
Dallas	7.3%	19.7%	9.9%	13.9%
Polk	1.9%	79.8%	14.9%	55.6%
Warren	11.5%	82.5%	12.3%	60.8%

*Access to Healthy Food*

Because of multiple challenges in their lives, people with food security issues have difficulty making healthy food choices. The Des Moines Public School District, the largest school district in the region, continues to have significantly high numbers of free and reduced price lunch (FRPL) students. There were 45 percent of students eligible for FRPL in the Des Moines Schools in 2001 and 72 percent in 2015, a 60 percent increase.

In comparing 2000 to 2013 data, all three counties demonstrated an increase in the number of individuals receiving financial assistance for food and the number of students eligible for free or reduced-price lunches during the school year. Below is a table highlighting the data from the 2013 Kids Count Report:

County	Food Assistance, 2013 Rate	2000-2013 Change	Free or Reduced-Price Lunch Eligibility 2013 Rate	2000-2013 Change
Dallas	5.9%	201.9%	23.0%	27.0%
Polk	16.0%	266.8%	44.6%	68.5%
Warren	8.7%	364.8%	25.4%	89.6%

Recommendations:

- Enhance and expand existing family support and parent education programs and implement home and group based programming that support the healthy development of children ages 0-8 years.
- Provide training and coaching to program staff and parents/families.
- Build the local infrastructure for a comprehensive early childhood system of care to promote positive development for children ages 0-8 and their families.
- Increase availability of healthy foods with emphasis on local foods (mobile food pantry, SNAP application available at more locations, community gardens).
- Increase public awareness of resources to address the issues of access to care.

Please contact Vernon Delpesce - [Vernon.Delpesce@dmymca.org](mailto:Vernon.Delpesce@dmymca.org) - if you have questions about the content of this document.

<b>Child Health Scorecard</b> Private Foundation Commonwealth Fund													
Data Year	2011												
Release Date	Feb 2011												
Highlights	<table border="1"> <thead> <tr> <th>Metric</th> <th>Iowa</th> </tr> </thead> <tbody> <tr> <td>Children’s health (overall)</td> <td>1</td> </tr> <tr> <td>Access and affordability</td> <td>6</td> </tr> <tr> <td>Prevention and treatment</td> <td>1</td> </tr> <tr> <td>Potential to lead healthy lives</td> <td>2</td> </tr> <tr> <td>Equity</td> <td>7</td> </tr> </tbody> </table>	Metric	Iowa	Children’s health (overall)	1	Access and affordability	6	Prevention and treatment	1	Potential to lead healthy lives	2	Equity	7
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About the survey	The <i>State Scorecard on Child Health System Performance, 2011</i> , examines states’ performance on 20 key indicators of children’s health care access, affordability of care, prevention and treatment, the potential to lead healthy lives, and health system equity.												

<b>F as in Fat</b> Private Organization and Foundation Sponsored Trust for America's Health supported by the Robert Wood Johnson Foundation													
Data Year	2010 – 2013												
Release Date	2013												
Highlights	<table border="1" style="margin-left: 20px;"> <thead> <tr> <th colspan="3" style="background-color: #92d050;">Iowa</th> </tr> <tr> <th style="background-color: #92d050;">Metric</th> <th style="background-color: #92d050;">%</th> <th style="background-color: #92d050;">Rank</th> </tr> </thead> <tbody> <tr> <td>Obesity</td> <td>31.3%</td> <td>12<sup>th</sup> most</td> </tr> <tr> <td>10 -17 year olds who are obese</td> <td>13.6%</td> <td>35<sup>th</sup> most</td> </tr> </tbody> </table> <ul style="list-style-type: none"> <li>- Iowa has policies that result in taxes on soda (and sugar- sweetened beverages)</li> <li>- Iowa has nutritional standards for competitive foods sold in schools.</li> <li>- Iowa has policies that require physical education in schools.</li> <li>- BMIs and health information are each collected in Iowa schools.</li> <li>- Iowa has policies that require health education in schools.</li> <li>- There are several Farm-to-School programs in place in Iowa.</li> </ul>	Iowa			Metric	%	Rank	Obesity	31.3%	12 <sup>th</sup> most	10 -17 year olds who are obese	13.6%	35 <sup>th</sup> most
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Link	<a href="http://healthyamericans.org/report/100/">http://healthyamericans.org/report/100/</a> <a href="http://stateofobesity.org/">http://stateofobesity.org/</a>												
About the document	This report compiles data from several sources and aggregates them in a way that allows states to see where they stand when sized up against other states on several issues. It is published annually.												

<b>Medical Panel Expenditure Survey- Insurance Component (MEPS-IC)</b> Government Sponsored DHHS- Agency for Healthcare Research and Quality (AHRQ)	
Data Year	2014
Release Date	July 2015
Highlights	<p>Premium distributions (in dollars) for private-sector employees enrolled in <b>family coverage</b>:</p> <ul style="list-style-type: none"> <li>- For 2014, Iowa ranked 13<sup>th</sup> with an average family premium of \$15,899.</li> <li>- Alabama had the cheapest at \$14,143.</li> <li>- Alaska had the most costly at \$19,713.</li> <li>- The national average family premium was \$16,655</li> </ul> <p>Premium distributions (in dollars) for private-sector employees enrolled in <b>Single coverage</b>:</p> <ul style="list-style-type: none"> <li>- For 2014, Iowa ranked 14<sup>th</sup> with an average individual premium of \$5,557.</li> <li>- Arkansas had the cheapest at \$4,846.</li> <li>- Alaska had the most costly at \$7,099.</li> <li>- The national average individual premium was \$5,832.</li> </ul>
About the survey	The <a href="#">Insurance Component</a> (IC) collects data from a sample of private and public sector employers on the health insurance plans they offer their employees. The survey is also known as the Health Insurance Cost Study.

National Survey of Children's Health (NSCH) Government Sponsored Department of Health and Human Services (DHHS)																									
Data Year	2011/2012																								
Release Date	Fall 2011 (released every 2 years)																								
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Link	<a href="http://www.childhealthdata.org/browse/snapshots?geo=17#">http://www.childhealthdata.org/browse/snapshots?geo=17#</a>																								
About the survey	The NSCH examines the physical and emotional health of children ages 0-17 years of age. Special emphasis is placed on factors that may relate to well-being of children, including medical homes, family interactions, parental health, school and after-school experiences, and safe neighborhoods.																								

Pediatric Nutrition Surveillance System (PedNSS) Government Sponsored CDC	
Data Year	2010
Release Date	2011
Highlights	- 14.7% of Iowa children ages 2-5 are obese
Link	<a href="http://www.cdc.gov/PEDNSS/">http://www.cdc.gov/PEDNSS/</a>
About the survey	<p>PedNSS collects data about risk factors associated with infant mortality and poor birth outcomes for low-income pregnant women who participate in federally funded public health programs in the United States (US).</p> <p>This survey was discontinued in 2012.</p>

Youth Risk Behavior Survey (YRBS) Government Sponsored CDC															
Data Year	2011														
Release Date	Every two years (often lagging)														
Highlights	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #92d050;">Measure</th> <th style="background-color: #92d050;">Iowa (2011)</th> </tr> </thead> <tbody> <tr> <td>% who drank a bottle or a can of soda one or more times per day</td> <td style="text-align: center;">28.1%</td> </tr> <tr> <td>% who are overweight</td> <td style="text-align: center;">14.5%</td> </tr> <tr> <td>% who are obese</td> <td style="text-align: center;">13.2%</td> </tr> <tr> <td>% who watched at least 3 hours of TV a day on an average day</td> <td style="text-align: center;">23.5%</td> </tr> <tr> <td>% who played video or computer games or who used a computer 3 or more hours per day (excluding schoolwork)</td> <td style="text-align: center;">25.0%</td> </tr> <tr> <td>% who were not physically active at least 60 min per day on 5 or more days</td> <td style="text-align: center;">48.5%</td> </tr> </tbody> </table> <p>Iowa didn't participate in the 2013 survey.</p>	Measure	Iowa (2011)	% who drank a bottle or a can of soda one or more times per day	28.1%	% who are overweight	14.5%	% who are obese	13.2%	% who watched at least 3 hours of TV a day on an average day	23.5%	% who played video or computer games or who used a computer 3 or more hours per day (excluding schoolwork)	25.0%	% who were not physically active at least 60 min per day on 5 or more days	48.5%
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Link	<a href="http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=IA">http://apps.nccd.cdc.gov/youthonline/App/Results.aspx?LID=IA</a>														
About the survey	<p>YRBS monitors six categories of priority health-risk behaviors among youth and young adults, including—</p> <ul style="list-style-type: none"> <li>• Behaviors that contribute to unintentional injuries and violence</li> <li>• Tobacco use</li> <li>• Alcohol and other drug use</li> <li>• Sexual risk behaviors</li> <li>• Unhealthy dietary behaviors</li> <li>• Physical inactivity</li> </ul> <p>In addition, YRBS monitors the prevalence of obesity and asthma</p>														

## Workforce Task Force

### **Executive Summary**

Despite Iowa's low unemployment rate and the highest graduation rates in the U.S., poverty and unemployment continue to exist. Often the unemployment rate is a reflection of a skills gap, which contributes to provider shortages and access issues for Central Iowans.

A number of initiatives currently exist in Central Iowa. Those include the United Way of Central Iowa Income Goal, Bridges to Success, EDGE, and Central Iowa Works. All focus on using education to grow the workforce and the incomes of Central Iowans.

The Workforce Work Group identified five priority areas to improve overall health care:

1. Increase the percentage of Central Iowans who are financially self-sufficient

2. Ensure access to high quality pre-K and K-12 education for Central Iowa children
3. Increase recruitment, retention and training of the health, long-term care, and mental health workforce
4. Increase capacity and support for individuals seeking high school equivalency, basic skills, or career training in high demand occupations with career pathways
5. Improve Ability and Capacity to Analyze and Share Data

### **Current state of affairs**

#### *Economic Climate*

Central Iowa enjoys a relatively low unemployment rate at 3.4 percent as of June 2015.<sup>1</sup> The median household income in 2012 was \$60,110, above the United States average and the State of Iowa's median household income of \$51,509.<sup>2</sup> Iowa has strong job growth, and the labor force (those actively seeking employment) grew by over 43,000 people between

2005 and 2010.<sup>3</sup> Central Iowa is regularly recognized as a top place to live, work, and raise families. Waukee recently ranked in the top 10 best towns for families, Clive was named a top 100 best small town, and Des Moines ranked the fourth best tech city to start a career, the fourth most business-friendly city, the number one city for community pride, and the number six city for mid-sized metro areas for college graduates to find employment.

Despite Central Iowa's positive economic environment, many families are disproportionately affected by poverty and unemployment. The percentage of Central Iowans at or below 100 percent of the federal poverty level (FPL) increased to 11.6 percent in 2013. That percentage increases significantly with certain groups: 35 percent of single mothers in Polk County and nearly 40 percent of African Americans live at or below 100 percent of the poverty level.<sup>4</sup> According to the Iowa Policy Project's Cost of Living in Iowa 2014 report, individuals need to make about 250 percent of the FPL to meet basic needs, and one-third of Central Iowans currently live below that threshold.<sup>5</sup>

Six out of 100 Central Iowans do not have a high school diploma (33,000). Individuals with less than a high school diploma are most likely to be unemployed, and poverty rates are significantly higher among those without a high school diploma or equivalency. Individuals without a high school diploma are 32 percent more likely to become unemployed and twice as likely to be receiving public assistance compared to those with a diploma. Conversely, those who achieve at least an equivalency diploma stand to earn 38 percent more per week and more than \$700,000 over their working life. With the addition of some post-secondary training, up to an Associate's degree, weekly earnings increase by more than 54 percent. In Central Iowa, only 29 percent of enrollees into the High School Equivalency Test (HiSET) process complete and receive their equivalency.<sup>6</sup>

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<sup>1</sup> Economy at a Glance: Des Moines-West Des Moines, [http://www.bls.gov/eag/eag.ia\\_desmoines\\_msa.htm](http://www.bls.gov/eag/eag.ia_desmoines_msa.htm).

<sup>2</sup> Des Moines Regional Research, Stats and Data Hub, Median Household Income, [www.desmoinesmetrodata.com/chart\\_forms/mhhi/](http://www.desmoinesmetrodata.com/chart_forms/mhhi/)

<sup>3</sup> Iowa Workforce and Economic Development Status Report, January 2012, [www.iowaworkforcedevelopment.gov/sites/search.iowaworkforcedevelopment.gov/files/statewidestatusreport\\_2012.pdf](http://www.iowaworkforcedevelopment.gov/sites/search.iowaworkforcedevelopment.gov/files/statewidestatusreport_2012.pdf)

<sup>4</sup> Poverty report by United Way

<sup>5</sup> The Iowa Policy Project, Cost of Living in Iowa – 2014 Edition, [www.iowapolicyproject.org/2014Research/140409-COL-Part2.html](http://www.iowapolicyproject.org/2014Research/140409-COL-Part2.html)

<sup>6</sup> United Way of Central Iowa, High School Equivalency Diploma Statistics, ...

“Poverty is both a cause and a consequence of poor health” (Health Poverty Action). Issues related to poverty hamper well-being. Environmental factors like poor housing, financial factors like affordability of healthcare and medicine, and stress all negatively impact health and mental health.<sup>7</sup> According to Robert Wood Johnson Foundation, “laid-off workers are 54 percent more likely to have fair or poor health, and 83 percent more likely to develop a stress-related health condition.” While poverty and unemployment can negatively impact health, employment can have significant health benefits. Work creates a sense of purpose and improves access to healthcare coverage and access to healthcare services. Over the last several decades, the life expectancy of male workers in the top half of the income distribution has risen 6 years but only 1.3 years for those with lower incomes.<sup>8</sup>

### *Workforce Trends and Projections*

According to Iowa Workforce Development, “Iowa’s economy is heavily dominated by trade, healthcare and manufacturing, that combined employ over 44 percent of the state’s workers. Healthcare and social assistance employment increased by nearly 17,000 between 2005 and 2010, the largest industry increase in the state.”<sup>9</sup>

Workers between the ages of 48 and 66 accounted for about 40 percent of the labor force in 2010. At the same time that these workers will be retiring, the labor force is expected to grow more slowly. The loss of the Baby Boomer workforce is further hindered by data that shows that a “substantial portion of the working-age population does not demonstrate a sufficient level of literacy and numeracy skills to full participate in the current work environment.”<sup>10</sup>

According to Iowa Workforce Development, 50 percent of job openings in 2010 were in middle skills jobs. These are jobs that require more than a high school diploma but not a four-year degree. The occupations range greatly and include jobs like electricians, dental hygienists, machinists, paralegals, and construction supervisors – many of which require skills in STEM (Science, Technology, Engineering and Math) subjects.<sup>11</sup> The need for an educated workforce is expected to increase by 2020, where 65 percent of all jobs will require some form of postsecondary education.

### *Healthcare Workforce*

In addition to the ‘middle skills gap,’ Central Iowa faces high demand in many healthcare professions. Healthcare is experiencing the same challenges of an aging workforce and shrinking labor pool, and is often further challenged by issues related to insurance reimbursement rates, appropriate training, and placement pipelines.

Currently, healthcare accounts for 8.9 percent of Iowa’s total employment.<sup>12</sup> Per the Bureau of Labor Statistics’ Standard Occupational Classification System, healthcare employment includes Medical and Health Services Managers, Healthcare Practitioners and Technical Occupations, Healthcare Support Occupations, and Community Health Workers. The 2012-2022 Iowa Industry Projections indicate two major industries – the Healthcare and Social

<sup>7</sup> Key Facts: Poverty and Poor Health, Health Poverty Action

<sup>8</sup> Robert Wood Johnson Foundation, How Does Employment – or Unemployment – Affect Health? [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf403360](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360)

<sup>9</sup> Iowa Integrated Workforce Plan for Workforce Investment Act Title 1/Wagner-Peyser Act and Department of Labor Workforce Programs, July 1, 2012 – June 30, 2017

<sup>10</sup> Iowa Integrated Workforce Plan for Workforce Investment Act Title 1/Wagner-Peyser Act and Department of Labor Workforce Programs, July 1, 2012 – June 30, 2017

<sup>11</sup> Iowa Integrated Workforce Plan for Workforce Investment Act Title 1/Wagner-Peyser Act and Department of Labor Workforce Programs, July 1, 2012 – June 30, 2017.

<sup>12</sup> Kaiser Family Foundation, Healthcare Employment as a Percent of Total Employment, <http://kff.org/other/state-indicator/health-care-employment-as-total/>.

Services sector and the Trade, Transportation, and Utilities sector – are expected to account for over 40 percent (74,840 jobs) of the state’s job growth.<sup>13</sup>

Adding to the current demand, the average age of those in the Central Iowa healthcare sector is 50, with nearly 2 out of 5 between the ages of 55 and 64.<sup>14</sup> This dramatically affects the future needs of the healthcare industry in Central Iowa. Not only is Iowa experiencing significant growth in need in this sector, Central Iowa stands to lose a significant number of healthcare employees to retirement in the next five to ten years. Unfortunately, this places Central Iowa at a crossroads given the mismatch between the healthcare sector demand and the percentage of individuals who lack the skills, education, and credentials to fill the growing needs.

Although Iowa ranked 6<sup>th</sup> in the nation for ratio of family physicians to population, the state ranks low in access to many specialties, including emergency medicine, obstetrics and gynecology, psychiatry, and child and adolescent psychiatry. Iowa is ranked 47<sup>th</sup> and 46<sup>th</sup> in the nation for number of psychiatrists and psychologists, respectively, per population. According to the Iowa Medical Society, “at least 44 percent of Iowa’s practicing physicians are over 50, an age at which surveys have shown many physicians consider reducing their patient care activities.”<sup>15</sup> Efforts to recruit and retain healthcare workers, especially mental health professionals, is hampered by the lack of Health Professional Shortage Area designations in Central Iowa that would support loan repayment in exchange for commitment to the community. The dental workforce has similar aging and shortage issues. According to the University of Iowa, half of all dentists in Iowa are age 50 or older, and almost 17 percent are part-time.<sup>16</sup>

The direct care workforce, which includes certified nurse aides, home care aides, hospice, and personal care aides, make up Iowa’s largest workforce at approximately 78,000 in 2014. Demand is increasing at a rate faster than supply due to the aging workforce and high turnover. The Iowa Direct Care Workforce Initiative estimates a need for an additional 20,000 workers by 2020.<sup>17</sup> These trends reflect a national crisis. According to a recent report from the Journal of the American Society of Aging, 80 percent of all care for older Americans is provided by direct care workers, and the availability and training of the workforce is inadequate compared to the dramatic increase in aging Americans.<sup>18</sup> During the Iowa White House Conference on Aging, participants highlighted high staff turnover, lack of workers, need for training, and the need for professional career paths as significant concerns.

### *Demographic and Cultural Considerations*

Iowa is ranked 11<sup>th</sup> in the nation in percentage of the population age 60 or older. In 2012, 21.2 percent of the population was over 60. However, when it comes to the older aging population, Iowa is ranked 4<sup>th</sup> in the nation for the percentage of individuals age 75 and older and also age 85 and older. The four largest industries with the highest percentage of workers age 55 to 99 are manufacturing, retail trade, educational services, and health services.<sup>19</sup> The high percentage of the current population and workforce in the 48 to 66 year-old range (Baby Boomers) will have a significant impact on both regional workforce capacity via retirements and the health and long-term care sectors because of the increasing need for services and support.

Data from the Iowa Department of Education shows that minority students made up 20.2 percent of total public school enrollment in 2010-2013, with Hispanic student population at 9.3 percent. Iowa’s public high school graduating

<sup>13</sup> Iowa Workforce Development, Iowa Workforce and the Economy, 2014.

<sup>14</sup> Iowa Workforce Development, Greater Des Moines Healthcare Laborshed Statistics, 2014)

<sup>15</sup> Iowa Medical Society, Physician Workforce.

<sup>16</sup> University of Iowa, 2013 Dentist Tracking System Annual Report.

<sup>17</sup> Prepare to Care, Who are Direct Care Professionals? <http://www.iowapreparetocare.com/About+the+Initiative>.

<sup>18</sup> Ensuring Care for Aging Baby Boomers: Solutions at Hand, Volume 39: Number 2.

<sup>19</sup> Iowa Workforce Development, Older Workers in Iowa: 2006.

classes are projected to rapidly become more racially and ethnically-diverse in the years ahead. As a community, Central Iowa needs to consider the importance of hiring a diverse workforce that matches the changing population as well as ensuring a culturally competent workforce of the future.

Iowa, and Central Iowa in particular, has a long-standing practice of welcoming refugee communities. Refugees bring unique skills and cultures to our community but face significant language and cultural barriers as well as health and mental health issues. Many previously lived in refugee camps for years and faced horrific conditions in their home countries. Des Moines Public Schools now reports nearly 100 languages spoken, and school districts in Polk and Dallas counties are experiencing high percentages of English Language Learners in the classrooms. In Perry, 19.4 percent of their students are ELL; in Des Moines, it is 17 percent, and Urbandale has 10 percent.

Approximately 650 refugees annually resettle in Central Iowa. Resettlement agencies are tasked with providing assistance with housing, education, and job training for the newly arrived residents. Since federal resettlement regulations focus on rapid employment, Central Iowa agencies have created high quality, short-term job training and placement strategies. Although job placement rates are high, refugees do not have enough opportunities in such a short amount of time to gain advanced and technical skills to enter the competitive employment market and make higher wages. Once in the workforce, barriers such as time, transportation, and child care make efforts to gain advanced skills nearly impossible. The Des Moines Refugee Planning Coalition is a diverse group of stakeholders in Central Iowa focused on improving education, health, and employment outcomes for refugees. More information about their efforts is included in the Appendix and referenced in the Priorities section.

#### *Efforts Underway*

In order to match jobs seeker skills with employer demands, it will be necessary to not only focus efforts on recruiting and training workers exiting high school but also on retraining the existing workforce to become more competitive in the job market and creating supports for individuals with barriers to build skills to enter career pathways. Central Iowa is home to several unique and innovative initiatives striving to increase self-sufficiency, improve educational opportunities, and increase the percentage of Central Iowans with post-secondary training and advanced skills that prepare them for career pathways. These initiatives include:

- **United Way of Central Iowa Income Goal**, focused on increasing the percentage of central Iowans who are self-sufficient to 75 percent by 2020.
- **Bridges to Success**, focused on increasing the number of central Iowans who achieve a high school equivalency diploma, by 2020, through an evidence-based equivalency preparation program.
- **EDGE**, a Cradle thru Career initiative, led by the Greater Des Moines Partnership along with a group of more than 140 stakeholders that includes elementary, secondary, and higher education as well as adult re-skilling called, **“Education Drives Our Great Economy.”**
- **Central Iowa Works**, a public/private partnership designed to help businesses find qualified workers and job seekers obtain the skills they need to find livable wage employment through a robust industry sector approach.

#### **Priorities**

1. Increase the percentage of Central Iowans who are financially self-sufficient: Ensuring financial self-sufficiency should be at the core of any effort to create a high quality workforce that is healthy and productive and can drive our economy.

This priority aligns with the United Way of Central Iowa Community Income Goal to “Increase the percentage of Central Iowans who are financially self-sufficient to 75 percent by 2020.” This priority also aligns with the Education Drives our Great Economy (EDGE) initiative milestone to “increase the number of adults earning a living wage through access to education and employment.” Both organizations define self-sufficiency and livable wage as an income at 250 percent of poverty or above. Additional information about United Way and EDGE are included in the Appendix.

2. Ensure access to high quality pre-K and K-12 education for Central Iowa children: High quality early childhood and secondary education prepares students for high school graduation, postsecondary education, and career opportunities in high-demand jobs.
  - a. Increase access to quality early learning environments that promote school readiness
  - b. Increase K-12 students’ proficiency in literacy, reading, and math
  - c. Identify and engage at-risk students and improve school success by addressing barriers for students and families
  - d. Support public-private partnerships to expose young people to careers (i.e., Wellmark job training partnership with Des Moines Public Schools and the Waukee Aspiring Professionals Exchange (APEX) program that partners with several local employers)
  
3. Increase recruitment, retention and training of the health, long-term care, and mental health workforce: With an aging population and workforce shortages in many sectors of healthcare, efforts must focus on both recruitment and retention.
  - a. Recruit and train individuals in high-demand careers. Existing initiatives that should be supported and enhanced include Central Iowa Works, Prepare to Care training for direct care professionals (led by the Iowa Department of Public Health and University of Iowa), and the Home Base Iowa initiative aimed at recruiting veterans to relocate in Iowa.
  - b. Increase exposure to STEM skills in K-12 and postsecondary to ensure optimal preparation for the jobs most in demand
  - c. Engage employers to create innovative approaches to recruitment, training, and retention of workers. This may include partnerships with K-12 for on-the-job learning, access to HiSET education on-site for employees, and creation of career ladders that incentive growth and retention.
  - d. Identify ways to continue to engage the aging workforce through flexible hours, mentorship, and volunteering opportunities.
  
4. Increase capacity and support for individuals seeking high school equivalency, basic skills, or career training in high demand occupations with career pathways: In order to meet the community’s demand for middle skills and to increase financial self-sufficiency, efforts must focus on engaging the existing workforce in education and training.
  - a. Support and enhance existing initiatives to increase high school equivalency and in-demand job training:
    - i. Bridges to Success Initiative
    - ii. EDGE
    - iii. Existing community partnerships with this focus

- b. Address barriers for underserved populations (refugee, poverty, long-term unemployed, incarcerated)
    - i. Support and enhance the efforts of the Des Moines Refugee Planning Coalition. The employment subcommittee of the coalition is focused on providing more intensive English language training prior to first employment, encouraging more employers to offer English as a Second Language (ESL) classes on-site, and creating educational programs that reduce transportation and child care barriers for participants.
  - c. Increase completion rates and re-engage non-completers
  - d. Minimize education debt through financial literacy and increase access to funding opportunities for postsecondary education
5. Improve Ability and Capacity to Analyze and Share Data: Although various data is collected throughout the education, workforce, and human services systems, Central Iowa does not have a sophisticated way of analyzing the data and sharing relevant information with the community.
- a. Analysis should reflect populations of focus, i.e., refugees, unemployed, underemployed, and others
  - b. First identify what is being measured and collected and by who, and then determine what is missing and how to communicate key points to the public.
  - c. The EDGE initiative is compiling a plan to collect and share key data points, which presents an opportunity for the community to coalesce around consistent metrics in this area.

**Action Targets** (Measurable milestones) – In 3 years:

1. UWCI Community Income Goal (2018) – 70 percent of Central Iowans will be financially self-sufficient
2. 6,000 additional Central Iowans will receive a high school equivalency diploma
3. UWCI Community Education Goal (2018) – 94 percent graduation rate
4. Improved data tracking and analysis that is relevant and accurate
5. Increased opportunities for individual to enter career pathways
6. Policies have been adopted that impact barriers to achieving financial self-sufficiency
7. Growth in enrollment in program areas that support economic development trends

**Appendix**

- United Way of Central Iowa Community Report Card
- EDGE Goals and Metrics
- Refugee Planning Group Employment Subcommittee Goals
- Community Partners addressing workforce needs through basic skills and career preparedness and retention