Iowa State Plan on Aging

Federal Fiscal Years 2026-2029

October 1, 2025

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Date: May 16, 2025

U.S. Health and Human Services Department - Administration on Aging
Attn: Kari Benson, Deputy Director
330 C St SW
Washington, DC 20201

RE: Signatory Authority Granted to Iowa Health and Human Service Director for Signing the Iowa State Plan on Aging

Dear Ms. Benson,

Please allow this letter to serve as notice that I, Iowa Governor Kim Reynolds, delegate signatory authority to Iowa Health and Human Services Director, Kelly Garcia to act on my behalf for the purpose of signing Iowa's State Plan on Aging that is submitted to the U.S. Health and Human Services Department - Administration on Aging. This delegation of signing authority for the Iowa State Plan on Aging is not subject to further delegation without prior notice and express written consent.

Sincerely,

Kim Reynolds

Iowa Governor Kim Reynolds

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Division of Aging and Disability Services

Verification of Intent to Comply

The Division of Aging and Disability Services hereby submits this State Plan on Aging effective October 1, 2025, for Federal Fiscal Years 2026-2029 as required under Title III of the Supporting Older Americans Act (OAA) of 1965, as amended in 2020. The Plan was developed in accordance with all rules and regulations specified under the OAA and Code of Iowa section 231.31.

The Plan includes all required assurances and plans to be carried out by the Division of Aging and Disability Services, which is the state unit on aging and has been given authority to develop and administer the State Plan on Aging in accordance with all requirements and purposes of the Act.

Zach Rhein, Division Administrator
Aging and Disability Services

6/12/25
Date

The State Plan on Aging for FFY2026-2029 is hereby submitted to the Director of the Iowa Department of Health and Human Services and constitutes authorization from the Governor to proceed with activities under the State Plan upon approval by the U.S. Health and Human Services Department - Administration on Aging.

I hereby approve the State Plan and submit the Plan to the U.S. Health and Human Services Department - Administration on Aging for approval.

Kelly Garcia, Director

Iowa Department of Health
and Human Services

06/12/2025
Date

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Table of Contents

Executive Summary

The Iowa Department of Health and Human Services (Iowa HHS) serves as the State Unit on Aging with the Division of Aging and Disability Services (ADS) charged with administering the Older Americans Act (OAA) services. The 2023 health and human services alignment moved the State Unit on Aging into Iowa HHS. This alignment brought significant opportunities for collaboration and coordination with multiple programs and initiatives connected to Iowa's older population. In addition to OAA services, ADS oversees Aging and Disability Resource Center (ADRC) services, adult protective services, disability services, Medicaid fee-for-service case management, Office of Public Guardian, and Preadmission Screening and Resident Review (PASRR). Together, ADS staff work to achieve ADS' vision to maximize independence of aging Iowans and Iowans with disabilities. ADS' core values are person-first, collaboration, compassion, reliability, knowledge, and excellence.

Iowa's Older Population by the Numbers

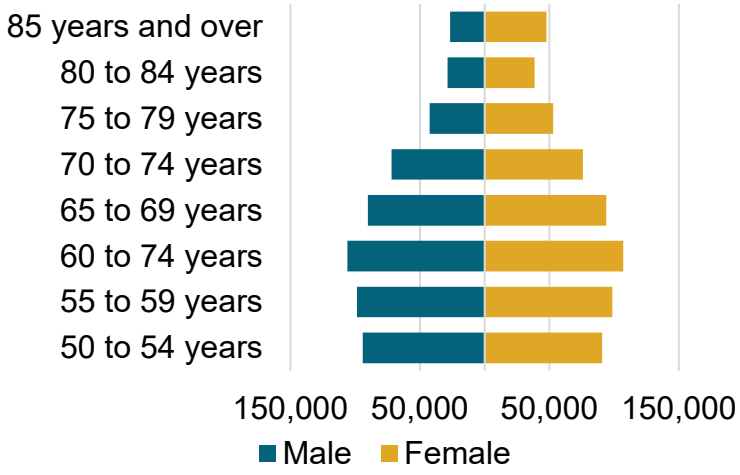
The estimated number of Iowans aged 60 years and over was 810,697, or 25 percent of Iowa's total population, in 2023[1]. Iowa ranks sixth in the nation for the percentage of persons aged 85 years and over. The percentage of adults aged 65 years and over living in metro areas increased by 8.4 percent and by 5.5 percent in non-metro areas between 2013 – 2023[2].

Table 1: Percentage of Population Living in Metro, Micro, and Rural by Age

Type	Age 0-24	Age 25-44	Age 45-64	Age 65+
Metro Central	34.3%	27.0%	22.7%	16.0%
Metro Outlying	30.7%	24.0%	25.4%	19.96%
Micropolitan	31.2%	23.4%	24.4%	20.9%
Rural	30.9%	22.2%	24.5%	22.5%
U.S.	30.9%	26.9%	24.6%	17.7%

In 2022, 32 percent of Iowans aged 65 and over lived in five counties: Polk, Linn, Scott, Black Hawk, and Johnson[3]. However, the rural areas continue to have a higher percentage of older adults than Iowa's metropolitan areas (Table 1). The number of males and females ages 50+ is relatively the same ratio until age 75 when females begin to outpace the number of males[4] (Figure 1). In 2023, an estimated 26.7 percent of people aged 60 years and over reported having a disability compared to the state's average percentage of 13.2 percent of the civilian, noninstitutionalized population with a reported disability[5].

Figure 1: Iowa Population Aged 50 Years and over by Age and Sex S0101 | 2023



Iowa's older population and demographic statistics have not changed significantly in the past four years. However, assessments conducted by the State Unit on Aging, Area Agencies on Aging (AAAs) and other partners, and the feedback provided by individuals accessing services and service providers, demonstrate that changes have occurred in the needs of older Iowans and in the challenges faced by the Aging Network. Increasing costs, fewer providers, and more complex health concerns are the main drivers of change.

Needs of Older Iowans and Caregivers

Meeting the needs of older Iowans and family caregivers has become more complex and requires additional time and resources to address. AAAs find themselves tackling issues such as malnutrition, housing insecurity, and lack of in-home supports when helping individuals navigate services. Prioritizing services for individuals in greatest need and implementing wait lists for services is increasingly common. When local services such as homemaker, personal care, or respite care are not available, older adults and family caregiver needs go unmet. Following are key need areas of older Iowans and family caregivers including: 1) access to services and supports, 2) health and wellness, and 3) at risk for institutionalization.

Access to Services and Supports

The best-case scenario is that all older adults and their family caregivers create a long-term care plan to assist with aging in place for as long as possible. Unfortunately, it often takes a crisis for individuals and concerned family/neighbors/friends to reach out for assistance. Feedback from older Iowans and caregivers has shown difficulty in accessing services and supports in Iowa, with confusion about eligibility criteria and how to apply for assistance, limited access to services in rural areas, and lack of follow-up to support recovery after a hospitalization. Older adults and caregivers need objective navigation and person-centered service coordination to be able to easily access short- and long-term services and supports (STSS, LTSS) that promote health and independence.

Iowa has three main call centers that connect Iowans to local health and human services providers to assist with meeting their needs: 211 Iowa, Iowa Compass, and ADRC call centers. The 211 Iowa call center provides more general and anonymous assistance. In 2024, over 11,800 older adults received information and referral services. The most frequently recorded topics reported by 211 Iowa for older adults were related to housing, income support/assistance, individuals/family support, utilities, and transportation (Table 2)[6]. Iowa Compass connects people with disabilities and complex health-related needs to services and supports. Top service requests include assistive technology equipment loan, semi-independent living residences for adults with disabilities, rent payment assistance, and assistive technology equipment sales[7].

Table 2: Top 10 Topics for Information and Assistance

211 IOWA TOP 10 TOPICS	OAA TOP 10 TOPICS
Housing	Meals or Food Assistance
Income Support / Assistance	Medicaid
Individual / Family Support	Emergency Financial Assistance
Utilities	Family Caregiver Support
Transportation	Medicare
Health Care	Homemaker Services
Food and Meals	Assisted Transportation
Legal, Consumer, Public Safety	Long-Term Care & Skilled Nursing
Information Services	Housing Assistance
Clothing/Personal/Household Items	Caregiver Education

When an individual contacts an AAA for help, the AAA engages in an interactive conversation to fully understand an individual's request and tailor referrals to local community services, other public support programs, additional OAA services and more. In SFY 2024, nearly 17,000 individuals received this information and assistance service. The most frequently discussed topics during these contacts related to access to food, Medicaid/Medicare, financial assistance, housing, homemaker, transportation, and caregiver supports (Table 3) [8]. In SFY 2024, the most frequently discussed topics for older adults needing OAA legal assistance included housing, income, other/miscellaneous, health care, defense of guardianship/protective services, and abuse/neglect.

Individuals who call an AAA for help are connected to additional services as needed and appropriate. For example, if an individual needs in-depth assistance beyond initial information and assistance, the individual is referred to for options counseling. Options counseling offers an in-home visit, a detailed assessment of need, and the option to create a person-centered care plan. If an individual has more complex needs that require ongoing assistance, the individual is referred for case management services. Case management provides a monthly check-in, a person-centered care plan, and long-

term assistance. The percentage of consumers that receive additional services typically increases when the level of care needs increase (Table 3)[9]. In most cases, an older adult only needs one or two in-home supports to meet their health and independent living needs. Receiving meals at a community meal site or a home delivered meal decreases the risk of experiencing food insecurity, malnutrition, and loneliness. A ride to a doctor's office following a hospitalization can decrease the risk of a readmission.

Table 3: Percentage of OAA consumers also enrolled in an additional OAA service

	Information and Assistance	Options Counseling
Nutrition Education	10.4%	19.3%
Home Delivered Nutrition	9.8%	26.6%
Congregate Nutrition	5.4%	5.1%
Material Aid: Other	4.9%	5.4%
Homemaker	2.4%	15.6%
Emergency Response System	1.0%	5.9%

Health and Wellness

Chronic Diseases

Chronic diseases are the leading cause of death and disability for adults. Nearly eight in ten adults aged over 65 have at least one chronic disease, and four in ten have two or more. Conditions such as heart disease, cancer, diabetes, obesity, and arthritis are impacted by health behaviors. Physical inactivity, lack of fruit and vegetable consumption, or excessive alcohol use contribute to prevalence of chronic diseases in Iowans (Table 4)[10,11,12,13].

Table 4: Key Health Indicators for Persons Aged 65 Years and Over

	Iowa	U.S.
Obesity	34.8%	30.2%
Physical inactivity	32.6%	32.0%
Rate of suicide per 100,000 persons aged 75 to 84 years	24.0	19.4
Depression	12.3%	14.7%
Excessive drinking	7.4%	6.9%
Frequent mental health distress	6.9%	8.7%
Fruit and vegetable consumption	5.9%	7.3%
Food insecurity for people aged 60 years and over	5.7%	8.7%
Access to Geriatrician (per 100,000 people aged 65 year and over)	23.20	38.00

Alzheimer's and Related Dementia

The likelihood of developing dementia increases significantly with age. One in 14 people aged over 65 has dementia[14]. The incidence rises to one in three for people aged over 85[15]. According to the 2024 Iowa Alzheimer's statistics compiled by the Alzheimer's Association, over 62,100 Iowans have Alzheimer's disease or other dementias. In SFY 2023, the AAAs provided services to 296 caregivers caring for individuals with dementia. Those caregivers had been providing care for the care recipient for an average of 4.9 years. The caregivers' assessed strain index showed that 88 percent of the caregivers experienced high stress compared to 73 percent of caregivers served who were not caring for an individual with dementia. These caregivers received counseling, respite, case management, and options counseling to support their informal caregiving role[16].

Social Determinants of Health (SDOH)

The ability to make healthy choices are impacted by the conditions in which one lives, works, and plays. SDOH such as social and economic factors, where someone lives, and access to quality health care also contribute to an older adult's health and wellbeing. Iowa HHS implements a SDOH Survey with individuals enrolled in Medicaid. In 2024 Q4 there were 3,473 individuals aged 65+ who completed the survey. The family needs reported most often are for transportation, followed by dental care, and then food (Table 5)[17]. The main reasons cited for being unable to access transportation when needed was due to not having a personal vehicle, a car broke down, and the person who usually takes the individual was unavailable.

Table 5: Family Needs of Social Determinants of Health (SDOH) Survey Respondents Aged 65 Years and Over (2024 Quarter 4; N=428)

Transportation	50.7%
Dental Care	29.9%
Food	23.8%
Eye Care	15.9%
Clothing	13.6%
Phone	11.9%
Medical Care	10.5%
Mental Health	8.6%

The Aging Network offers a variety of evidence-based health promotion classes to help increase mobility and prevent the number of unintentional fall related injuries. Classes such as Tai Chi, water aerobics, Stepping On, and more are offered to older adults to help increase their physical activity. By end of year 2024, AAAs served 555 individuals with evidence-based health promotion classes and 5,524 individuals with nonevidence-based health promotion. Congregate dining and home delivered meals ensure older

Iowans have access to regular nutritious meals to reduce food insecurity and prevent malnutrition. By end of SFY 2024, AAAs served over 15,000 older adults with nearly 700,000 meals at congregate dining sites and over 9,600 older adults with nearly 1.2 million home-delivered meals[18].

At Risk for Institutionalization

The population of Iowa is aging and the percentage of people aged 60 years and over will continue to increase in the next decade. This population shift will increase the service gap for in-home supports as the demand for personal care and homemaker services already outpaces the capacity to meet in-home care needs. Another concerning issue is Iowa's rate of high percentage of nursing home residents with low care needs: 14.8 percent vs. the U.S. average of 8.9 percent. Listed below are four critical factors that contribute to older adults being at risk for institutionalization.

- **Housing Insecure/Unhoused** – The percentage of Iowans ages 65 and over who live in a cost burdened household or pay 30 percent or more of their household income in housing costs is 21.5 percent for those with a mortgage and 50.8 percent for those who are renting[19,20]. In SFY 2024, AAAs provided 3,064 older adults with 16,488 hours of options counseling and 956 older adults with 12,005 hours of case management to support their health and independence. Also, 8,982 older adults received material aid to support rent deposits, utilities, and other identified housing and service needs.
- **Transition Supports** – Of preventable hospitalizations, Iowa has a rate of 1,177 discharges per 100,000 Medicare beneficiaries ages 65-74 vs. the U.S. rate of 1,452[21]. Iowa has a ratio of 39.0 home health care workers per 1,000 adult age 65+ vs. U.S. ratio of 61.0[22]. In SFY 2024, AAAs received 2,196 Iowa Return to Community (IRTC) referrals and admitted 43 percent or 969 consumers within the program[23].
- **Elder Rights/Abuse Prevention** – Abuse and neglect can have serious physical and psychological effects on older adults. Survivors report higher rates of depression and social withdrawal, leading to increased hospitalization and premature death[24]. Of individuals 65+ enrolled in Iowa Medicaid, 5.4 percent reported they sometimes, often or frequently felt unsafe in their neighborhood and 2.4 percent have been afraid of their partner or ex-partner[25]. In SFY 2024, AAAs provided elder abuse prevention and awareness services to assist with keeping 832 older adults safe[26].
- **Caregiver Support** – An American Association of Retired Persons (AARP) study found 84 percent of survey respondents said that caregiving had a moderate or high impact on the stress they feel daily. Of working caregivers, 27 percent said they ultimately had to shift from full-time to part-time work or reduce their hours[27].

In SFY 2024, AAAs provided caregiver supportive services to 4,467 informal caregivers[28].

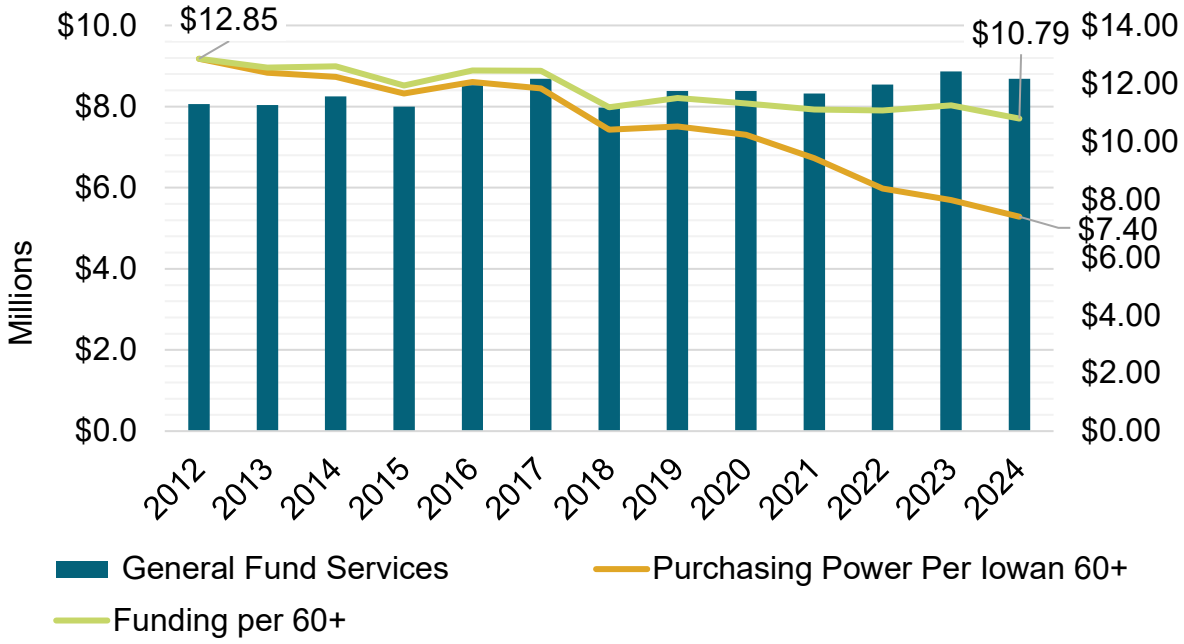
State of the Aging Network

The average life expectancy in Iowa is 78.1 years compared to that of the U.S. which is 77.6 years[29]. Qualitative and quantitative assessments demonstrate that the Aging Network is reaching those who are at greatest economic need and greatest social need as defined in the OAA. Over the past four years, the AAAs developed new and innovative strategies to streamline service delivery and work closely with providers and partner agencies to coordinate services.

Challenges

AAAs rose to the challenges presented by the COVID-19 pandemic. AAAs quickly altered service delivery by shifting from congregate settings to one-on-one and home delivered services. As the pandemic protocols lifted, AAAs turned to innovative services such as connecting older individuals to non-traditional congregate meal sites which benefitted both the consumer and the local restaurants still recovering from the disruption. AAAs also connected with individuals whose needs were more complex.

Figure 2: State General Fund History



With the Older Americans Act American Rescue Plan Act funds fully expended and funding returned to pre-pandemic levels, the Aging Network is again pivoting to meet the needs with available resources. While the state funding increased slightly between 2012 to 2024, the purchasing power and funding per older adult aged 60 years and over

has decreased over time (Figure 2) [30]. AAAs took necessary action to initiate wait lists for congregate meals, home delivered meal, transportation, personal care, homemaker, respite services, and more to align service delivery with available resources. The increasing costs, loss of providers, and implementation of wait lists underscores the importance of coordination and collaboration among state and local partners through a robust Aging and Disability Resource Center network, internal connections with Iowa HHS partners, and interagency collaboration.

Addressing Service Fragmentation for Older Adults and Caregivers

In FFY 2024, the U.S. Government Accountability Office completed a study to review potential duplication between programs authorized under the OAA and federal programs authorized under other laws. The study found that services funded by the OAA overlap with 36 other federal programs but do not duplicate efforts as the programs differ in population served, goals and services provided, or both[31]. The recommendation is for OAA-funded services to coordinate efforts with other federally funded programs that service older adults to prevent duplication. With the realignment of the Iowa HHS, ADS has already made significant connections to other programs and services within Iowa HHS that overlap but do not duplicate the OAA services in the state. ADS is exploring ways to build a strong collaborative partnership between the aging and disability system and state Medicaid programs such as the HOME project. Hope and Opportunity in Many Environments (HOME) is a part of Iowa's waiver redesign that aims to ensure everyone can access quality behavioral health, disability, and aging services close to home.

Laying the Foundation for the Future

In 2020, 67 counties had at least 20 percent of residents that were age 65 or over. The percentage is projected to increase to 80 counties in 2060[32]. ADS is working in concert with HHS partners to assess current and future needs of older Iowans and to develop Iowa's four-year State Plan on Aging, the next six-year State Health Improvement Plan and a 10-year Multisector Plan for Aging. These collaborative efforts bring together multiple divisions, state agencies, and community partners to develop common goals to address aging issues and leverage and maximize resources.

State Plan on Aging Goals

ADS will work toward the fulfillment of four goals in FFY 2026 - 2029 to address the needs of older adults and informal caregivers. ADS used assessments of existing and emerging needs, AAAs' area plans, population demographics, the federally required topic areas, input from stakeholders and partners, and ADS' strategic vision and core values to identify priority areas as well as develop objectives, strategies, and measures for the goals. ADS will accomplish the objectives in partnership with AAAs, ADRCs,

HHS divisions and other state agencies, Tribal communities, community partners, and other ADS collaborative efforts.

- GOAL 1: MAXIMIZE INDEPENDENCE: Older adults have access to high quality, equitable and person-centered services that maximize independence, community integration, and self-sufficiency.
- GOAL 2: IMPROVE HEALTH AND WELLNESS: Older adults are empowered to utilize programs that improve their health and wellness.
- GOAL 3: IMPROVE SAFETY AND QUALITY OF LIFE: Older adults are safe from all forms of mistreatment and are empowered to improve their quality of life.
- GOAL 4: STAY ENGAGED AND SUPPORTED: Older adults have social connections within their communities and are supported by formal and informal caregivers of their choice.

Context

Individuals in Greatest Need

With the anticipated changes due to spend down of the American Rescue Plan Act funds, ADS worked with AAAs for more than a year on identifying and assessing populations in greatest economic need and greatest social need. ADS began with technical assistance on conducting a needs assessment for the development of the new SFY 2026-2029 Area Plans on Aging. ADS also shared the OAA Final Rule 45 CFR 1321 definitions for greatest economic need and greatest social need populations.

ADS identified common risk factors for individuals in greatest need that contribute to negative outcomes including 1) institutional placement of residents with low-care needs, 2) age or impairment-related health conditions, 3) barriers to accessing services, 4) food insecurity/unhoused and 5) social isolation. The findings were discussed with AAAs and were used to assess and identify strategies and outcomes for older adults and family caregivers in greatest economic need and/or greatest social need as defined by the following in order of precedence: (1) statute; (2) executive order; (3) 45 Code of Federal Regulations (CFR) 1321 Grants to State and Community Programs an Aging; (4) 2 CFR Part 200 as codified by U.S. HHS at 45 CFR, Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards; (5) agency policies; and (6) any additional terms and conditions identified in the department's notice of award.

Conditions Impacting Older Iowans

Below is a summary of conditions impacting older Iowans ability to maintain or optimize their health and independence as they age.

Navigation of Services

Iowa ranks 41st in the nation with 55 percent progress towards a fully functional Aging and Disability Resource Center/No Wrong Door (ADRC/NWD) system vs. the national average of 72 percent[33]. Iowa continues to progress in implementing a fully functional ADRC to improve navigation of aging and disability services. In 2024, Iowa HHS began implementing a system redesign by establishing regional disability access points (DAPs) to provide information and referral and options counseling services to individuals of any age with a disability. The addition of the DAPs as designated ADRC entities will greatly enhance Iowa's navigation services and serve populations that complement the older adults and caregivers that the AAAs served previously as the only designated ADRCs. Another HHS effort to improve service navigation is 'Thrive Iowa' which will provide Iowans with a closed loop referral. This means Iowa HHS will help Iowans navigate the service system to ensure individuals are connected to the right service they are seeking.

Poverty and Low-Income

In 2023, the estimated number of Iowans aged 60 years and over living below the Federal Poverty Level (FPL) is 9.4 percent compared to 11.3 percent for all Iowans. An additional 36 percent of older adults aged 65 years and over are considered low-income or have a household income that is between 100 - 300 percent of the FPL, which translates to an individual household income of $15,650 to $46,950[34]. Thirty-one percent of households with people aged 60 years and over were employed[35]. Most older Iowans receive Social Security retirement income and just over half receive other retirement income. A much smaller number of older households receive Supplemental Security Income, cash public assistance income, or Food Stamp/SNAP benefits. Service data shows that the AAAs are reaching older adults in greatest economic need.

Of OAA consumers who received at least one service and for whom poverty status was determined, nearly 23 percent were at or below the federal poverty level (FPL) in SFY 2024[36]. AAAs provided application assistance and referrals to older adults who need additional resources to prevent institutionalization, housing insecurity, or unhoused. Services range from finding affordable housing options, applying for rent assistance, offering limited assistance with rent deposits, and receiving additional in-home supports to help maintain independence and level of care needs. Both income and resource limits for public benefits are not uniform; however, many set income limits at 150 percent FPL (or $22,590 for an individual). Most older Iowans who are accessing AAA services are not likely to be eligible for other public benefits. While evaluating income information is an important measure of potential need, it is worth noting that resources

such as pensions, annuities, and property beyond primary residence can disqualify an individual with low income from benefits programs. Providing OAA services to older Iowans and caregivers who may not be currently eligible for public assistance or require limited assistance can prevent or slow reliance on increased public assistance.

Disabilities and Health Conditions

Over one-quarter of Iowans aged 60 years and over reported having a disability.[1] That percentage increases to 42 percent for adults aged 75+[37]. There are 29 counties in Iowa reporting at least 30 percent or more of their population aged 60 years and over with a disability. The most prevalent disability is difficulty with ambulation or mobility, followed by hearing difficulty, and then independent living difficulty.
While it is not unusual for older adults to acquire an impairment that requires supports and services to maintain or retain independence, many will need assistance for fewer than three years[38]. Of OAA consumers receiving a registered service, 19 percent reported having two or more limitations with activities of daily living (ADLs) such as bathing, eating, getting dressed, toileting, and getting out of a bed or chair and/or instrumental activities of daily living (IADLs) such as managing finances, transportation, meal preparation, house cleaning, managing medications. etc. The connection with in-home supports increases along with ADL/IADL limitations[39] (Table 6).

Table 6: OAA Consumers with ADLs/IADLs by Most Utilized Registered Services

OAA Service (In-home Supports)	0 ADLs / 0 IADLs limitations	2+ ADLs / Any IADLs limitations	2+ IADLs/ Any ADLs limitations
Home Delivered Nutrition	998	2,237	3,417
Congregate Nutrition	4,020	471	714
Transportation	607	370	566
Assisted Transportation	166	170	277
Homemaker	13	413	615
Personal Care	3	165	214

Social Isolation

Iowa ranks ninth in the nation for the percentage of adults aged 65 years and over that are considered at risk for social isolation[40]. Loneliness and social isolation increase the risk for premature death by 26 percent and 29 percent respectively[41]. In addition, poor or insufficient social connection is associated with increased risk of disease, including a 29 percent increased risk of heart disease and a 32 percent increased risk of stroke, and with increased risk for anxiety, depression, and dementia. [42,43] Risk factors for social isolation include living in poverty; living alone; being divorced, separated, or widowed; having never married; having a disability; and having an independent living difficulty[44].

Malnutrition and Food Insecurity

A 2022 National Survey of Older Americans Act Participants (NSOAAP) found that 19 percent of home delivered nutrition consumers and 17 percent of congregate nutrition consumers were at risk for malnutrition. The economic burden of disease-associated malnutrition in older adults in Iowa is estimated to cost $25 - $49 million annually[45]. Nearly six percent of Iowans aged 60 years and over are living with food insecurity. A report from Feeding America found that older adults with a disability had food insecurity rates over twice the rate of older adults without a disability[46]. Older adults may develop disabilities and other health problems as they age, and those can make accessing groceries and cooking more difficult[47]. In Iowa, 89 out of 99 counties have areas identified as having low food access and approximately 238,290 Iowans are food insecure[48].

Iowa ranks 44th in the nation for Supplemental Nutrition Assistance Program (SNAP) reach of older adults aged 60 years and over with less than 50 percent of eligible persons receiving food assistance versus the U.S. average of 81 percent[49]. Malnutrition also leads to more complications, falls and higher 30-day hospital readmission rates. Falls were the leading cause of unintentional injury deaths for all ages in Iowa in 2020. Most falls in Iowa occur in those ages 65 and older, which resulted in 542 unintentional injury deaths in 2020[50]. A Community Preventive Services Task Force found that participation in congregate nutrition services reduced malnutrition by 9.0 percentage points and home delivered nutrition services by 15.5 percentage points among older adults who were malnourished[51].

Housing Insecure and Homeless Prevention

The percentage of Iowans aged 60 years and over who live in a cost burdened household or pay 30 percent or more of their household income in housing costs is 20.7 percent for those with a mortgage and 50.2 percent for those who are renting[52]. Providing services to older Iowans who are unhoused can be challenging to navigate. An unhoused older adult may not have access to their own phone which makes providing follow up difficult and sometimes impossible. When an unhoused person contacts an AAA, the main priority is making sure they are safe and have access to shelter. If older adults are unable to secure a shelter stay for that night hotel vouchers are used short-term until they can connect with one of Iowa's coordinated entry points. In a 2024 Iowa homeless point-in-time count, a total of 2,631 persons in Iowa were found as unhoused on any given day. Of that total, 17 percent or 443 unhoused individuals were aged 55 years and over[53].

The best way to serve older Iowans with complex needs is to make sure they are connected to the appropriate supports to keep them from becoming unhoused or housing insecure. There are 17 coordinated entry regions across Iowa. Persons who

are unhoused or housing insecure are referred to these entry points to coordinate housing and services. There are also specific services offered to unhoused veterans and persons with a criminal history to remove barriers that may be preventing them from attaining permanent housing. Some AAAs offer targeted case management to serve rural older adults with complex needs who are at risk of institutionalization or becoming unhoused. Early intervention can ensure consumers remain in secure housing and are connected to community resources to promote independence.

Transition Supports

Falls are the leading cause of injury-related death among Iowa adults aged 65 or older. In 2023, there were 30,995 fall-related injury emergency department visits for persons aged 65 years or older and 6,591 fall-related injuries that resulted in a hospitalization[54]. Of preventable hospitalizations, Iowa has a ratio of 1,177 discharges per 100,000 Medicare beneficiaries ages 65-74 vs. the U.S. rate of 1,452[55].[40] Iowa has a ratio of 39.0 home health care workers per 1,000 adults age 65+ vs. U.S. rate of 61.0[56].[40] The Aging Network offers transitions care called Iowa Return to Community (IRTC) program. With this program, an older adult in need of assistance for in-home supports is referred to the older adult's local AAA. The AAA then assists the older adult to successfully transitions from the health facility back home with the right level of support to help with recovery. In SFY 2024, AAAs received 2,196 IRTC referrals and assisted 43 percent or 969 consumers with transition supports[57].

Elder Rights and Abuse Prevention

While pre-pandemic sources estimated approximately one in ten adults age 70+ have experienced some form of elder abuse, a more recent study found that 1 in 5 older adults reported elder abuse during the COVID-19 pandemic[58]. Another study estimated that only one in 24 cases are reported to authorities[59]. Common characteristics of perpetrators are that they are female, someone the older adult knows, and between the ages of 18 to 59 years. Caregiver strain and lack of support in providing care for an older adults can impact the occurrence of abuse. Abuse and neglect can have serious physical and psychological effects on older adults. Survivors report higher rates of depression and social withdrawal, leading to increased hospitalization and premature death[60].

Listed below are key services Iowa HHS provides to help keep older adults safe from abuse.

> **Dependent Adult Protective Services** – Receives reports of abuse, neglect, and exploitation of dependent adults. HHS evaluates concerns of possible abuse, assesses an individual's needs and makes appropriate recommendations and referrals. In FY2024, HHS conducted 3,062 abuse investigations where the

reported subject was an adult aged 60 years and over. The following types of dependent adult abuse for individuals aged 60 years and over was substantiated: 322 instances of self-neglect, 198 instances of neglect, 184 instances of exploitation, 78 instances of physical abuse, and 22 instances of personal degradation.

Office of Public Guardian – Assists Iowans who are not capable of making their own decisions about legal, financial, or health matters. In SFY 2024, 172 individuals received assistance from the Office of Public Guardian.

Legal Services Developer – Increases awareness of and access to least-restrictive alternatives to guardianship, conservatorship or more restrictive fiduciary proceedings, such as supported decision making; provides technical legal assistance, provides resources for legal assistance, and provides estate planning tools and resources. In SFY 2024, 3,324 older adults received 11,982 hours of legal assistance from contracted providers.

Abuse Prevention, Awareness, and Outreach – Focuses on the prevention, intervention, detection and reporting of adult abuse, neglect and financial exploitation. AAA elder rights specialists provide wellness checks, assessment of need, and connection to supportive services. In SFY 2024, AAAs provided elder abuse prevention and awareness services to 832 individuals[61].

Office of the State Long-Term Care Ombudsman (OSLTCO) – Protects the rights of individuals residing in long-term care facilities, including nursing facilities, assisted living programs, residential care facilities and elder group homes, and educates, empowers and advocates for Medicaid managed care members living in a long-term care facility or enrolled in one or more of Iowa's Home and Community-Based Services (HCBS) waiver. In FFY 2023, the OSLTCO received 1,148 complaints and closed 690 cases, reflecting increases from the previous year in both complaints (11.67 percent) and cases (14.62 percent)[62].The most common complaint categories for both nursing facilities and residential care communities are Care, Autonomy/Choice and Rights, Financial and Property, and Admissions/Transfers/Discharges/Evictions.

Caregiver Challenges

The AARP Public Policy Institute estimates there are 330,000 family caregivers in Iowa who deliver 310 million hours of unpaid family care with an economic value of $16.80 per hour at total estimated economic value of $5.2 billion in Iowa[63]. Family caregivers provide a variety of tasks depending on their recipient's care needs. Tasks can include helping with activities of daily living (ADLs), such as eating, walking, getting dressed, bathing and using the toilet; helping with instrumental activities of daily living (IADLs),

such as housework, cooking, transportation, and managing finances; and assisting with more complex care needs such as medication management and recovery from a hospitalization. The pandemic spurred further social isolation and risk of loneliness for family caregivers. Significantly more caregivers reported severe loneliness and social isolation in the pandemic[64]. Family caregivers who did not have strong social support networks pre-pandemic struggled even more to maintain connections[65].

According to the 2024 Iowa Alzheimer's statistics compiled by the Alzheimer's Association, over 62,100 Iowans have Alzheimer's disease or other dementias and over 98,000 people serve as informal, unpaid caregivers[66]. Caring for people living with dementia (PLWD) is all-consuming, and informal caregivers often neglect their own health to focus on caring for their family, friend or neighbor living with dementia. Of the informal, unpaid caregivers caring for PLWD, 61 percent have a chronic health condition, 27 percent are living with depression and 14 percent have poor physical health[67]. In Iowa, a large percentage of PLWD live in rural areas, away from bigger population centers and resources[68]. A third of PLWD live alone, and another 13 percent live with a spouse who also requires help with activities of daily living[69]. The connections that the AAAs have made with caregivers shows that caregivers are representative of Alzheimer's Association's findings. In SFY 2023, the AAAs provided services to 296 caregivers caring for individuals with dementia. Those caregivers had been providing care for the care recipient for an average of 4.9 years. The caregivers assessed strain index showed that 88 percent of caregivers served experienced high stress compared to 73 percent of caregivers served who were not caring for an individual with dementia. Those caregivers received counseling, respite, case management, and options counseling[70].

Iowa ranks 27th in the nation for the number of home health care workers per 1,000 population ages 65 and over with a ratio of 39.0 vs. an average U.S. ratio of 61.0[71]. In 2022, the entry level wage for a home health and personal care aid was $11.45 with an experience hourly wage of $15.62[72]. This wage is below the estimated $20.89 living wage needed for one adult working with no children and $19.98 estimated living wage needed to help cover the cost of two adults working and their child's minimum basic needs while still being self-sufficient[73]. Addressing direct care workforce shortages is an elevated issue to be addressed within Iowa's Multisector Plan for Aging. ADS will lead efforts to bring state agencies, community partners, and people with lived experience together to create a long-term strategic plan on how to ensure Iowa has the direct care workforce needed to provide essential in-home care services to Iowa's older adults and people with disabilities.

Emergency Preparedness

The National Institute on Aging states, “while everyone is at risk during a natural weather-related disaster or similar emergency, older adults can be especially vulnerable during these challenging times. Being prepared in advance can literally mean the difference between survival and death, particularly for those who may have special medical or mobility needs.” In 2024, Iowa experienced 14 state disaster proclamations and three presidentially declared disasters related to severe storms, flooding and tornadoes. All six AAAs had counties that were impacted in their planning and service areas. When a disaster occurs, ADS notifies the impacted AAA(s) and offers additional support as needed. Resources on how to apply for State and Federal disaster assistance are also shared. Refer to **Attachment B:** Information Requirements for details on additional state assurances regarding emergency coordination and planning efforts.

Methodology: Developing State Plan Goals and Objectives

ADS engaged in a multi-year assessment process that involved research, data analysis from multiple reliable data sources, stakeholder feedback and partner engagement to develop the context information provided above and the goals and strategies identified in this plan. Those efforts are summarized here. Additional information is available in attachments to this plan.

Internal SUA and AAA Assessment

On October 12, 2022, ADS held a facilitated session with all six AAA directors and key program staff to identify issues and priorities that are most critical to Iowans as they age. The findings from the discussion were used as an initial guide for developing a Multisector Plan for Aging and a State Plan on Aging. AAA-elevated concerns included 1) access to services, 2) affordability of services, 3) social isolation/social supports in community, 4) funding, 5) skilled workforce, 6) competing priorities, and 7) coordination of services. Recommendations AAAs identified for strengthening communities and the ADRC/No Wrong Door system included 1) better coordination of statewide services/closed loop referrals, 2) age- and dementia-friendly communities, 3) sustainable and flexible funding, and 4) better communication across the ADRC/NWD system.

In 2023, ADS implemented an assessment with AAAs to identify needs, inform goals, develop objectives, strategies, and measures. The assessment was used to define how ADS will fulfill its vision to maximize independence of aging Iowans, support caregivers, and achieve its core values of person first, collaboration, compassion, reliability, knowledge, excellence. As a part of the internal review process, ADS assessed the current State Plan and AAA Area Plans to identify common needs and service gaps.

Each strategy was assessed to determine what had been accomplished and what needed to carry forward within the new State Plan.

As a part of the external review process, ADS assessed state evaluations, plans, and data reports to identify populations in greatest economic need and greatest social need, underserved areas, unmet needs, service needs and gaps, and emerging trends within Iowa's aging and disability network and long-term services and supports system. A list of specific documents used to help shape the State Plan is located within Attachment F.

AAAs also conducted regional community needs assessments using demographic data, OAA service usage data, community surveys, participant feedback, and discussions with local advisory boards, community stakeholders, service providers, OAA consumers, and target populations. ADS provided technical assistance throughout the 2024 calendar year to ensure AAAs were well equipped and supported in implementing a community needs assessment. AAAs were required to use assessment findings to identify unmet needs for populations of greatest economic need and greatest social need to address within their area plans on aging.

The State Plan on Aging goals and objectives were used to develop a template for AAAs to complete their area plans on aging. AAAs selected objectives, strategies, target populations, and measures that most closely aligned with their community needs assessment findings. AAAs then submitted a draft of their area plan narratives to help further refine the strategies listed for each of the State Plan objectives.

ADS shared the State Plan on Aging goals and objectives with AAAs, other HHS divisions and community partners to further integrate and align ADS' work with existing efforts. A complete draft was reviewed by a select group of stakeholders and HHS/ADS management. A summary of the State Plan on Aging was posted for public comment 14 days prior to holding a public hearing. The public was given the opportunity to submit comments using a written form via email or mail, and/or by attending the virtual public comment session. Refer to **Attachment E**: Evidence of Providing the Minimum Comment Period for details on the public comment session.

Multisector Plan for Aging (MPA) Assessment

Iowa is in the process of developing an MPA as a part of the IA SAIL: Iowa Solutions for Aging with Independence and Longevity project. An MPA is a cross-sector, state-led strategic planning resource to help improve the infrastructure and coordination of services for Iowa's aging population as well as people with disabilities. IA SAIL brings together government agencies, community partners, and nonprofits to plan for and address aging issues. The Iowa MPA mission is *to understand, plan for and address aging issues across multiple sectors and systems and to ensure everyone has access to person-centered services and supports needed to age well within their community of*

choice. The Iowa MPA vision is: *All persons in Iowa age with independence and health across their lifespans*. Please refer to **Attachment F** for information on the MPA community engagement process and a list of partners.

The ten most frequently shared issues across all community engagement strategies are listed below. Iowa HHS has elevated these areas of focus for further study and will provide the foundation for developing Iowa's first MPA.

- **Access to Health and Community Based Services (HCBS)** – Accessing services that allow people to stay in their homes or community settings for as long as possible.
- **Informal Caregiver Support** – Connecting to information and resources to help with mental, physical, and financial stressors of informal caregiving.
- **Direct Care Worker/Professional Support** – Addressing concerns about the Direct Care Worker/Professional workforce shortage and low pay/benefits.
- **Coordination of Services and Person-centered Services** – Removing barriers to navigating system of services. Also includes training, education, and opportunities for incorporating person-centered strategies into service delivery.
- **Health Disparities** – Addressing concerns about language competency, understanding and respecting cultural values, and access to health care for underserved populations.
- **Paying for Services** – Paying for doctors, dentists, mental health care, and other medical services, prescriptions, long-term care, and some medical bills.
- **Transportation** – Availability of community transportation options in rural areas, safe driving, making vehicle modifications to support drivers and passengers with disabilities, transportation to healthcare appointments, and community events and social engagements.
- **Affordable and Accessible Housing** – Accessibility and affordability of housing options for independent living.
- **Social Isolation** – Identifying at-risk persons for loneliness and social isolation and offering meaningful interventions.
- **Quality of Care** – Assessing for and continuing to improve the quality of care provided in both public and private sectors.

Connections to Other State Plans

Once the MPA focus areas were identified, ADS began to align and integrate MPA findings with other State plans to enhance and not duplicate existing efforts. Healthy Iowans State Health Assessment and State Health Improvement Plan are existing State efforts with multiple connection points. The 2021 – 2022 State Health Assessment had identified seven overarching health disparities that can impact the health and wellbeing of Iowans including: access to care, economic stability & income, housing, mental health & mental disorders, active living & eating, substance use, and cancer. The 2023 - 2028 State Health Improvement Plan itself is focused on addressing 1) access to care related to behavioral health and 2) active living and healthy eating related to food insecurity and increasing physical activity.

After identifying common goals, ADS and the Healthy Iowans Team developed an integrated framework to guide work moving forward. Below is a crosswalk on how Iowa's SHA, SHIP, MPA and State Plan on Aging goals align. Moving forward, three MPA workgroups will be formed to further enhance the State's collective efforts.

Table 7: Crosswalk of Common State Plan Goals

State Health Assessment (SHA)	State Health Improvement Plan (SHIP)	Multisector Plan for Aging (MPA)	State Plan on Aging
State Health Assessment Priority: Access to Care	Improve access to behavioral health services for all people in Iowa Strengthen Iowa's behavioral health system by increasing available resources and capacity	Goal: Increase the number of available and inclusive health and human services Focus Area 1 & 2: Access to HCBS/Person-Centered Services Focus Area 3: Direct Care Professionals Support Focus Area 4: Health Disparities Focus Area 5: Quality of Care	Maximize Independence - Older adults have access to high quality, equitable and person-centered services that maximize independence, community integration and self-sufficiency
State Health Assessment Priority: Economic Stability and Income	No current goals identified	Goal: Increase the number of affordable and accessible housing and transportation options Focus Area 6: Paying for Services	No current goals identified

State Health Assessment (SHA)	State Health Improvement Plan (SHIP)	Multisector Plan for Aging (MPA)	State Plan on Aging
Housing		Focus Area 7: Affordable and Accessible Housing Focus Area 8: Affordable and Accessible Transportation	
State Health Assessment Priority: Mental Health and Mental Disorders	Improve access to behavioral health services for all people in Iowa Strengthen Iowa's behavioral health system by increasing available resources and capacity	Goal: Increase community connections and support of socially isolated individuals and family caregivers Focus Area 9: Social Isolation Focus Area 10: Unpaid Caregiver Support	Stay Engaged and Supported - Older adults are supported by formal and informal caregivers of their choice and have social connections within their communities
State Health Assessment Priority: Active Living and Healthy Eating	Reduce barriers to affordable, nutritious foods for all people in Iowa. Increase engagement in active living among all people in Iowa.	No current goals identified.	Improve Health and Wellness - Older adults are empowered to utilize programs that improve their health and wellness.

Stewardship and Oversight

Iowa has six designated Area Agencies on Aging that provide OAA services to older adults aged 60 years and over, and adults aged 18 years and over with disabilities, and informal caregivers (refer to **Attachment D**). By the end of State Fiscal Year 2024, a total of 48,836 consumers received over 2.46 million units of OAA registered services.[8] OAA services were provided to residents living in all 99 counties in Iowa. The most utilized registered services by the number of consumers included information & assistance, followed by nutrition education, and then congregate nutrition. The following tables provide a summary of top utilized registered and non-registered services along

with total number of consumers served and units of service delivered with a description of the unit measure by the end of Federal Fiscal Year 2024. Refer to **Attachment F** for a complete list of registered and non-registered services, consumers served, and units of service delivered.

Table 8: FFY 2024 OAA Top Registered Services by Consumers Served and Units of Service Delivered

OAA Registered Services	Consumers Served	Units of Service Delivered
Information & Assistance	17,314	34,353 contacts
Nutrition Education	15,256	116,888 sessions
Congregate Nutrition	14,813	669,624 meals
Home Delivered Nutrition	9,289	1,153,956 meals
Health Promotion Non-Evidence Based	6,005	NA
Legal Assistance	3,324	11,982 hours
Caregiver Information & Assistance	3,823	7,240 contacts
Transportation		146,367 one-way trips
Options Counseling	3,077	15,190 hours
Homemaker	1,297	41,127 hours
Assisted Transportation	1,150	44,813 one-way trips

Table 9: FFY 2024 OAA Top Non-Registered Services by Consumers Served and Units of Service Delivered

OAA Non-Registered Services	Consumers Served	Units of Service Delivered
Caregiver Information Services	65,689	526 activities
Outreach	6,135	8,411 contacts
Legal Assistance	3,324	11,982 hours

Below are demographics of a typical OAA registered service consumer. Percentages are calculated based on the number of consumers who completed demographic questions related to their age, sex, and household status.

- 91 percent or 38,748 are aged 60 years and over.
    - 47 percent or 18,138 are aged 60-74 years.
    - 32 percent or 12,388 are aged 75-84 years.
    - 21 percent or 8,222 are aged 85 years and over.
- 65 percent or 28,423 are female.
- 53 percent or 20,069 live alone.

Below are demographics of populations in greatest economic need and greatest social need receiving an OAA registered service. Percentages are compiled based on consumers who completed demographic questions related to their geographic location, poverty status, racial minority status.

Table 10: Iowa Population & OAA Service Consumers

Characteristic[74]	Iowa's Population	OAA Consumers
Rural	36.85%	58% (27,359)
Federal Poverty	9.4%	30%(10,911)
Racial Minority	5.9%	6.0% (2,330)
Hispanic	2.0%	1.95% (706)

Effective Management

The ADS' management process focuses on the state plan on aging and aging area plans on aging outcomes, compliance, quality data collection, and consumer input to identify positive outcomes and areas of constraint or concern. ADS and AAA staff utilize quarterly reports as the basis for evaluation. This information identifies areas in need of discussion, best practices, barriers, and needs for technical assistance and training. The ADS uses quality improvement activities to ensure effective and responsive management of the aging network's resources. Refer to **Attachment G** for a schedule of annual activities.

Quarterly Performance Reports and Semi-annual Progress Meetings. ADS utilizes quarterly performance reports and semi-annual progress meetings to assess progress on plan activities and outcomes. The ADS, in collaboration with the AAAs, identify a core set of performance measures for service outcomes that are included in quarterly reports. ADS staff meet with each AAA twice annually to review progress and develop technical assistance or share successful strategies. These annual meetings also serve to gather feedback on state performance goals and on emerging trends and needs. During the next plan period, the ADS will work to establish realistic, yet consumer-focused performance standards for these measures.

Ensuring Consistent, High-Quality Data Collection. ADS uses several dashboards to track consumer impact, service delivery targets and resource usage and to evaluate whether AAA services are meeting a consumer's self-identified needs. Staff review missing or erroneous data to identify and correct data entry problems. Particular attention is given to required reporting elements and sharing best practices on consumer data collection methods. ADS issues missing data reports to AAAs when a threshold of 10 percent or greater is noted as missing.

Evaluating Performance with Measurable, Data-Driven Outcomes. ADS uses a performance evaluation process focused on positive outcomes for older Iowans, Iowans with disabilities, and their families and caregivers. ADS will engage in the following quality assurance activities over the plan period:

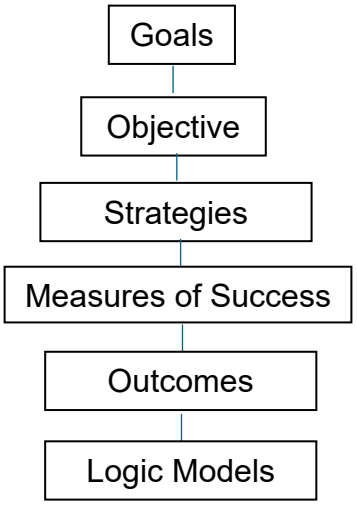
Evaluate Service Funding and Expenditure Requirements. The ADS will research the effectiveness and impact of establishing funding levels for select services and implementing unit cost methodologies for those services.

Continuous Improvement Activities. ADS works with the HHS Compliance division to complete the most recent quality improvement activity focused on the fiscal processes. ADS may also conduct surveys, focus groups and similar activities to obtain consumer feedback that will inform quality improvement activities.

Goals, Objectives, Strategies, and Outcomes

To address the growing needs of older Iowans and caregivers, four main goal areas have been created to describe the strategic direction in which the State is moving. Underneath each goal is a desired long-term outcome to describe the benefits older adults will experience from the State Plan on Aging goals. Objectives provide clarity on the steps that will be taken to achieve the goals. Strategies outline how the State along with the Aging Network will accomplish the goals and objectives. Area Agencies on Aging collect data on common statewide performance measures. AAAs' measures capture service delivery performance and ADS' measures capture service system performance. The two performance measures work together to achieve the desired outcomes. Conceptional logic model on how activities across different entities and service systems relate to short-term, intermediate and long-term outcomes are located within **Attachment F**.

Figure 3: Flow of Information Diagram



Goal 1: Maximized Independence

Desired Long-term Outcome: Older adults have access to high quality, equitable and person-centered service that maximize independence, community integration, and self-sufficiency.

What ADS is doing:

Objective 1.1: The Aging Network provides objective, decision-making information and person-centered service navigation.

#	Strategy
1.1a	Establish and annually assess an ADRC Technical Assistance and Call Center charged with providing training, technical assistance, a resource database, and a statewide call center.
1.1b	Create an internal Iowa HHS critical response team for older adults and family caregivers modeled on the response teams utilized by the Iowa HHS disability services and Medicaid.
1.1c	Convene multi-disciplinary ADRC meeting that includes ADRC member organizations and other interested stakeholders to increase collaboration of ADRC member organizations, identify system barriers and solutions, evaluate reach to priority populations and provide training on how to make appropriate referrals to OSLTCO and Adult Protective Services.
1.1d	Expand the Iowa ADRC member organizations to establish statewide coverage and include organizations focused on serving individuals with disabilities and their caregivers and organizations focused on serving older individuals and their caregivers.
1.1e	Identify opportunities for co-location of one or more services with ADRC member organizations and other local partners within each planning and service area.
1.1f	Provide eight hours of annual continuing education opportunities to ADRC member organizations based on evaluation activities that annually identify needs from navigators.
1.1g	Hold discussions biannually with AAAs and Tribal communities to coordinate efforts among Title III programs and Title VI Native American programs.
1.1h	Infuse hope-centered language and processes into the intake and assessment to use across the aging network, streamline intake process, and reduce consumer burden.

Objective 1.2: Older adults receive person-centered care coordination to reduce housing instability and risk of institutionalization.

#	Strategy
1.2a	Ensure older individuals at risk for unnecessary institutional placement have access to case management services that connect them with in-home supports with an emphasis on serving those with mobility issues in need of transportation living in rural areas.
1.2b	Coordinate with the Iowa Community Care Hub to increase referral pathways for services and explore diversified funding options for services.
1.2c	Expand resources to support ADRC activities through: 1. Increase organizations that participate in ADRC Medicaid Administrative

#	Strategy
	Claiming (MAC); and 2. Improve service coordination for waiver-covered services and increase connection to benefits programs available through Medicare Improvement for Patients and Providers Act (MIPPA).
1.2d	Increase care coordination and appropriate referrals among Iowa HHS Program of All-Inclusive Care for the Elderly (PACE) and OAA Case Management programs.
1.2e	Increase care coordination between managed care organizations and ADRC Network.
1.2f	Assess training needs of case managers and develop training in coordination with ADRC Technical Assistance and Call Center based on identifiable needs such as dementia capable, trauma-informed and how best to outreach and serve at-risk and underserved populations.

Goal 1 Measures of Success

AAA Measure	ADS Measure	Desired Outcome
#/% of information and assistance callers indicating they received the information they were seeking.	# counties served by an ADRC member organization with a disability and older adult focus.	Older adults will receive information in a manner that allows them to make educated decisions about long-term supports and how to obtain them.
#/% of options counseling consumers who indicate they were provided information to make an informed decision on goal and service need.	# of entities in Aging Network using and shared hope-centered intake and assessment.	Older adults will receive accurate information and guidance in a manner that allows them to make informed choices about long-term supports and how to obtain them.
#/% of case management cases closed because case management service was no longer needed.	# of trainings added/adapted based on identified needs	An increase in the number of at-risk and underserved case management consumers cases closed due to received supports and services they need to remain at the residence of their choice for as long as services are needed or desired.
Average number of months a case management consumer experiencing independent living impairments can remain safely at home prior to transitioning to facility.	#/% of referrals accepted by HHS PACE program from OAA case management.	An increase in the number of at-risk and underserved case management consumers who receive supports and services for as long as they need or desire them to remain in their community of choice.

Goal 2: Improve Health and Wellness

Desired Long-term Outcome: Older Adults make healthy lifestyle choices to reduce risk of chronic diseases and fall injuries.

What ADS is doing:

Objective 2.1: Older adults make healthy lifestyle choices to reduce risk of chronic diseases and fall injuries.

#	Strategy
2.1a	Collaborate with Iowa HHS Public Health Injury Prevention to coordinate statewide falls prevention which includes evidence-based fall prevention programs offered by the aging network.
2.1b	Provide technical assistance to Area Agencies on Aging on implementing referral pathways between health promotion programming and nutrition services.
2.1c	Identify and leverage data to improve access to services for those in greatest need, including identifying gaps in service delivery and availability.
2.1d	Collaborate with the Nutrition and Aging Resource Center, National Chronic Disease Self-Management Education Resource Center, the National Falls Prevention Resource Center and the National Council on Aging to deliver an engaging session at the 2025 Age + Action conference highlighting innovative grantee work to promote healthy aging.

Objective 2.2: Older Iowans at risk for malnutrition or food insecurity have access to nutritious food.

#	Strategy
2.2a	Collaborate with the State Health Improvement Plan and Iowa HEAL Partnership to reduce food insecurity for older adults by expanding partnerships, supporting innovation, leveraging resources, improving availability and purposeful use of food and nutrition insecurity data, integrating lived experiences, and educating stakeholders.
2.2b	Provide technical assistance to AAA on evaluating appropriate evidence and leveraging transfer flexibility in the provision of “grab and go” meals that enhance and not diminish the congregate meals program.
2.2c	Implement standardized consumer satisfaction surveys for nutrition consumers to assess quality of services.
2.2d	Consult with the AAAs on processes that easily identifies consumers whose intake or assessment responses show risk for malnutrition for referrals to additional service interventions, such as nutrition counseling or options counseling or other supports through the NWD system.
2.2e	Provide technical assistance to AAA nutrition directors and service providers on malnutrition risk factors, malnutrition risk screenings, and malnutrition.

#	Strategy
2.2f	Revise the nutrition policies and procedures to reflect a modernized approach to services that includes adjustments for cultural considerations and medically tailored meals.
2.2g	Develop resources to capture learnings and needs identified by the AAA Malnutrition Learning Collaborative that will benefit aging nutrition programs. The resource will address organizational and participant focused approaches and activities to address malnutrition risk factors, malnutrition risk and malnutrition.

Objective 2.3: Older adults receive transitional care from hospital to home to reduce risk of readmission or institutionalization.

#	Strategy
2.3a	Provide Iowa Return to Community (IRTC) program services at discharge to older individuals who are at high risk for hospital readmission.
2.3b	Coordinate efforts with University of Iowa Center for Disabilities and Development at University of Iowa and Easterseals Iowa to increase access to assistive technology options for IRTC consumers as needed and appropriate.
2.3c	Coordinate with Iowa's Medicare Rural Hospital Flexibility Program (Flex Program) to connect rural, critical access hospitals with community providers; develop a mechanism for increasing revenue to the system to provide supports.
2.3d	Coordinate efforts with the Office of the State Long-Term Care Ombudsman to refer individuals returning home from skilled nursing to AAAs for service navigation.

Goal 2 Measures of Success

AAA Measure	ADS Measure	Desired Outcome
#/% of nutrition consumers served who indicate during intake that they are lonely or socially isolated.	#/% of new vs. existing nutrition consumers served who indicate during intake that they are lonely or socially isolated.	Older adults who are at risk for social isolation have more opportunities for community engagement through referrals to congregate nutrition, evidence-based programming or other programs and services of their choice.
#/% of nutrition consumers served who indicate during intake that they are at higher nutrition risk.	#/% of consumers served who indicate during intake that they are at high nutrition risk and receiving nutrition counseling.	Older adults who are at high nutrition risk receive service interventions that directly address their specific risk area.
#/% nutrition consumers served who indicate during intake that they are food insecure.	#/% of new vs. existing consumers served who indicate during intake that they are at risk for food insecure.	The aging network is successfully reaching older adults who are at risk for food insecure connected to OAA and other nutrition programs.

AAA Measure	ADS Measure	Desired Outcome
#/% nutrition consumers served who indicate during intake that they are at risk for malnutrition.	#/% of new vs. existing consumers served who indicate during intake that they are at risk for malnutrition.	Older adults who are at risk for malnutrition receiving meaningful interventions to reduce their risk of malnutrition.

Goal 3: Improve Safety and Quality of Life

Desired Long-Term Outcome: Older adults are safe from all forms of mistreatment and are empowered to improve their quality of life.

What ADS is doing:

Objective: 3.1: Older adults prepare for emergencies and are safe from abuse.

#	Strategy
3.1a	Assess Elder Abuse and Prevention screening tools utilized by AAAs and Iowa HHS dependent adult assessment tools to align screenings and intervention tactics.
3.1b	Implement a statewide and regional structure for adult protective responses, including multidisciplinary teams, to address duplication of adult protective responses, improve outcomes for individuals, and clarify appropriate response.
3.1c	Provide trauma-informed training to ADRC navigators, Elder Rights specialists, and Adult Protective staff who work directly with individuals who may experience abuse, neglect, or exploitation.
3.1d	Implement a memorandum of understanding between Sac and Fox Tribe of the Mississippi (Meskwaki Nation) and Adult Protective Services that outlines a process for dependent adult abuse reports involving a tribal member.
3.1e	Implement a coordinated emergency response plan with the AAAs, Tribal communities, and the Iowa HHS emergency response team.
3.1f	Participate on the PrepWise Advisory Board to support and guide further development and promotion of online emergency preparedness tool among the aging and disability network.

Objective 3.2: Older adults' access legal assistance and Office of State Long-Term Care Ombudsman (OSLTCO) to advocate for their rights.

#	Strategy
3.2a	Direct the coordination between the AAAs and Iowa legal services to individuals in greatest economic need and greatest social need.
3.2b	Provide legal assistance education and networking for organizations serving older relatives caring informally for grandchildren not involved in the juvenile court system. Example partnerships include Iowa Area Education Agencies, Iowa HHS Women, Infants, and Children programs, and Iowa HHS early childcare programs.

#	Strategy
3.2c	Provide legal assistance education and networking for organizations who may serve older relative caregivers caring for adult children with a disability. Potential topic areas include continuity of care in case of death or incapacity and supported decision making. Example partnerships include Iowa Targeted Case Management, Disability Access Points, and the ADRC.
3.2d	Provide estate training and planning resources to older Iowans. Work with public and private sector entities to identify appropriate alternatives to public guardianship and to develop a data-driven approach to identifying those individuals best served by public guardianship services.
3.2e	With support from the OSLTCO staff increase the number of Family Councils to build additional support around residents in long-term care facilities.
3.2f	Increase in-person facility visits to provide additional oversight and ensure residents have access to OSLTCO services.
3.2g	Restructure and streamline the volunteer OSLTCO program certification process and develop strategies to increase retention rates.

Goal 3 Measures of Success

AAA Measure	ADS Measure	Desired Outcome
#/% of elder abuse prevention and assessment (EAPA) consultation consumers whose needs are met through provider referrals for self-advocacy.	#/% of ADRC navigators, Elder Rights specialists, and Adult Protective staff who work directly with individuals who may experience abuse, neglect, or exploitation provided with trauma-informed training.	Individuals seeking information and referrals will have appropriate information to self-advocate in resolving a situation involving abuse, neglect, or exploitation situations.
#/% of EAPA assessment and intervention consumer cases closed with services no longer needed.	Streamlined EAPA and HHS dependent adult assessment tool that aligns with intervention tactics.	Increase the number of EAPA assessment and interventions consumer cases with services no longer needed.
# of OAA consumers receiving legal assistance.	% of individuals in greatest need receiving legal assistance.	Increase legal assistance services to populations in greatest economic need and greatest social need.
#/% of consumers with unmet legal assistance needs.	# of legal assistance education and networking opportunities offered.	Decrease the number of older adults with unmet legal assistance needs.
NA	# of existing and new family councils engaged with by the OSLTCO	Increase the number of family councils engaged with by the OSLTCO

AAA Measure	ADS Measure	Desired Outcome
NA	% of long-term care facilities that receive a yearly visit by OSLTCO staff.	Ensure all long-term care facilities receive at least one annual visit by OSLTCO staff.

Goal 4: Stay Engaged and Supported

Desired Long-Term Outcome - Older adults are supported by formal and informal caregivers of their choice and have social connections within their communities.

What ADS is doing:

Objective 4.1: Older adults participate in social engagement opportunities to reduce loneliness and prevent social isolation.

#	Strategy
4.1a	Expand access to social engagement opportunities by connecting older adults at risk for social isolation with meaningful interventions of their choice.
4.1b	Coordinate efforts among State Plan on Aging, Multisector Plan for Aging, State Health Improvement Plan, and HHS Behavioral Health division to address social isolation.
4.1c	Iowa Workforce Development (IWD) coordinates Iowa's Senior Community Service Employment Program (SCSEP) and will provide funding to a sub-grantee July 1, 2025, through June 30, 2026. Information on how to make referrals to new subgrantees will be shared with AAAs and ADRC partners.

Objective 4.2: Caregivers receive supportive services to reduce risk of stress, depression, and financial cost burden.

#	Strategy
4.2a	Assess caregivers for their level of caregiver strain and provide at-risk caregivers with additional supports to reduce stress, depression, and/or financial cost burden.
4.2b	Coordinate efforts among State Plan on Aging, Multisector Plan for Aging, State Health Improvement Plan, and HHS Behavioral Health division to address caregiver stress and depression.
4.2c	Expand access to programs, services, and supports in rural areas by addressing direct care workforce shortage through Multisector Plan for Aging efforts and by looking for future funding opportunities to support caregivers in greatest need such as the Lifespan Respite Care program.
4.2d	Utilize the Grand Families & Kinship Support Network National Technical Assistance Center to coordinate activities focused on learning opportunities, enhancing the quality of services available and building a capacity to better serve kinship/grand families.

Objective 4.3: Age-Friendly and Dementia Capable communities support older adults as they age in place.

#	Strategy
4.3a	Expand/implement dementia specific training for options counselors that increases ability to recognize the unique needs of people living with dementia and their caregivers.
4.3b	Participate in the HHS Division of Public Health's BOLD (Building Our Largest Dementia Infrastructure) Coalition to help update and implement Iowa's State Strategic Plan for Alzheimer's Disease & Related Dementias.
4.3c	Collaborate with and support efforts on becoming and age-friendly state through the Multisector Plan for Aging efforts.
4.3d	Coordinate efforts among State Plan on Aging, Multisector Plan for Aging, and HHS Division of Public Health on becoming a recognized Age-Friendly Public Health Systems (AFPHS) in Iowa.

Goal 4 Measures of Success

AAA Measure	ADS Measure	Desired Outcome
#/% of caregiver consumers indicating Caregiver Counseling and/or Respite are service allowed them to maintain their caregiver role, with particular attention to caregivers of persons experiencing dementia.	#/% of Aging Network staff who participant in dementia specific training.	Caregivers are provided the supports needed to continue to provide informal care to care recipients experiencing dementia.
#/% of congregate nutrition consumers who score 6 or higher for being at risk for social isolation during intake.	#/% of new vs. existing congregate nutrition consumers who score 6 or higher for being at risk for social isolation during intake.	Congregate nutrition consumers at higher risk of social isolation receive meaningful, person-centered interventions to reduce their social isolation.
#/% of home delivered nutrition consumers who score 6 or higher for being at risk for social isolation during intake.	#/% of new vs. existing home delivered nutrition consumers who score 6 or higher for being at risk for social isolation during intake.	Home delivered nutrition consumers at higher risk of social isolation receive meaningful, person-centered interventions to reduce their social isolation.

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Attachment A – State Plan Assurances and Required Activities

Supporting Older Americans Act, As Amended in 2020

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2020.

Sec. 305, ORGANIZATION

(a) In order for a State to be eligible to participate in programs of grants to States from allotments under this title—. . .

(2) The State agency shall—

(A) except as provided in subsection (b)(5), designate for each such area after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area;

(B) provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan; . . .

(E) provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas), and include proposed methods of carrying out the preference in the State plan;

(F) provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16); and

(G)(i) set specific objectives, in consultation with area agencies on aging, for each planning and service area for providing services funded under this title to low-income minority older individuals and older individuals residing in rural areas;

(ii) provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals;

(iii) provide a description of the efforts described in clause (ii) that will be undertaken by the State agency; . . .

(c) An area agency on aging designated under subsection (a) shall be—…

(5) in the case of a State specified in subsection (b)(5), the State agency;

and shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in

accordance with the plan within the planning and service area. In designating an area agency on aging within the planning and service area or within any unit of general purpose local government designated as a planning and service area the State shall give preference to an established office on aging, unless the State agency finds that no such office within the planning and service area will have the capacity to carry out the area plan.

(d) The publication for review and comment required by paragraph (2)(C) of subsection

(a) shall include—

(1) a descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic or social need,

(2) a numerical statement of the actual funding formula to be used,

(3) a listing of the population, economic, and social data to be used for each planning and service area in the State, and

(4) a demonstration of the allocation of funds, pursuant to the funding formula, to each planning and service area in the State.

Note: States must ensure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306, AREA PLANS

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who

are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3)(A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated;

(4)(A)(i) (I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(IV) older individuals with limited English proficiency;

(V) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals

participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs; and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health

services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

(14) provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title;

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;
(B) land use;
(C) housing;
(D) transportation;
(E) public safety;
(F) workforce and economic development;
(G) recreation;
(H) education;
(I) civic engagement;
(J) emergency preparedness;
(K) protection from elder abuse, neglect, and exploitation;
(L) assistive technology devices and services; and
(M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2)(A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3)(A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

Sec. 307, STATE PLANS

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then

the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) develop a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) that have the capacity and actually meet such need; and

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8)(A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency—

(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;

(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for

fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low- income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs

and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27)(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

(28) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

(29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS

(a) ELIGIBILITY. In order to be eligible to receive an allotment under this subtitle, a State shall include in the state plan submitted under section 307—

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order...

Kelly Garcia Director 06/12/2025

Signature and Title of Authorized Official *Date*

Attachment B – Information Requirements

Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (d) requires each State Plan must include a description of how greatest economic need and greatest social need are determined and addressed by specifying:

(1) How the State agency defines greatest economic need and greatest social need, which shall include the populations as set forth in the definitions of greatest economic need and greatest social need, as set forth in 45 CFR § 1321.3; and

(2) The methods the State agency will use to target services to such populations, including how OAA funds may be distributed to serve prioritized populations in accordance with requirements as set forth in 45 CFR § 1321.49 or 45 CFR § 1321.51, as appropriate.

"Greatest economic need" means the need resulting from an income level at or below the Federal poverty level and as further defined by State and area plans based on local and individual factors, including geography and expenses (45 CFR § 1321.3).

"Greatest social need" means the need caused by the following noneconomic factors as defined in 45 CFR § 1321.3.

A State agency's response must establish how the State agency will:

(1) identify and consider populations in greatest economic need and greatest social need;
(2) describe how they target the identified the populations for service provision;
(3) establish priorities to serve one or more of the identified target populations, given limited availability of funds and other resources;
(4) establish methods for serving the prioritized populations; and
(5) use data to evaluate whether and how the prioritized populations are being served.

RESPONSE:

(1) *Populations in greatest economic need and greatest social need.*
ADS determined the greatest economic need and greatest social need populations in Iowa per the requirements in the following by order of precedence: (1) statute; (2) executive order; (3) 45 CFR Part 1321 program regulations; (4) 2 CFR Part 200 as codified by HHS at 45 CFR, Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards; (5) Iowa HHS policies; and (6) any additional terms and conditions and remarks on Notice of Awards.

Other needs defined in the state and area plans were based on these local and

individual factors:

- Additional greatest economic need considerations:
  - Geography and expenses.
  - Persons living with low-income up to 300 percent of the Federal poverty level.
  - Persons applying for State benefits for self or other persons aged 60 years and over and need assistance during application process.
  - Caregivers who are experiencing or at risk for stress, depression, and financial cost burden due to their caregiver role.
  - Caregivers who need additional support in assisting others to live independently.

- Additional greatest social need considerations:
  - Living in underserved areas
  - Living alone
  - Persons aged 60 years and over who screen at higher nutrition risk
  - Persons aged 60 years and over with a substance use condition

(2) *Addressing service needs for populations in greatest economic need and greatest social need.*

ADS shared planning and service area (PSA) specific population demographics and service usage data to assist AAAs and with their needs assessment. Data sources and methodology used to identify greatest economic need and greatest social need and assess need are defined in the Context section and the endnotes. Refer to Attachment F for additional data sources used to assess needs.

(3) *Priorities to serve target populations with available resources.*

ADS used statewide data to identify priority needs as outlined in the plan narrative.

- ADS will continue to use its existing IFF methodology. For FFY 2026, ADS will utilize the most recent population data as of October 2025 to weight allotments for Title III B, C(1), C(2), and E funds. Title III D utilizes poverty population data and the number of physicians per 1000 of Iowans aged 60 years and over.

- AAAs include expenditure projections for their prioritized populations in their area plans.

(4) *Methods for serving the prioritized populations.*
AAAs use their needs assessment to identify in their Area Plan on Aging the populations of greatest economic need and greatest social need for each of their objectives. This approach directs OAA funding to those most in need at the local level.

(5) *Methods to evaluate whether and how the prioritized populations are being served.*
ADS will implement an internal plan monitoring tool to ensure the implementation

and evaluation of the strategies defined in the plan narrative. In addition, uses several dashboards and reports to evaluate progress and outcomes for prioritized populations (refer to Stewardship / Oversight section in the plan narrative for details).

Native Americans: Greatest Economic and Greatest Social Need

45 CFR § 1321.27 (g):
Demonstration that the determination of greatest economic need and greatest social need specific to Native American persons is identified pursuant to communication among the State agency and Tribes, Tribal organizations, and Native communities, and that the services provided under this Part will be coordinated, where applicable, with the services provided under Title VI of the Act and that the State agency shall require area agencies to provide outreach where there are older Native Americans in any planning and service area, including those living outside of reservations and other Tribal lands.

RESPONSE:
Methods to ensure the SUA/AAAs will coordinate Title III and Title VI services among the state agency and the PSAs.
The AAAs must assess and describe in their SFY 2026-2029 Area Plan on Aging how they intend to reach out to Tribes, Tribal organizations, and Native communities with Title III services within the agency's planning and services area.

One AAA has a Title VI program operating within their planning and service area. The AAA must provide the following information in their area plan for approval.

- Describe how your AAA has developed policies and procedures in coordination with the Title VI program director located in your planning and service area.
- How does your AAA, including contact service providers, provide outreach to Tribal elders and family caregivers regarding service for which they may be eligible under Title III?
- How does your AAA, including contact service providers, provide outreach to Tribal elders and family caregivers regarding service for which they may be eligible under Title III?
- Describe how Title VI programs may refer individuals who are eligible for Title III services.

Activities to Increase Access and Coordination for Native American Older Adults

OAA Section 307(a)(21):
The plan shall —…

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

45 FR § 1321.53:

(a) For States where there are Title VI programs, the State agency's policies and procedures, developed in coordination with the relevant Title VI program director(s), as set forth in § 1322.13(a), must explain how the State's aging network, including area agencies and service providers, will coordinate with Title VI programs to ensure compliance with sections 306(a)(11)(B) (42 U.S.C. 3026(a)(11)(B)) and 307(a)(21)(A) (42 U.S.C. 3027(a)(21)(A)) of the Act. State agencies may meet these requirements through a Tribal consultation policy that includes Title VI programs.

(b) The policies and procedures set forth in (a) of this provision must at a minimum address:

(1) How the State's aging network, including area agencies on aging and service providers, will provide outreach to Tribal elders and family caregivers regarding services for which they may be eligible under Title III and/or VII;

(2) The communication opportunities the State agency will make available to Title VI programs, to include Title III and other funding opportunities, technical assistance on how to apply for Title III and other funding opportunities, meetings, email distribution lists, presentations, and public hearings;

(3) The methods for collaboration on and sharing of program information and changes, including coordinating with area agencies and service providers where applicable;

(4) How Title VI programs may refer individuals who are eligible for Title III and/or VII services;

(5) How services will be provided in a culturally appropriate and trauma-informed manner; and

(6) Opportunities to serve on advisory councils, workgroups, and boards, including area agency advisory councils, as set forth in § 1321.63.

RESPONSE:

Activities to increase access to services for older individuals who are Native Americans.

ADS coordinated two planning discussions with the Title VI - Meskwaki Nation aging specialist, human services director, and attorney general along with an AAA representative from the PSA in which the Meskwaki Nation resides. Based on those planning meetings, the following coordination activities developed in partnership.

1. Outreach opportunities provided to Tribal elders and family caregivers:
    - AAA with a Title VI program within their region shall participate in an annual health fair that is offered on the settlement and partner with the tribe to deliver Falls Prevention classes to tribal members.
2. Communication opportunities provided to Title VI programs:
    - ADS will share additional information regarding the State agencies programs and initiatives.
3. Method for collaboration on and sharing of program information and changes:
    - ADS will include the Title VI Program director on a distribution list to receive updates on information that is shared with AAAs funding opportunities.
    - Meskwaki Nation is working the Elder Abuse Prevention and Awareness and Adult Protective Services programs on an agreement to better coordination Title VII efforts regarding vulnerable elder rights protection activities.
4. Method for how Title VI programs may refer individuals who are eligible for Title III and/or Title VII services:
    - ADS/AAA will develop a referral process for Tribal members to connect with Title III programs within their AAA service area as needed.
5. How services will be provided in a culturally appropriate and trauma-informed manner:
    - ADS will include the Title VI Program director on a distribution list to receive updates on information that is shared with AAAs regarding trainings and technical assistance.
6. Opportunities to serve on advisory councils, workgroups, and boards, including area agency advisory councils include:
    - AAA with Title VI program within their service area invited the Title VI program director and/or another tribal member to participate on their Advisory Board.
    - Meskwaki tribal members have been invited by ADS to participate in developing a Multisector Plan for Aging through serving on the MPA Steering Committee and completing the online community survey.

Low Income Minority Older Adults

OAA Section 307(a)(14):
(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low- income minority older individuals with limited English proficiency.

RESPONSE:

Serving Low Income Minority Older Adults in Iowa.

(A) The U.S. Census Bureau American Community Survey 2023 5-year estimates show:
The number of low-income, minority individuals in Iowa: 99,358
The number of low-income, minority individuals with limited English proficiency: 18,080

(B) ADS provided the number of low-income minority older individuals and low-income, minority individuals with limited English proficiency to the AAAs for their PSA. AAAs are required to identify and prioritize services to the populations in their PSA with greatest economic need and greatest social need, including low income, minority adults aged 60 years and over and with limited English proficiency.

Rural Areas – Hold Harmless

OAA Section 307(a)(3):
The plan shall—...

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances the State agency will spend for each fiscal year not less than the amount expended for such services for fiscal year 2000;

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

RESPONSE:

With respect to services for older individuals residing in rural areas.

(i) The State agency will not spend less in rural areas than the amount expended for such services for fiscal year 2000. This requirement is accomplished through changes in the IFF that adopted in 2023 that enhanced the weighting factors for rural criteria.

(ii) Per U.S. Census Bureau, approximately 36.85 percent of Iowans aged 60+ live in rural areas. Additionally, the dollar per county factors in the IFF ensure that PSAs that have larger geographic areas to cover in rural areas receive more funding compared to more urban PSAs. Therefore, the ADS is projecting that of the estimated $14.7 million awarded in Title III funds, $6.4 million will be spent in rural areas. Refer to Attachment C for additional IFF information.

(iii) With only 10 of Iowa's 99 counties considered to be statistical metropolitan areas, Iowa is a largely rural state. The IFF addresses the rural populations in three ways. First, a defined per county amount is allocated for both State and Federal funding. Second, the State funding includes a triple weighting of the rural population in the calculation. Third, the Title IIID funding formula utilizes physicians concentrated in urban areas and provides additional funds to more rural PSAs. This approach provides a fair balance to address the needs of PSAs with greater population density within fewer counties and of those PSAs with populations spread across a greater number of counties. The approach ensures that all OAA consumers throughout Iowa have access to services to meet their needs.

Rural Areas – Needs and Fund Allocations

OAA Section 307(a)(10):

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

RESPONSE:

The Context section of the plan narrative includes an evaluation of service reach and service impact to older Iowans residing in rural areas. To ensure that the specific needs of older Iowans residing in rural areas are taken into consideration, the State agency and AAA staff review and evaluate the number and percentage of rural consumers served by agency and service. Service gaps and trend data trigger policy recommendations and technical assistance to AAAs and stakeholders as needed. Both federal and state formulas are weighted to ensure sufficient funds are available to serve rural populations. Please refer to **Attachment C** for more details showing weighted allocations for targeted populations.

Assistive Technology

OAA Section 306(a)(6)(I):
Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the area agency will, to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

RESPONSE:
Dissemination of information about access to assistive technology.
AAAs provide information on assistive technology options to older individuals in a variety of ways. OAA Information and Assistance service provides this information if someone contacts the AAA and requests information on assistive technology options. In SFY 2024, four of six AAAs served 166 older individuals and/or family caregivers with 546.3 units of supplemental assistance related to assistive technology/durable medical equipment. The State agency has a strategy within Goal 2 to coordinate efforts with the University of Iowa Center for Disabilities and Development and with Easterseals Iowa to increase access to assistive technology options for Iowa Return to Community (IRTC) consumers as needed and appropriate. The IRTC program helps support older individuals as they transition from a health care facility or nursing facility to living at home.

Minimum Proportion of Funds

OAA Section 307(a)(2):
The plan shall provide that the State agency will —…

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2). *(Note: those categories are access, in-home, and legal assistance. Provide specific minimum proportion determined for each category of service.)*

RESPONSE:
Iowa's Minimum Proportion of Title IIIB funds.
ADS ensures that AAAs expend a minimum percentage of OAA Title III-B funds, less administration costs, for priority services within the categories of Access, In-Home, and Legal Assistance services. The AAA fiscal reporting system includes validations to ensure that the minimum proportions are met in budgets and expenditures.

Category	Min. Percentage	Services
Access Services	10%	• Information & Assistance • Assisted Transportation • Transportation

Category	Min. Percentage	Services
		• Case Management • Outreach
In-Home Services	5%	• Adult Day Care/ Health • Chore • Homemaker • Personal Care
Legal Assistance Services	3%	Legal Assistance

Assessment of Statewide Service Delivery Model

OAA Section 307(a)(27):

(A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals aged 85 and older in the State is expected to affect the need for supportive services

RESPONSE:

The State agency has elected to not conduct an assessment.

Shelf Stable, Pick-Up, Carry-Out, Drive-Through, or Similar Meals Using Title III Congregate Nutrition (C-1) Service Funding (Optional, only for States that elect to pursue this activity)

45 CFR § 1321.87(a)(1)(ii):
Title III C-1 funds may be used for shelf-stable, pick-up, carry-out, drive-through, or similar meals, subject to certain terms and conditions:

(A) Such meals must not exceed 25 percent of the funds expended by the State agency under Title III, part C-1, to be calculated based on the amount of Title III, part C-1 funds available after all transfers as set forth in 45 CFR § 1321.9(c)(2)(iii) are completed;

(B) Such meals must not exceed 25 percent of the funds expended by any area agency on aging under Title III, part C-1, to be calculated based on the amount of Title III, part C-1 funds available after all transfers as set forth in 45 CFR § 1321.9(c)(2)(iii) are completed;

(iii) Such meals are to be provided to *complement* the congregate meal program:

(A) During disaster or emergency situations affecting the provision of nutrition services;

(B) To older individuals who have an occasional need for such meal; and/or

(C) To older individuals who have a regular need for such meal, based on an individualized assessment, when targeting services to those in greatest economic need and greatest social need; and

45 CFR § 1321.27 (j):

If the State agency allows for Title III, part C-1 funds to be used as set forth in §1321.87(a)(1)(i), the State agency must include the following:

(1) Evidence, using participation projections based on existing data, that provision of such meals will enhance and not diminish the congregate meals program, and a commitment to monitor the impact on congregate meals program participation;

(2) Description of how provision of such meals will be targeted to reach those populations identified as in greatest economic need and greatest social need;

(3) Description of the eligibility criteria for service provision;

(4) Evidence of consultation with area agencies on aging, nutrition and other direct services providers, other stakeholders, and the general public regarding the provision of such meals; and

(5) Description of how provision of such meals will be coordinated with area agencies on aging, nutrition and other direct services providers, and other stakeholders.

RESPONSE:

How Title III C-1 funds will be used for shelf-stable, pick-up, carry-out, drive-through, or similar meals.

The State agency will allow for Title III, part C-1 funds to be used as set forth in §1321.87(a)(1)(i) within the SFY 2026 – 2029 State Plan on Aging. Below are the

additional questions AAAs will complete within the SFY 2026-2029 Area Plan template if they anticipate using Title III C-1 funds for shelf stable and/or “grab and go” meals.

AAAs are given options to select either 1) agency does not intend to utilize grab and go meals in SFY 2026 or 2) agency anticipates using Title III C-1 funds of up to 25 percent, after all transfers are made, to be used for shelf stable and/or “grab and go” (pick-up, carry-out, drive-through or similar meals) in SFY 2026.

If AAAs select option two, they are prompted to complete the information below to describe how this service delivery approach complements the Congregate Nutrition program.

(1) Provide a description of how shelf stable and/or “grab and go” meals will improve congregate nutrition services, using participation projections based on existing data and how the area agency will track and evaluate the impact on congregate nutrition services.

(2) & (3) Provide eligibility criteria and how populations in greatest economic need and greatest social need will be prioritized for shelf stable and/or “grab and go” meals.

(4) & (5) Provide stakeholder input, including service providers and the public, regarding the need for and provision of shelf stable and/or “grab and go” meals, and how services will be coordinated.

To provide this assurance ADS will implement the following: 1) monitor the impact on congregate nutrition program participation, and 2) ensure that the eligibility criteria laid out in the area plan meets the requirement to complement the congregate program (during disaster or emergencies, to those with an occasional need, or to those with a regular need based on an individualized assessment and qualifying those in greatest economic need and greatest social need for services).

Funding Allocation – Ombudsman Program

45 CFR Part 1324, Subpart A:

How the State agency will coordinate with the State Long-Term Care Ombudsman and allocate and use funds for the Ombudsman program under Title III and VII, as set forth in 45 CFR part 1324, subpart A.

RESPONSE:

*State Agency coordination efforts with the Office of the State Long-Term Care Ombudsman***.** In 2023, the Iowa Department on Aging was aligned under the Iowa Health and Human Services department. The SUA director and the Older Americans Act Title III services operate under the Aging and Disability Services division. The Office of the State Long-Term Care Ombudsman (OSLTCO) operates under the Compliance division. Notice of Awards for both the Title III and Title VII programs are managed by the Fiscal division. Fiscal information will be shared with the OSLTCO in a timely

manner and budgetary issues will be discussed on a routine basis. The Title III and Title VII funded programs coordinate through regular meetings among the OSLTCO and SUA directors and Title III program staff. Joint initiatives include improvements in referrals among ADRCs and the OSLTCO for care transitions, coordination in emergency preparedness and response, and quality improvement project for the Preadmission Screening and Resident Review (PASRR) program.

Funding Allocation – Elder Abuse, Neglect, and Exploitation

45 CFR § 1321.27 (k):
How the State agency will allocate and use funds for prevention of elder abuse, neglect, and exploitation as set forth in 45 CFR part 1324, subpart B.

RESPONSE:

Addressing Elder Abuse, Neglect, and Exploitation.
ADS utilized both Title VII, part B funds and state funds for activities to develop and strengthen programs for the prevention, detection, assessment, and treatment of, intervention in, investigation of, and response to elder abuse, neglect, and exploitation. ADS utilizes its Title VII, part B funds to cover a portion of the Adult Abuse Prevention, Awareness and Coordination Officer position. This position serves as subject matter expert and coordinates activities between the AAA Elder Abuse Prevention and Awareness program and the Adult Protective Services program. The state provides state funds for the AAAs to provide abuse, neglect, and exploitation prevention, assessment, and service coordination for older adults who have experienced abuse.

Monitoring of Assurances

45 CFR § 1321.27 (m):
Describe how the State agency will conduct monitoring that the assurances (submitted as Attachment A of the State Plan) to which they attest are being met.

RESPONSE:
The State agency will conduct the following monitoring activities that we attest are being met in the assurances submitted as Attachment A of the State Plan.

- Document opportunities for public comment for Funding Formula process as required by OAA 305(a)(2)(B)
- Document how preference is given to providing services to older Iowans with greatest economic and social need as required by OAA 305(a)(2)(E)
- Document that ADS has required outreach efforts described in OAA 307(a)(16) as required by OAA 305(a)(2)(F)
- Document specific program development, advocacy and outreach efforts taken that focus on the needs of low-income minority older Iowans as required by 305(a)(2)(G)

- Verify from AAA annual expenditure reporting that the minimum adequate proportion amounts for services required in OAA section 307(a)(2) have been provided as required by OAA 306(a)(2)
- Document the amount spent in each federal year of the State Plan cycle for rural older Iowans to verify that the amount spent per year was not less than the funding amount for FY 2000 as required by OAA 307(a)(3)(B)
- Document the procedures used to assure proper disbursement of and accounting for, Federal funds paid to Iowa under the OAA as required by OAA 307(a)(7)(A)
- Document compliance with ADS conflict of interest policies and procedures as required by 307(a)(7)(B)
- Document that there is an Office of the State Long-Term Ombudsman and the funding for the office as required by OAA 307(a)(9)
- Document opportunities for rural older Iowans to provide public comment and how older Iowans living in rural areas are considered in distribution of funding as required by OAA 307(a)(10)
- Document how ADS complied with providing legal assistance as required by OAA 307(a)(11)
- Monitor AAA's EAPA programs and require corrective action to resolve any program requirements not met by the AAA as required by OAA 307(a)(12)
- Verify staff working with the Legal Assistance Developer and review plan and/or progress for developing legal assistance programs for older Iowans as required by OAA 307(a)(13)
- Document guidance provided to AAAs for provision of services under OAA 307(a)(15)
- Document outreach efforts required by ADS as required by OAA 307(a)(16)
- Document coordination annually as required by OAA 307(a)(17)
- Monitor AAAs strategies and implementation in conducting efforts to facilitate coordination of community-based long-term care services as required by OAA 307(a)(18)
- At the end of the State Plan cycle, ADS will report compliance with assurances required by OAA 307(a)(19)
- Document activities related to provision of technical assistance to minority service providers as required by OAA 307(a)(20)
- Document coordination with Title VI grantees and ADS work to increase access by Native American Older individuals to all aging programs as required by OAA 307(a)(21)
- Document any relevant case management activities that apply to OAA 307(a)(22)
- Report on completed activities for coordination of OAA services with other state services that support older Iowans as required by OAA 307(a)(23)
- Report on efforts to assist older Iowans with transportation services for access to OAA services as required by OAA 307(a)(24)

- Monitor and document AAA's compliance with measuring quality for in-home services as required by OAA 307(a) (25)
- Monitor and document AAAs efforts at providing services consistent with self-directed care as required by OAA 307(a)(26)
- Verify dates annual reports are submitted to the Assistant Secretary as required by OAA 307(a)(30)

State Plans Informed by and Based on Area Plans

45 CFR § 1321.27 (c):
Evidence that the State Plan is informed by and based on area plans, except for single planning and service area States.

RESPONSE:

Methodology for consultation with and feedback from AAAs to inform the State Plan.

In October 2023, the former Department on Aging initiated collaboration activities with the AAAs to identify and assess populations in greatest economic need and greatest social need. Technical assistance began with guidance on how to conduct a needs assessment in preparation for AAAs new SFY 2026-2029 Area Plan development. The department shared the Final Rule 1321.3 definitions of greatest economic need and greatest social need populations. Staff researched common factors of at-risk populations that contribute to a variety of negative outcomes. Results were used to assess and identify strategies and outcomes to address greatest economic need and/or greatest social need as defined by the following in order of precedence: (1) statute; (2) executive order; (3) program regulations; (4) 2 Code of Federal Regulations (CFR) Part 200 as codified by HHS at 45 CFR, Part 75, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards; (5) agency policies; and (6) any additional terms and conditions identified in the department's notice of award.

In 2024, with guidance from the Administration on Aging and Advancing States, ADS staff held three technical assistance sessions with each AAA on using demographic and service data to identify target populations. Collaborative technical assistance sessions involving all AAAs were offered covering topics such as: identifying diverse and underserved populations, community engagement with underserved communities, and measuring impact.

Iowa's new State Plan on Aging goal areas encompass current State and AAA programs, services, and initiatives along with the Administration on Aging's required topic areas. The new State Plan on Aging goals and objectives shaped the SFY 2026-2029 Area Plan template. AAAs were required to align with three statewide objectives for each goal area based on their community needs assessment findings regarding specific target populations and areas of need. AAAs submitted a draft of area plans to ADS in January 2025 to review and provide feedback on area plan alignment with state

plan on aging goals and objectives. The process also helped ADS to further refine and align statewide strategies to help support AAAs efforts.

Public Input and Review

45 CFR § 1321.29:

Describe how the State agency considered the views of older individuals, family caregivers, service providers and the public in developing the State Plan, and how the State agency considers such views in administering the State Plan. Describe how the public review and comment period was conducted and how the State agency responded to public input and comments in the development of the State Plan.

RESPONSE:

Methods for obtaining input on the State Plan on Aging.
Since 2022, Iowa HHS has actively solicited public input through open forums, town halls, speaking engagements, and written feedback on several initiatives to move the entire health and human services system toward a person-focused system that improves the lives of older Iowans including a Medicaid waiver re-design, changes to the state behavioral health and disability services systems, and the Multisector Plan for Aging. Comments and recommendations came from the public, advocacy organizations, providers, professional associations, and more. Several common themes emerged from these sources including better access to services, strengthening the direct care workforce, supporting individuals diagnosed with Alzheimer's Disease and related dementia, supporting caregivers, better system coordination/navigation to assist with continuity of care.

Methods for incorporating views into the State Plan on Aging.
Comments and summary reports with findings relevant to older Iowans, family caregivers, and older relative caregivers were incorporated into the ADS' goals, objectives, and strategies. Within the public comment session there were several concerns elevated to consider addressing within the State Plan on Aging. Addressing access to affordable and quality services and supports was a top elevated issue. The plan addresses this concern through the expansion of Iowa's Aging and Disability Resources Centers across Iowa. Another elevated issue was addressing the needs of people with disabilities. This concern is being addressed with the development of disability access points along with updating Iowa's Olmstead Plan. Addressing the mental health needs of older adults such as loneliness and caregiver stress was also shared. Goal 4 addresses the importance of social connections and providing caregiver supports to decrease emotional stress and financial cost burden. Supporting individuals diagnosed with Alzheimer's Disease and related dementia along with caregivers will be addressed within Goal 4 in by supporting the development of age-friendly and dementia capable communities. Refer to **Attachment E** for additional details.

Program Development and Coordination Activities (Optional, only for States that elect to pursue this activity)

45 CFR § 1321.27 (h):
Certification that any program development and coordination activities shall meet the following requirements:

(1) The State agency shall not fund program development and coordination activities as a cost of supportive services under area plans until it has first spent 10 percent of the total of its combined allotments under Title III on the administration of area plans;
(2) Program development and coordination activities must only be expended as a cost of State Plan administration, area plan administration, and/or Title III, part B supportive services;
(3) State agencies and area agencies on aging shall, consistent with the area plan and budgeting cycles, submit the details of proposals to pay for program development and coordination as a cost of Title III, part B supportive services to the public for review and comment; and
(4) Expenditure by the State agency and area agency on program development and coordination activities are intended to have a direct and positive impact on the enhancement of services for older persons and family caregivers in the planning and service area.

RESPONSE:

The State agency elected to not pursue program development and coordination activities.

Legal Assistance Developer

45 CFR § 1321.27 (l):
How the State agency will meet responsibilities for the Legal Assistance Developer, as set forth in part 1324, subpart C.

RESPONSE:
*Responsibilities for the Legal Assistance Developer***.**
Iowa HHS staffs a Legal Assistance Developer (LAD) position who holds no other conflict of interest roles. The LAD provides technical assistance to AAAs upon request and regularly meets with adult protective services, the Office of the State Long-Term Care Ombudsman, the legal service provider, older individuals' rights advocates, and disability rights advocates to discuss systemic legal issues facing older Iowans and older Iowans with disabilities to identify possible solutions. The LAD initiated collaborations with not-for-profit legal provider and advocate partners to promote autonomy through estate planning. The LAD utilizes the support of the Administration on Aging and National Center on Law and Elder Rights (NCLER) by participating in cohort experiences, trainings, and receiving technical assistance. The LAD reviews reporting of the legal assistance provider and engages in necessary follow-up. The LAD participates in trainings and speaking events related to defense of guardianship and

alternatives to guardianship. The LAD reports directly to the State Unit on Aging Director in the Aging and Disability Services division.

Emergency Preparedness Plans – Coordination and Development

OAA Section 307(a)(28):

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

RESPONSE:

Emergency Preparedness and Response Coordination.

ADS requires AAAs to develop and submit an emergency plan within their Area Plan. AAA Area Plan on Aging instructions include the OAA and 45 CFR 1321.97 requirements for AAA emergency plan development and implementation. ADS also created an Emergency Preparedness Handbook for AAAs to provide additional guidance on emergency plans. ADS held collaborative discussions with the Title VI program peers and AAAs that have the Title VI program within their planning and services area to ensure all entities are coordinating emergency planning efforts. Within the SFY 2026-2029 Area Plan Template, AAAs are also required to describe their process for assisting OAA consumers in developing an individual emergency plan.

Emergency Preparedness Plans – Involvement of the head of the State agency

OAA Section 307(a)(29):

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

RESPONSE:

*Iowa HHS Emergency Preparedness and Response Plan***.**

The Iowa HHS Bureau of Emergency Preparedness and Response coordinates emergency planning efforts for all the departmental divisions including ADS. The ADS division director and/or designee are included within the planning process for the State Public Health Emergency Preparedness and Response Plan efforts. ADS has dedicated staff who work on emergency preparedness that ranges from attending department emergency planning meetings to attending Homeland Security and Emergency Management trainings and scheduled drills. ADS is seeking partnership opportunities with Iowa's Title VI Tribal Communities along with Disaster PrepWise, an online emergency preparedness tool for individuals and family caregivers. ADS staff also participates within the Disaster PrepWise Advisory Board.

Attachment C – Intrastate Funding Formula (IFF) Funds Distribution Plan

Effective July 1, 2022

A descriptive statement of the formula's assumptions and goals, and the application of the definitions of greatest economic need and greatest social need, including addressing the populations identified pursuant to 45 CFR § 1321.27(d)(1).

Intrastate Funding Formula (IFF) Description

Goals and Assumptions. The goal of the IFF is to ensure that funds are distributed proportionally to the need in the state and to achieve adequate statewide coverage. The department utilizes population groups identified to be in greatest economic need and greatest social need in Iowa to inform its IFF. Iowa has a high percentage of Iowans over the age of 70 and a high percentage of older adults living in rural areas. The formula must also consider the geographic coverage area for the planning and service areas as the PSA territories range from 5 counties to 29 counties.

To achieve adequate statewide coverage and address potentially higher costs for those AAAs with larger territories, the formula includes a specific per county allocation in the federal and state funding formulas. In addition, the formula utilized weighting factors to ensure that funds are distributed proportional to the needs of its populations in greatest economic need and greatest social need. The distribution plans for federal and state funds describe the factors considers in the formula and the tables show how the formula is applied and affects each PSA.

In the event there is insufficient funding for every AAA to the minimum levels, such as may arise from a reduction in OAA funding, the allocations to the AAAs will be proportionately adjusted.

Rural Emphasis. With only 10 of Iowa's 99 counties considered to be statistical metropolitan areas, Iowa is a largely rural state. The IFF addresses the rural populations in three ways. First, a defined per county amount is allocated for both State and Federal funding. Second, the State funding includes a triple weighting of the rural population in the calculation. Third, the Title IIID funding formula utilizes physicians concentrated in urban areas and provides additional funds to more rural PSAs. This approach provides a fair balance to address the needs of PSAs with greater population density within fewer counties and of those PSAs with populations spread across a greater number of counties.

Formula and Distribution Plan for Title III Funds for State Plan Administration

State Plan Administration. Per 45 CFR 1321.49 (b), the department as the state unit on aging retains the greater of $750,000 or 5.0 percent of the total Title III B, C(1), C(2), D, and E funds per the NoA to use for state plan administration.

Emergency Set Aside. Per 45 CFR 1321.99, the department may elect to withhold up to 5.0 percent of Title III funds for the Emergency Set Aside provision. The department is not electing to reserve funds for the emergency set aside. The department will annually re-evaluate and communicate with the AAAs on this election.

Office of the State Long-Term Care Ombudsman (OSLTCO). In Iowa, the OSLTCO program is operated as a state administered program supported by state funds and Title VII funds. The area agencies on aging do not perform ombudsman activities. Therefore, Iowa will not allocate Title IIIB funds to the OSLTCO program.

Distribution. Refer to Table 2 for details on the state funding determination.

Formulas and Distribution Plan for Title III Funds for Area Plan Administration and Services

Once the amount for the state plan administration has been determined, the department distributes the remaining awarded funds to the AAAs. The department uses two formulas to distribute the Title III funds to each AAA: one for Titles III B, C, and E funds and a second for the Title IIID funds. The department issues Notice of Grant Awards (NGA) to the AAAs once the funds have been determined through process identified in this plan.

Titles III B, C(1), C(2), and E Formula

The department uses the following methodology to distribute Titles III B, C(1), C(2), and E funds to each PSA.

Administration Funds. Ten (10.0) percent of total Title III B, C(1), C(2), and E funds determined for area plan administration. The administration funds are distributed to each PSA as follows:

1. The greater of 0.25 percent of the Administration total or $24,000 for each PSA,
   plus
2. The greater of 0.04 percent of the Administration total or $4,000 per county in the PSA,
   plus

3. The remainder as determined per the PSA's population weighting factor. (Refer to the *Population Data for Federal Funds* heading below for population data used in the weighting calculations.)

Services Funds. Ninety (90.0) percent of total Title III B, C(1), C(2), and E funds determined for area plan services. The Title III services funds are distributed to each PSA as follows:

1. For each county in the PSA, the AAA receives $10,000 from funding titles proportionally to their overall total,
   plus
2. The remainder as determined per PSAs population weighting factor. (Refer to the *Population Data for Federal Funds* heading below for population data used in the weighting calculations.)

Refer to Tables 3a, 3b, and 3c for the application of the IFF and population weighting within the IFF.

Title IIID Formula

The department uses the following methodology to distribute the Title IIID funds to each PSA.

- Fifty (50.0) percent of the Title III D funds are distributed as determined by the PSAs population weighting factor for persons aged 60 years and over living at or below the poverty level of income. (Refer to the *Population Data for Federal Funds* heading below for population data used in the weighting calculations.)

- Fifty (50.0) percent of the Title III D funds are distributed as determined by the PSAs population weighting factor for Medically underserved persons aged 60 years and over. The estimated number of Medically underserved persons aged 60 years and over is determined by using the estimated population of persons aged 60 years and over living in the PSA and the number of physicians in the PSA. This rate is then inverted to favor the PSAs with a lower physician per 1,000 rate and distributed proportionally.

A mathematical formula to demonstrate this would be as follows:

- (total funds awarded * 0.50) = Funding Distribution Category Amount (1&2).
- [(estimated 60+ population below poverty / estimated 60+ Population) / statewide total of the proportion below poverty] * Funding Distribution Category 1.
- [estimated physicians / (estimated 60+ population/100)] / inverse the rate based on the percentage of physicians per 1000 60+ / distribution the percentage of the total * Funding Distribution Category 2.

Population Data for Federal Funds

The following population data is used in the formula to allocate Title III funds to each PSA:

- Persons aged 60 years and over (1 weight),
- Persons aged 60 years and over who are minorities (1 weight), and
- Persons aged 60 years and over who or below the poverty level (2 weight).

Each PSA's share of these total population estimates will be its population weighting factor in the federal funding formula. A mathematical formula to demonstrate this would be as follows: [(weighting for Factor 1 * estimated population) + (weighting for Factor 2 * estimated population) + (weighting for Factor 3 * estimated population)] / Weighted statewide population estimate * total award amount for category.

Data Sources. To ensure the most recent data available is used in the Title III formulas, the department retrieves the data each October and applies it to the next fiscal year. Population data used for weighting factors in the funding formula come from the following sources:

- The most recently published American Community Survey, Special Tabulation on Aging – Population Characteristics https://agid.acl.gov/ - minority estimates
- The most recently published Decennial Census. U.S. Census Bureau – rural population
- The most recently published American Community Survey - population by age and poverty estimates
- Physician Data for III D weighting factor comes from Iowa Health Fact Book, Office of Statewide Clinical Education Programs, College of Medicine, University of Iowa

Formula and Distribution Plan for Nutrition Services Incentive Program (NSIP)

The department distributes the NSIP funds to the AAAs based on the agency's proportion of eligible meals to the total of NSIP eligible meals for all PSAs as reported for the most recent State Program Report fiscal year.

A mathematical formula to demonstrate this would be as follows: (total meals reported by an AAA / total meals reported statewide) * total awarded amount of funds.

Formula and Distribution Plan for State Funds for Aging Services

The department uses the following methodology to distribute state funds authorized for Aging Services to each PSA.

Total Funds.

1. For each county in the PSA, the AAA receives $5,000,
   plus
2. The remainder as determined per PSAs population weighting factor. (Refer to the *Population Data for State Funds* heading below for population data used in the weighting calculations.)

Administration Funds.

The AAA may use up to 7.5 percent of its allocated state aging services funds for administration.

Refer to Table 5 for the application of this formula and population weighting.

Population Data for State Funds

The following population data is used in the formula to allocate state aging services funds to each PSA:

- Persons aged 60 years and over (1 weight),
- Persons aged 60 years and over at or below the poverty level (3 weight),
- Persons aged 60 years and over living in rural areas (3 weight),
- Persons aged 60 years and over and who are minority individuals (3 weight), and
- Persons aged 75 years and over (3 weight).

The department uses the same sources and process as described for Population Data for Federal Funds to obtain and apply the population data in the funding formula. A mathematical formula to demonstrate this would be as follows: [(weighting for Factor 1 * estimated population) + (weighting for Factor 2 * estimated population) + (weighting for Factor 3 * estimated population) + (weighting for Factor 4 * estimated population) + (weighting for Factor 5 * estimated population)] / Weighted statewide population estimate * total award amount for category.

Funding Formula Weights, Data Sources, and Application

This section identifies the weighting factors and shows how the formula is applied and affects each PSA. The sample application of the funding formulas reflects the most recent Notice of Award amounts for each AAA.

Table 11: Funding Formula Weighting and Award Components

Table 1a. Titles III B, C(1), C(2), and E PSA Distribution

Population Weighting Factor	Weight
Individuals aged 60 years and over	1
Minority individuals aged 60 years and over	1
Individuals aged 60 years and over at or below 100% of the Federal Poverty Level	2

Services Funding Component	Weight
Per County in the PSA Amount	$10,000
Population Weighting Factor	As Determined Above

Administration Funding Component	Weight
Per PSA Amount	Greater of 0.25% of Admin or $24,000
Per County in PSA Amount	Greater of 0.04% of Admin or $4,000
Population Weighting Factor	As Determined Above

Table 1b. Title III D PSA Distribution

Services Funding Component	Weight
Proportion of individuals aged 60 years and over at or below 100% of the Federal Poverty Level	1
Proportion of individuals aged 60 years and over medically underserved	1

Table 1c. Nutrition Services Incentive Program (NSIP) PSA Distribution

Services Funding Component	Weight
Proportion of qualifying meals served by the PSA in the most recent reporting determination.	1

Table 1d. State Aging Services PSA Distribution

Population Weighting Factor	Weight
Individuals aged 60 years and over	1
Minority individuals aged 60 years and over	3
Individuals aged 60 years and over at or below 100% of the Federal Poverty Level	3
Individuals aged 60 years and over living in rural areas	3
Individuals aged 75 and over	3

Award Funding Component	Weight
Per County in the PSA Amount	$5,000
Population Weighting Factor	As Determined Above

Administration Funding Component	Weight
Percentage of total award with the remainder spent on services.	7.5%

Table 2. FFY 2026 Title III Funding to Area Agencies on Aging

	Title IIIB	Title IIIC-1	Title IIIC-2	Title IIID	Title IIIE	Total
Estimated FFY 2026 Notice of Award	$4,264,292	$5,509,305	$3,603,592	$250,563	$1,845,722	**$15,473,474**
State Administration (5% of Federal Award)	213,215	275,465	180,180	12,528	92,286	**$773,674**
Ombudsman	0	0	0	0	0	**$0**
Emergency Set Aside (Up to 5%)	0	0	0	0	0	**$0**
Estimated Funding to AAAs	**$4,051,077**	**$5,233,840**	**$3,423,412**	**$238,035**	**$1,753,436**	**$14,699,800**

Table 3. FFY 2026 AAA Title III Planning Projections

Table 3a. Administration Funding

Area Agency	Title IIIB	Title IIIC(1)	Title IIIC(2)	Title IIID	Title IIIE	Total
Elderbridge	$78,800	$101,807	$66,591	-	$34,107	**$281,305**
Northeast Iowa	72,598	93,794	61,350	-	31,423	**$259,165**
Aging Resources	71,268	92,075	60,226	-	30,847	**$254,416**
Heritage	48,996	63,301	41,405	-	21,207	**$174,909**
Milestones	70,401	90,956	59,494	-	30,472	**$251,323**
Connections	63,045	81,451	53,275	-	27,288	**$225,059**
Total	**$405,108**	**$523,384**	**$342,341**	**-**	**$175,344**	**$1,446,177**

Table 3b. Per County Funding (B, C, E Service)

Area Agency	Title IIIB	Title IIIC(1)	Title IIIC(2)	Title IIID	Title IIIE	Total
Elderbridge	$87,871	$107,492	$55,811	-	$38,826	**$290,000**
Northeast Iowa	54,541	66,719	34,641	-	24,099	**180,000**
Aging Resources	24,240	29,653	15,396	-	10,710	**80,000**

Area Agency	Title IIIB	Title IIIC(1)	Title IIIC(2)	Title IIID	Title IIIE	Total
Heritage	21,210	25,946	13,472	-	9,372	**70,000**
Milestones	51,511	63,013	32,717	-	22,760	**170,000**
Connections	60,601	74,133	38,490	-	26,776	**200,000**
Total	**$299,974**	**$366,956**	**$190,527**	**-**	**$132,542**	**$990,000**

Table 3c. Population Weighted Factor Amount Funding[1]

Area Agency	Title IIIB	Title IIIC(1)	Title IIIC(2)	Title IIID	Title IIIE	Total
Elderbridge	$81,236	$104,954	$68,649	-	$35,161	**$290,000**
Northeast Iowa	50,422	65,144	42,610	-	21,824	**$180,000**
Aging Resources	22,410	28,953	18,938	-	9,699	**$80,000**
Heritage	19,609	25,334	16,571	-	8,486	**$70,000**
Milestones	47,621	61,524	40,243	-	20,612	**$170,000**
Connections	56,025	72,382	47,344	-	24,249	**$200,000**
Total	**$277,323**	**$358,291**	**$234,355**	**-**	**$120,031**	**$990,000**

Table 3d. Total Services Funding

Area Agency	Title IIIB	Title IIIC(1)	Title IIIC(2)	Title IIID	Title IIIE	Total
Elderbridge	$606,531	$783,615	$512,556	$40,313	$262,526	**$2,205,541**
Northeast Iowa	656,970	848,782	555,181	40,941	284,358	**$2,386,232**
Aging Resources	760,005	981,898	642,252	27,492	328,954	**$2,740,601**
Heritage	476,514	615,638	402,684	34,745	206,249	**$1,735,830**
Milestones	639,891	826,715	540,748	43,549	276,966	**$2,327,869**
Connections	506,058	653,808	427,650	50,995	219,039	**$1,857,550**
Total	**$3,645,969**	**$4,710,456**	**$3,081,071**	**$238,035**	**$1,578,092**	**$13,253,623**

[1] Residual funding after per county distribution based upon percentage of Title funding as compared to the total applicable funding.

Table 3e. Administration & Services Funding

Area Agency	Title IIIB	Title IIIC(1)	Title IIIC(2)	Title IIID	Title IIIE	Total
Elderbridge	$685,331	$885,422	$579,147	$40,313	$296,633	**$2,486,846**
Northeast Iowa	729,568	942,576	616,531	40,941	315,781	**$2,645,397**
Aging Resources	831,273	1,073,973	702,478	27,492	359,801	**$2,995,017**
Heritage	525,510	678,939	444,089	34,745	227,456	**$1,910,739**
Milestones	710,292	917,671	600,242	43,549	307,438	**$2,579,192**
Connections	569,103	735,259	480,925	50,995	246,327	**$2,082,609**
Total	**$4,051,077**	**$5,233,840**	**$3,423,412**	**$238,035**	**$1,753,436**	**$14,699,800**

Table 4. FFY 2026 AAA Federal Nutrition Services Incentive Program Planning Projections

Area Agency	FFY 2023 Meal Count Proportion	Commodity Election FFY 2026	Cash FFY 2026	FFY 2026 Total
Elderbridge	22.40%	$0	$86,723	**$86,723**
Northeast Iowa	9.70%	0	37,554	**$37,554**
Aging Resources	27.90%	0	108,017	**$108,017**
Heritage	15.10%	0	58,461	**$58,461**
Milestones	15.60%	0	60,397	**$60,397**
Connections	9.30%	0	36,006	**$36,006**
Total	**100.00%**	**$0**	**387,158**	**$387,158**

Table 5. SFY 2026 AAA State Aging Services Programs Funding Planning Projections

Area Agency	Administration Funding	Service Funding	Total State Aging Programs
Elderbridge	$96,537	$1,190,626	**$1,287,163**
Northeast Iowa	96,503	1,190,206	**$1,286,709**
Aging Resources	84,266	1,039,276	**$1,123,542**
Heritage	61,007	752,416	**$813,423**
Milestones	83,625	1,031,381	**$1,115,006**

Area Agency	Administration Funding	Service Funding	Total State Aging Programs
Connections	71,595	883,006	**$954,601**
Total	**493,533**	**6,086,911**	**$6,580,444**

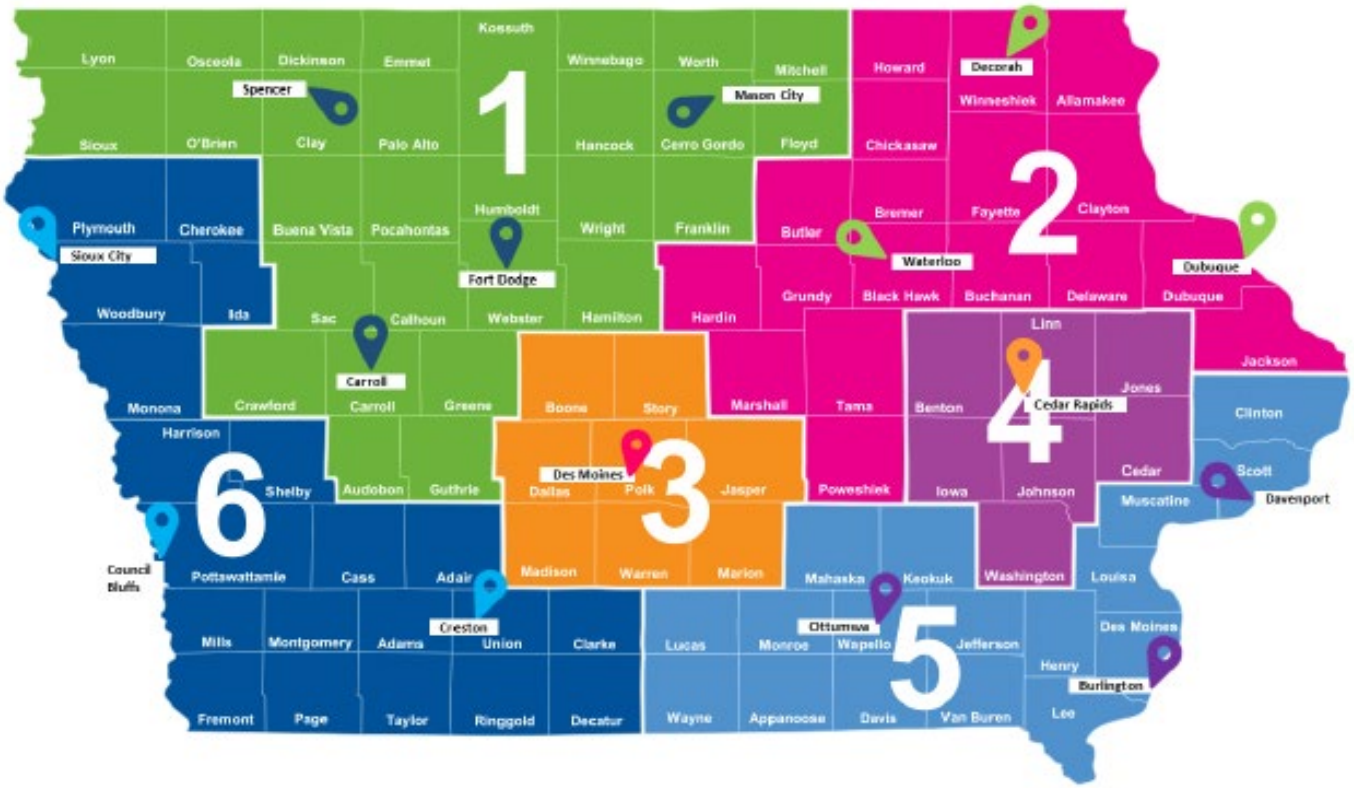
Table 6. SFY 2026 AAA State Appropriations for Elder Abuse Prevention and Awareness

Area Agency	Administration Funding	Services Funding	Total
Elderbridge	$5,204	$69,380	64,176
Northeast Iowa	5,204	69,380	64,176
Aging Resources	5,204	69,381	64,177
Heritage	5,204	69,381	64,177
Milestones	5,204	69,380	64,176
Connections	5,204	69,381	64,177
Total	**$31,224**	**$416,283**	**$385,059**

Table 7. SFY 2026 AAA State Appropriations Aging and Disability Resources Funding Planning Projections

Area Agency	Administration Funding	Service Funding	Total AAA Aging & Disability Resource
Elderbridge	$10,353	$138,042	**$138,042**
Northeast Iowa	10,540	140,528	**$140,528**
Aging Resources	10,267	136,897	**$136,897**
Heritage	9,324	124,328	**$124,328**
Milestones	10,111	134,820	**$134,820**
Connections	9,672	128,959	**$128,959**
Total	**$60,267**	**$803,574**	**$803,574**

Attachment D – Planning and Service Area Boundaries of each Designated Area Agency on Aging



PSA 1: Elderbridge Agency on Aging

Counties Served

Audubon, Buena Vista, Calhoun, Carroll, Cerro Gordo, Clay, Crawford, Dickinson, Emmet, Floyd, Franklin, Greene, Guthrie, Hamilton, Hancock, Humboldt, Kossuth, Lyon, Mitchell, O'Brien, Osceola, Palo Alto, Pocahontas, Sioux, Winnebago, Worth, Sac, Webster, and Wright.

Office Locations

City	Address	Phone
Mason City Office	22 N. Georgia Street Suite 216 Mason City, IA 50401	(641) 424-0678 or (800) 243-0678
Fort Dodge Office	308 Central Avenue Fort Dodge, IA 50501	(800) 243-0678
Carroll Office	514 N Court Street, Suite 1 Carroll, IA 51301	(712) 792-3512 or (800) 243-0678
Spencer Office	714 10th Avenue East, Suite 1 Spencer, IA 51301	(712) 262-1775 or (800) 243-0678

PSA 2: Northeast Iowa Area Agency on Aging (NEI3A)

Counties Served
Allamakee, Black Hawk, Bremer, Buchanan, Butler, Chickasaw, Clayton, Delaware, Dubuque, Fayette, Grundy, Hardin, Howard, Jackson, Marshall, Poweshiek, Tama, and Winneshiek

Office Locations

City	Address	Phone
Decorah Office	915 Short Street, Suite 169 Decorah, IA 52101	(800) 779-8707
Dubuque Office	2728 Asbury Road Dubuque, IA 52001	(800) 779-8707
Waterloo Office	201 Tower Park Drive, Suite 100 Waterloo, IA 50701	(800) 779-8707

PSA 3: Aging Resources of Central Iowa

Counties Served
Boone, Story, Dallas, Polk, Jasper, Madison, Warren, and Marion

Office Location
Des Moines

5838 Grand Avenue, Suite 106
Des Moines, IA 50312-5352
(800) 747-5352 or (515) 255-1310

PSA 4: Heritage Area Agency on Aging

Counties Served
Benton, Cedar, Iowa, Johnson, Jones, Linn, and Washington

Office Location
Cedar Rapids, IA

6301 Kirkwood Boulevard SW
Cedar Rapids, IA 52404
(319) 389-5559 or (800) 332-5934

PSA 5: Milestones Area Agency on Aging

Counties Served

Appanoose, Clinton, Davis, Des Moines, Henry, Jefferson, Keokuk, Lee, Louisa, Lucas, Mahaska, Monona, Muscatine, Scott, Van Buren, Wapello, and Wayne

Office Locations

City	Address	Phone
Burlington Office	509 Jefferson Street Burlington, IA 52601	(319) 752-5433 or (800) 292-1268
Davenport Office	935 E. 53rd Street Davenport, IA 52807	(563) 324-9085 or (800) 292-1268
Ottumwa Office	117 North Cooper Street, Suite 2 Ottumwa, IA 52501	(641) 682-2270 or (800) 292-1268

PSA 6: Connections Area Agency on Aging

Counties Served

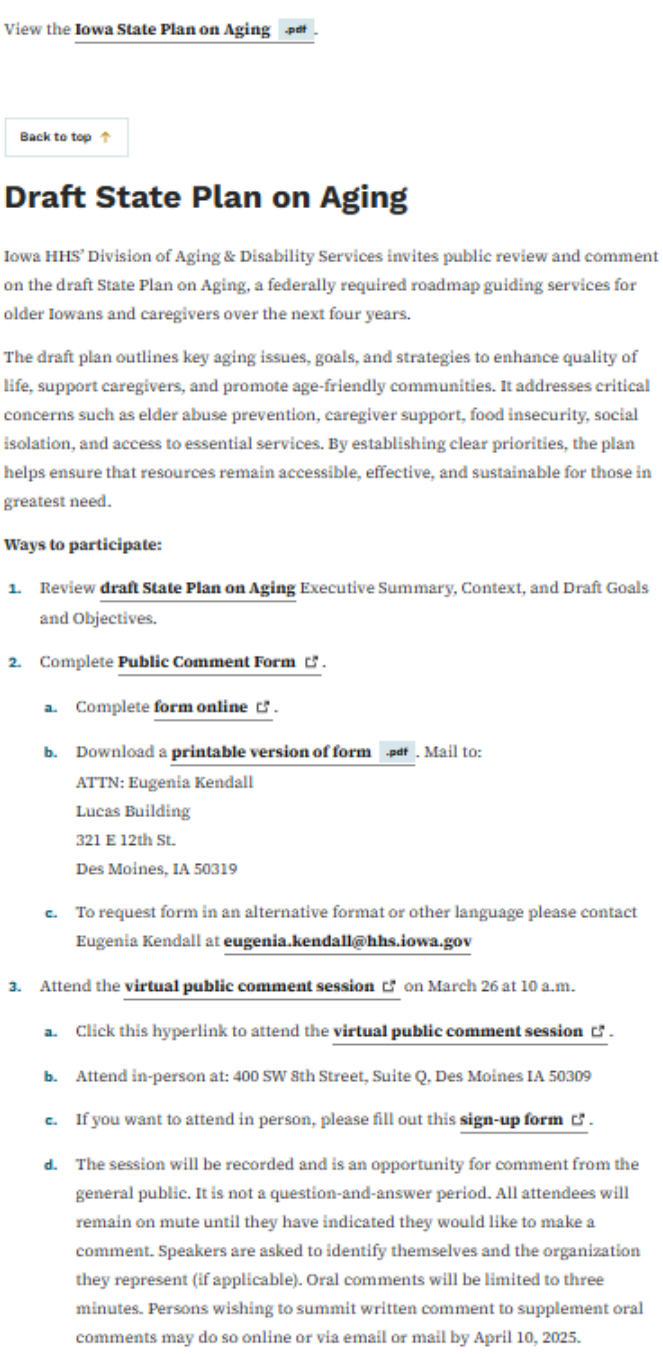
Adair, Adams, Cass, Cherokee, Clarke, Decatur, Fremont, Harrison, Ida, Mills, Monona, Montgomery, Page, Plymouth, Pottawattamie, Ringgold, Shelby, Taylor, Union, and Woodbury

Office Locations

City	Address	Phone
Sioux City Office	2301 Pierce Street Sioux City, IA 51104	(712) 279-6900 or (800) 432-9209
Creston Office	215 E. Montgomery Street Creston, IA 50801	(641) 782-4040 or (800) 432-9209
Council Bluffs Office	300 West Broadway, Suite 240 Council Bluffs, IA 51523	(712)328-2540 or (800)432-9209

Attachment E – Evidence of Providing the Minimum Comment Period

For the public comment period a session was held on March 26 from 10:00 – 11:00 a.m. Materials for the session were posted online from March 6 through April 11. A notice regarding the posted materials and scheduled session was sent to over 10,000 HHS members, providers, and stakeholders. Individuals were given instructions to complete and submit either an online comment form or download and submit a printed version of the form. Individuals were also provided with an opportunity to request the form within a different language if needed (see screenshot on the right).



View the **Iowa State Plan on Aging** .pdf .

Back to top

Draft State Plan on Aging

Iowa HHS' Division of Aging & Disability Services invites public review and comment on the draft State Plan on Aging, a federally required roadmap guiding services for older Iowans and caregivers over the next four years.

The draft plan outlines key aging issues, goals, and strategies to enhance quality of life, support caregivers, and promote age-friendly communities. It addresses critical concerns such as elder abuse prevention, caregiver support, food insecurity, social isolation, and access to essential services. By establishing clear priorities, the plan helps ensure that resources remain accessible, effective, and sustainable for those in greatest need.

Ways to participate:

1. Review **draft State Plan on Aging** Executive Summary, Context, and Draft Goals and Objectives.
2. Complete **Public Comment Form** .
   a. Complete **form online** .
   b. Download a **printable version of form** .pdf . Mail to:
      ATTN: Eugenia Kendall
      Lucas Building
      321 E 12th St.
      Des Moines, IA 50319
   c. To request form in an alternative format or other language please contact Eugenia Kendall at **eugenia.kendall@hhs.iowa.gov**
3. Attend the **virtual public comment session** on March 26 at 10 a.m.
   a. Click this hyperlink to attend the **virtual public comment session** .
   b. Attend in-person at: 400 SW 8th Street, Suite Q, Des Moines IA 50309
   c. If you want to attend in person, please fill out this **sign-up form** .
   d. The session will be recorded and is an opportunity for comment from the general public. It is not a question-and-answer period. All attendees will remain on mute until they have indicated they would like to make a comment. Speakers are asked to identify themselves and the organization they represent (if applicable). Oral comments will be limited to three minutes. Persons wishing to summit written comment to supplement oral comments may do so online or via email or mail by April 10, 2025.

<u>Comment Period Summary</u>

On March 26, a total of 60 individuals attended the one-hour public comment session and 12 individuals submitted comments using an online form.

Representatives from the following entities provided comments during the session or via online form:

- People with lived experience such as older adults, people with disabilities, and family caregivers.
- Iowa Developmental Disabilities Council
- Iowa CareGivers
- AARP Iowa
- LeadingAge Iowa
- The Hale Group
- Linn County Public Health
- Catholic Charities
- Candeo

- Southwest Iowa MHDS Region
- Bartels Lutheran Retirement Community
- University of Iowa

Common Themes

Themes that respondents requested or suggested for inclusion in the plan were:

- Address access to affordable services and quality care
- Address the needs of people with disabilities within plan
- Address home health care workforce shortage especially in rural areas
- Address mental health needs of older adults such as loneliness and caregiver stress
- Support individuals diagnosed with Alzheimer's Disease and related dementia along with their caregivers
- Provide education to older individuals and caregivers on available resources, emotional and financial support, substitute decision making, financial cost of in-home vs. skilled nursing, OAA services, Consumer Directed Attendant Care (CDAC) and Consumer Choice Option (CCO)
- Address the needs of all older Iowans not just at-risk individuals and address needs of those who live in skilled nursing
- Work with community partners to use standardized tools to assist with continuity of care

Some respondents shared their personal stories of how the system impacts their ability to care for themselves or others. Follow-up was given to offer additional resources as needed.

Attachment F – State Unit on Aging / Area Agency on Aging Activity Schedule

Table 12: ADS and AAA staff annual activities schedule

Activity	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
New or Updated Area Plan Effective Date	1											
New or Updated Policy & Procedures Effective Date	1											
On-Site Program and Fiscal Monitoring	PSA 2, 3, 4	PSA 1, 5, 6										
SFY 2025 EoY - Fiscal Close out		15										
Area Plan Annual Eval Planning				PSA 2, 3, 4	PSA 1, 5, 6							
SFY 2027 Area Plan Update Instructions					15							
FFY 2025 EoY - Fiscal & SPR Variance						15						
Area Plan Progress Update								All				
Policy / Procedure Update Consultations												
SFY Area Plan Update Due										1		
Training / Webinars												

Attachment G – Supplemental Data Sources, Analysis

Data Sources and Other References for the Iowa State Plan on Aging

The following sources and reports informed the content of this State Plan on Aging in addition to citations in the plan narrative.

- Review of population demographics
  - U.S. Census Bureau, American Community Survey, 2022, 2023 1-year estimates
  - State of Iowa Data Center Profiles, 2024
- Review of OAA consumers served demographics, SFY 2024
- Area Plans on Aging from Iowa's six designated Area Agencies on Aging, SFY 2022 -2025, SFY 2026 – 2029
- Building the Community 2020: Community Integration Strategic Plan
- Iowa's Olmstead Plan
- Healthy Iowans – Iowa's State Health Assessment, 2021- 2022
- Iowa's Health Improvement Plan, 2023 - 2027
- Iowa Medicaid Strategic Plan, 2022 – 2024
- Strengthening Iowa's Community-Based Services System: Transformation Plan, Mathematica 2023
- Multisector Plan for Aging Community Engagement Results & Proposed Recommendations for Iowa Aging and Disability Services, Sellers Dorsey 2024
- State LTSS AARP Report, AARP 2023
- America's Health Rankings – 2024 Senior Report, United Health Foundation

FFY 2024 OAA Registered and Non-Registered Services Delivered

OAA Registered Services	Consumers Served	Units of Service Delivered
Information & Assistance	17,314	34,353 contacts
Nutrition Education	15,256	116,888 sessions
Congregate Nutrition	14,813	669,624 meals
Home Delivered Nutrition	9,289	1,153,956 meals
Health Promotion Non-Evidence Based	6,005	
Legal Assistance	3,324	11,982 hours
Caregiver Information & Assistance	3,823	7,240 contacts
Transportation		146,367 one-way trips
Options Counseling	3,077	15,190 hours
Homemaker	1,297	41,127 hours
Assisted Transportation	1,150	44,813 one-way trips

OAA Registered Services	Consumers Served	Units of Service Delivered
Material Aid: Other	1,033	2,218 supplies
Case Management	1,013	11,984 hours
Adult Day Care	137	48,064 hours
EAPA Consultation	749	2,208 contacts
Material Aid: Consumable Supplies	612	10,446 items
Health Promotion: Evidence-Based	611	
EAPA Assessment & Intervention	466	3,642 hours
Emergency Response	440	2,528-month payments
Caregiver Counseling	935	3,694 hours
Caregiver Respite Care: In-Home	356	23,784 hours
Caregiver Case Management	325	2,864 hours
Personal Care	324	11,319 hours
Chore Services	270	9,932 hours
Caregiver Supportive Services: Other	256	4,144 supplies
Material Aid: Home Modification/ Repair	201	536 items
Nutrition Counseling	164	199 hours
Material Aid: Assistive Technology & DME	138	436 items
ORC* Information & Assistance	116	295 contacts
Caregiver Support Groups		424 sessions
Caregiver Training	73	371 hours
Caregiver Respite Care: Out-of-Home (Day)	46	8,284 hours
ORC* Supportive Services: Other	45	381 supplies
ORC* Support Groups		304 sessions
ORC* Counseling	30	79 hours
Caregiver Supportive Services: Assistive Technology/Durable Medical Equipment	88	411 items
Caregiver Respite Care: Out-of-Home (Overnight)	5	614 hours
ORC* Respite Care: In-Home	6	215 hours
ORC* Respite Care: Out-of-Home (Day)	1	504 hours
Caregiver Supportive Services: Consumable Supplies	72	6,705 items

*ORC = Older Relative Caregiver

OAA Non-Registered Services	Consumers Served	Units of Service Delivered
Caregiver Information Services	65,689	526 activities
Outreach	6,135	8,411 contacts
Legal Assistance	3,324	11,982 hours
Training & Education	195,285	2,215 activities
EAPA Training & Education	39,750	239 activities

Additional Details on Multisector Plan for Aging

In September 2023, the former Iowa Department on Aging contracted with Sellers Dorsey, a consulting firm, to support the department with its initiative to develop a comprehensive, long-term Multisector Plan for Aging (MPA). The plan also included considerations for aging with disabilities as part of the Iowa Solutions for Aging with Independence and Longevity (IA SAIL) project. Sellers Dorsey's support for ADS included project planning, conducting research on other states' MPA efforts, development of a community partner engagement strategy, engaging community members to solicit feedback for MPA development, including assisting with development and deployment of a community survey, facilitating steering committees, and compiling and summarizing all feedback from public input. Sellers Dorsey provided recommendations on how to use the information to shape MPA priorities and strategies.

Concurrently, the department partnered with Easterseals Iowa, AARP Iowa, Iowa Development and Disabilities Council, Iowa Medicaid, and Iowa Finance Authority to participate in a national, ten-state Multisector Plan for Aging Learning Collaborative. The learning collaborative helped inform the development of Iowa's MPA timeline and community engagement process, which recognized the value of engaging with Iowan consumers, caregivers, stakeholders, and members of the public. Ultimately, the Iowa MPA planning team employed a five-pronged strategy for MPA community engagement that included:

1. Establishing a voluntary MPA **steering committee** to develop proposed recommendations for consideration in the MPA

2. Conducting a **community survey** to gauge Iowans' priorities related to the MPA

3. Conducting **focus groups** to ensure insights from traditionally under-represented groups were gathered

4. Hosting **town halls** to educate the public and key partners about IA SAIL and MPA efforts, and get feedback

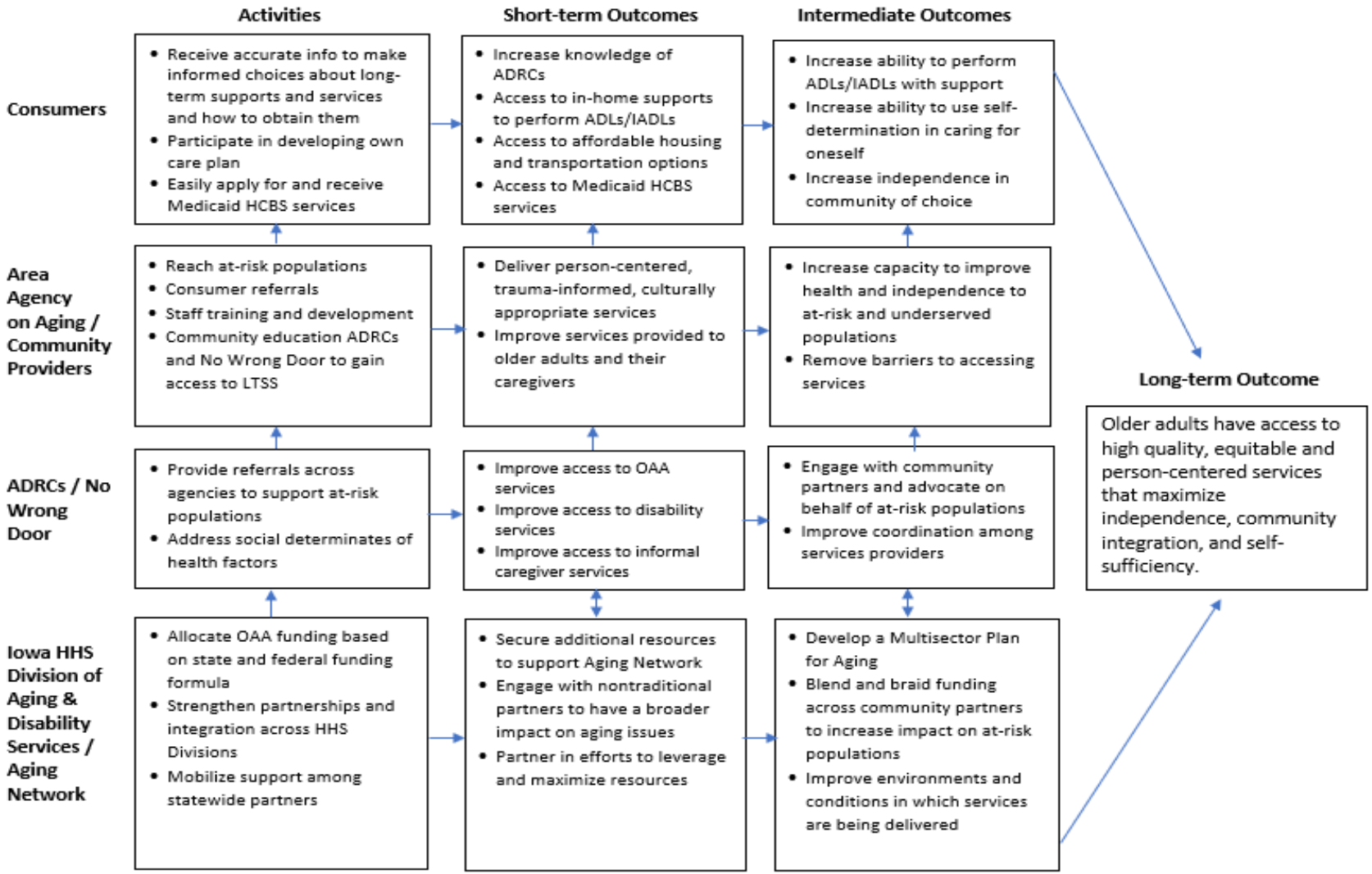
5. Conducting **targeted interviews** to gain additional input on key topic areas

List of MPA Steering Committee Members

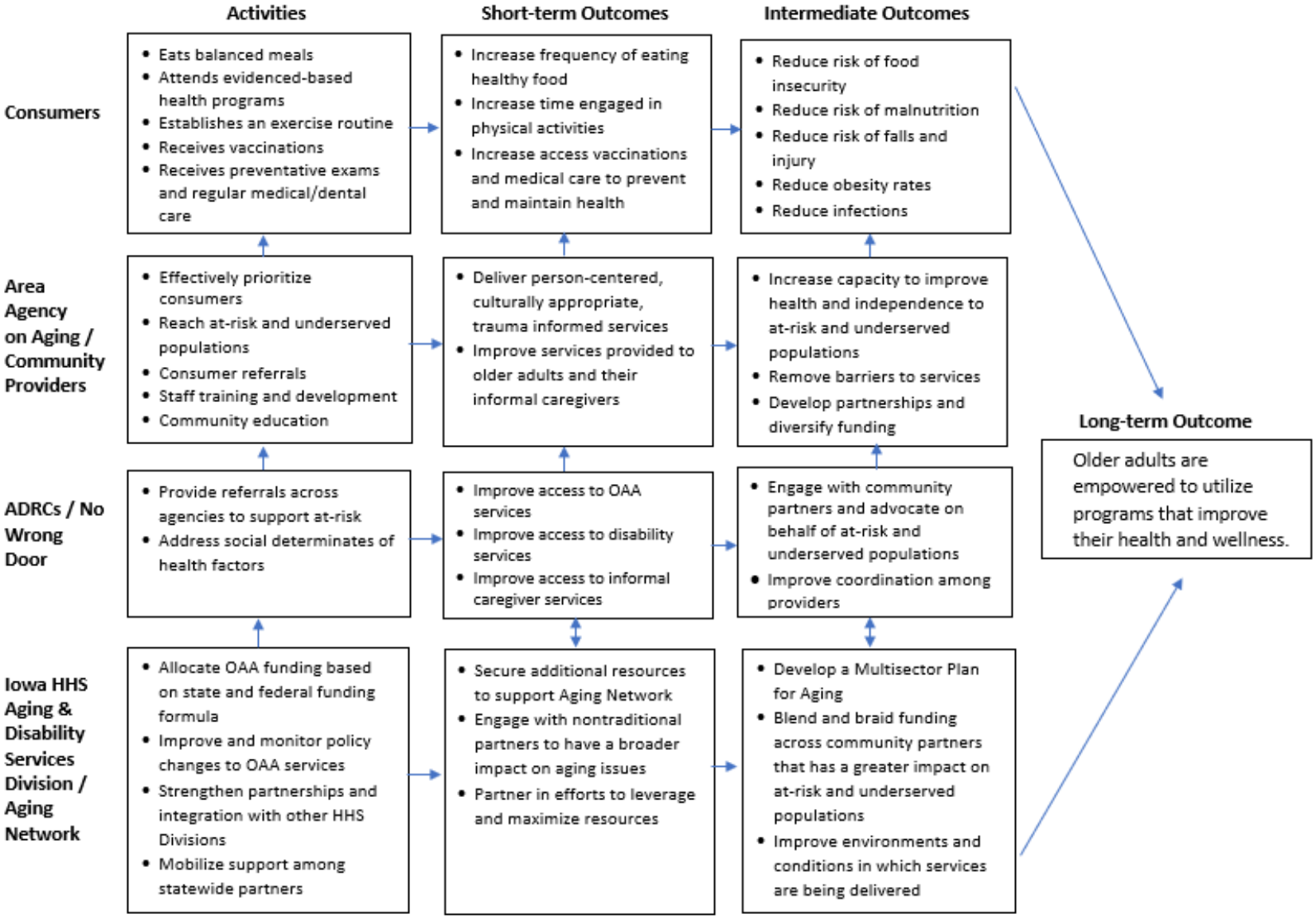
- AARP
- Alzheimer's Association Iowa Chapter
- Csomay Center for Gerontological Excellence
- Department for the Blind
- Department of Transportation
- Department of Veterans Affairs
- Iowa Area Agency on Aging Association
- Iowa Association of Councils of Government
- Iowa CareGivers
- Iowa Community Action Association
- Iowa Department of Corrections
- Iowa Department of Workforce Development
- Iowa Developmental Disabilities Council
- Iowa Health and Human Services, Division of Administration
- Iowa Health and Human Services, Division of Aging and Disability Services
- Iowa Health and Human Services, Division of Behavioral Health
- Iowa Health and Human Services, Division of Chronic, Congenital, & Inherited Conditions
- Iowa Health and Human Services, Division of Community Access
- Iowa Health and Human Services, Division of Family Well-Being & Protection
- Iowa Health and Human Services, Division of Public Health
- Iowa Health and Human Services, Division of Strategic Operations
- Iowa Health and Human Services Iowa Medicaid
- Iowa Housing Partnership
- Iowa Office of Health Equity
- Iowa State Association of Counties
- Iowa Transportation Coordination Council
- Iowa's University Center for Excellence in Developmental Disabilities
- Office of the Chief Information Officer
- Older Iowans Legislator
- Olmstead Consumer Task Force
- Onelowa
- Tribal Representative
- University of Iowa, Health Management and Policy

Conceptual Logic Models

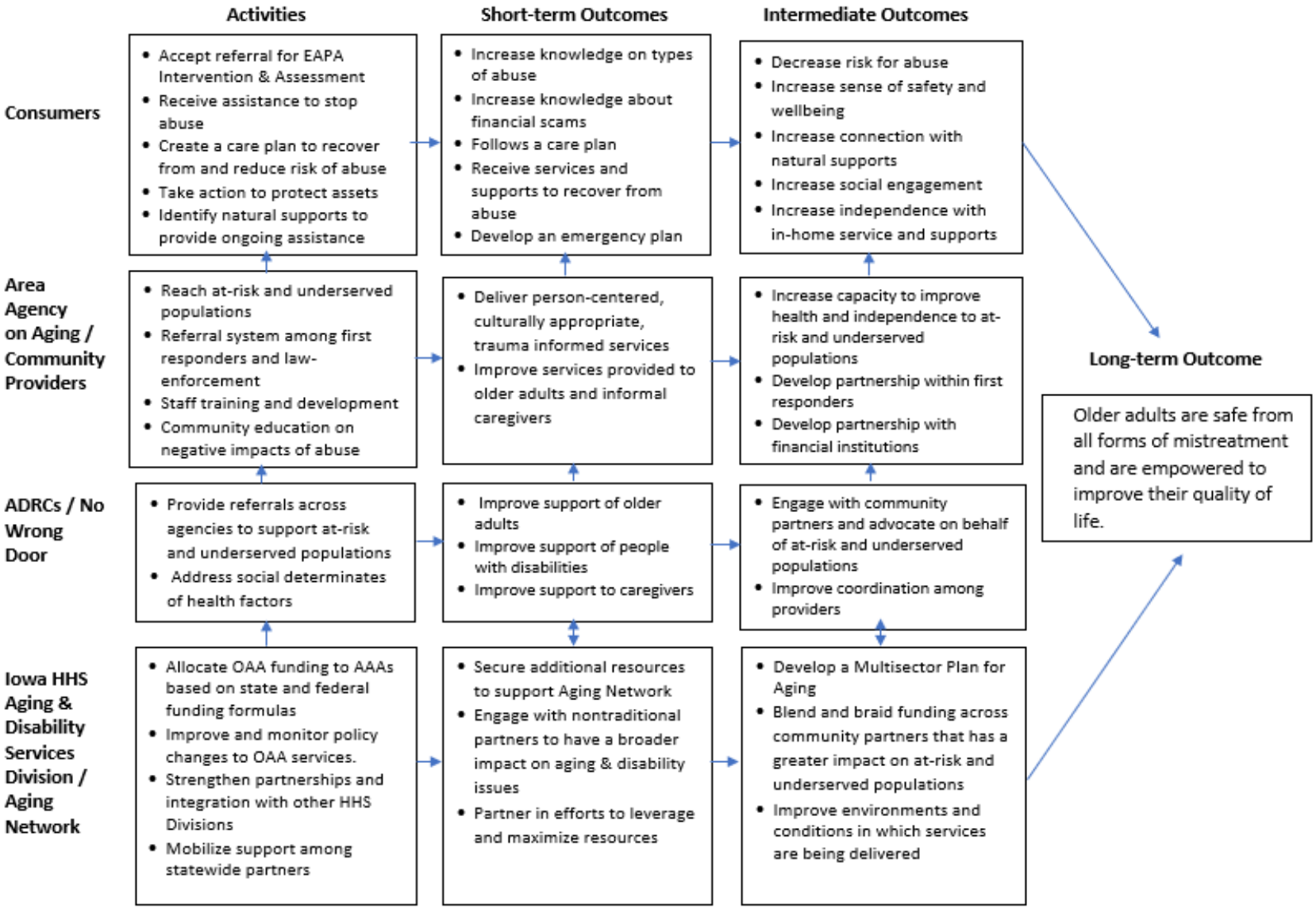
Goal 1: Maximize Independence Conceptual Logic Model



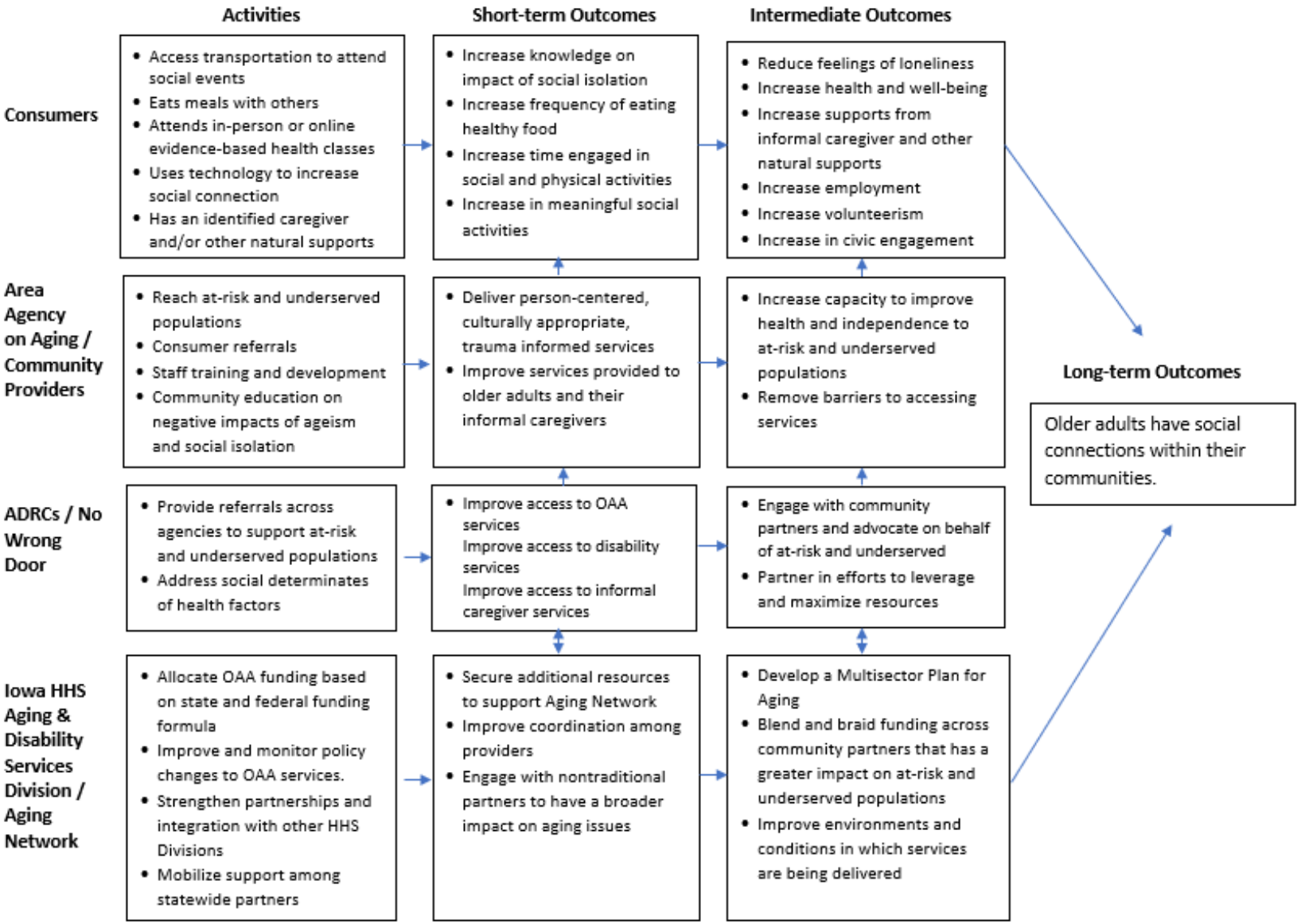
Goal 2: Health and Wellness Conceptual Logic Model



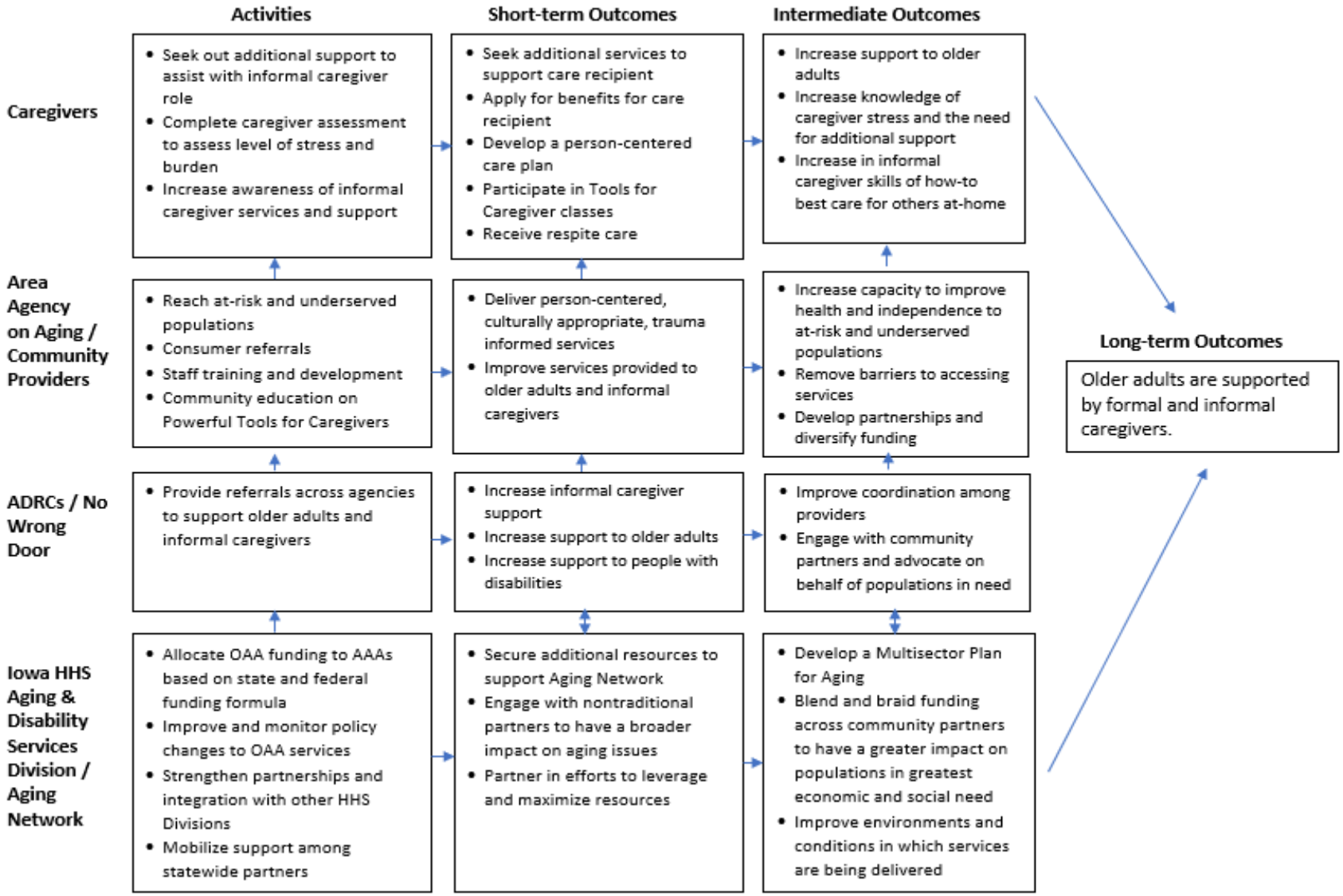
Goal 3: Improve Safety and Quality of Life Conceptual Logic Model



Goal 4: Social Connection Conceptual Logic Model



Goal 4: Caregiver Supports Conceptual Logic Model



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Recommendations for Developing Iowa's Multisector Plan for Aging (MPA), including Aging with Disabilities

June 2025

IOWA™ | Health and Human Services
Division of Aging and Disability Services

Contents

Glossary

Aging and Disability Resource Center (ADRC) / No Wrong Door (NWD) Systems Initiative – a collaborative effort to streamline access to services by providing information and assistance and options counseling to individuals needing either public or private resources.

Aging and Disability Services (ADS) – a division of Iowa Health and Human Services.

- *State Plan on Aging* – a Federally required, multi-year plan created to receive and administer Older Americans Act funding. The state plan delineates statewide goals and objectives related to assisting older individuals and family caregivers and serves as a blueprint for achieving goals and objectives during a four-year period.

Direct Care Workers/Professionals - is an umbrella name for one of the largest sectors of the workforce in Iowa. Direct care professionals are defined as individuals who provide supportive services and care to people experiencing health conditions, illnesses, or disabilities and receive compensation for such services. They work in home-based, community-based, or facility settings. They may have job titles such as direct support professional, supported community living worker, home health aide, universal worker, hospice aide, personal assistant, patient care technician, consumer directed attendant care provider, senior helper/companion, and certified nursing assistant.

Family or Informal Caregivers – are defined as individuals who provide unpaid supportive care for persons in need of assistance. Supportive care ranges from providing transportation to health care appointments, grocery shopping, paying bills, to assisting with activities of daily living such as bathing, toileting, and dressing. There are an estimated 330,000 family or informal caregivers providing unpaid care in Iowa.

Health and Human Services (HHS) – a state agency department.

Health Disparities – are differences in health outcomes for specific populations based on their physical location, access to care, and economic and social factors.

Healthy Iowans – a collaborative process that sets the agenda for solving the top health issues facing Iowans so they can live longer, healthier lives, more productive lives and enjoy a rich quality of life. It has two main components.

- *State Health Assessment (SHA)* – involves public and private partners as well as people from across Iowan in identifying Iowa's top health issues.
- *State Health Improvement Plan (SHIP)* – for the purposes of this report SHIP means to engage partners on planning to address Iowa's top health issues.

Home and Community Based Services (HCBS) – are medical, social and support services for Iowans with functional, cognitive and other physical or mental health needs. Services are meant to help people live and receive services in a home and community-based setting instead of an institution.

Iowa Solutions for Aging with Independence and Longevity (IA SAIL) – a public and private sector collaborative to understand, plan for and address aging issues across multiple sectors and systems to ensure all Iowans have access to the right services and support to age well in their communities. The main function is to develop and implement a Multisector Plan for Aging.

Long Term Services and Supports (LTSS) – services and supports provided to people of all ages in need of long-term care because of disabling conditions or chronic illness. Services and supports are provided in a continuum of care settings ranging from community-based services, supportive independent living, assisted living facilities, to 24-hour skilled nursing care.

Managed Long Term Services and Supports (MLTSS) – services and supports are paid through Medicaid and provided to people of all ages in need of long-term care services because of disabling conditions or chronic illness. Medicaid covers a range of these services over a continuum of care settings, from skilled nursing facilities to community-based services provided within the home or community of choice.

Multisector Plan for Aging (MPA) – a multi-year strategic planning effort that brings together government agencies and community partners and nonprofits to plan for and address aging issues. The plan delineates goals and objectives to address top issues related to aging and serves as a blueprint for achieving the goals and objectives over a 10-year period.

Short Term Supportive Services (STSS) – services provided on a short-term, episodic basis that help individuals maintain their health and independence within their community of choice.

Social Determinants of Health (SDOH) – are non-medical factors that influence health outcomes such as access to healthcare, education, safe housing, and nutritious foods.

Supportive Services – services provided to an individual based on their care needs to help support their health and independence while living within the community of their choice.

Person-Centered Services – services that are tailored to meet an individual's personal needs and preferences.

Executive Summary

The Division of Aging and Disability Services (ADS) within Iowa HHS launched a project in 2024 that brought together government agencies and community partners and nonprofits to plan for and address aging and aging with disability issues. The project, called, "**Iowa Solutions for Aging with Independence and Longevity**," or "IA SAIL" conducted community engagement activities with people across Iowa through steering and subcommittee meetings, a community survey, focus groups, and town hall discussions. Based on results from these activities ten issues were elevated to further explore and shape the development of Iowa's first Multisector Plan for Aging (MPA). The MPA is a cross-sector, state-led strategic planning resource to improve the infrastructure and coordination of services for Iowa's aging population including people aging with disabilities. The IA SAIL mission is *to understand, plan for and address aging issues across multiple sectors and systems, and to ensure everyone has access to person-centered services and supports needed to age well within their community of choice*. The IA SAIL vision is *All persons in Iowa age with independence and health*.

Ten Elevated MPA Focus Areas

1. Access to Supportive Services
2. Informal Caregiver Support
3. Direct Care Professionals
4. Coordination of Services and Person-Centered Services
5. Health Disparities
6. Paying for Services
7. Transportation and Vehicle Modifications
8. Social Isolation
9. Housing
10. Quality of Care

This report provides a summary of the elevated focus areas based on input from other state agencies, community providers, and the public. State plans with similar goals were also assessed for opportunities for collaboration and alignment to prevent duplication of existing efforts. The MPA focus areas are grouped by similar State Health Assessment priority areas. For more details refer the Iowa Solutions for Aging

within Independence and Longevity website. For a more information on Iowa's population demographics and state health priority areas refer to Iowa's State Health Assessment located on the Healthy Iowans webpage and also the Iowa Data Profiles located on the State Data Center website.

Summary of Common State Plan Goals

State Health Assessment (SHA)	State Health Improvement Plan (SHIP)	Multisector Plan for Aging (MPA)	State Plan on Aging
State Health Assessment Priority: Access to Care	Improve access to inclusive behavioral health services in Iowa Strengthen Iowa's behavioral health system by increasing available resources and capacity	Increase the number of available and inclusive health and human services • Access to Supportive Services/Person-Centered Services • Direct Care Professionals Support • Health Disparities • Quality of Care	Maximize Independence - Older adults have access to high quality, equitable and person-centered services that maximize independence, community integration and self-sufficiency
State Health Assessment Priority: Economic Stability and Income/ Housing/ Transportation	No current goals identified	Increase the number of affordable and accessible housing and transportation options • Paying for Services • Affordable and Accessible Housing • Affordable and Accessible Transportation	No current goals identified
State Health Assessment Priority: Mental Health and Mental Disorders	Improve access to behavioral health services for all people in Iowa Strengthen Iowa's behavioral health system by increasing available resources and capacity	Increase community connections and support of socially isolated individuals and unpaid caregivers • Social Isolation • Unpaid Caregiver Support	Stay Engaged and Supported - Older adults are supported by formal and informal caregivers of their choice and have social connections within their communities

MPA Focus Areas and Recommendations

The following is a summary of elevated MPA focus areas organized by similar State Health Assessment (SHA) priority areas. This section provides a brief statement on feedback obtains from the community engagement strategies, data from state and national benchmarks and a list of initial recommendations that were developed out of subcommittee discussions.

PRIORITY AREA: ACCESS TO CARE

MPA Focus Areas: Access to Person-Centered, Supportive Services

What We Heard

Access to supportive services and coordination of person-centered services where the most frequently discussed topics across community engagement activities. Whether its finding in-home care options to assist with daily living activities or knowing who to call to enroll in home delivered meals, a person's ability to find and receive supportive services can significantly impact their health and independence. This elevated focus area aligns with ongoing efforts related to the expansion of the Aging and Disability Resource Centers/No Wrong Door (ADRC/NWD) system and the Hope and Opportunities in Many Environments (HOME) project regarding home and community-based services (HCBS) waiver redesign efforts.

What the Data Shows

- Iowa ranks 41st in the U.S. on progress towards developing a fully functional Aging and Disability Resource Center/No Wrong Door system. In 2022, Iowa performed only 55 percent of the functions that would be part of a fully functional system compared with the U.S. average of 72 percent[1]. Aging and Disability Resource Centers are a part of Iowa's No Wrong Door system which includes a network of organizations at the state and community levels that help consumers and family caregivers navigate public and private Long Term Supportive Service (LTSS) options.

- Iowa ranks 37th in the U.S. for the rate of home health and personal care aides per 100 people with an Activity of Daily Living (ADL) disability, aged 18 years and

over. In 2020, Iowa's rate was 15.8 which is lower than the U.S. rate of 24.8[2]. Activities of Daily Living include bathing, dressing, and using the toilet; help with household chores including housekeeping, cooking, grocery shopping, help with paying bills; and other support such as lawn mowing and snow shoveling. For people with disabilities this also includes help with job couching and skill building to help them live independently in their communities.

MPA Recommendations

1. Increase awareness of statewide, regional, local and hyperlocal private services.
2. Increase access to general and specialized resources, and navigation of services and supports.
3. Increase services and supports to Iowans with disabilities above the current income and/or asset limits.
4. Provide person/family-centered, rapid, relevant, and reliable access to information, services, and supports both public and private.
5. Ensure coordination of services to older Iowans and to Iowans with disabilities.
6. Enhance Iowa HHS practice culture of Person and Family Centered Service Provision.

MPA Focus Area: Direct Care Workforce Shortage

What We Heard

The shortage of the direct care workforce or non-licensed individuals paid to provide personal care services, is a known national issue, and it came up frequently throughout the community engagement discussions. Alongside informal caregivers, the direct care workforce is the backbone of the home and community-based services system. Offering higher pay, better benefits, and training opportunities are some of the recommendations to improve the direct care workforce shortage to ensure all Iowans have access to in-home care options.

What the Data Shows

- In 2022, Iowa's entry level wage for a home health and personal care aide was $11.45 with an experienced aide earning $15.62[3]. This wage is below the estimated $20.89 living wage needed for one adult working with no children and the $19.98 estimated living wage needed to help cover the cost of two adults working and their child's minimum basic needs while still being self-sufficient[4].

- Lower wage healthcare positions such as medical assistants, home health aides, and nursing assistants serve critical roles in the healthcare industry. A report by

Mercer projects Iowa will have a shortage of 36,000 low-wage health workers by 2026[5].

MPA Recommendations

1. Increase number of available, local direct care professionals.
2. Understand status of workforce needs and initiatives across the state.
3. Develop additional workforce recruitment, training, and retention opportunities.
4. Understand status of workplace benefits across the state.
5. Address wage disparities in the direct care workforce.
6. Develop career opportunities for direct care workers.
7. Understand current adult day and respite landscape.
8. Provide financial incentives to establishing and providing quality adult day and respite services.

MPA Focus Area: Health Disparities

What We Heard

Health disparities emerged as an important issue especially within focus groups with underserved populations. Health disparities are largely preventable differences in health outcomes that adversely affect populations who experience greater challenges to meeting their basic needs and are closely linked to social, economic, and/or environmental disadvantages[6]. Access to health care for underserved populations was one of the main discussion topics for this focus area.

What the Data Shows

Social Determinants of Health (SDOH) such as social and economic factors, where someone lives, and access to quality health care can contribute to one's ability to meet their individual and family needs. Iowa HHS implements a SDOH Survey with individuals enrolled in Medicaid. In 2024 Quarter 4, a total of 6,637 surveys were completed across all age groups. Listed below are the percentage of individuals who indicated challenges with meeting their individual and/or family needs (Table 1)[7].

Table 1: Family Needs of SDOH Survey Respondents (2024 Qtr4; N=6,637)

Dental Care	38.1 percent
Food	35.1 percent
Transportation	32.1 percent
Eye Care	19.5 percent
Clothing	18.9 percent
Mental Health	14.8 percent
Phone	14.3 percent
Medical Care	13.9 percent
Child Care	7.2 percent

Question: In the past year have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

MPA Recommendations

1. Improve access and affordability of key rehabilitation therapies such as physical, occupational, speech, and cognitive therapies after initial onset of disability.
2. Increase access, availability, and affordability of assistive technology, home and vehicle modifications, and other adaptation/accommodation aids that improve independence and wellness.
3. Reduce barriers to mental health care and health disparities cause by stigma.
4. Ensure adequate insurance coverage of needed services, especially behavioral health services (including Medicaid and private insurance).

MPA Focus Area: Quality of Care

What We Heard

Quality of care was an issue elevated by the steering committee members, community advocates and was within the top 10 issues to address from the disability focus group discussion. Receiving high quality of care can improve an individual's health outcomes, longevity, and quality of life. Quality of care discussions centered on the quality of the services offered and provided.

What the Data Shows

- Iowa has 404 certified nursing home facilities with 27,500 beds. As of July 2024, the average occupancy percentage is 72.7 percent (19,991 residents per day). Of facilities that have been rated (398), 57 percent received an overall quality provider rating of 3-stars or above while 43 percent received a rating of 2-stars or below[8].

- Lower wage healthcare positions such as medical assistants, home health aides, and nursing assistants serve critical roles in the healthcare industry. A report by Mercer projects Iowa will have a shortage of 36,000 low-wage health workers by 2026[9].

MPA Recommendations

1. All Iowans, including people with disabilities and complex health care needs, have access to high quality healthcare, including preventative care, in the communities of their choice.
2. Increase access to primary and specialized physical and mental health care.

PRIORITY AREA: ECONOMIC STABILITY AND INCOME, HOUSING, AND TRANSPORTATION

MPA Focus Area: Paying for Services

What We Heard

Paying for services and healthcare was the number one issue identified within community survey results and specifically among caregivers and underserved populations. It includes paying for doctors, dentists, mental health care and other medical services, prescriptions, long-term care, and some bills. Accessing financial supports such as the Medicare Improvement for Patients and Providers Act (MIPPA) program helps Medicare beneficiaries with limited income and access learn about programs that may sabe them money on their Medicare costs. Other programs such as Medicare Part D Low-Income Subsidy (LIS) and Medicare Savings Programs (MSP) helps to lower Medicare costs including out-of-pocket costs for premiums, deductibles and/or prescription drugs for beneficiaries who meet certain income and resource eligibility requirements.

What the Data Shows

- Home Care Cost: Iowa ranks 5th highest in the U.S. for the cost of home care services versus a person's income.[1] In 2023, Iowa's home care costs were 95 percent of the total income of an average household, which is above the U.S. average of 83 percent[10].

- Medicaid Long Term Services and Supports (LTSS) Balance: Spending. Iowa ranks 38th in the U.S. for percentage of Medicaid LTSS spending going to HCBS for older people and adults with physical disabilities. In 2020, Iowa spent 27.6 percent which is below the U.S. average of 53.3 percent[11].

- Medicaid for Low-Income People with Disabilities. Iowa ranks 41st in the U.S. in the percentage of people with Activities of Daily Living (ADL) disability at or below 250 percent of poverty receiving Medicaid or other government health insurance (ages 21+). In 2020-21, Iowa was 52.1 percent which is below the U.S. average of 59 percent[12].

[1] Annual private pay cost of licensed home health aide services (based on 30 hours of care per week multiplied by 52 weeks) divided by the median household income for households headed by someone aged 65 or older.

MPA Recommendations

1. Ensure Iowans can afford care across the lifespan they need to stay in their homes by planning for and maintaining income and supports and increasing economic security.
2. Increase percentage of spending on home and community-based services from 27 percent to 53.3 percent toward national average.

MPA Focus Area: Affordable and Accessible Housing

What We Heard

Affordable and accessible housing was an important discussion subtopic with the Aging in Place and Aging with Economic Security subcommittee. One in four survey respondents also indicated they had challenges in finding and paying for housing. By 2030, Iowa is expected to require an additional 21,110 homes to meet the demands of its thriving and robust economy. Most of this demand, will be for owner-occupied homes, totaling 14,793 (70 percent), while the remaining 30 percent will be for rental homes, amounting to 6,318 units[13]. Within this in mind the Steering Committee recommended to elevate this issue as a focus area within the MPA.

What the Data Shows

- Median home value in Iowa is $195,900 and median home rent is $949[14]. Many Iowan renters (40.2 percent) and homeowners (16.7 percent) are cost burdened (i.e., spending 30 percent or more of their income on housing) [15].

- Access to Housing Assistance for People with Disabilities. Iowa ranks 34th in the U.S. for the percentage of people with disabilities who are eligible for housing assistance but not enrolled. In Iowa, 12.2 percent of people with disabilities eligible for housing assistance are enrolled vs. the U.S. average of 15.6 percent[16].

- Of Iowans receiving state benefits, 5.6 percent (1,582 individuals) reported they have housing today but are worried about losing housing in the next 6 months and 3.6 percent (1,015 individuals) reported they are unhoused[17].

MPA Recommendations

1. Assessing the housing needs of Iowans with disabilities across the lifespan with regards to housing availability, affordability, and accessibility.
2. Increase affordable and accessible housing throughout Iowa.
3. Avoid homelessness, unnecessary hospitalization, and poverty.

4. Increase knowledge of home modifications enhancing the capacity of aging in place and avoiding early institutional care placement.

MPA Focus Area: Affordable and Accessible Transportation

What We Heard

Transportation includes the availability of community transportation options, safe driving and stopping driving, making vehicle modifications to support drivers or passengers with disabilities, transportation to healthcare appointments, community events or social engagements, and the lack of transit options in rural areas of Iowa. Transportation was noted as an issue across all the community engagement activities. Subcommittee recommendations on transportation will be reviewed in the context of transportation services funded by the Older Americans Act, Medicaid, and through state and local transportation agencies to explore opportunities for coordination of services.

What the Data Shows

- Of Iowans receiving state benefits, transportation is reported as the #1 service that individuals were unable to access and use when needed. The main reasons why they are having access issues include not having a personal vehicle, car broke down, person who usually provides transportation was unavailable, costs too much, or transit system is not available.

- Iowa's AARP Livability Index score for transportation in Iowa is 54 out of 100. Indicators Iowa performs within bottom third include:
    - Frequency of local transit service for Iowa in 2024 is 1.5 buses and trains per hour which is below the median US State value of 2.4[18].
    - ADA-accessible stations and vehicles for Iowa in 2024 is 84.7 percent which is below the median US State percentage of 86.5 percent[19].
    - Household transportation cost for Iowa in 2024 is $16,235 per year which is above the median US State cost of $15,794[20].

MPA Recommendations

1. Ensure transportation options are available and accessible.
2. Increase knowledge of access to vehicle modifications enhancing the capacity for aging in place and avoiding early institutional care placement.

PRIORITY AREA: Mental Health

MPA Focus Area: Social Isolation

What We Heard

Social isolation is a growing epidemic that can have long-term effects on one's mental and physical health. This issue was mentioned within the State Health Assessment and is also part of a State Plan on Aging goal to ensure older adults have social connections within their communities. Challenges or barriers to social engagement included socializing with different age groups, having access to companionship, and having reliable transportation to social events.

What the Data Shows

In 2023, more than 18 percent of Iowa adults aged 65 years and over reported that they sometimes, rarely, or never receive the social and emotional support they need. Moreover, nearly 24 percent reported feeling lonely sometimes, usually, or always.[21] Loneliness and social isolation increase the risk for premature death by 26 percent and 29 percent respectively.[22] In addition, poor or insufficient social connection is associated with increased risk of disease, including a 29 percent increased risk of heart disease and a 32 percent increased risk of stroke, with increased risk for anxiety, depression, and dementia. [23,24] Risk factors for social isolation and the percentage of Iowans aged 65 and older affected include: living in poverty (8.2 percent); living alone (41.8 percent); being divorced, separated, or widowed (35.3 percent); having never married (5.4 percent); having a disability (30.3 percent); and having an independent living difficulty (10.3 percent).[25]

MPA Recommendations

1. Promote programs and policies that improve resilience, connectivity, and holistic wellbeing for individuals and communities.
2. Increase physical, mental, social, and psychological health among Iowa's aging and disability communities.
3. Ensure awareness of preventative health care, mental health services, recovery resources, and essential support services to promote healthy aging for all Iowans.
4. Provide accessible transportation, access to digital skill training opportunities for virtual social engagement and promote opportunities for volunteerism.
5. Prepare/plan for life transitions (Examples: birth of a child, getting married, starting school, starting new a job, changing jobs, retirement, end of life, etc.)

6. Public spaces including parks, downtown districts, and other recreation spaces will be designed to encourage people of all ages and abilities to safely navigate and engage with their amenities.

MPA Focus Area: Unpaid Caregiver Support

What We Heard

While not everyone participating in a community engagement approach was a caregiver, informal caregiver support emerged as a priority issue when weighted across all approaches. Top challenges report by caregiver respondents included managing the emotional and mental toll of caregiving, finding financial support for caregiving, access to services that support caregivers, finding time for breaks from caregiving. Informal caregiver support includes helping caregivers navigate supportive services to help with the mental, physical and financial stressors of informal caregiving.

What the Data Shows

- Support for Family Caregivers. Iowa ranks 33rd in the U.S. on support for family caregivers. “In a high-performing LTSS system, family caregivers are recognized, and their needs are assessed and addressed so they can receive the support they need to continue their essential roles[26].”

- Iowa ranks 33rd in the U.S. for the number of adult day services total licensed capacity per 10,000 population aged 65 years and over. In 2020 Iowa had a total of 20 licensed adult day services per 10,000 population aged 65 years and over which is below the U.S. average of 54.

MPA Recommendations

1. Address emotional, physical, and mental health concerns of unpaid caregivers by providing them access to peer support groups.
2. Address emotional, physical, and mental health concerns of paid caregivers by providing them access to essential training.
3. Reduce the stigma associated with unpaid and unpaid caregivers asking for help.
4. Enforce and enhance current laws and regulations that support the collaboration between unpaid caregivers and the healthcare system.
5. Raise awareness to resources available to unpaid caregivers.
6. Provide navigation services to unpaid caregivers.
7. Establish an unpaid caregiver tax credit.
8. Centralize statewide caregiving resources.
9. Give unpaid caregivers the ability to receive payment for the care they provide.

Next Steps

Three IA SAIL workgroups have been created to further assess the status of the ten elevated focus areas. Over the next six months the workgroups will develop goal statements, objectives, strategies, and measures to form action plans around the initial recommendations. Short-term, intermediate, and long-term outcomes will be created to help set priorities and provide a timeline for needed action. Once the MPA has been finalized the work will shift from development of the plan to implementation of the plan. Progress reports will be published on an annual basis to provide an update on MPA implementation and accomplishments.

For More Information

IA SAIL

Visit the website at:
https://hhs.iowa.gov/aging-services/ia-sail

Healthy Iowans

Visit the website at:
https://hhs.iowa.gov/performance-and-reports/healthy-iowans

Addendum

Steering Committee Members

Listed below are members who participated in at least one or more of the planning meetings to develop the MPA.

- AARP, Iowa
- Alzheimer's Association - Iowa Chapter
- Barbara and Richard Csomay Center for Gerontological Excellence
- Connections Area Agency on Aging
- Elderbridge Agency on Aging
- Iowa Association of Area Agencies on Aging
- Iowa Association of Councils of Government
- Iowa CareGivers
- Iowa Community Action Association
- Iowa Department for the Blind
- Iowa Department of Corrections
- Iowa Department of Workforce Development
- Iowa Department of Transportation
- Iowa Department of Veterans Affairs
- Iowa Developmental Disabilities Council
- Iowa Health and Human Services Division of Administration
- Iowa Health and Human Services Division of Aging and Disability Services
- Iowa Health and Human Services Division of Behavioral Health
- Iowa Health and Human Services Division of Chronic, Congenital, & Inherited Conditions
- Iowa Health and Human Services Division of Community Access
- Iowa Health and Human Services Division of Family Well-Being & Protection
- Iowa Health and Human Services Division of Public Health
- Iowa Health and Human Services Division of Strategic Operations
- Iowa Health and Human Services Iowa Medicaid
- Iowa Housing Partnership
- Iowa Office of Health Equity
- Iowa Rural Health Association
- Iowa State Association of Counties
- Iowa Transportation Coordination Council
- Iowa's University Center for Excellence in Developmental Disabilities
- Meskwaki Nation Representative
- Office of the Chief Information Officer
- Older Iowans Legislator

- Olmstead Consumer Task Force
- OneIowa
- Sioux City Human Rights Commission – Tribal Representative
- University of Iowa, Health Management and Policy

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[9] Mercer, "US Healthcare Labor Market," Mercer (2021), https://www.mercer.com/content/dam/mercer/assets/content-images/north-america/united-states/us-healthcare-news/us-2021-healthcare-labor-market-whitepaper.pdf.
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Office of the State Long-Term Care Ombudsman

FFY 2023 Annual Report

Angela Van Pelt
State Long-Term Care Ombudsman

IOWA Health and Human Services

December 31, 2024

The Honorable Kim Reynolds

Members of the General Assembly

Dear Governor Reynolds and Members of the General Assembly:

Attached is the annual report of the Office of the State Long-Term Care Ombudsman for federal fiscal year 2023. This report is produced pursuant to Iowa Code 231.42, which requires that this office annually report to the governor and general assembly on:

1. The activities of this Office; and
2. Recommendations for improving the health, safety, welfare and rights of residents and tenants of long-term care facilities, assisted living programs and elder group homes.

This report reflects the efforts of the Long-Term Care Ombudsmen by sharing program highlights and discussing issues encountered by the Office in carrying out it's mandate to act as an advocate for the residents of long-term care facilities.

Sincerely,

Angela R. Van Pelt

Angela Van Pelt

Title: State Long-Term Care Ombudsman

Office of the State Long-Term Care Ombudsman

Angela Van Pelt
State Long-Term Care Ombudsman

Beth Burke
Local-Long-Term Care Ombudsman

Kim Cooper
Local Long-Term Care Ombudsman

Tiffani Crow
Long-Term Care Ombudsman / Residential Care and Managed Care

Jennifer Golle
Local Long-Term Care Ombudsman

Chasity Jones
Administrative Team

Melanie Kempf
Local Long-Term Care Ombudsman

Pam Mollenhauer
Empowerment Specialist

Julie Pollock
Local Long-Term Care Ombudsman

Pam Railsback
Local Long-Term Care Ombudsman

Pamela Rupprecht
Long-Term Care Ombudsman / Managed Care

Lisa Van Klavern
Volunteer Coordinator

Kim Weaver
Local Long-Term Care Ombudsman

Staff as of 9/30/2023

Contents

Program Overview

Mission

The mission of the Office of the State Long-Term Care Ombudsman (Office) is to provide individual and systemic advocacy to protect the health, safety, welfare, and rights of individuals residing in long-term care by investigating complaints, seeking resolutions to problems, and providing advocacy to enhance the quality of life and care.

In 2015, the mission was expanded to advocate for Medicaid managed care members who receive care in a healthcare facility, assisted living program, or elder group home, or are enrolled in one of the seven Medicaid waiver programs.

In Federal Fiscal Year (FFY) 2023 (Oct. 1, 2022 – Sept. 30, 2023), the programs administered by the Office included the Local Long-Term Care Ombudsman Program (LLTCOP), the Volunteer Ombudsman Program (VOP) and the Managed Care Ombudsman Program (MCOP).

Program Authority and Mandates

The Long-Term Care Ombudsman Program (LTCO) is authorized by the federal Older Americans Act and the Older Iowans Act. The functions of the Long-Term Care Ombudsman Program are to:

- Identify, investigate, and resolve complaints made by or on behalf of residents or tenants that adversely affect their health, safety, welfare, or rights.
- Make referrals to appropriate licensing, certifying, and enforcement agencies to ensure appropriate investigation of abuse complaints and corrective actions.
- Provide services to assist residents or tenants in protecting their health, safety, welfare, and rights.
- Inform residents and tenants about the means of obtaining services offered by providers or agencies.
- Ensure residents and tenants have regular and timely access to the services provided through the Office and that residents, tenants, and complainants receive timely responses.
- Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect their health, safety, welfare, and rights.
- Provide administrative and technical assistance to local and volunteer long-term care ombudsmen.
- Analyze, comment on, and monitor the development and implementation of federal, state, and local laws, regulations, and other governmental policies and actions that pertain to the health, safety, welfare, and rights of residents and tenants.
- Provide training for representatives of the Office, promote the development of citizen organizations to participate in the program, and provide technical support for the development of resident and family councils to protect the well-being and rights of residents and tenants.
- Establish and implement a statewide confidential uniform reporting system.
- Publicize the Office and provide information and education to consumers, the public, and other agencies about the issues related to long-term care in Iowa.
- Annually report on the activities of the Office and make recommendations for improving the health, safety, welfare, and rights of residents and tenants of long-term care facilities and residential care communities.
- Participate in inquiries, meetings, or studies that may lead to improvements in the health, safety, welfare, and rights of residents and tenants.
- Recruit, train, educate, support, and monitor volunteers serving as representatives of the Office.
- Coordinate ombudsman services with the Older Americans Act legal assistance and elder abuse awareness and prevention programs.

- Coordinate services with state and local law enforcement agencies and courts of competent jurisdiction.
- Ensure confidentiality and a program free of conflicts of interest.

Structure

In July 2023, the Office of the State Long-Term Care Ombudsman was part of a government realignment in Iowa and was moved from the Iowa Department on Aging to the Iowa Department of Health and Human Services (HHS). The Office of the State Long-Term Care Ombudsman operates as an independent entity within the Iowa Department of Health and Human Services and is now housed within the Compliance Division under Internal Controls and Accountability.

In FFY 2023, the Office of the State Long-Term Care Ombudsman had 13 staff positions: the State Long-Term Care Ombudsman (SLTCO), program and administrative staff, local long-term care ombudsmen (LLTCO), a managed care ombudsman, and the volunteer coordinator. The Office also had 38 volunteer ombudsmen providing advocacy services.

To assist in fulfilling the long-term care ombudsman duties outlined by law, the Office has designated local long-term care ombudsmen to serve residents and tenants in specific areas of the state. Local Long-Term Care Ombudsmen are all located remotely and are required to travel and conduct in-person facility visits within their assigned region. All staff attend in-person quarterly staff meetings, participate in bi-weekly calls and have 1:1 touch base meetings with lead workers and the SLTCO to ensure ongoing communication occurs while working remotely.

Occurring in July, the new alignment served as a catalyst for evaluation of OSLTCO leadership, and the existing staff structure / service delivery system as it existed in Iowa, including the functionality of the Managed Care and Volunteer Ombudsman Programs.

For the remainder of FFY 2023, the Office focused primarily on establishment of priorities, building the team to do the work and personal leadership development. This time of focus, evaluation and planning, would lay the groundwork for upcoming conversation about office restructuring to ensure that resources are being used in the most impactful way in FFY 2024.

Activities of the Office

Individual Advocacy

The primary role of the Long-Term Care Ombudsman Program is advocacy – or serving as the voice for residents and tenants residing in long-term care settings. Individual advocacy efforts ensured that residents' and tenants' voices were heard and that their rights were maintained in nursing facilities and residential care communities within the state.

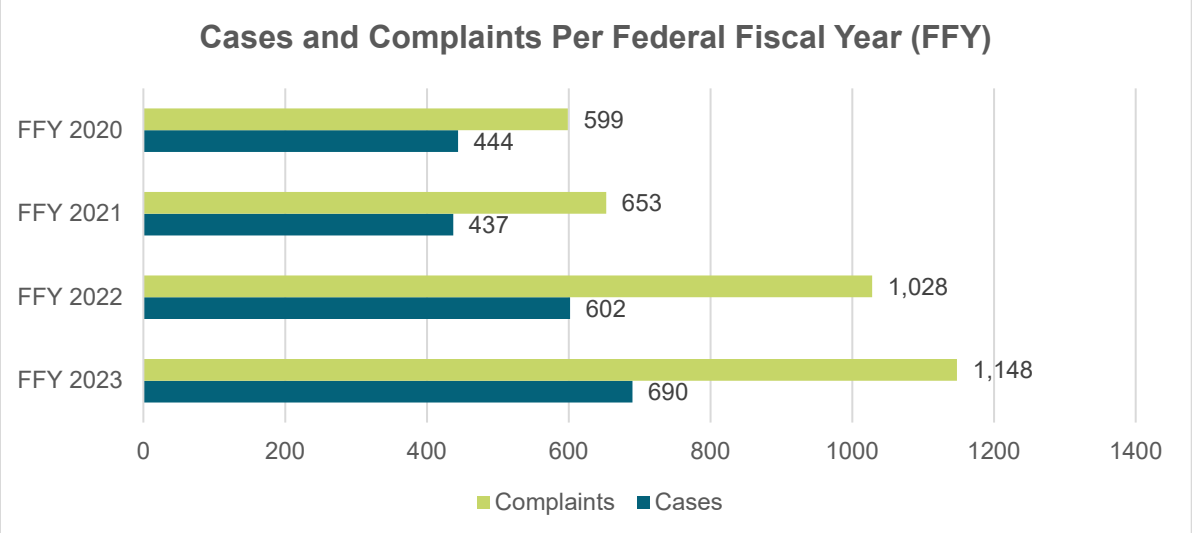
CASES AND COMPLAINTS

The Office is responsible for identifying, investigating, and resolving complaints made by or on behalf of residents or tenants in long-term care facilities. These complaints relate to issues that negatively impact their health, safety, welfare, or rights. A complaint is defined as a concern raised to or initiated by the Long-Term Care Ombudsman for investigation and action on behalf of one or more residents or tenants.

With the resident's or tenant's permission, Long-Term Care Ombudsmen are required to investigate and try to resolve complaints made by or on behalf of residents or tenants in long-term care facilities. Each inquiry brought to, or initiated by, the Long-Term Care Ombudsman on behalf of a resident or a group of residents that involves one or more complaints requiring investigation, resolution strategies, and follow-up is considered a case

In FFY 2023, the Office received 1,148 complaints and closed 690 cases, reflecting increases from the previous year in both complaints (11.67%) and cases (14.62%). The most common complaint categories for both nursing facilities and residential care communities are:

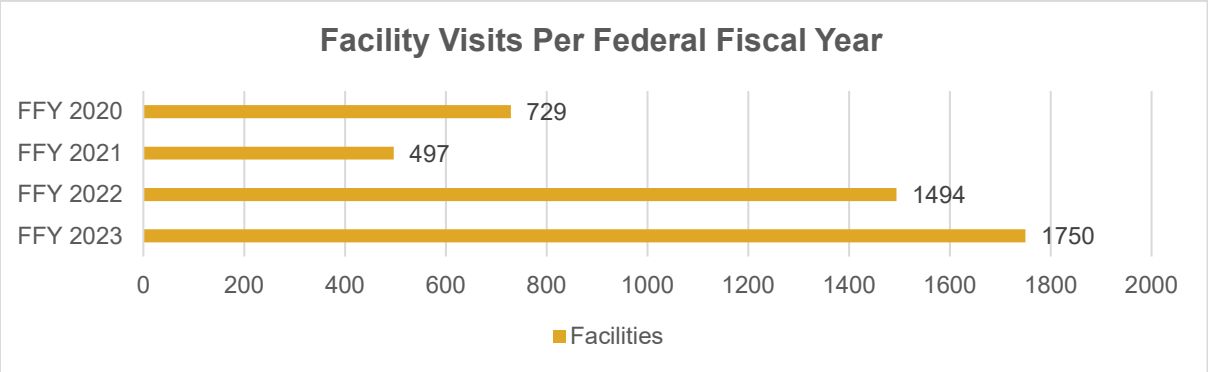
- Care
- Autonomy, Choice and Rights
- Financial and Property
- Admissions, Transfers, Discharges, and Evictions



COMPLAINT CODE	Total	Verified	Not Verified	Resolved/ Partially Resolved	Withdrawn	Not Resolved
All Settings						
A. Abuse, gross neglect, exploitation	**19**	13	6	9	5	5
B. Access to information	**36**	31	5	25	4	7
C. Admission, transfer, discharge, eviction	**161**	141	20	117	20	24
D. Autonomy, Choice, Rights	**193**	148	45	116	40	37
E. Financial, Property	**169**	132	37	124	22	23
F. Care	**326**	240	86	197	55	74
G. Activities and community integration and social services	**29**	21	8	21	3	5
H. Dietary	**57**	43	14	36	8	13
I. Environment	**67**	48	19	52	8	7
J. Facility policies, procedures and practices	**24**	19	5	14	4	6
K. Complaints about an outside agency (non-facility)	**21**	13	8	14	3	4
L. System and others (non-facility)	**46**	39	7	28	15	3

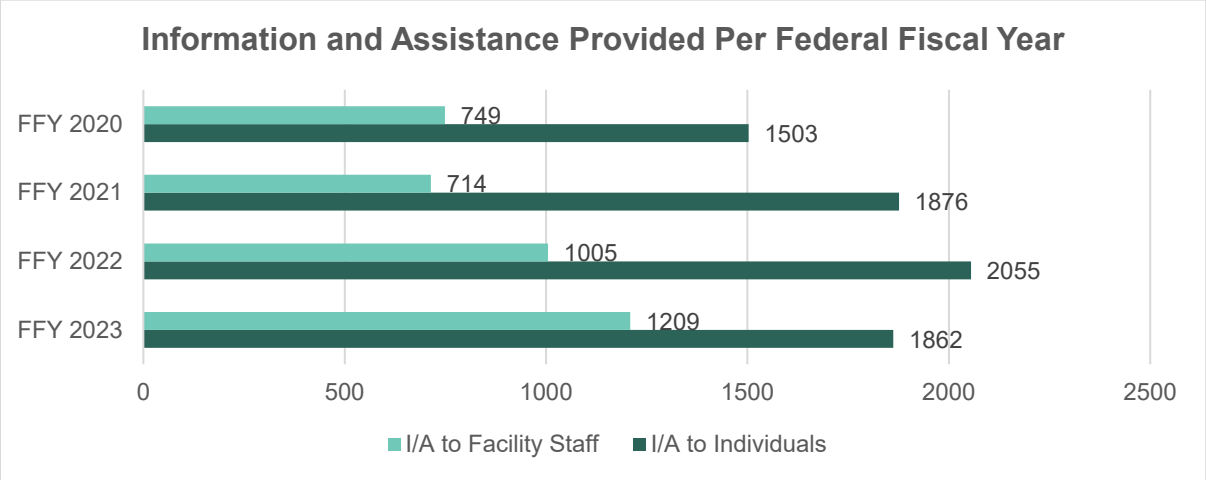
FACILITY VISITS

The Long-Term Care Ombudsman's Office may respond to inquiries, calls, e-mails, and reported concerns by visiting with residents and tenants. Visits are either complaint-related (non-routine) or non-complaint-related (routine). Facility visits allow the local and volunteer long-term care ombudsmen to assess a situation, provide education and information, and empower residents or tenants to act, as well as to obtain additional information to pursue the concern as a complaint or case if needed. In FFY 2023, representatives of the Office continued to be in facilities regularly to work on complaints, assess resident situations, and observe general conditions of the facility. Due to several urgent closure situations, staff made additional facility visits as necessary and needed, to assist in resident transfer efforts and to provide much appreciated support during these times. Facility visits increased by 17% (256 visits) from in FFY 23.



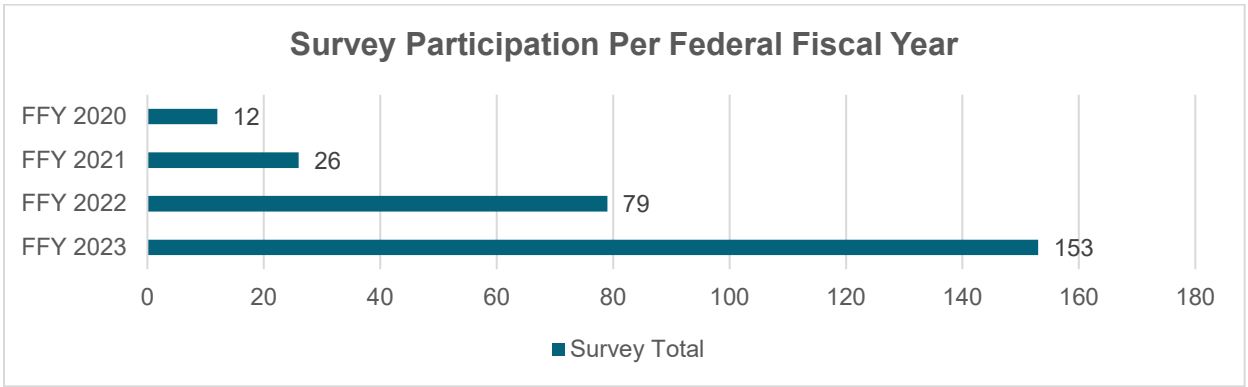
INFORMATION AND ASSISTANCE

The Office offers information and assistance to individuals, facilities, and service providers. This information and assistance often cover topics such as residents' rights, issues related to the abuse, neglect, or financial exploitation of residents or tenants, the role of long-term care ombudsmen and their intervention abilities, as well as concerns related to nursing facilities and assisted living services, and involvement of family and friends. It's important to note that providing this information and assistance does not involve investigating or resolving complaints. In FFY 23, the OSLTCO provided 1,862 instances of information and assistance to individuals and 1,209 instances of information and assistance to facility staff.



PARTICIPATION IN FACILITY SURVEYS

The Long-Term Care Ombudsman's Office participates in surveys conducted by the Department of Inspections, Appeals & Licensing (DIAL), which serves as the regulatory entity for long-term care facilities in Iowa to ensure their compliance with federal and state laws. The role of the Office is to provide comments; share concerns on behalf of residents, tenants, family members, and volunteers; and ensure residents' and tenants' voices are heard. Participation by the Office may include pre-survey briefing or attending the resident group interview or exit interview. In FFY 2023, Representatives of the Office participated in 153 facility surveys throughout Iowa, again reflecting a significant increase in participation.



ENGAGEMENT WITH RESIDENT AND FAMILY COUNCILS

The OSLTCO assists resident and family councils by attending meetings, upon request, and by providing technical assistance in the development and continuation of these councils. Resident and family councils are separate meetings that give residents and their families opportunities to reach out to

similarly situated individuals to discuss issues, care needs, frustrations, and personal experiences, as well as to receive support and encouragement. Representatives participated in 90 resident or family council meetings in FFY 2023 compared to 71 in FFY 2022.

	FFY 2020	FFY 2021	FFY 2022	FFY 2023
Resident Council	43	3	69	86
Family Council	0	1	2	4

Volunteer Ombudsman Program

The Office utilizes a Certified Volunteer Ombudsman trained to listen, empower, and advocate to serve as a voice for nursing facility residents. In FFY 23, the Volunteer Ombudsman Program used volunteer ombudsman to visit with and advocate for residents. Volunteer Ombudsman conduct unannounced visits to an assigned facility monthly and engage with residents to address their concerns. Volunteers have been an essential part of the Long-Term Care Ombudsman program. Their value, according to the Independent Sector of $33.49 per hour, is significant as reflected in the graphic below.

But volunteers bring more than a monetary benefit to the program, they are a familiar face that residents come to know and trust. They provide an extra set of eyes and ears to see what's occurring and to provide advocacy when needed. Since COVID, the OSLTCO has seen a consistent decline in volunteers. While this is not unique to Iowa's Ombudsman Program alone, the decision was made to start reviewing the program's current operational structure, evaluate issues, and identify strategies for improvement so that volunteers could easily and professionally navigate the process and engage more fully in their experience.

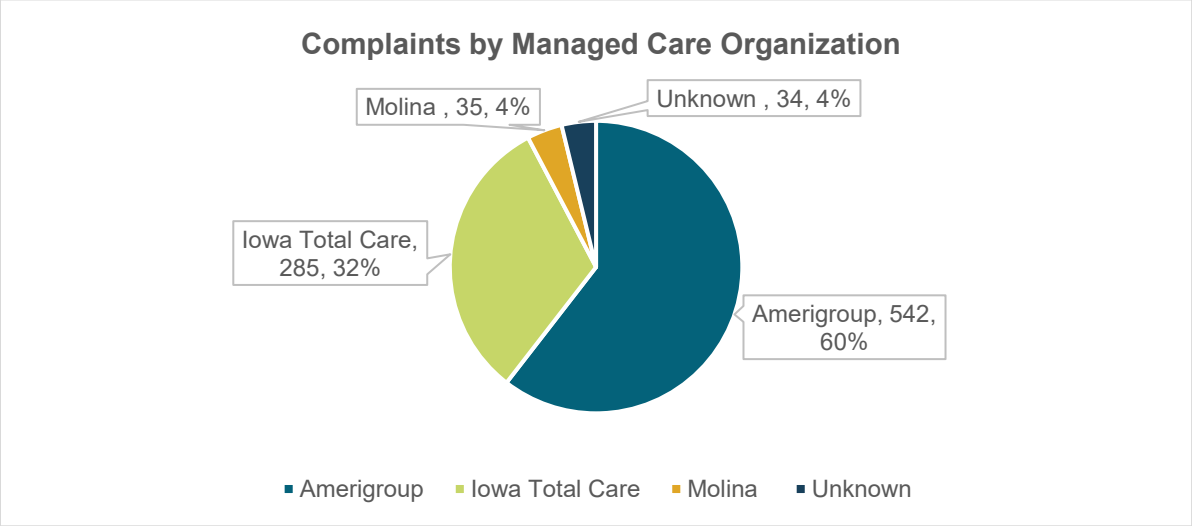
In fall of FFY 23, OSLTCO and HHS partners began to look at the feasibility of moving all certification training to an online platform for all staff and volunteers. HHS offered to pilot the project and will start work on this in FFY 2024. In conjunction with the updates to the certification training platform, discussion occurred regarding programmatic resources available to the OSLTCO to assist in restructuring the volunteer ombudsman components of the overall work of the office. During this period recruitment efforts were put on hold to avoid inconvenient or duplicative processes during onboarding and to focus on program re-building in FFY 2024.

Managed Care Ombudsman Program

Since the launch of Medicaid Managed Care in Iowa on April 1, 2016, the Managed Care Ombudsman Program has advocated for managed care members enrolled in one of Medicaid's seven home and community-based services (HCBS) waiver programs. These programs include the Children's Mental Health Waiver, the Elderly Waiver, the Health and Disability Waiver, the Intellectual Disability Waiver, the Physical Disability Waiver, the AIDS/HIV Waiver, and the Brain Injury Waiver.

In addition to advocacy, the Managed Care Ombudsman Program offers education and information about managed care plans, services, and processes. It provides guidance on the formal grievance and appeals process, as well as assistance with complaint resolution for members who need help navigating their managed care organization or the overall managed care system.

In FFY 23, the Managed Care Ombudsman Program received 893 complaints from members in managed care. These were largely from Amerigroup and Iowa Total Care, as Molina was not a provider for the State until July 2023.



The top compliant issues for managed care members were access to services and benefits, issues with consumer direct attendant care and problems with care coordination and poor customer service. Most of the complainants were on the Elderly Waiver, the Health and Disability Waiver and the Intellectual Disability Waiver.

As with the VOP, a review was initiated to determine the current structure and operation of the MCOP to ensure operations and service delivery is as efficient as possible. More detailed analysis will occur in FFY 2024.

Individual Advocacy Success Stories

A resident at a nursing facility had behaviors due to post traumatic stress disorder (PTSD) that was untreated at the facility. The resident refused cares because of this and would become upset when certain staff tried to care for her. The facility thought they could involuntarily transfer her to another facility without a notice or without the resident's input. The Local Long-Term Care Ombudsman became involved and was able to prevent the discharge and worked with the care staff to find the appropriate treatment for her PTSD and history of sexual abuse. The resident's behaviors and rapport with the staff improved as staff were educated on how to approach resident resulting in the resident being able to remain at the facility.

A resident of an assisted living facility shared that she had money stolen and that the facility would not investigate, claiming that she was probably "confused and had likely misplaced it". The Local Long-Term Care Ombudsman advocated for the program to investigate the report, by reminding them that it is required by law and must be self-reported to the appropriate agencies. The facility was found to be non-compliant and as a result the program reimbursed the tenant. The same individual had also been told that she would not be allowed to purchase her medications through her mail-order pharmacy, at half the cost. The facility was reminded that tenants have a right to choose their own pharmacy- the tenant was able to resume use of her preferred mail order pharmacy where she was able to save money.

A resident at an assisted living facility was issued a 30-day discharge/eviction notice. The tenant requested help from the Local Long-Term Care Ombudsman saying that she would prefer to move to her home state where she could live in a less restrictive environment. Even though she had family willing to

take her in, the tenant had not been able to contact her family as she had no access to a computer or smartphone nor a debit or credit card to purchase a plane ticket even if they were agreeable to taking her in. Through several in-person visits, phone calls and emails, the LLTCO coordinated with the tenant, facility administration, HHS, out-of-state entities, tenant's financial institution and out-of-state family to work towards a successful discharge from the assisted living facility in Iowa to a less restrictive setting in the tenant's home state.

Systemic Advocacy

Legislative, Regulatory and Policy Monitoring

In addition to individual advocacy, the Office provides systemic advocacy. A major part of systemic advocacy is reviewing and commenting on rules, regulations and laws; recommending policy changes when the health, safety, welfare or rights of residents and tenants are impacted; or educating residents, family, providers, policymakers and the public on issues of concern to individuals residing in long-term care facilities, and residential care communities. In FFY 2023, the State Long-Term Care Ombudsman monitored proposed legislation and rules and provided declarations or comments, on bills similar to:

SF 561	Medicaid, Veterans and Personal Needs Allowance
HF 685/SF 567	Nursing Facility (NF) Change of Ownership, Certificate of Need, NF Bed Need
HF 537	Authorized Electronic Monitoring in Nursing Facilities
HF 357/SF 327	Health Care Employment Agencies
HF 288	Alzheimer's Advisory Council and State Plan
HF 457	Medicaid Reimbursement Rates for NF for Registered Sex Offenders
SF 537/HF 619	Hospital / Nursing Facility Visitation Policies

In FFY 22 and FFY 23, the Office of the State Long-Term Care Ombudsman actively engaged residents, facilities and stakeholders in a grassroots effort to increase the Personal Needs Allowance (PNA). This is the amount that residents receiving Medicaid are allowed to keep monthly, currently it is $50 in Iowa and the proposal is to increase it to $65 with an annual cost of living adjustment.

This has been an ongoing effort through the circulation of a petition; creation and posting of resident testimony on social media; interviews with local media; development of a PNA infographic and other materials and direct legislative education and engagement by residents and the SLTCO. In March of 2023, the Office hosted it's first PNA Facebook Live event to educate the public on the issue. While efforts have not been successful yet, we will continue to support this resident priority in FFY 24 and would encourage legislators to support the increase.

Collaborative Engagement and Efforts with Stakeholders

The Long-Term Care Ombudsman's Office participates in federal, state and local efforts to ensure that the rights of and issues impacting residents and tenants in long-term care facilities, assisted living programs and elder group homes are communicated. Through these efforts, long-term care ombudsmen share systemic issues and day-to-day concerns that adversely impact the health, safety, welfare or rights of residents/tenants, serving as visible advocates working toward resolution of these very issues. In FFY 23, the OSLTCO participated in work groups and discussions with stakeholder on issues such as:

- Quality of care for residents
- Closures and transfer trauma
- Nursing facility stability and the long-term care landscape in Iowa, present and future state
- Overuse of agency staffing, including quality and fiscal impacts to the resident
- Nursing Home ownership and accountability, including impacts of private equity buyouts
- Identification of at risk-facilities prior to emergency situations
- Patient mix and occupancy levels
- Change of Ownership Process (CHOW) and vetting / financial review of prospective buyers
- Long-Term Care Fraud
- Innovative housing-Intergenerational Housing Models, Green House Models

Community Education and Outreach Efforts

The Long-Term Care Ombudsman Program presents relevant and timely information to the community on such topics as the role of the long-term care ombudsman; the rights of residents and tenants; how to advocate on behalf of or empower residents and tenants; and various subject matter topics, including powers of attorney, guardianship, conservatorship, visitation, voting rights, residents' right to sexual expression, admissions, discharges and evictions from long-term care facilities.

In FFY 2023, the OSLTCO again actively pursued and engaged in opportunities to raise visibility and awareness of our role in Iowa in for residents in Long-Term Care Facilities. This includes accepting opportunities for public speaking engagements and media interviews, presenting at webinars and working intentionally to build a stronger social media presence. The Office had 25 instances of community education in FFY 23, up from 15 the prior year.

Given the high profile of facility bankruptcy and closures occurrences in Iowa, we wanted to develop additional outreach materials to ensure that loved ones and residents had the tools they needed to make these transitions easier on their loved ones. We prepared 5 educational pieces in paper and video format for availability on our social media sites. The information covered includes:

- Resident Rights
- Long Term-Care Ombudsman Services
- Involuntary Discharge or Transfer
- Facility Closure-Know your rights!
- Dependent Adult Abuse

These additional resources are especially helpful during the closure process. We find that people are shocked and struggling to process what is occurring in these moments, so having a tangible piece of information that they can take with them and a reference point for additional materials and support is very much appreciated.

The Office will continue to be intentional in building the presence of our work across the state in the coming year.

Challenges and Opportunities

Holding Facility Ownership Accountable

Long-term care (LTC) facilities serve a vulnerable population, including elderly and disabled individuals, many of whom rely heavily on these institutions for their health, safety, and quality of life. Facility closures in Iowa are on the rise and in FFY 2023, more than 20 facilities closed in Iowa.

Name	City	Facility Type	Date
QHC Mitchellville	Polk	Free Standing NF/SNF	2022-10-01
Westmont Healthcare Community	Logan	Free Standing NF/SNF	2022-11-02
Pride Group at Lincoln	Le Mars	RCF	2022-11-02
Good Samaritan-Postville	Postville	Free Standing NF/SNF	2022-11-03
Good Samaritan-Fontanelle	Fontanelle	Free Standing NF/SNF	2022-11-17
Crestview Acres	Marion	Free Standing NF/SNF	2022-11-19
Donald Lundak Center Assisted Living	Cresco	ALP/D	2022-11-28
Patty Elwood Center	Cresco	Free Standing NF/SNF	2022-12-28
Pleasant View Home	Albert City	Free Standing NF/SNF	2023-02-17
QHC Fort Dodge Villa	Fort Dodge	Free Standing NF/SNF	2023-02-20
QHC Humboldt North	Humboldt	Free Standing NF/SNF	2023-02-24
QHC Winterset North	Winterset	Free Standing NF/SNF	2023-02-24
QHC Madison Square LLC	Winterset	ALP-D	2023-02-24
Rock Rapids Healthcare Center	Rock Rapids	Free Standing NF/SNF	2023-03-02
Spurgeon Manor	Dallas Center	RCF	2023-03-17
Legacy Gardens	Iowa City	ALP/D	2023-03-20
Mercy One Oelwein Senior Care	Oelwein	HSP-SNF/NF	2023-04-07
Evergreen Estates III	Cedar Rapids	RCF	2023-04-26
Kosgrove Estates	Sioux Center	ALP	2023-06-15
Pocahontas Manor	Pocahontas	Free Standing NF/SNF	2023-07-14
Countryside Health Care Center	Sioux City	Free Standing NF/SNF	2023-07-26
Aspire of Primghar	Primghar	Free Standing NF/SNF	2023-09-13
Emerson Point	Iowa City	ALP	2023-09-23

The closure of an LTC facility can have profound and far-reaching consequences for residents, families, and the community. Transitions to new environments can lead to psychological distress, worsening of medical conditions or even death.

Facility ownership must be held accountable when closures occur to protect resident's rights and wellbeing and to ensure that closures are conducted with minimal harm, prioritizing residents' needs over financial interests. The state needs to ensure that current state laws, regulation and policy holds existing owners accountable both prior to any acquisition or change of ownership and during the facility closure process by:

- Strengthening regulatory oversight by establishing a pre-approval process prior to closure to ensure plans also meet legal and ethical standards during the closure.

- Enhancing financial accountability by requiring owners to disclose financial health indicators leading up to the closure and auditing and investigating if closures seem financially motivated.
- Increasing ownership scrutiny for owners with a history of mismanagement of neglect.

The closure of an LTC facility is a critical event with significant consequences. To protect vulnerable residents, uphold ethical standards, and preserve public trust, greater scrutiny and accountability for facility ownership are essential. By implementing robust oversight mechanisms, States can ensure that closures are handled responsibly, minimizing harm and promoting justice for all affected parties.

Utilization of an Involuntary Transfer and Discharge Portal

Per federal and state regulation, facilities are required to submit copies of all facility-initiated (involuntary) transfer or discharge notices to the Ombudsman Program, these come in multiple formats, certified mail, email and regular mail. Upon receiving a notice, the LLTCO contacts the impacted resident to see if they would like assistance with an appeal. These time frames for appeal are short and require quick action, failure to effectively respond within the time frames can result in discharge.

Due to the large volume of discharges received monthly and the various formats they come in, it would be highly beneficial for Iowa to use a more streamlined, electronic process and portal that all parties could use for discharge notice submission. This electronic reporting system would enhance transparency and accountability in the management of involuntary discharges and transfers within long-term care facilities. By streamlining the reporting process, it aids in protecting residents' rights and ensures that facilities adhere to legal requirements.

Optimization of Long-Term Care Program Operations

Additional funding into the LTCOP in Iowa is essential to continue the momentum that has been gained since COVID. For the last several years, the influx of additional federal COVID relief funds have provided additional resources for staffing, travel, outreach and marketing but without these funds, the program will barley sustain personnel cost alone. Funds are needed to have adequate staff; engage in volunteer recruitment and retention strategies; to build and expand resident and family councils and to provide training for staff and individuals in these roles.

A robust volunteer pool is essential to expanding our reach in rural and underserved areas. Expanding Iowa's volunteer ombudsman program offers a cost-effective, community-driven solution to the growing challenges in long-term care oversight. By increasing volunteer engagement, the state can enhance its capacity to monitor care facilities, address complaints, and protect the rights of long-term care residents, all while empowering volunteers and strengthening the connection between residents, families, and the broader community. Volunteers are an integral part of a more responsive, proactive, and effective ombudsman program that ensures higher standards of care and greater advocacy for Iowa's aging population

Developing and strengthening resident and family councils in Iowa's long-term care facilities can provide significant benefits to residents, families, and the facilities themselves. These councils are formal or informal groups of residents and family members who come together to discuss issues, advocate for improvements, and support the well-being of those living in long-term care settings. Resident and family councils provide an essential mechanism for advocacy, engagement, and support, ultimately creating a better living environment for residents and a more collaborative, responsive care environment. This is a necessary key step in enhancing Iowa's long-term care system and ensuring that the voices of residents and families are heard and acted upon in meaningful ways.

Healthy Iowans

Iowa's State Health Assessment

June 2022

Coordinated by the Iowa Department of Public Health

Acknowledgements

Thank you to the hundreds of partners that have contributed their time, expertise, hard work, and other resources to making health improvements in Iowa over the last three decades.

Thank you to all those who responded to the Iowa Health Assessment survey. Your responses provided valuable input and helped to shape the state health assessment.

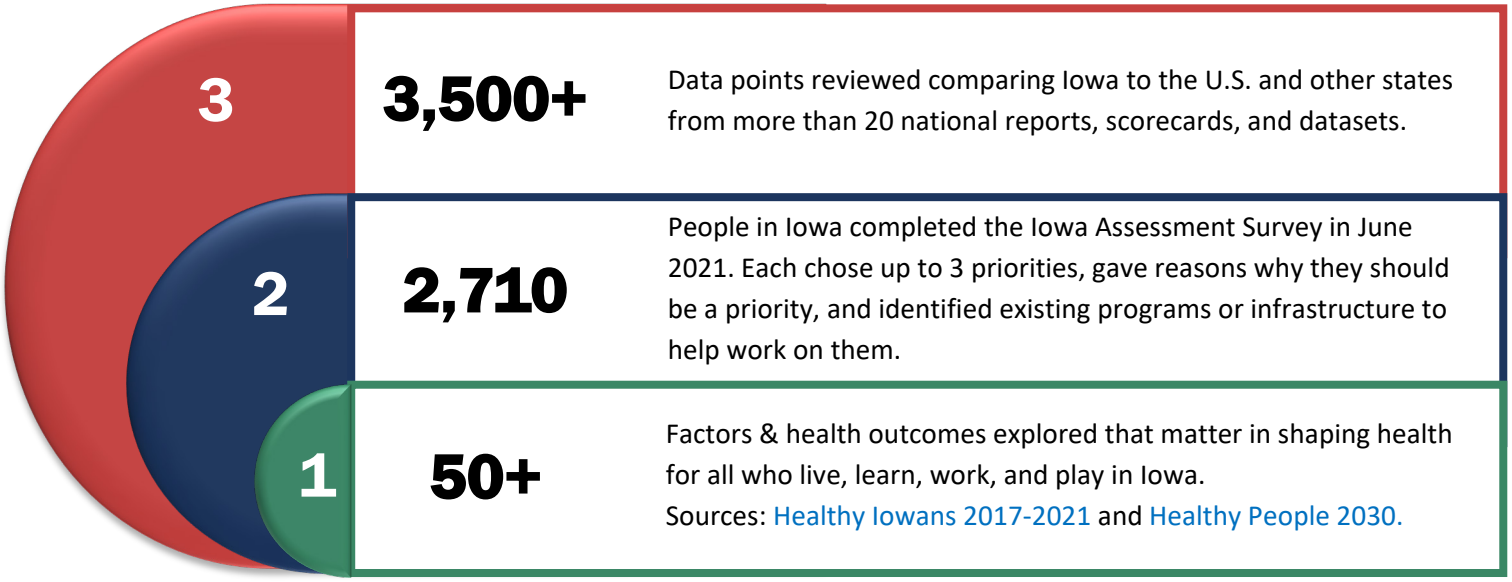
Table of Contents

Introduction

Every five years, the Iowa Department of Public Health leads a collaborative process, known as Healthy Iowans. The process includes a state health assessment (SHA) and a state health improvement plan (SHIP). The 2021-22 SHA identifies the most important factors that shape health for all who live, learn, work, and play in Iowa based on summary data points and what we heard from people in Iowa. It also includes selected priorities based on that data.

The priorities highlighted in this SHA report will help guide the development of Iowa's 2023-2027 SHIP. Communities and organizations can also use the report as they plan local strategies to achieve better health for all. The report includes data points on health outcomes and the social, economic, and environmental factors that affect everyone's health. These system-wide factors are complex and require collaboration and attention from a variety of sectors, including public health.

SHA Process at a Glance: 3 Main Parts



Report Layout

This SHA report includes two main sections: background data (including demographics) and data on seven identified priorities. Within each section, there are three basic elements: why it matters, what the data shows, and what we heard.

Why it matters contains information from various reputable national sources such as Healthy People about how the topic relates to and shapes health.

What the data shows contains data from national reports, scorecards, and data sets such as US Census Bureau, CDC, and America's Health Rankings.

What we heard contains data and quotes from Iowans who took the Iowa Health Assessment survey in June 2021.

Why It Matters

What the Data Shows

What We Heard

Health Equity

"Health equity is the attainment of the highest possible level of health for all people. It means achieving the environmental, social, economic, and other conditions in which all people have the opportunity to attain their highest possible level of health. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequities, historical and contemporary injustices, and the elimination of health, and healthcare disparities."[1] Health equity is crucial to a vibrant state; however, many communities and specific groups have experienced generations of isolation from opportunity. Policies and practices at every level have created deep-rooted barriers to good health.[2]

Throughout the SHA, the data indicates many disparities across population-specific groups, in particular for people of color (such as African American and Indigenous people), people with disabilities, people who are lesbian, gay, bisexual, and transgender, and people who live in rural areas. What the data is not able to fully provide is the context or root cause analysis of why these disparities exist; however, much of the cause can be attributed to unequal treatment, unjust systems, and inequitable community and economic development.[3] Further community engagement is needed to identify unique opportunities within communities for stakeholders to implement collaborative and meaningful solutions.

What We Heard

- "Adequate public health infrastructure is critical for ensuring good public health outcomes, equity in health care access and impacts all community members."
- "Society and community interactions impact health equity which impacts all other health outcomes."
- "Social cohesion, equity, and inclusion are pivotal in ensuring community well-being."
- "Policies in all sectors of the economy impact the social determinants of health, which ultimately impact the ability of all Iowa's populations to equitably live and enjoy optimal health…"

Notes*: Health Equity*

[1] Healthy People 2030
[2] Robert Wood Johnson Foundation
[3] Robert Wood Johnson Foundation

COVID-19

The 2021-22 SHA process began during the global COVID-19 pandemic. The pandemic worsened existing health disparities and showed the effects that economic and social factors have on every health issue.

COVID-19 also caused delays in the collection and analysis of some health data. As a result, several data points used in the SHA were pre-COVID-19 (pre-2020). The Iowa Health Assessment Survey was completed during the pandemic in June 2021; therefore, the responses to the survey were likely influenced by the health, social, economic, and environmental impacts from the pandemic that will remain for years to come.

While the pandemic is a major public health crisis, people in Iowa face many other broad, interacting challenges that may make it difficult for individuals, communities, and the state as a whole to be healthy. The 2021-22 SHA aims to bring focus to these issues.

What We Heard

> The homeless or those with housing insecurity are in danger. The pandemic has forced more to be on the streets and that is a public health issue for adults and children.

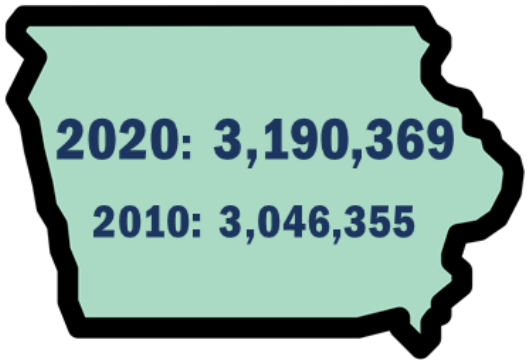
> Due to COVID-19, we are experiencing an overwhelming amount of new or worsened mental health issues.

> COVID-19 has spotlighted inequities in access to care and availability of care for many in our community.

> This past year has been a year of chaos and crippling stress for many, resulting in business losses, unemployment, transportation barriers, social isolation, a lack of childcare….

Iowa's People

4.7% **increase in Iowa's population since 2010[1]**



Age

Every age group has health and social needs that are unique to them. For example, strategies that focus on increasing breastfeeding rates, promoting vaccinations and developmental screenings, and encouraging safe sleep practices are key to improving infants' health.

Children and adolescents who get stable and supportive care, screenings, early education, and who practice healthy behaviors are more likely to stay healthier and prevent many long-term problems. As of 2020, nearly 1 in 4 of all Iowans were under age 18.

Population in Iowa by Age, 2020[2]

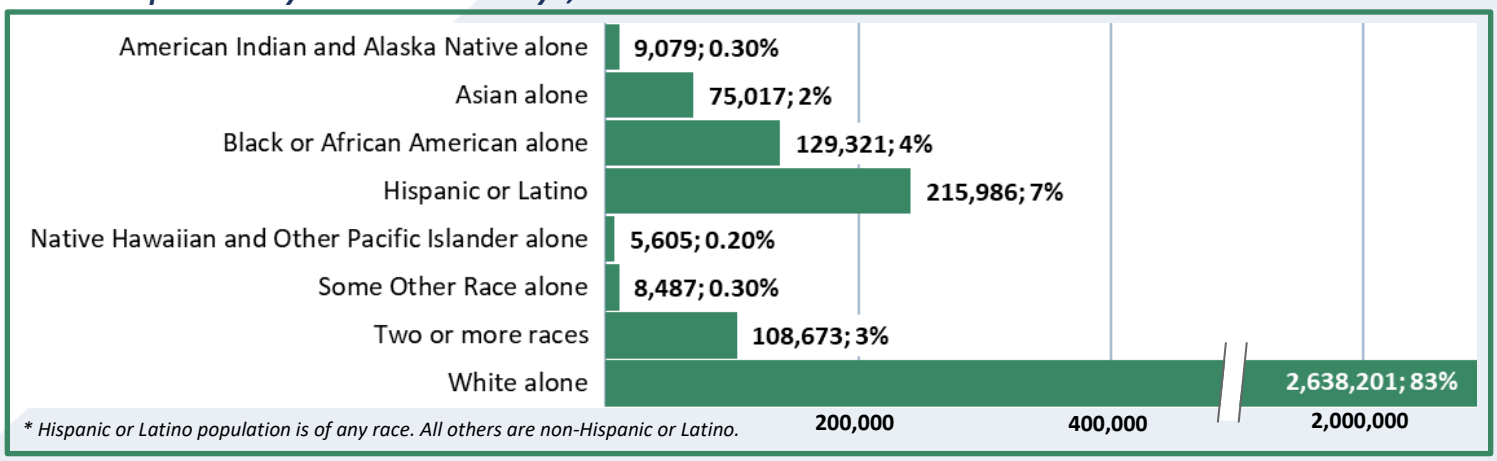
Age Group	Estimate	Percent
0 to 5 years	233,211	7%
6 to 11 years	241,674	8%
12 to 17 years	250,674	8%
18 to 24 years	313,856	10%
25 to 34 years	398,796	13%
35 to 44 years	390,589	12%
45 to 54 years	357,591	11%
55 to 64 years	411,034	13%
65+ years	566,136	18%

Race and Ethnicity

Nearly every topic examined in the SHA shows differences in health outcomes by race and ethnicity. While there can be challenges in analyzing data when there are smaller population counts for some racial categories, it is important to break down data by race and ethnicity to identify disparities in health outcomes and the social, economic, environmental factors that affect these health outcomes.

When breaking down Iowa's population by different race and ethnicity categories, the state continues to increase diversity as 17% of the state's population identify with one or more of at least 45 different racial categories. About 83% of the state identifies as White, non-Hispanic.[1]

Iowa's Population by Race and Ethnicity*, 2020[1]



** Hispanic or Latino population is of any race. All others are non-Hispanic or Latino.*

Languages

Most people in Iowa use English as their primary language in their home (91%). Still, more than 260,000 people (9%) speak one of more than 65 non-English languages at home, though this is much lower than the national average (22%). Spanish was the second most often used language at home (over 130,000 people). It is important to note that 3% of the population reported speaking English "less than very well." Meaning roughly 106,000 Iowans face a barrier to getting the services they need, as not all services in the state are equipped with translation support.[3]

Sexual Orientation and Gender Identity

Based on survey data collected between 2015 and 2017, an estimated 3.6% of Iowa adults identified as lesbian, gay, bisexual, or transgender (LGBT).[4] In addition, 12.5% of Iowa high school students identified as lesbian, gay, or bisexual (LGB) in the 2019 Iowa Youth Risk Behavior System survey (YRBS). Another 5% of students were unsure of their sexual orientation. People identifying as LGBT experience health disparities linked to social stigma, discrimination, and stress.[5] As more health data is collected on sexual orientation and gender identity, it will be important to identify differences in health outcomes and in the social, economic, environmental factors that affect these health outcomes.

Living with Disability

About 12% of people in Iowa reported living with a disability in 2020. People with disabilities often do not get the health care and preventive services they need to stay healthy. They also may face barriers to working, going to school, finding accessible places to live, accessing safe spaces for physical activity, or accessing transportation. These barriers can be a factor in poor mental health as well as lead to other types of health issues (e.g., lack of exercise, falls).

380,000
Iowans live with a disability

People with Disabilities in Iowa, 2020[6]

120,019
IOWANS WITH
Hearing Difficulty

136,523
IOWANS WITH
Cognitive Difficulty

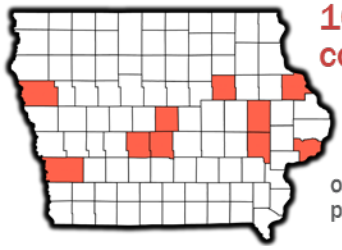
163,556
IOWANS WITH
Ambulatory Difficulty

119,407
IOWANS WITH
Independent Living Difficulty

Population Trends

Iowa's population is URBANIZING

Areas of population growth and decline vary around the state. Between 2010 and 2020, 68 of Iowa's 99 counties had a population decline. While there was growth in several counties across Iowa, most population increases took place in or near urban areas. Population growth in urban areas can expand access to employment, education, and health care; however, it also can lead to congestion, higher crime rates, pollution, increased inequality, and social exclusion.[7]



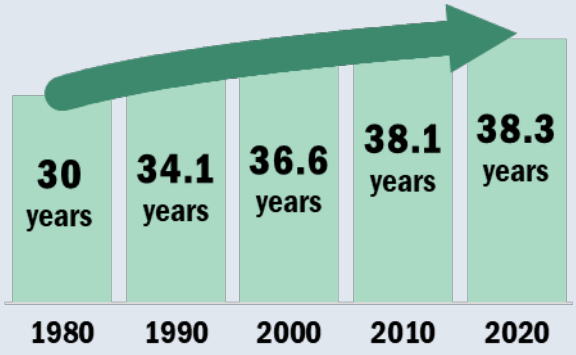
10 counties make up **over half** of Iowa's population

Black Hawk
Dallas
Dubuque
Johnson
Linn
Polk
Pottawattamie
Scott
Story
Woodbury

U.S. Census Bureau, 2020

Iowa's population is AGING

Median Age[9]

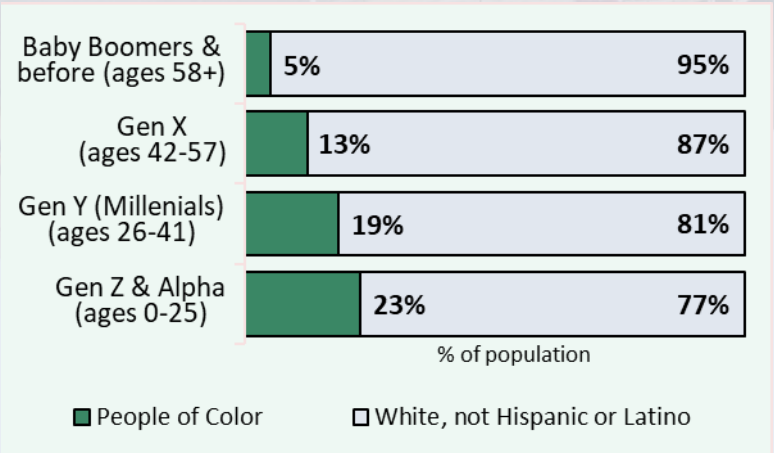


Older adults are at higher risk for chronic health problems like diabetes, osteoporosis, and Alzheimer's disease that require a variety of health services from prevention and treatment to support from family and the community. As Iowa ages, there will be a greater need for caregivers and support services for older adults.

Iowa's population is MORE RACIALLY & ETHNICALLY DIVERSE

In 2000, people of color represented 7.3% of Iowa's total population. By 2020, this proportion had increased to 17.3%. Additionally, 23% of Iowa's younger people (ages 0-25) were people of color. Eliminating disparities in systems such as education, employment, health, income, and other social, economic, and environmental factors will improve overall health in Iowa and increase economic growth.[8]

Iowa's Population by Race/Ethnicity and Generation, 2020[2]



Notes: *Iowa's People*

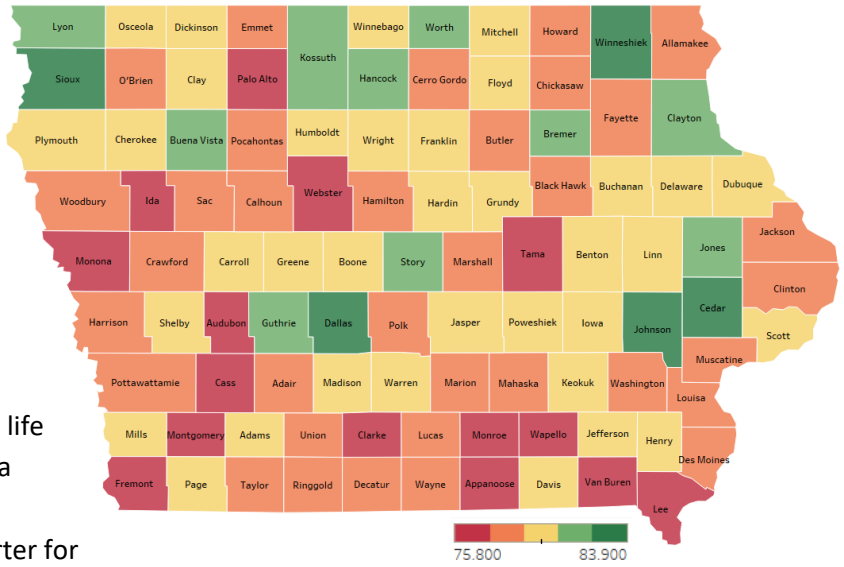
[1] U.S. Census Bureau, 2020
[2] CDC WONDER Online, U.S. Census Bureau, 2020
[3] U.S. Census Bureau, American Community Survey, 2019
[4] Williams Institute, 2019
[5] Healthy People 2020, LGBT Health
[6] U.S. Census Bureau, American Community Survey, 2020
[7] United Nations, Department of Economic and Social Affairs, 2020
[8] National Equity Atlas, 2015-2019
[9] Iowa State Data Center, 1980-2000; U.S. Census Bureau, Decennial Census, 2010; & American Community Survey, 2020

Overall Health Profile

Life Expectancy

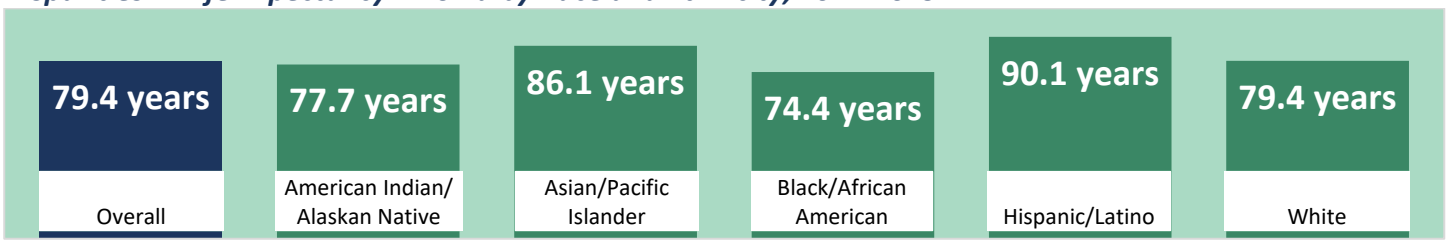
Life expectancy is the average number of years that a group of newborns is expected to live if the age-specific death rates from the year of their birth stayed consistent throughout their life. While Iowa's life expectancy (79.4 years) was slightly longer than the nation's (78.6 years), it varies based on where people live. Montgomery County, Iowa had the lowest life expectancy (75.8 years), while the highest was in Sioux County (83.9 years), a difference of eight years.[1]

Life Expectancy by County, 2017-2019[1]



Disparities in life expectancy can also reflect how different life experiences for people in Iowa can affect the lifespan. Data shows that average life expectancy is longer for Asian/ Pacific Islander and Hispanic/Latino Iowans and much shorter for American Indian/Alaskan Native and Black/African American Iowans. More research needs to be done to understand why these disparities exist.

Disparities in Life Expectancy in Iowa by Race and Ethnicity, 2017-2019[1]



Leading Causes of Death, 2020

Rank	Causes of Death in Iowa[2]	Total Deaths	Death Rate*
1	Heart Disease	7,499	172.9
2	Cancer	6,304	147.8
3	COVID-19	4,336	99.0
4	Chronic lower respiratory diseases	1,704	39.4
5	Unintentional injuries	1,647	45.7
6	Alzheimer disease	1,467	31.9
7	Cerebrovascular diseases	1,408	31.9
8	Diabetes	1,047	24.7
9	Suicide	552	18.0
10	Influenza and pneumonia	538	12.4

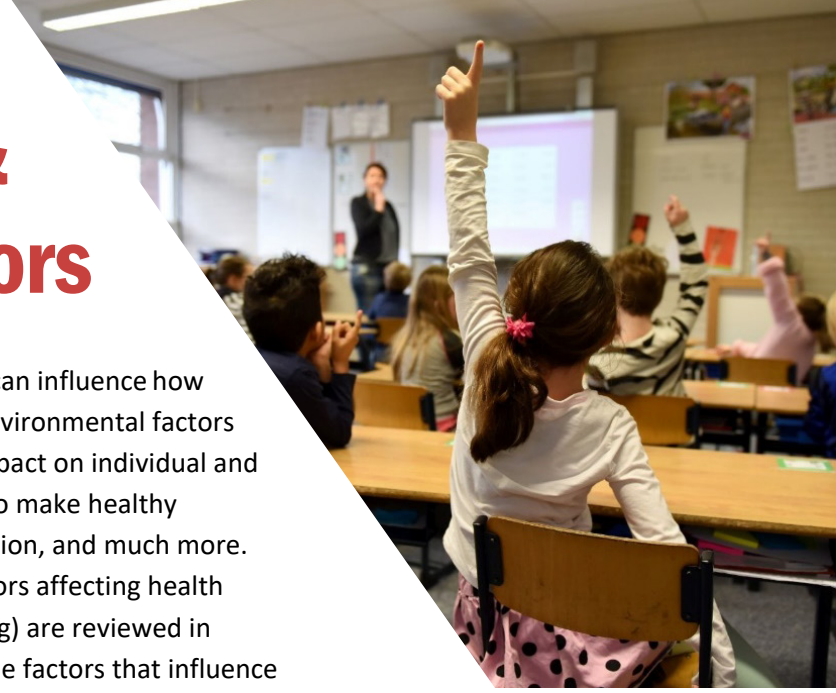
** Per 100,000 Iowa residents, adjusted by age.*

Deaths from heart disease were the leading cause of death for Iowans ages 80 and older as well as for those ages 45-54. Because almost half of all deaths in 2020 were Iowa residents ages 80 and older, heart disease also was Iowa's overall leading cause of death. However, cancers were the leading cause of deaths for ages 55-79. Unintentional injuries were the leading cause of deaths for ages 1 to 44. For infants, birth defects were the leading cause of death. Iowa had higher death rates than the U.S. for heart disease, cancer, COVID-19, chronic lower respiratory diseases, and suicide.[2]

Notes*: Overall Health Profile*

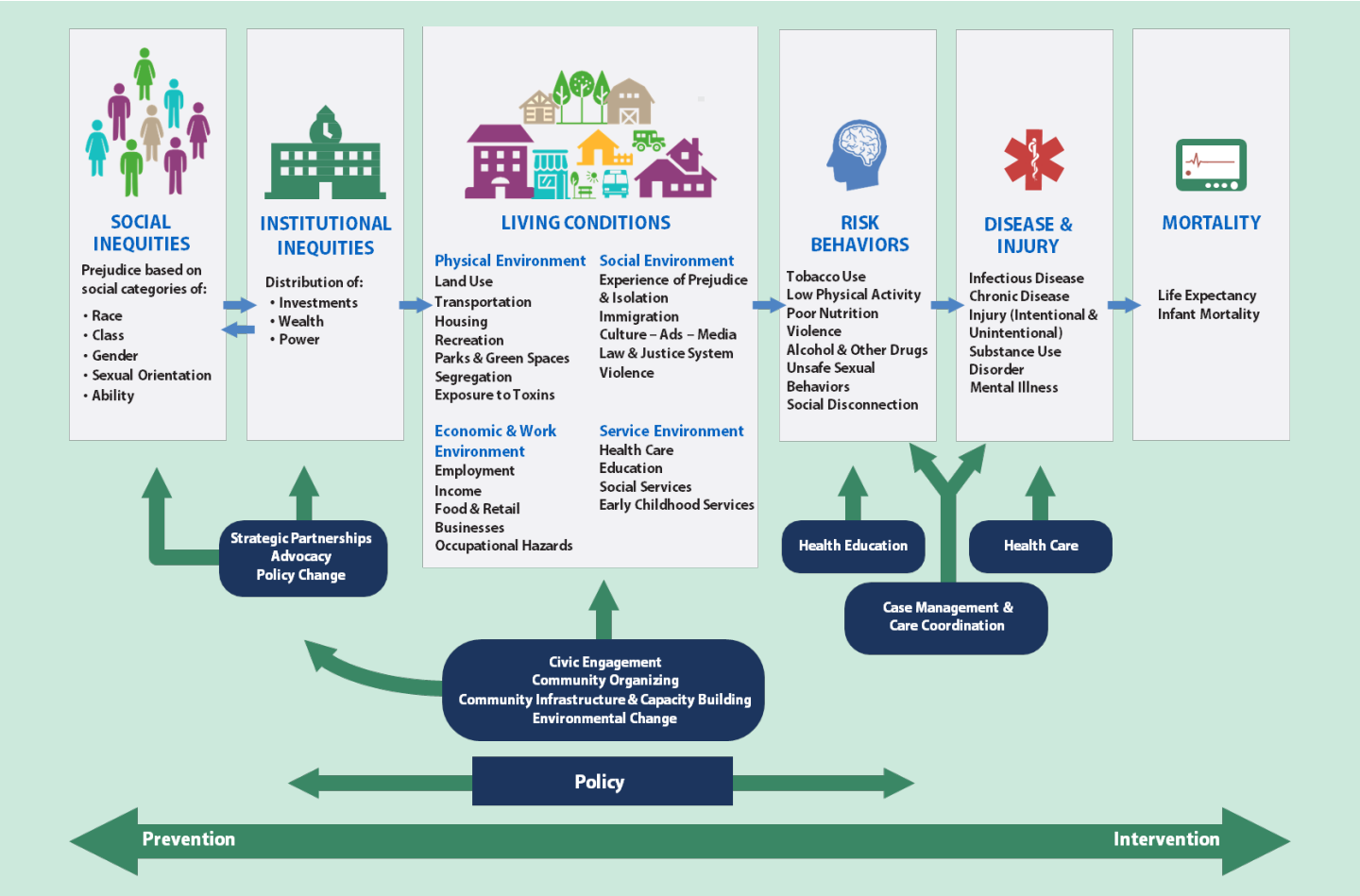
[1] County Health Rankings, 2021
[2] NCHS: Multiple Cause of Death on CDC WONDER Online Database

Social, Economic, & Environmental Factors



The conditions in which people live, learn, work, and play can influence how healthy they are.[1] In other words, social, economic, and environmental factors and the interrelationships among these factors have an impact on individual and population health. These factors can influence the ability to make healthy choices, afford health care and housing, access transportation, and much more. Other important social, economic, and environmental factors affecting health (access to care, economic stability and income, and housing) are reviewed in following sections. The graphic below describes many of the factors that influence health and wellbeing.

Social, Economic, and Environmental Factors Influencing Health



Adapted from A Public Health Framework for Reducing Health Inequities. Bay Area Regional Health Inequities Initiative (BARHII)

Data indicators were analyzed for every one of the social, economic, and environmental factors shown above using Healthy People and Iowa's 2016 SHA to identify factors and health outcomes for the 2021-2022 SHA.[2] Each one had at least one data indicator showing Iowa could do better. In addition, each one of the factors and health outcomes included in the 2021 Iowa Health Assessment survey was chosen as a priority by at least one person who took the survey.

Education

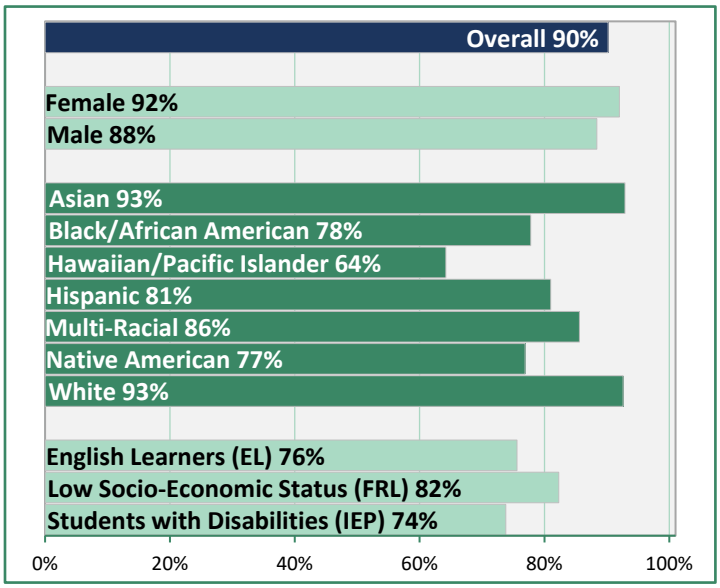
Many of the factors and health outcomes assessed in this SHA show differences in outcomes based on people's level of education. Education creates opportunities for better health and leads to jobs with safer working conditions and higher earnings. For people to lead healthy and productive lives, they need knowledge about preventing sickness and disease. People with less education are more likely to have serious health conditions.[3] For children, growing up in a low-income neighborhood is associated with reduced educational attainment and lower adult earnings.[4]

Data shows that adverse childhood experiences (ACEs) affect student engagement in school, i.e., caring about doing well in school and doing required homework.[5] ACEs are potentially traumatic events children and their families may face, such as financial problems, violence, poor mental health, substance abuse, among others. Lower engagement in school also can lead to less effective learning and fewer opportunities to succeed, even if the student graduates from high school.[6]

Iowa parent-reported school engagement for children experiencing ACEs, 2019-2020[5]

Number of ACEs	% not always/ usually engaged
Zero	15.8%
One	19.1%
Two+	38.0%

Iowa High School 4-Year Graduation Rates, Class of 2021[7]



For the 2020-2021 school year, Iowa's high school graduation rate was 90%, which is one of the highest rates in the nation. However, looking only at the overall rate does not give a full picture of the experiences of every student. For example, White and Asian students in Iowa graduate from high school on time at higher rates compared to Hispanic, American Indian, African American, and Hawaiian and Pacific Islander students. Disparities also exist among students with lower socioeconomic status, students learning English as a second language, and students with an individualized education plan (those who participate in special education programs).[7]

Society & Community Interactions

In addition to level of education, how people interact with family, friends, co-workers, and community members can have a large impact on their health and well-being.[8] Many people face challenges and dangers beyond their control — such as unsafe neighborhoods, discrimination, or trouble affording the things they need — making building relationships more difficult. These factors often have negative effects on health and safety throughout life and ultimately may lead to social isolation. Addressing these factors can help reduce these negative impacts.[8]

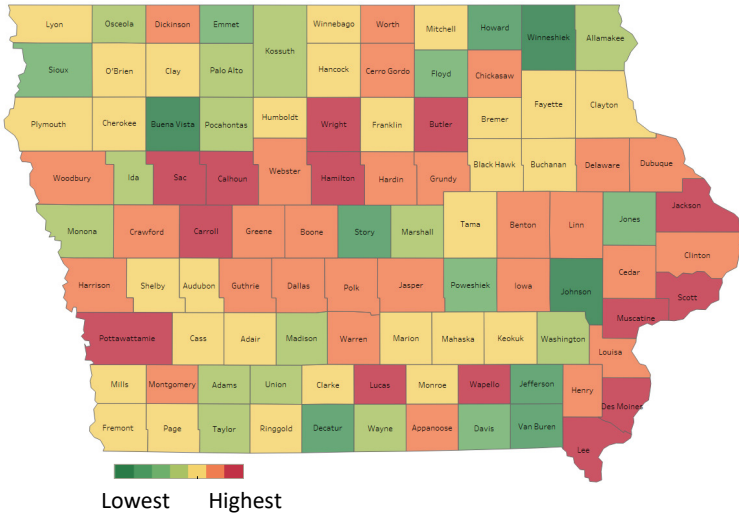
Iowans ages 65+ have a higher risk of social isolation, especially if they are:[8]

- divorced, separated, widowed, or never married;
- living with a disability;
- living alone;
- living with independent living difficulty; or
- experiencing poverty

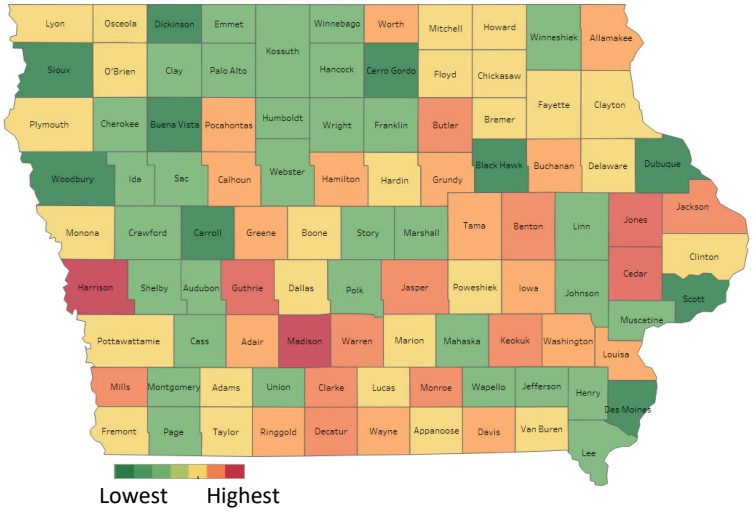
Transportation

The transportation choices communities and individuals make can affect health through less active living, poor air quality, and traffic crashes. Choices for commuting to work can include walking, biking, public transit, carpooling, or driving alone. Driving alone is the most damaging to health; yet, in most counties, driving alone is the main way people travel to work.[9] How people choose to get to work depends on community design, such as sidewalks, safer intersections, or options for public transit. In addition, longer commuting distances relate to poorer mental and physical health.[10] On average in Iowa, 80% of the workforce drove alone to work, ranging from 69% (Johnson County) to 86% (Muscatine, Scott).[9] Of these people driving alone, 21% had a long commute (30+ minutes), ranging from 9% (Black Hawk) to 50% (Harrison).[10]

Driving Alone to Work, 2016-2020[8]



Long Commute (30+ minutes) Driving Alone, 2016-2020[9]



What We Heard

> When people know more, they have the ability to make better decisions for themselves and their communities. They know how their decisions affect different populations and have the information they need to proceed.

> Education is the underlying key to understanding health and how to care for yourself. It's the strongest preventive measure there is.

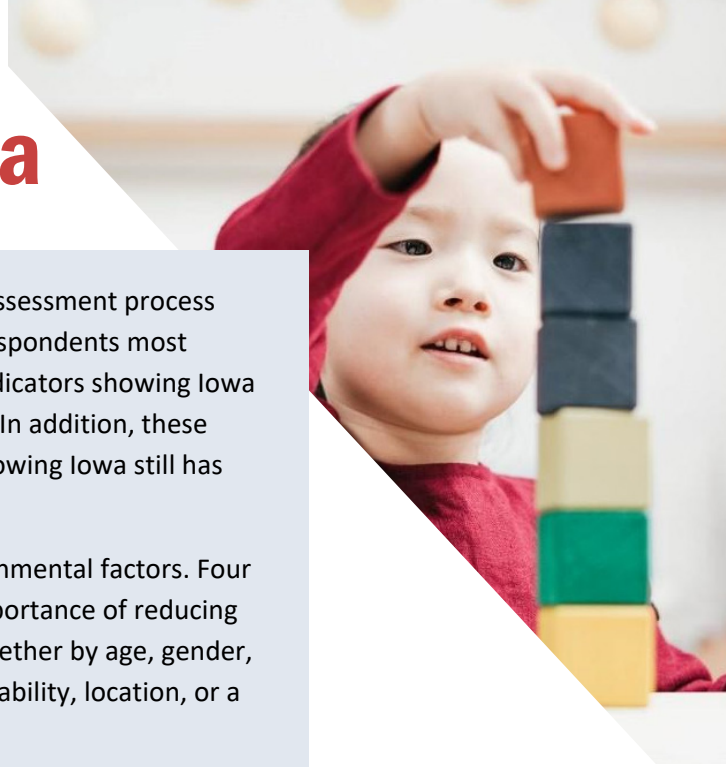
> Without transportation, people cannot get to their doctor and medical appointments or to grocery stores to purchase healthy food.

> Education is the key to economic stability and productive members of society. Educated people tend to be better advocates for themselves and their community. This will be an investment into preventing some of the other issues listed.

Notes: *Social, Economic, and Environmental Factors*

[1] Healthy People 2030, Social Determinants of Health
[2] Healthy Iowans 2017-2021 and Healthy People 2030
[3] America's Health Rankings, 2021
[4] Institute for Research on Poverty, 2017
[5] National Survey of Children's Health, 2019-2020
[6] American Psychological Association, 2015
[7] Iowa Department of Education, 2021
[8] Healthy People 2030, Social & Community Context
[9] County Health Rankings, 2016-2020
[10] County Health Rankings, 2016-2020

Seven Priorities for Iowa



Seven of the topics examined during the 2021-2022 state health assessment process stand out as priorities for Iowa. Iowa Health Assessment survey respondents most frequently chose these topics as priorities. Each had many data indicators showing Iowa has room for improvement compared to other states and the U.S. In addition, these topics were identified as top issues in the previous SHA (2016), showing Iowa still has improvement work to do in these areas.

Three of the seven priority topics are social, economic, and environmental factors. Four are health behaviors or outcomes. Overarching all seven is the importance of reducing health disparities. Health disparities exist for all of these topics whether by age, gender, sexual orientation, race and ethnicity, education level, income, disability, location, or a combination of several characteristics.

Overarching Theme: Health Disparities

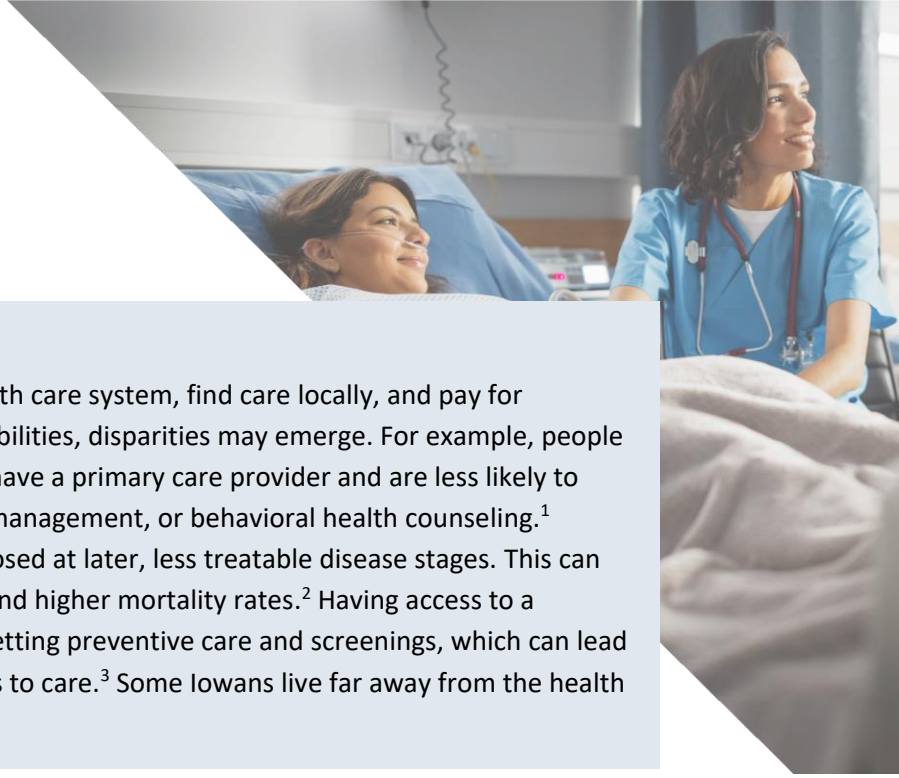
Social, Economic, and Environmental Factors

- Access to Care
- Economic Stability & Income
- Housing

Health Behaviors & Outcomes

- Mental Health & Mental Disorders
- Active Living & Healthy Eating
- Substance Use
- Cancer

Access to Care



Why It Matters

Access to care includes the ability to navigate the health care system, find care locally, and pay for services. When someone lacks one or more of these abilities, disparities may emerge. For example, people without affordable health insurance are less likely to have a primary care provider and are less likely to receive preventive care, dental care, chronic disease management, or behavioral health counseling.[1] Additionally, those without insurance are often diagnosed at later, less treatable disease stages. This can lead to worse health outcomes, lower quality of life, and higher mortality rates.[2] Having access to a primary care provider can increase the likelihood of getting preventive care and screenings, which can lead to improved health. Location is also a barrier to access to care.[3] Some Iowans live far away from the health care services they need.

What the Data Shows

Health Insurance

In 2019, nearly 5% of Iowa's population was living without health insurance. People of color, people with less education, and people with lower incomes are more likely to be uninsured in Iowa. More research needs to be done to understand why these disparities exist. Despite people of color being 17% of Iowa's total population, they account for 33% of the uninsured.[4]

Iowans Not Covered By Health Insurance by Race and Ethnicity, 2019[4]

	Iowa %	US %
Overall	**4.9**	**9.4**
American Indian & Alaska Native	25.2	20.7
Asian/Native Hawaiian and Pacific Islander	5.9	6.8
Black or African American	8.4	11.0
Hispanic or Latino*	14.6	18.9
All Other Races and Two or More Races	8.5	8.1
White	3.8	6.4

** Hispanic or Latino is of any race. All races are non-Hispanic or Latino.*

Providers

Iowa had

4,867

primary care physicians

as of September 2021, a decrease from 2016.[5]

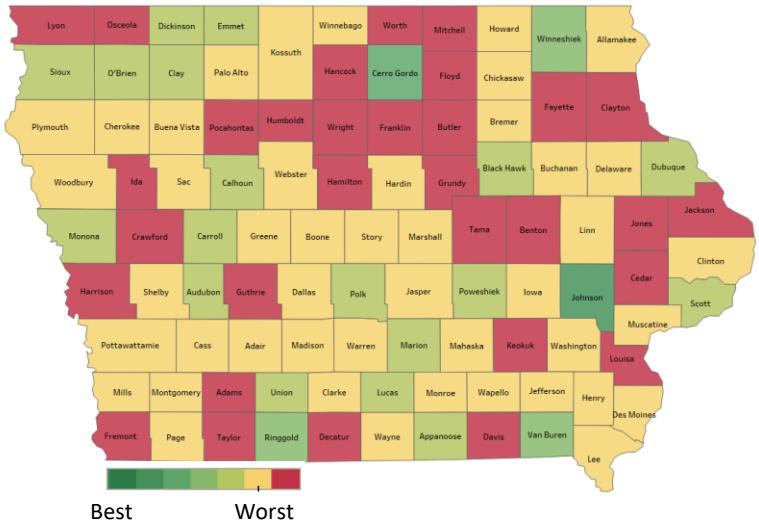
Accessing routine, high-quality health care has a large impact on individual health. Yet, more than one in five adults (22.6%) in Iowa do not have a regular primary care provider. In Iowa, people of color, males, adults ages 18-34, and people with less education were more likely to indicate they do not have a primary care provider.[5]

The United States, as well as Iowa, is currently facing a shortage of physicians due to the nation's growing health care needs. Having a sufficient supply of primary care physicians in a community has numerous benefits, including: lower rates of low birthweight births, lower all-cause mortality, longer life spans, reductions in health system costs, and reductions in health disparities.[6] Iowa ranks in the bottom 10% of the country for the number of obstetricians, gynecologists, and midwives per 100,000 females ages 15 and older making accessing women's health services difficult across the state.[7]

Primary Care Physicians

In 2019, Iowa had about 1,347 people living in the state for every primary care physician, down from 1391:1 in 2016—a 3% decrease.[8] Iowa had the 31st lowest ratio nationally. The U.S average was 1307:1.

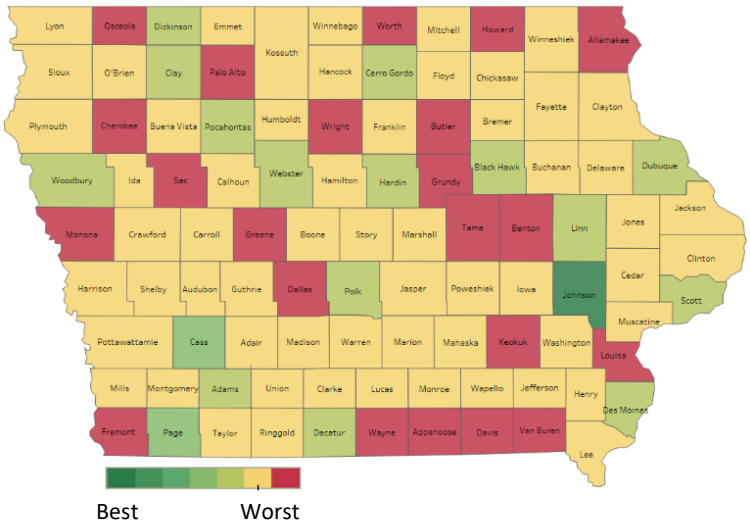
Ratio of Population to Primary Care Physicians, 2018[7]



Dentists

In 2020, Iowa had about 1,436 people living in the state for every dentist, down from 1561:1 in 2016—an 8% decrease.[9] Iowa had the 22nd lowest ratio nationally. The U.S. average was 1399:1.

Ratio of Population to Dentists by County, 2019[8]



What We Heard

19% of respondents chose **health care access & quality, health insurance, or hospital & emergency services** as a priority

Common reasons: lack of providers, rural access, cost of care and medications, and universal health insurance

> "There are too many people who do not have access to quality health care because of lack of insurance or the high cost of health care. We need to make healthcare a right for all."

> "...There is an overall lack of health care providers for both routine medical care, and specialized needs. Providers do not stay long in the community, so it's difficult for citizens to find consistent care."

> "Adequate accessible healthcare is lacking in rural and lower income areas within Iowa."

> "If people have access to good quality health care that is affordable they can catch health issues early before they turn into a crisis situation. And they can learn about better healthy living..."

Notes: *Access to Care*

[1] Healthy People 2030, Health Insurance
[2] Agency for Healthcare Research and Quality
[3] Healthy People 2030, Health Care Access & Quality
[4] US Census Bureau, American Community Survey, 2019
[5] BRFSS, 2020
[6] America's Health Rankings, Annual Report, 2021
[7] America's Health Rankings, Health of Women and Children, 2021
[8] County Health Rankings, 2021
[9] County Health Rankings, 2021

Economic Stability & Income

Why It Matters

Economic stability is the connection between the financial resources people have and their health. Most of the topics examined in this SHA show differences in outcomes based on income. Having a job with a livable wage that provides enough money for safe and affordable housing, access to transportation, health insurance, healthy food, childcare, and other essential services is critical to supporting physical and mental health.

Many factors can contribute to inequitable access to resources and opportunities, which may result in poverty. People living in poverty are at greater risk for mental illness and chronic diseases, such as heart disease, diabetes, and obesity.[1] Multiple aspects of employment—including job security, the work environment, financial compensation, and job demands—may affect health.[2]

What the Data Shows

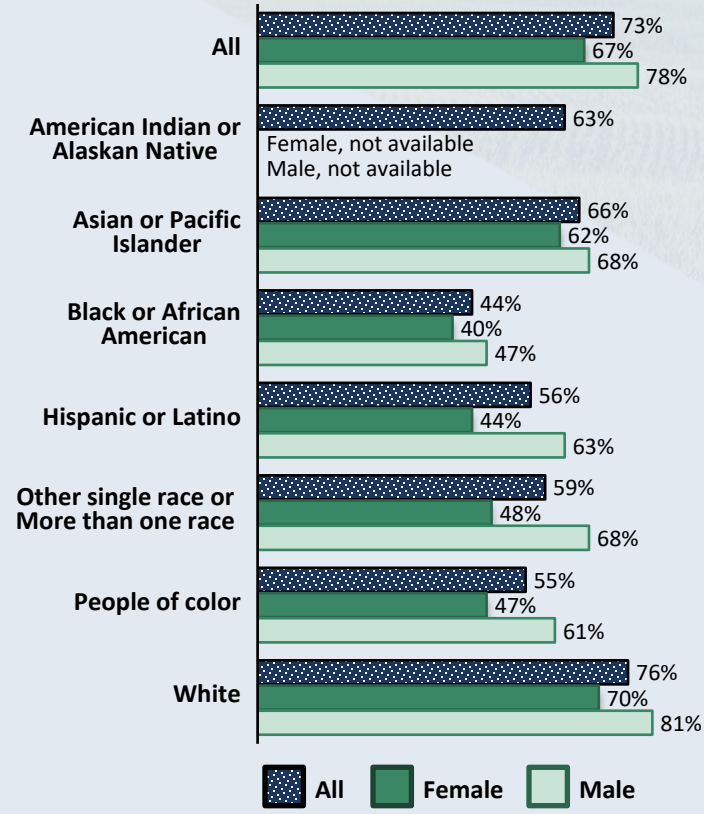
Income and Living Wage

A living wage is the minimum income necessary for workers to meet their basic needs. The minimum wage in Iowa follows the federal guidelines of $7.25 per hour, as of May 2022. In 2019, 76% of White workers earned at least $15 per hour compared to 55% of people of color. Women in Iowa from all race/ethnicity groups also were less likely than men were to earn $15 per hour.[4]

Iowa Living Wage, 2020[3]:

- $13.62/hour (1 adult, no children)
- $42.18/hour (1 adult, 2 children)
- $24.21/hour (2 working adults, 2 children)

People in Iowa Earning at Least $15 Per Hour, 2019[4]



Poverty

In Iowa, women, people of color, people with disabilities, and people with a high school degree or less experience higher rates of poverty than the state average. These disparities are influenced by various historical factors such as racial segregation, lack of access to education, and higher paying jobs.[4] Ongoing factors, like decades of a lack of investment in infrastructure and social programs as well as discrimination also contribute to poverty.[4] From 2015-2019 in Iowa, children, adolescents, and young adults of color were especially hard hit – three of every ten – faced poverty.[4]

Poverty for All Ages, 2019[4,5]

	Iowa %	U.S.%
OVERALL	**11.7**	**13.5**
Female	12.9	14.7
American Indian and Alaska Native, non-Hispanic	27.7	25.7
Asian/Pacific Islander, non-Hispanic	16.2	11.1
Black or African American, non-Hispanic	32.7	23.0
Hispanic or Latino origin (of any race)	21.0	19.8
Other single race or more than one race, non-Hispanic	18.3	16.3
With any disability	18.9	20.5
Less than high school graduate	25.7	30.7
High school graduate (includes equivalency)	13.9	16.9

People of color in Iowa ages 0 -24 are more likely to experience poverty:

Under age 5 – 32.1%
Age 5-17 – 26.5%
Age 18-24 – 32.8%[4]

What We Heard

10% of respondents said **economic stability and income** are priorities

Common reasons: links with many health issues, low minimum wage, employer sponsored healthcare, and affording basic needs

> A healthy, diverse economy is the bedrock of a community. Low income can be directly correlated to stress, poor health (mental and physical), and a variety of other serious concerns.

> Health improves when people don't have to choose between going to the doctor or going to work.

> Those who don't have a living wage struggle with housing, jobs, and child care.

> If people are worried about where to sleep, eat, and feel safe they cannot focus on their health.

Notes*: Economic Stability and Income*

[1] Healthy People 2030, Poverty
[2] Healthy People 2030, Employment
[3] MIT Living Wage Calculator, 2020
[4] National Equity Atlas, Poverty, 2015-2019
[5] U.S. Census Table S1703, 2015-2019

Housing

Why It Matters

People's homes and where they are located have a large impact on their health and well-being. Owning a home provides social, economic, and health benefits. On the other hand, housing instability as well as unsafe, unhealthy, or unaffordable housing negatively affects mental and physical health. Across Iowa, some struggle to afford their homes or are spending more than half of their income on housing.[1] These cost-burdened households have to choose between spending on housing, paying for utilities, and paying for food or health care. Children who move frequently are more likely to have chronic conditions and poor physical health.[1] In addition, they may be less likely to have consistent health insurance coverage. Homelessness is the most extreme form of housing instability. People who are homeless are at greater risk of chronic disease, depression, and substance use disorders.[1]

Housing quality and safety can also affect mental and physical health. Poor housing quality inside and outside the home can expose people to harm from poor air quality, insects, allergens, lead, and homes that are too hot or too cold. People with disabilities and older adults also face challenges finding homes that are safe and accessible.[2]

What the Data Shows

Homelessness

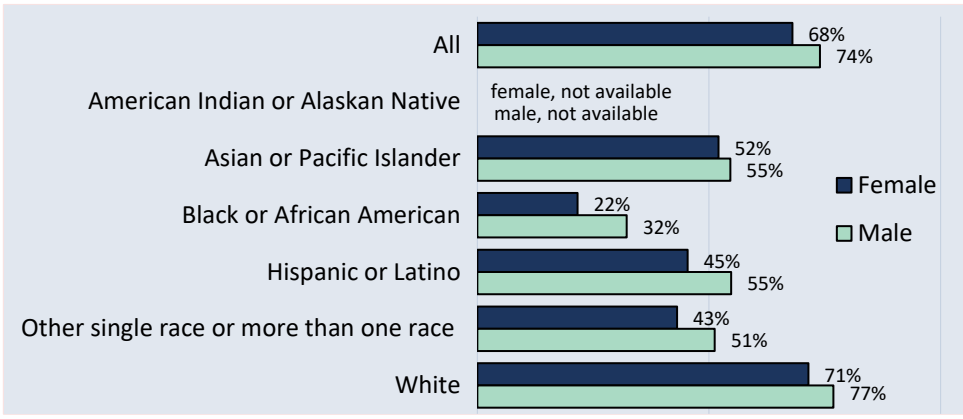
Homelessness includes people living on the street, in shelters, in transitional housing, or sharing housing with others due to housing loss. Homelessness and health are interrelated and can affect each other. Poor physical health, such as an injury or illness, can lead to employment and financial problems that may ultimately lead to the loss of stable housing. Homelessness can also create new health problems or make existing ones worse.[3] During the 2018-2019 school year, the US Department of Education estimated that 7,295 public school students in Iowa experienced homelessness over the course of the school year.[4]

There were
2,647
people in Iowa experiencing homelessness on any given day, as of January 2020.[4]

Homeownership

Overall, Iowa has one of the highest percentages in the nation of people who own their own home. Still, almost 30% of households in Iowa are renters. People of color have much lower homeownership rates compared to non-Hispanic white Iowans (43% vs. 74%). Women in Iowa of all racial and ethnicity categories also have lower homeownership rates compared to men.[5]

Iowa Homeowners by Race, Ethnicity, and Sex, 2019[5]

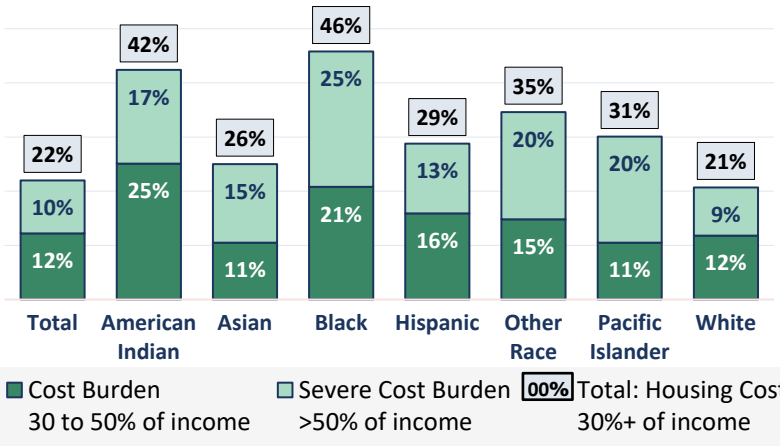


** Hispanic or Latino population is of any race. All others are non-Hispanic or Latino.*

Housing Affordability

In Iowa, cost-burden, spending more than 30% of income on housing costs, is the most common housing problem — including 39.5% of renters and 16.1% of homeowners.[6] Families with incomes below 50% of Iowa's median family income ($39,750) were the most severely housing cost-burdened in the state, with 68% of these families having to pay more than 30% of their income on housing costs.[6]

Housing Cost Burden in Iowa by Race and Ethnicity, 2019[6]



Housing Problems

Exposure to lead is a problem due to the age of Iowa's housing stock. Lead exposure is highly toxic, especially to young children and pregnant women and most frequently occurs through ingestion or inhalation of contaminated house paint, house dust, soil, and water. Housing built before 1950 has the highest risk of lead exposure. With 26% of houses built before 1950 in the state, Iowa has one of the nation's highest percentages of housing with a risk of lead exposure.[7]

Radon is an invisible cancer-causing radioactive gas that has been identified as a leading cause of lung cancer among non-smokers.[8] Iowa has the highest radon concentration levels in the nation, with 71.6% of homes above the US Environmental Protection Agency action level.[9] As of 2022, there is no state requirement for rental properties to conduct radon testing unlike single family homes that are required to test when selling the property. Furthermore, renters may not have legal or financial control to mitigate radon.

What We Heard

9% of respondents chose **housing access & affordability or housing safety & quality** as a priority

Common reasons: rental affordability, rural, homelessness, low-income housing, and safety

> "Rentals are overpriced and affordable senior housing is hard to find…"

> "Housing is a basic need and when people don't have security in it, it radiates to every area of their lives. Stress rises, mental health may worsen, and healthcare is at the back of their minds. As people's basic needs are met they will be better equipped to be healthier overall."

> "Housing access and affordability is a huge issue in our rural communities."

Notes: *Housing*

[1] Healthy People 2030, Housing Instability
[2] Healthy People 2030, Quality Housing
[3] National Health Care for the Homeless Council, 2019
[4] U.S. Interagency Council on Homelessness, 2020
[5] National Equity Atlas, 2015-2019
[6] Iowa Finance Authority, 2021
[7] America's Health Rankings, Annual Report, 2021
[8] Environmental Protection Agency
[9] Iowa Department of Public Health, 2019

Mental Health & Mental Disorders

Why It Matters

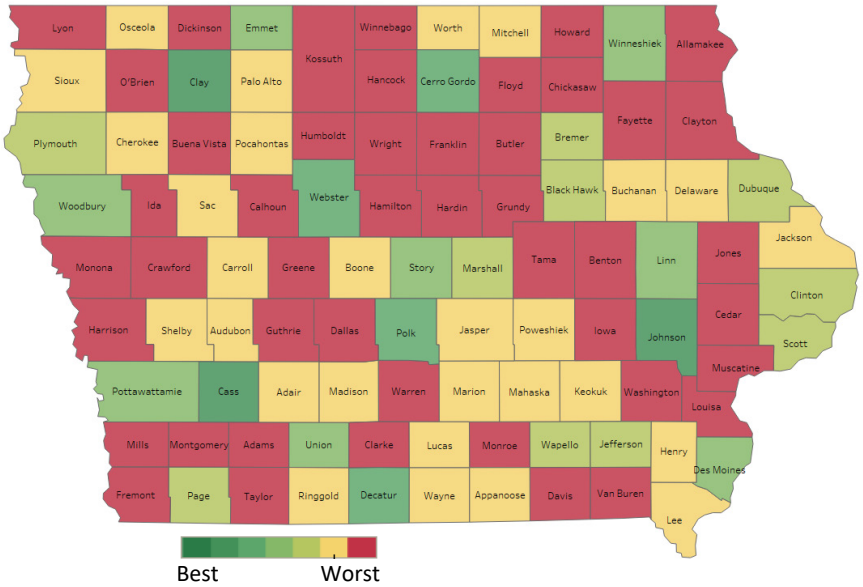
According to Healthy People 2030, mental health conditions and mental disorders affect people regardless of age, social and economic background, or racial and ethnic group, but some populations are more affected than others are. Mental health and physical health are related and closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it more difficult for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.[1] Frequent mental distress is associated with smoking, physical inactivity, housing insecurity, food insecurity, and insufficient sleep.[2] In some cases, mental health distress leads to suicide, which is Iowa's ninth highest cause of death overall and second highest cause of death for people ages 15-39.

What the Data Shows

Access and Providers

Some Iowans struggle to find mental health care. There are far fewer mental health providers in Iowa than the national average. In 2020, the ratio of population to mental health providers for the state was 610:1 compared to the national average of 270:1. Additionally, wide differences exist depending on where someone lives. The provider ratio varied across the state, ranging from three counties at or better than the national average of 270:1 (Cass, Clay, Johnson) to four counties with ratios of more than 9,000:1 (Davis, Franklin, Lyon, Winnebago).[3]

Ratio of Population to Mental Health Providers*, 2020[3]



*Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care.[3]

Depression

The rate of ever having depression among Iowa adults differs by age, sex, education, income, race and ethnicity, and for people with disabilities. In 2020, people in Iowa with incomes of $25,000 or less were nearly three times more likely to indicate ever having depression than those with incomes of greater than $75,000 (31.6% v. 10.7%).[4] People living with disability in 2019 were more than three times more likely to indicate having depression than those reporting no disability (39.3% v. 11.4%).[5] People ages 65+, college graduates, men, and people with incomes greater than $50,000 reported levels of diagnosed depression lower than the state average (17.4%).[6]

Frequent Mental Distress

Frequent mental distress is defined as 14 or more mentally unhealthy days in the last month. Differences exist by age, sex, education, income, race and ethnicity, and for people with disabilities. In 2019, in Iowa living with disability were more than four times more likely to experience frequent mental distress than those without disability (34.4% v. 7.9%).[7] In 2020, people in Iowa with incomes less than $25,000 were more than three and a half times more likely to experience frequent mental distress than those with incomes $75,000 or more (24.9% v. 6.8%).[8]

12.9% of Iowans reported experiencing frequent metal distress in 2020 – similar to the national average.[8]

Suicide

In 2020, there were 552 deaths by suicide in Iowa.[9] Of these, 81.9% were male (452), 60 were ages 18-24, and 17 were under age 18. Also troubling are the numbers of Iowa high school students who reported seriously considering suicide, making a plan to attempt it, actually attempting suicide, and injuring themselves from attempts. Female students and students who identify as lesbian, gay, or bisexual are more likely to have these dangerous thoughts and to act on them by attempting suicide.[10]

Iowa High School Students & Suicide by Sex & Sexual Orientation, 2019[10]

	Considered suicide	Planned suicide	Attempted suicide	Injured by an attempt
Total Percent	**20**	**14.9**	**9.7**	**4.5**
Female %	26.5	19.4	11.7	5.1
Male %	13.4	10.5	7.7	3.9
Bisexual %	48.7	40.9	19.7	7.9
Gay or lesbian %	45.9	31.1	29.4	16.4
Heterosexual (straight) %	15.3	11.2	7.3	3.6
Not sure %	35.6	29	16.3	9

What We Heard

37% of respondents chose **mental health & mental disorders** as a priority

Common reasons: timely access to services, availability of providers, treatment affordability, connection to social and economic factors, stigma, connection to substance abuse and violence, suicide

> "It is very hard to find mental health services in this area."

> "Mental health and understanding the importance of it is extremely important and affects more people than we know. Many people are unsure what to do in a crisis or how to support those struggling with mental health issues."

> "Rural areas are underserved and lack resources to help those with mental health issues."

> "Iowa lacks comprehensive care for mental health. It is incredibly hard to be seen due to a lack of providers. Mental health issues affect all areas of one's life."

Notes: *Mental Health & Mental Disorders*

[1] Healthy People 2030, Mental Health & Mental Disorders
[2] America's Health Rankings, Annual Report, 2021
[3] County Health Rankings, 2021
[4] America's Health Rankings, Annual Report, 2021
[5] CDC, Disability and Health Data System, 2019
[6] BRFSS, 2020
[7] CDC, Disability and Health Data System, 2019
[8] America's Health Rankings, Annual Report, 2021
[9] NCHS, CDC WONDER Online Database, 2020
[10] Youth Risk Behavior Survey (YRBS), 2019

Active Living & Healthy Eating

Why It Matters

Active living and healthy eating are important factors of overall health. Both active living and healthy eating can help people maintain a healthy body weight and decrease the risk of becoming overweight or obese. Being overweight or obese can lead to serious health issues such as cardiovascular disease, diabetes, stroke, depression, and certain cancers.[1]

Access to healthy foods and beverages and opportunities for physical activity can increase healthy behaviors and improve health. Unfortunately, differences in social determinants of health – the conditions in which people are born, live, work, play, and age – can contribute to less opportunity to engage in healthy behaviors and lower health status.

Adults who lack consistent access to food (food insecure) are more likely to have chronic diseases such as diabetes, high blood pressure, and obesity, while children who are food insecure have a greater risk of obesity and developmental problems.[2] Having easy, regular access to grocery stores that sell fruits, vegetables, and other staples at affordable prices is necessary for people to eat a well-rounded, nutritious diet that is essential for better health.[3]

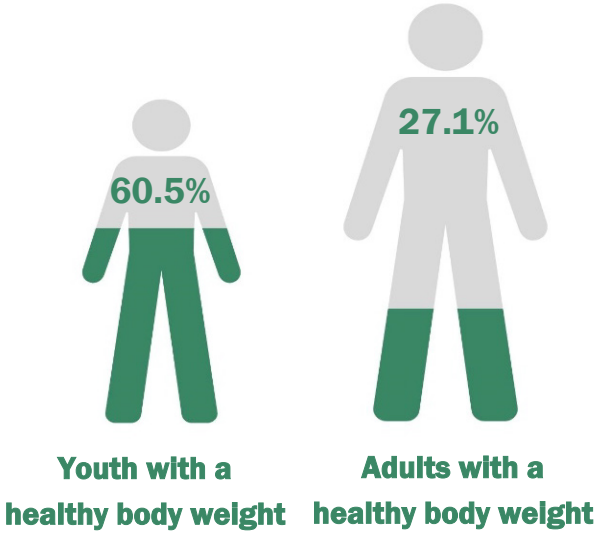
What the Data Shows

Healthy Body Weight

Since 2011, the percentage of overweight adults in Iowa has stayed about the same (35%), while the percentage of obese adults has increased from 28% in 2011 to 36.6% in 2020. Every demographic group has high percentages of being overweight or obese. Some have even higher percentages compared to others – e.g., females, people with lower incomes, people of color, people with disability.

- Youth (ages 10-17) with a healthy body weight decreased from 65.4% (2016) to 60.5% (2019-2020)[4]
- Adults (ages 18+) with a healthy body weight decreased from 34.9% (2011) to 27.1% (2020)[5]

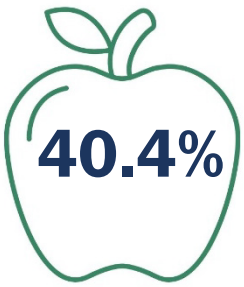
Iowans with Healthy Body Weight 2019-2020[4,5]



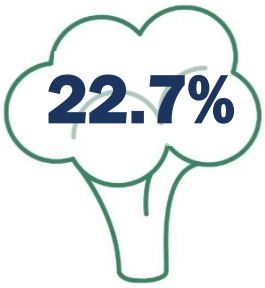
Nutrition & Healthy Eating

Diets high in fruit and vegetables reduce the risk of chronic diseases such as obesity, Type 2 diabetes, heart disease, and certain cancers.[6] The 2020 Dietary Guidelines recommends a healthy diet at every age including adolescents and adults having 2 ½ to 4 cups of vegetables and 1 ½ to 2 ½ cups of fruit each day.

Fruit and Vegetable Consumption by Iowa Adults, 2019[6]



consumed less than one fruit per day



consumed less than one vegetable per day

Added sugars in foods and drinks can make it hard for people to get the nutrients they need without consuming too many calories. People who eat too much added sugar may be at higher risk for tooth decay and obesity.[6] Many people in the United States consume too much added sugar.[7] In Iowa, sugar sweetened drinks are a common source of added sugars for many high school students. In 2019, 72% of students reported having any soda or pop in the last seven days. Over 17% had one or more sodas every day. Nearly 11% had two or more sodas per day.[8]

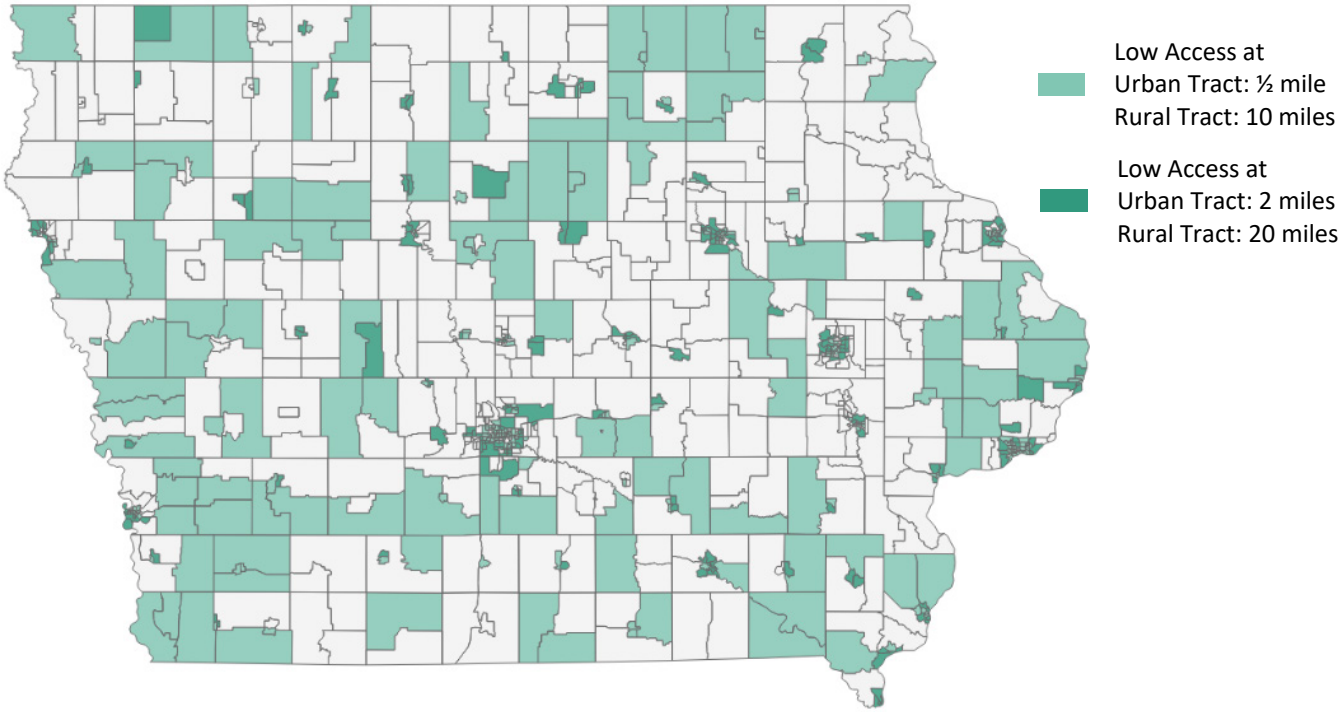
Food Access

In Iowa, 89 out of 99 counties have areas identified as having low food access. Low food access is defined as urban census tracts that are at least half a mile from the nearest supermarket and rural census tracts that are at least 10 miles from the nearest supermarket. In the map below, the light green represents low access at half a mile and 10 miles, while the darker green represents lower access at 2 miles and 20 miles.

Due to inflation, food today is 8% more expensive on average than it was a year ago. In Iowa, a family of four - two adults and two children - can expect to spend an average of $8,885 on food in 2022.[9]

More than 25%
of Black & Hispanic families struggle to afford food, 10% of white families struggle to afford food.[3]

Areas of Low Food Access by Census Tract, 2019[10]

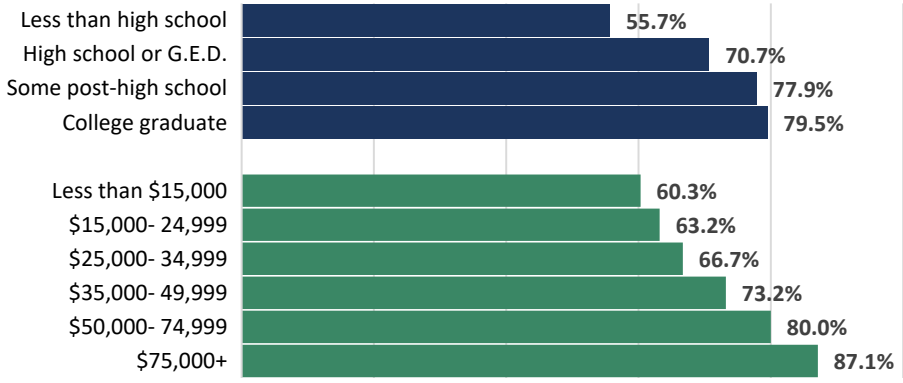


Physical Activity

Most Iowans are participating in some physical activity; however, only about one in five are meeting the recommended guidelines for physical activity.

In 2020, the percentage of adult Iowans reporting engaging in no physical activity or exercise other than their regular job in the past 30 days was slightly higher than national average, 23.6% versus 22.4% respectively.[11]

Percent of Iowa Adults Reporting Any Leisure-Time Physical Activity by Education and Income, 2020[11]



People of color, people with lower incomes, people with disabilities, and people with lower levels of education have higher rates of physical inactivity.[11] Access to recreational facilities such as walking trails, playgrounds, parks, and sports fields is not distributed evenly across the state. In Iowa, 61.7% of adults reported using recreational facilities.[12] Walking is a simple form of physical activity, and having access to safe spaces to walk can encourage individuals to walk. There is also a disparity of access to sidewalks among rural and urban areas - 54% of rural residents reported having access to sidewalks compared to 73% percent of urban residents.[12]

What We Heard

28% of respondents chose one or more of **food access, nutrition & healthy eating, overweight & obesity, or physical activity** as a priority

Common reasons: links with many other health problems, food and exercise costs, places for activity, costs to the health system, importance of starting with youth

> Our county has a high number of children and adults with obesity. Limited resources for weight loss with limited incomes for many.

> It is hard to eat healthy when some of those options are expensive.

> We have members in our community that don't have access to healthy and fresh foods due to income barriers and/or lack of quality grocery stores in their neighborhoods coupled with transportation barriers.

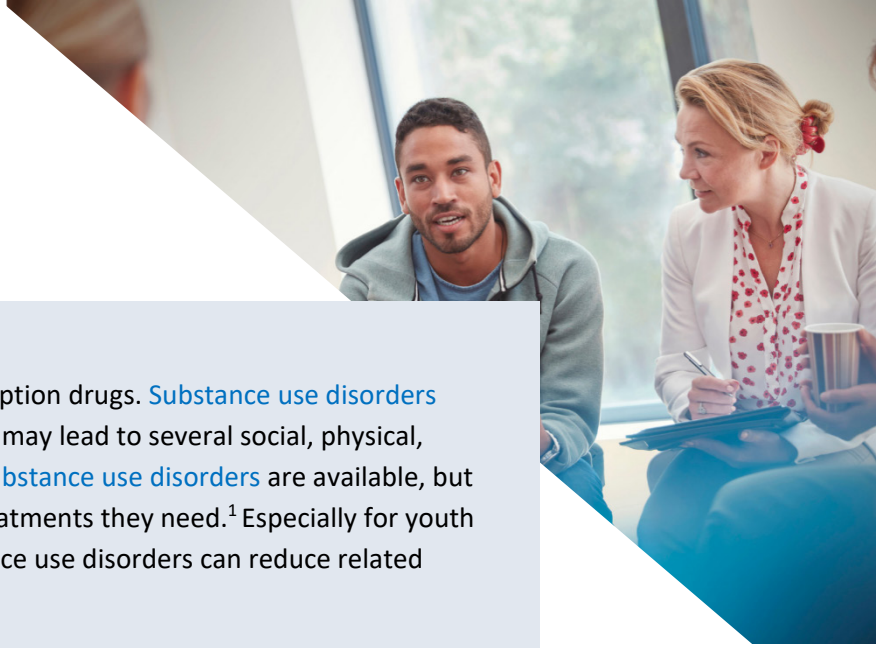
> We need quality food access at a reasonable price.

> I think we all could benefit from more physical activity. I feel like there are not enough trails or fun things to do…

Notes: *Active Living and Healthy Eating*

[1] Healthy People 2030, Overweight & Obesity
[2] Effects of Hunger, Feeding America
[3] The Food Trust
[4] National Survey of Children's Health, 2016-2020
[5] BRFSS 2011-2020
[6] CDC, Chronic Disease Fact Sheets
[7] Healthy People 2030, Objective NWS-10
[8] Youth Risk Behavior Survey (YRBS), 2019
[9] Economic Policy Institute, 2022
[10] USDA Food Access Research Atlas, 2021
[11] America's Health Rankings, Annual Report, 2021
[12] IDPH, Bureau of Nutrition and Physical Activity Data Report, 2020

Substance Use



Why It Matters

Substance use includes alcohol and illicit and/or prescription drugs. Substance use disorders involve misuse of one or more of these substances and may lead to several social, physical, mental, and public health problems[1]. Treatments for substance use disorders are available, but for a variety of reasons, most people do not get the treatments they need.[1] Especially for youth and young adults in Iowa, strategies to prevent substance use disorders can reduce related health problems and prevent deaths.

What the Data Shows

People with Substance Use Disorder

Substance use disorder is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications. In 2019-2020, there were approximately 33.3% of Iowa adults ages 18 -25 with substance abuse disorder, including alcohol and illicit drug use, compared to 24.4% in the nation.[2]

As of 2019-2020, Iowa had the highest rate in the nation for adults 18 -25 with substance use disorder.[2]

Alcohol Use & Binge Drinking

Alcohol is the most commonly misused substance in Iowa. Iowa's alcohol use rates for almost every demographic are among the highest in the nation.[3] In 2019-2020, young adults ages 18-25 in Iowa also had the fourth highest percentage in the nation for those who need but are not receiving treatment (19.9%).[2]

**Excessive drinking is the percentage of adults reporting binge drinking is (four or more [women] or five or more [men] drinks on one occasion in the past 30 days) or heavy drinking is 8 or more [women] or 15 or more [men] drinks per week. [3]*

Excessive Drinking* by Age and Sex, 2020[3]

Population	Iowa %	US %
Age 18-44	32.2	23.4
Age 45-64	20.8	15.5
Age 65+	7.2	7.4
Female	16.6	13.6
Male	29.1	21.3

Drug Use

Overall, drug use rates in Iowa are similar to the rest of the nation. Drug use among youth in Iowa is higher compared to other states, but similar to the national average.

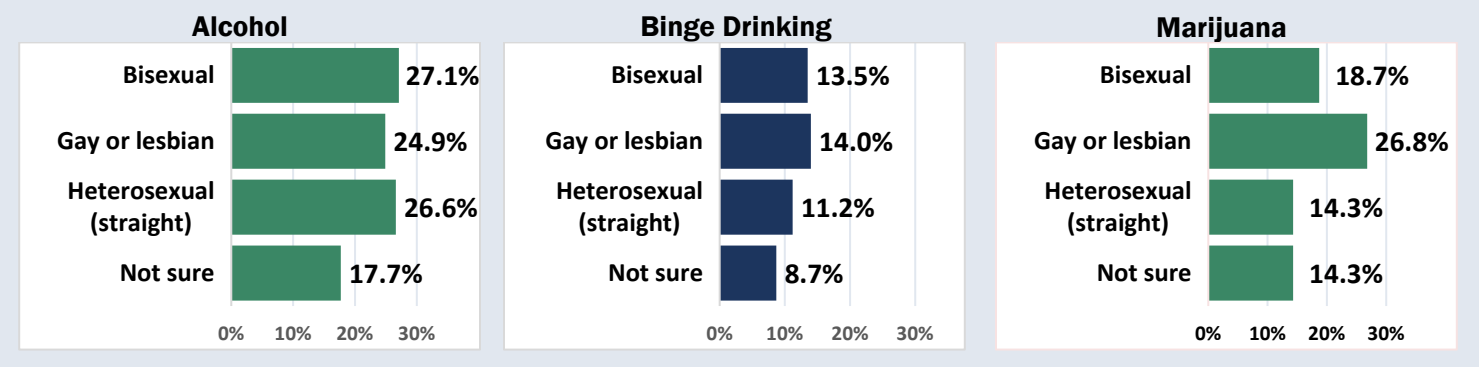
Opioid drugs, including prescription painkillers and illicit street drugs, are a leading cause of overdoses in Iowa and across the nation. Opioid-related deaths jumped nearly 36% in Iowa from 2019 to 2020, from 157 to 213, respectively.[4]

Illicit Drug Use in the Last Month Estimates by Age, 2019-2020[2]

Age Group	Iowa	U.S.
12 - 17	7.97%	7.71%
18 +	10.68%	13.79%

For Iowa's youth, prescription pain reliever misuse in the past year among youth ages 12-17 (2.2%) was slightly above the national average (1.9%).[1] Students in Iowa that reported ever taking prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it was slightly lower (11.6%) than the national average (14.3%).[5] LGBTQ+ people often face significant stressors that may lead to alcohol and drug use.[6] While gay, lesbian, or bisexual (or LGB) high school students had similar current alcohol use and binge drinking as other students, LGB students reported higher rates of current marijuana use.

Current Marijuana and Alcohol Use among Iowa High School Students by Sexual Orientation, 2019[7]



LGB youth also reported higher rates of ever trying drugs like cocaine, ecstasy, heroin, inhalants, and methamphetamines, or misusing prescription pain medication at least once.

Iowa High School Students Ever Using Specific Drugs by Sexual Orientation, 2019[7]

Sexual Orientation	Cocaine	Ecstasy	Heroin	Inhalants	Methamphetamines	Prescription Pain Medicine[5]
Bisexual %	5.6	5.9	2.7	17.5	1.5	22.5
Gay or lesbian %	29.9	18.1	15.3	18.3	16.1	28.2
Heterosexual (straight) %	1.8	2.0	1.0	4.6	0.9	9.9
Not sure %	4.9	5.3	2.8	14.9	6.7	6.7

What We Heard

8% of respondents chose **alcohol & drug use** as a priority

Common reasons: prevention, access to treatment, related to mental health and other issues, use by youth, crime & violence, effect on families

> "Preventing drugs and alcohol from getting into the hands of children and adolescents, as a lifetime of use and the negative impacts on the community tend to begin then."

> "Drug addiction damages all aspects of society. Health, family, employment, finances, crime, victimization, domestic violence, public safety. Everyone is negatively affected by addiction."

> "Limited services for people with drug and alcohol dependencies…"

> "Drugs and alcohol are widely used and affect whole families, not just the user."

Notes: *Substance Use*

[1] Healthy People 2030, Drug & Alcohol Use
[2] National Survey on Drug Use and Health, 2019-2020
[3] America's Health Ranking, 2020
[4] IDPH, Iowa Substance Abuse Deaths
[5] YRBS, 2019
[6] National Institute on Drug Use
[7] YRBS, 2019

Cancer

Why It Matters

Although advances in cancer detection and treatment have led to fewer deaths, cancer is still the second leading cause of death both in Iowa and nationally. Race and ethnicity is a social construct and therefore not a stand-alone risk factor for cancer. However, disparities in social and economic factors may differ by race and ethnicity and therefore contribute to cancer burden and deaths.[1] Thus, death rates are higher for some cancers and groups of people.[2] Many risk behaviors linked to cancer can be prevented, such as excessive drinking, using tobacco products, physical inactivity, poor nutrition, and ultraviolet light exposure. Screenings also help reduce cancer deaths; however, the same social and economic factors also play a large role in determining whether people have cancer risk behaviors or get cancer screenings.[2]

What the Data Shows

Cancer Burden

Between 2014 and 2018, Iowa had the nation's third highest cancer incidence rate (number of new cases of cancer per 100,000 population).[3] Males in Iowa are more likely than females to be diagnosed with cancer. In Iowa, non-Hispanic Black or African American people have the highest rates of cancer of all racial and ethnic groups for those ages 50-79 years; Iowa's White population has the highest rates among those 80 and older.[4]

Cancer Deaths

Iowa's overall cancer death rate (number of deaths per 100,000 population, age-adjusted) is slightly higher than the U.S. average.[5] In 2020, cancer was the leading cause of death for Iowans ages 55 to 79. Iowa's Black or African American people experience higher overall rates of death from cancer, especially compared to other states. Higher death rates often reflect less or delayed access to primary care, cancer screenings, and treatment. In particular, colorectal and lung cancer death data shows large disparities.[5]

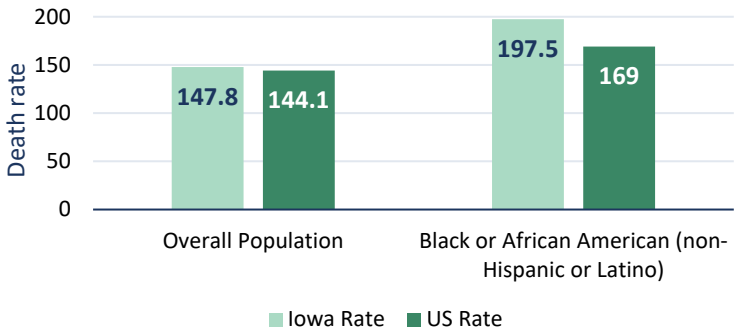
2 in 5 Iowans

will be diagnosed with cancer in their lifetimes.

Most Common Cancers by Rate, 2018*

1. Female breast cancer: **135.8**
2. Male Prostate cancer: **117.0**
3. Lung & Bronchus cancer: **58.7**
4. Colorectal cancer: **39.9**
5. Uterine cancer: **30.5**

*Source: Iowa Cancer Registry.*New cancer cases per 100,000 people, age-adjusted*



Lung Cancer Deaths

In Iowa, lung cancer death rates for non-Hispanic Black or African American men and women and non-Hispanic White men were higher than Iowa's overall rate for 2016-20. The lung cancer death rate for non-Hispanic Black or African American men was Iowa's highest while the rate for non-Hispanic Black or African American women was the highest in the U.S.[6]

Lung Cancer Death Rates (age-adjusted), 2016-2020[6]	Iowa Rate	U.S. Rate
OVERALL	**37.9**	**34.9**
Female, Black or African American*	48.7	27.8
Male, Black or African American*	55.9	50.7
Male, White*	46.4	44.8

**non-Hispanic or Latino*

Colorectal Cancer Deaths

In Iowa, colorectal cancer death rates for non-Hispanic Black or African American men and non-Hispanic White men were higher than Iowa's overall rate for 2016-20. The colorectal cancer death rate for non-Hispanic Black or African American men was third highest in the U.S.[7]

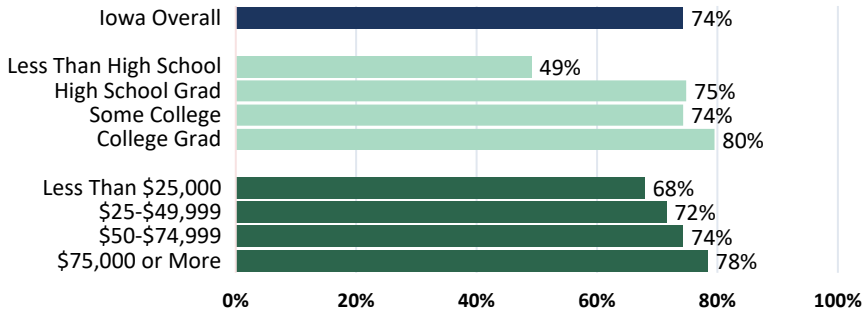
Colorectal Cancer Death Rates (age-adjusted), 2016-2020[7]	Iowa Rate	U.S. Rate
OVERALL	**13.9**	**13.4**
Male, Black or African American*	27.2	22.4
Male, White*	16.4	15.7

**non-Hispanic or Latino*

Cancer Screening

Cancer screening tests can help detect cancer at earlier stages, before symptoms develop, making treatment easier and improving rates of survival. In Iowa, people with less education and lower incomes were less likely to get recommended colorectal cancer screenings.[8]

Iowa Population Receiving Recommended Colorectal Cancer Screenings by Education and Income, 2020[8]



What We Heard

6% of respondents chose **cancer** as a priority

Common reasons: treatment access, treatment affordability, burden on family and community, personal connection to someone affected by cancer

> "Cancer has touched almost every Iowa family and despite the progress we have made, too many people die from this disease."

> "Burden of cancer in Iowa is one of the leading causes of death and loss of work days."

> "Cancer affects almost every Iowan, we need to support research efforts, equitable access to quality treatment, and diagnosis and social support."

> "Cancer affects so many people and their families. It not only affects physical health, it also can affect mental health of those directly affected and their families."

Notes: *Cancer*

[1] Iowa Cancer Registry, 2021
[2] Healthy People 2030 and National Cancer Institute
[3] National Cancer Institute: State Cancer Profiles
[4] Iowa Cancer Registry, 2021
[5] CDC Wonder, 2016-2020 (ICD 10 codes C00-C97)
[6] CDC Wonder, 2016-2020, (C18-C21)
[7] CDC Wonder, 2016-2020, (C33-C34)
[8] America's Health Rankings, 2021 Annual Report

Looking Forward

The next step is to use the themes and issues identified in the state health assessment (SHA) to develop a 2023-2027 State Health Improvement Plan (SHIP). The Healthy Iowans Partnership will use the data collected during the SHA to identify priorities and strategies for the SHIP. Working on these priorities and strategies will require collaboration with organizations and people across Iowa. In addition, anyone can use the SHA results in their own health improvement efforts and in building relationships with others to work on broader improvements.

Additionally, to align with Healthy People 2030, the national health improvement plan, the IDPH Healthy Iowans Team acknowledges the ongoing work in Iowa on all of the topics that affect health, including all of those from Iowa's SHA process and related ones from Healthy People 2030. The team will track improvement for these topics to build a complete picture of health in Iowa. This includes collecting program or initiative highlights from organizations working on these important topics and monitoring related data. The team also encourages sharing data, strategies, and other health-related assessments with others working toward health improvement to raise attention for new topics or to add further insight into existing ones.

Get in Touch

If you have any questions about the 2021-22 State Health Assessment or would like to get involved, contact the Healthy Iowans Team:

- Email: healthy.iowans@idph.iowa.gov
- Visit idph.iowa.gov/healthy-iowans/assessment to learn more.

Iowa's State Health Improvement Plan

2023-2028

A Focus On

- Access to Care: Behavioral Health
- Healthy Eating & Active Living

Healthy Iowans

Revised March 2025

IOWA Health and Human Services

Table of Contents

Message from the Director of Iowa HHS

Dear fellow Iowans,

Building pathways for Iowans to thrive is the driving force behind our agency and guides the work we do every day. It's what feeds our passion and pursuit to inspire every Iowan to lead healthy and independent lives. Our renewed commitment to building a healthier Iowa begins now and with your partnership.

For over 30 years, the Iowa Department of Health and Human Services (HHS) has coordinated the state's health assessment and health improvement planning process, known as Healthy Iowans. Today, I share with you the 2023-2028 State Health Improvement Plan.

Members of the Healthy Iowans Partnership worked together to identify goals, objectives and strategies to help address the state's top health issues. This plan builds on the data highlighted in the 2021-2022 State Health Assessment.

Grounded in data, collaboration and health equity, the 2023-2028 State Health Improvement Plan upholds the Iowa Department of Health and Human Services' (HHS) guiding principles. In addition, the State Health Assessment and State Health Improvement Plan are informing our systems alignment work.

We encourage you to use this plan to further collaborate and strengthen our collective work toward a simple goal: better health for everyone in Iowa. Thank you for joining us in this important work!

All my best,

Kelly Garcia

Kelly Garcia
Director, Iowa Department of Health and Human Services

Acknowledgments

Healthy Iowans is made possible through the Healthy Iowans Partnership and the support of organizations and community members across Iowa. Thank you for your dedication to health improvement among all who live, learn, work and play in Iowa.

The 2023-2028 SHIP is a living document. This means that changes may occur throughout the course of the six-year period.

Suggested Citation

Iowa Department of Health and Human Services, Division of Administration, Bureau of Performance and Operations. *Iowa's 2023-2028 State Health Improvement Plan*. March 2025 revision.
https://hhs.iowa.gov/about/performance-and-reports/healthy-iowans

History of Healthy Iowans

For more than 30 years, Iowans have worked to achieve healthy living through a series of Healthy Iowans state plans - known as the State Health Assessment (SHA) and State Health Improvement Plan (SHIP).

Plan contributors draw on their own life experiences and personal commitment to identify health challenges and seek solutions.

While challenges continue to evolve, the approach has been steady: collaboration with public and private groups together to assess health status in Iowa using innovative ideas, resources, statistical information, research and direct input from Iowans.

Ensuring leaders from the community and Iowans from many walks of life are involved in the development of the plans is key. The plans have measurable objectives that are monitored and can be revised to align with changing circumstances.

Similar processes occur at both the local and national levels. Using input from thousands of Iowans, all 99 counties have developed community health improvement plans. Many of these local processes preceded Healthy Iowans in the late 1980s and are considered to be the first organized community planning efforts in the country.

Iowa also leverages Healthy People 2030, a national plan, to guide and align objectives in both the state and local health improvement plans. As a designated Healthy People Champion, Iowa has a direct line of communications with national experts.

Standards of Excellence

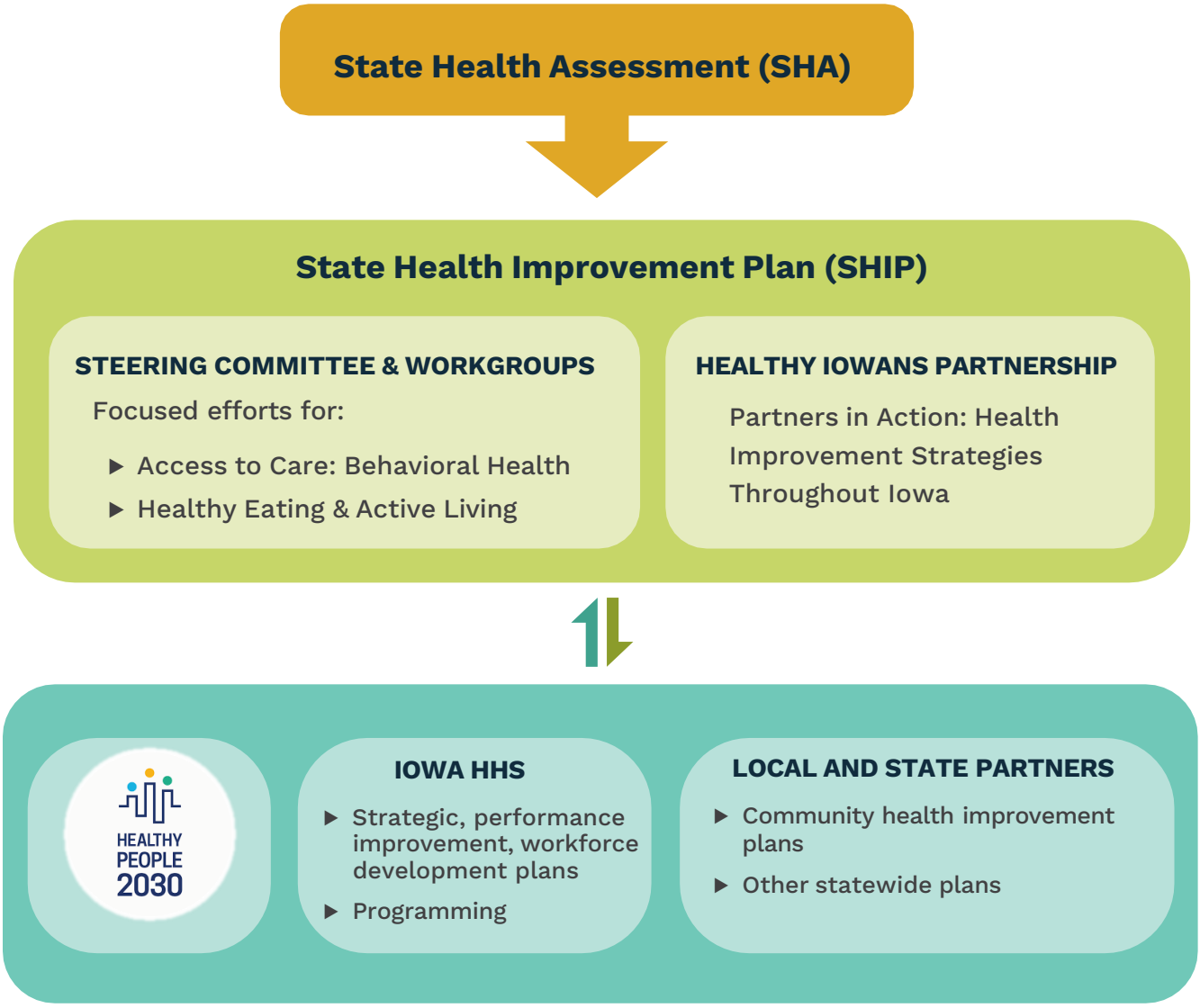
As SHA and SHIP processes became more established across the nation, the Public Health Accreditation Board (PHAB) recognized their role as a fundamental public health practice. In response, PHAB added completion of a SHA and SHIP to their list of required elements to achieve accreditation, the process verifying health departments meet national quality standards. These standards inform continuous improvements in Healthy Iowans. Iowa HHS received initial accreditation from PHAB in November 2018.

Healthy Iowans Today

Today, the Healthy Iowans process brings together partners from across the state in a unified effort to improve the health of Iowans.

The state health assessment and the components of the state health improvement plan fit together to inform collaborative action on Iowa's health challenges through connecting the local, state and national health improvement plans. The following sections describe the Healthy Iowans Partnership as well as the results from the state health assessment and the state health improvement plan.

Healthy Iowans: Collaborating on Action, Making Connections for Health Improvement



What Is the Healthy Iowans Partnership?

The Healthy Iowans Partnership is coordinated by Iowa HHS and consists of a steering committee, local organizations and individuals throughout Iowa.

Together, the Partnership works to address the priorities outlined in the state health assessment (SHA) and state health improvement plan (SHIP). The Partnership plans to include more direct service providers and community decision makers such as private businesses, infrastructure-based organizations, healthcare providers, elected officials, faith-based organizations and other community leaders.

To join the Healthy Iowans Partnership, please email the Iowa HHS Healthy Iowans team at healthyiowans@hhs.iowa.gov.

Healthy Iowans Partnership Steering Committee

The Healthy Iowans Partnership Steering Committee guides a strong coalition of partners and works to inspire structured, collective action aimed at improving the health of all who live, learn, work and play in Iowa.

Members were selected for their state or regional focus, their commitment to improving health and their experience with health equity initiatives.

The following organizations are represented:

- Delta Dental of Iowa Foundation
- Food Bank of Iowa
- Great Plains Action Society
- Healthiest State Initiative
- Iowa ACEs 360
- Iowa Behavioral Health Association
- Iowa Department of Education
- Iowa HHS Bureau of Human Rights and Equity
- Iowa HHS Division of Aging and Disability Services
- Iowa International Center
- Iowa Medicaid
- Iowa Primary Care Association
- Iowa Public Health Association
- Iowa Rural Health Association
- Iowa State University Extension and Outreach
- NAACP - Iowa Nebraska Chapter
- NAMI Iowa
- One Iowa
- The Wellmark Foundation
- United Way of Central Iowa
- University of Iowa Center for Disabilities and Development

Healthy Iowans Partnership Workgroups

The primary function of the Healthy Iowans Partnership Workgroups is to develop data-driven objectives and strategies for implementing integrated efforts that improve the health of all people in Iowa.

The workgroups connect the priority areas to work being done across the state in an effort to break down silos and build connections between community partners.

These workgroups are critical to the implementation of the SHIP. Workgroups include individuals from the Healthy Iowans Partnership Steering Committee and representatives from health care systems, academic institutions, private and non-profit organizations and advocacy organizations representing such groups as older adults, persons with disabilities and Iowans in diverse racial and ethnic communities.

Workgroup members were selected by the Healthy Iowans Partnership Steering Committee based on shared priorities, commitment to equity, subject matter expertise and capacity to participate.

Workgroup Members

Access to Care: Behavioral Health

- Cass County
- ICCBHC's Foundation 2 Crisis
- Iowa HHS Community Health Programs
- Iowa HHS Tobacco Program Manager
- Iowa HHS Prevention and Family Access
- Iowa Care Givers
- Iowa Hospital Association Iowa Peer
- Workforce Collaborative
- Iowa State University Extension and Outreach
- Iowa Vocational Rehabilitation Services
- National Alliance on Mental Illness
- Orchard Place
- Rural Policy Partners
- Scanlan Center for School Mental Health
- Seasons Center University of Northern Iowa Counseling Center
- Wellmark

Healthy Eating and Active Living

- Areas on Aging
- Des Moines Area Religious Council
- Feed Iowa First
- Food Bank of Iowa
- Grace Fitness
- Henry County Public Health
- Iowa Bicycle Coalition
- Iowa Community Hub
- Iowa Food System Coalition
- Iowa Food Waste
- Iowa HHS Community Health Programs
- Iowa HHS Healthy Eating and Active Living Partnership
- Iowa HHS Division of Aging and Disabilities
- Iowa Hospital Association
- Iowa State University Extension and Outreach
- Iowa State University U-Turn
- Knock and Drop Iowa
- Live Healthy Iowa
- United Way
- UnityPoint

State Health Assessment (SHA) Overview

In June 2021, Iowa HHS solicited feedback from people in Iowa and community organizations using the Iowa State Health Assessment Survey.

In total, more than 2,700 people in Iowa responded to the survey. Based on their responses, the final list of priorities identifies seven different issues. This list was further supported by multiple data sources, including Healthy People 2030, America's Health Rankings and the Centers for Disease Control and Prevention (CDC).

The 2021-2022 SHA highlights seven priority areas that impact health for all who live, learn, work and play in Iowa. Iowa's current health priorities include:

Overarching Theme: Health Disparities

Social, Economic, and Environmental Factors

Access to Care

Economic Stability & Income

Housing

Health Behaviors & Outcomes

Mental Health & Mental Disorders

Active Living & Healthy Eating

Substance Use

Cancer

For further descriptions of these priority areas, please reference the 2021-2022 SHA.

State Health Improvement Plan (SHIP) Overview

The Healthy Iowans Partnership Steering Committee used the seven priorities identified in the 2021-2022 SHA to begin developing the SHIP.

Based on feasibility and potential impact, the Steering Committee chose to begin with Access to Care: Behavioral Health and Healthy Eating & Active Living as their two main priorities for the 2023-2028 SHIP. Then, the Steering Committee set goals for both priority areas. The resulting goals were chosen after careful consideration and serve as the broad, overarching targets for the 2023-2028 SHIP. Using this information, the Healthy Iowans Partnership Workgroups created objectives and strategies, which will guide their concentrated efforts. Each objective (Is Anyone Better Off?) has a 2028 target for improvement set using the Healthy People 2030 Target-Setting Methods of percent improvement for rates/ratios and percentage point improvement for percentages.

While this SHIP document only outlines two of the seven priority areas, work will continue in the other five categories. There are numerous organizations throughout the state that will continue to address these important issues. These strategies are compiled in the second part of the 2023-2028 SHIP: Partners in Action: Health Improvement Strategies Throughout Iowa.

Many communities in Iowa experience preventable differences in health outcomes. These preventable differences commonly affect people of color (such as African American and Indigenous people), people with disabilities, people who are lesbian, gay, bisexual, and transgender, older individuals and people living in rural areas.

The Healthy Iowans Partnership is committed to using data, community input, and evidence-based strategies to create meaningful solutions that remove preventable differences in health outcomes.

Timeline

In 2023, the Healthy Iowans Partnership focused on strengthening relationships. As part of this phase, workgroups were developed for the two priority areas. Together, the workgroups created objectives and strategies and will carry them out from 2024 through 2028.

As part of this work, the Partnership created and will revise, as needed, specific action steps to address the objectives and strategies for Access to Care: Behavioral Health and Healthy Eating & Active Living.

The success of the SHIP will depend on contributions from the Healthy Iowans Partnership and community members across the state. Iowa HHS will monitor the activities of the SHIP to ensure accountability from all contributing parties.

2021-2022

SHA completed and published; Healthy Iowans Partnership Steering Committee formed; Steering Committee used SHA to select priorities and developed goals for the SHIP

2023

Steering Committee worked on strengthening partner relationships; SHIP published; SHIP workgroups formed; Workgroups developed objectives & strategies for priority area goals

2024

SHIP updated; Workgroups created action steps for SHIP strategies; Healthy Iowans Partnership began implementing SHIP strategies; Iowa HHS published an annual progress report

2025

Healthy Iowans Partnership continues implementing SHIP strategies; Iowa HHS publishes an annual progress report

2026

Healthy Iowans Partnership continues implementing SHIP strategies; Iowa HHS publishes an annual progress report; Planning begins for the 2027-2028 SHA

2027

Healthy Iowans Partnership continues implementing the strategies; Iowa HHS publishes an annual progress report; 2027-2028 SHA begins

2028

Healthy Iowans Partnership continues implementing the strategies; Iowa HHS publishes an annual progress report; 2027-2028 SHA is published; Healthy Iowans Partnership Steering Committee begins planning the next SHIP

Strengthening Relationships

To maximize impact in the 2023-2028 SHIP priority areas, organizations throughout the state must work together. Partnerships can avoid duplication of effort, ensure synergy of resources and enhance overall leadership within the state.[1]

To help foster the success of these relationships, it is important to have a shared directional framework. This was the main focus of the Healthy Iowans Partnership's work in 2023.

Goal 1

Build a strong Healthy Iowans Partnership

By the end of 2023, the Healthy Iowans Partnership will have an operating framework.

By the end of 2023, the Healthy Iowans Partnership will be prepared to address each priority area of the 2023-2028 SHIP.

Overview of Work

In 2023, members of the Healthy Iowans Partnership strengthened relationships and expanded collaboration with community organizations to advance progress in the priority areas:

- Access to Care: Behavioral Health
- Healthy Eating and Active Living

These partners participated in workshops to develop, refine and prioritize goals and strategies for the 2023-2028 SHIP.

The Healthy Iowans Partnership began implementing the plan in 2024 with action steps for the recommended strategies, engaging additional partners and creating accountability around the priority areas.

What Partners Are Saying

Members of the Healthy Iowans Partnership have found immense value in convening organizations statewide and are excited to see the result of everyone working towards common goals. Here is some of their feedback:

> "This process has convened many experienced leaders from across Iowa to arrive at tangible actions for health improvement."

> "The 2023-2028 SHIP dovetails perfectly with The Iowa Food System Plan, representing a strong, united front to address the complex problems Iowans face."

> "These efforts are in alignment with organizational strategic planning and it has helped get people focused."

Access to Care: Behavioral Health

In 2021, nearly two out of five high school students reported feeling sad or hopeless almost every day for at least two weeks that year, while 26% have seriously considered suicide.[2]

In 2022, 13% of adults in Iowa reported frequent mental distress.[3] This percentage increased significantly since 2018.[4] Frequent mental distress was notably higher for adults with lower household incomes, LGBT+ communities and adults with disabilities.[6]

Another important aspect of behavioral health is substance use. Alcohol is the most common misused substance in Iowa with 22.6% of adults reporting excessive drinking in 2022.[5,6]

Iowa's alcohol use rates are among the highest in the nation for almost every demographic.[6]

Yet, the behavioral health system is hard to navigate for many Iowans. In fact, 18.9% of adults who needed mental health services reported not knowing where to go in 2018-2019.[7]

Access to Care: Behavioral Health

Strategies for Improvement

GOAL 1 Improve access to behavioral health services for all people in Iowa

Focus Area 1.1: Awareness of Resources

- Promote culturally appropriate behavioral health services
- Promote formal and informal peer-based support and interventions*
- Encourage employers to adopt behavioral health policies and practices for employees
- Collaborate with employers to raise awareness of behavioral health services in the community

Focus Area 1.2: Factors Influencing the System

- Share the total costs of behavioral health care in Iowa with policymakers
- Support the use of therapists in schools
- Investigate barriers to accessing behavioral health services**

Focus Area 1.3: Non-Traditional Delivery of Services

- Expand existing behavioral health programming in rural areas through innovative partnerships
- Explore how community health workers could be used in behavioral health***

* *Examples of peer-based support: Peer Support Specialists, Peer Recovery Coach, Family Peer Support Specialists and NAMI Peer-to-Peer.*

** *Examples of possible barriers: wait times to access services in a rural area vs a urban area and negative perception surrounding mental health and help- seeking.*

*** *Community Health Worker is defined as a "frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served." Source: https://www.apha.org/apha-communities/member-sections/community-health-workers*

Access to Care: Behavioral Health

Is Anyone Better Off?

GOAL 1 Improve access to behavioral health services for all people in Iowa

Measures of Success	Baseline	2028 Target
Decrease the percent of adults reporting unmet need for mental health treatment due to "did not know where to go for services"[8]	18.9%	15.1%
Decrease the percent of adults reporting unmet need for mental health treatment[8]	7.6%	5.2%
Decrease the percent of people ages 12 and older reporting unmet need for treatment at a facility for substance use in the past year[8]	15.6%	12.1%
Decrease the suicide rate per 100,000 population[9]	17.5	15.7

Access to Care: Behavioral Health

Strategies for Improvement

GOAL 2 Strengthen Iowa's behavioral health system by increasing available resources and capacity

Focus Area 2.1: Children and Youth

- Increase prevention programming for youth ages 0-18
- Support collection and use of adolescent health data
- Promote mental health plans in schools
- Amplify existing behavioral health programming for children ages 0-5

Focus Area 2.2: Training and Support Services

- Increase access to training and continuing education on behavioral health issues*
- Encourage behavioral health screening at primary care level
- Promote behavioral health profession apprenticeship programs
- Encourage the use of many types of behavioral health professionals in different sectors**
- Investigate different licensure models for behavioral health professions

Focus Area 2.3: Collaboration

- Develop connections among behavioral health initiatives
- Promote the inclusion of people with lived experience in decision making and in the development of programming and policies

* *Examples of training and continuing education include: Behavioral Health ECHO, Scanlan Center for School Mental Health professional trainings, Mental Health First Aid, Relationships Can Heal: Knowing the Farmer Client, Question. Persuade. Refer.*

** *Types of behavioral health professionals may include: Psychologists, Counselors, Clinicians, Therapists, Clinical Social Workers, Psychiatrists, Mental Health Nurse Practitioners, Primary Care Physicians, Family Nurse Practitioners, Psychiatric Pharmacists, Certified Peer Specialists, Social Workers and Pastoral Counselors.*

Access to Care: Behavioral Health

Is Anyone Better Off?

GOAL 2 Strengthen Iowa's behavioral health system by increasing available resources and capacity

Measures of Success	Baseline	2028 Target
Decrease the suicide rate per 100,000 population - Ages 15-19[10]	13.6	12.2
Increase the percent of schools with universal mental health promotion programs (e.g., Positive Behavioral Interventions and Supports)[10]		
↳ All schools	89.2%	92.1%
↳ High schools	84.0%	87.5%
↳ Middle schools	91.9%	94.4%
↳ Junior/Senior high schools	91.1%	95.4%

Healthy Eating and Active Living

Proper nutrition and regular physical activity are key to one's overall health.[11] Many people in Iowa lack consistent access to healthy foods, healthy beverages and safe recreational areas.

A lack of consistent access to healthy food can lead to chronic diseases, obesity or developmental problems.[12] In Iowa, 89 out of 99 counties have areas identified as having low food access and approximately 238,290 Iowans are food insecure.[13] Diets high in fruits and vegetables also reduce the risk of chronic diseases.

According to data from the Iowa Behavioral Risk Factor Surveillance System (BRFSS)[5], 41.5% of adult Iowans consumed fruit less than one time a day and 23% consumed vegetables less than one time a day in 2021.

In 2022, an estimated 74.1% of adult Iowans reported any leisure-time physical activity in the last month.[4] In the 2021 Iowa Youth Survey (IYS) State Report[14], between 25% and 29% of youth in grades 6, 8 and 11 reported being physically active for at least 60 minutes on all seven days in the past week.

The Healthy Iowans Partnership hopes to make Healthy Eating & Active Living more attainable for all people in Iowa.

Food Security: Having enough food for an active, healthy life at all times. At a minimum, food security includes 1) readily available nutritionally adequate and safe foods, and 2) the ability to acquire those foods in socially acceptable ways. Source: *https://www.usda.gov/sites/default/files/documents/usda-actions-nutrition-security.pdf*

Nutrition Security: Having consistent access to the safe, healthy and affordable foods essential to optimal health and well-being. Nutrition security builds on food security by focusing on how the quality of our diets can help reduce diet-related diseases and disparities. Source: *https://www.usda. gov/sites/default/files/documents/usda-actions-nutrition- security.pdf*

Rural: An area of open countryside with population densities less than 500 people per square mile and places with fewer than 2,500 people. Source: *https://www.ers.usda.gov/topics/rural-economy-population/ rural-classifications/what-is-rural/*

Processing: Operations that alter the general state of the commodity, such as canning, cooking, freezing, dehydration, milling, grinding, pasteurization or homogenization. Source: *https://www.fda.gov/media/168142/download*

Small Food Producer: An operation with gross cash farm income under $250,000. Source: *https:// www.usda.gov/media/blog/2010/05/18/small-farms-big- differences*

Healthy Eating and Active Living

Strategies for Improvement

GOAL 1

Reduce barriers to affordable, nutritious foods for all people in Iowa

Focus Area 1.1: Food Insecurity

- Promote innovative food access initiatives
- Support participation in nutrition programs*
- Explore policy changes to expand the Farmer's Market Nutrition Program**
- Increase the number of school-based food pantries
- Identify gaps in access to culturally preferred foods

Focus Area 1.2: Locally Sourced Food

- Increase training opportunities for small food producers and processors***
- Support policies to increase the amount of locally sourced food available through community food nutrition programs
- Increase the number of small food producers and processors in rural areas

Focus Area 1.3: Collaboration

- Raise awareness of the Iowa Food Systems Plan
- Use a unified approach to educate various sectors on the difference between food and nutrition security
- Investigate food rescue practices in Iowa****

* *"Nutrition programs" includes: the Iowa Cafe, Iowa Farm to School, WIC, SNAP, Farmers Market Nutrition Program, Double Up Food Bucks, Produce Prescription Program, and community garden programs.*

** *This includes the Iowa WIC Farmers Market Nutrition Program and the Senior Farmers Market Nutrition Program.*

*** *Examples of possible trainings include: Home-Based Kitchen Operations, MarketReady, and Small Farm Sustainability.*

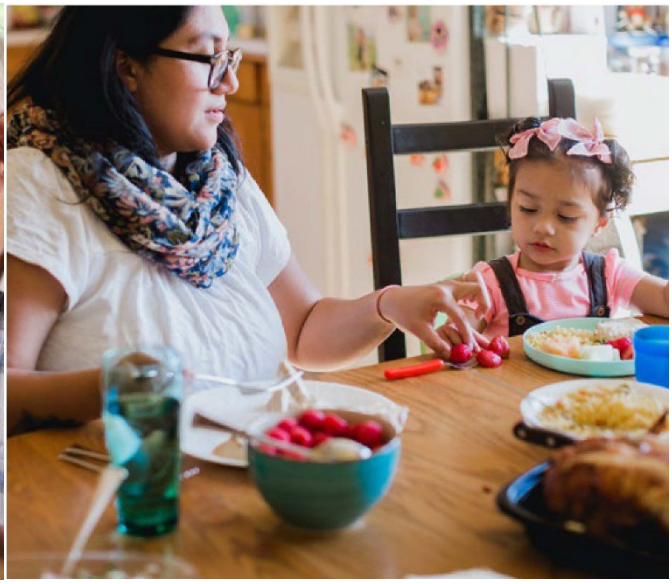
**** *Food Rescue, food recovery, food surplus, and food waste or loss prevention are many terms used to describe similar practices. Food rescue is the practice of collecting unsellable or unharvested food - but edible food that would have otherwise gone to waste - from restaurants, grocers, farmers and other food establishments and distributing to help feed people.*

Healthy Eating and Active Living

Is Anyone Better Off?

GOAL 1 Reduce barriers to affordable, nutritious foods for all people in Iowa

Measure of Success	Baseline	2028 Target
Decrease the percent of people who are food insecure[15]	7.5%	5.1%



Healthy Eating and Active Living

Strategies for Improvement

GOAL 2 Increase engagement in active living among all people in Iowa

Focus Area 2.1: Physical Activity Options

- Educate people on the variety of ways one can meet activity recommendations*
- Promote physical activity initiatives that improve access for all people
- Engage with partners to identify best practices in providing comprehensive access to physical activity services for all community members

Focus Area 2.2: Collaboration

- Collaborate with a variety of partners to cross-promote existing programs and expand their reach
- Improve the evaluation of active living programming**

* *Activity recommendations: U.S Department of Health and Human Services Physical Activity Guidelines for Americans*

** *Examples of ways to evaluate may include: utilization of programming and process and outcome measures.*

Healthy Eating and Active Living

Is Anyone Better Off?

GOAL 2 Increase engagement in active living among all people in Iowa

Measure of Success	Baseline	2028 Target
Increase the percent of adult Iowans who report engaging in physical activity[4]	74.1%	78.4%

Tracking Progress

The Healthy Iowans Partnership Steering Committee and Workgroups meet regularly throughout the year to collaborate and share updates on implementation.

Meanwhile, the Iowa HHS Healthy Iowans Team monitors statewide data indicators to determine if Healthy Iowans' efforts are moving the needle in each priority area.

The 2023-2028 SHIP is designed to be flexible and reflect changes in Iowa's health issues and in health improvement work. This means that each year, progress is tracked and reported, and revisions made as needed. With assistance from the Healthy Iowans Partnership, goals, objectives and strategies are updated annually to reflect the most current efforts to improve health for all people in Iowa.

Furthermore, the Healthy Iowans Partnership Workgroups continually evaluate assets and resources for addressing the identified priorities and assist in recruiting additional members from throughout the state.

These processes help ensure the 2023-2028 SHIP is an impactful statewide plan created in the best interest of all people in Iowa.

How to Use the SHIP

The information in the SHIP is intended to be useful, actionable and valuable in driving health improvement. Here are some ideas of how you can help bring the SHIP to life:

- Start a conversation with family, friends, co-workers and officials about your experiences and what your priorities are and what you see as important for your community
- Get involved - volunteer your time or expertise in an activity related to a health issue that is important to you.

For Organizations and Partners:

- Understand the priority health issues in the SHIP.
- Align your work with SHIP priorities and identify ways you can support or contribute to SHIP strategies.
- Share the SHIP with your partners and networks.
- Encourage community leaders to invest in programs and policy changes that give Iowans the tools and opportunities to achieve optimal health.
- Use the SHIP to connect your work to the needs in the state when thinking about programming, services, grant funding, etc.
- Share data that relates to the priority health issues.

Stay Connected

The 2023-2028 SHIP is a living document.

This means that changes may occur throughout the course of the six-year period. To stay up to date with these changes, and the Healthy Iowans process, please use the following resources:

Healthy Iowans Newsletter

A monthly publication, the Healthy Iowans Newsletter provides updates on the Healthy Iowans process, and also includes links to pertinent public health trainings, events, news and resources.

To subscribe, scan this QR code with your phone's camera:

Healthy Iowans Website

https://hhs.iowa.gov/about/performance-and-reports/healthy-iowans

Social Media

Find Iowa HHS on these social media platforms:

Sources

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