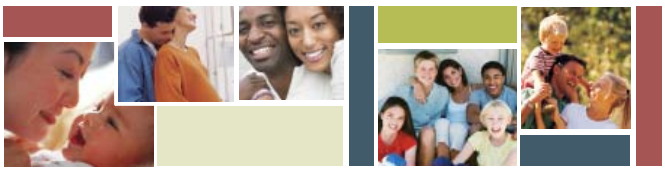
THE UPdate



June 6, 2011

The Update is a bi-weekly web newsletter published by the Iowa Department of Public Health's Bureau of Family Health. It is posted the second and fourth week of every month, and provides useful job resource information for departmental health care professionals, information on training opportunities, intradepartmental reports and meetings, and additional information pertinent to health care professionals.

In this issue...

Teen Pregnancy and Social Media

Find free, easy-to-use teen pregnancy communication tools that can help expand the reach of your health messages and help increase public engagement. Tools include buttons and badges that you and your partners can add to websites; an e-card encouraging parents to talk with teens about sex; Twitter and Facebook messages about teen pregnancy that you can post to your organizations' Facebook walls; a downloadable podcast and PSA about teen pregnancy; links to our mobile-ready teen pregnancy prevention web pages; and information on content syndication which enables partner organizations to display current CDC content on your websites.

What are badges? Badges are graphic images that include a message and link to an informational Web page that you can place on your website.

What are buttons? Buttons are graphic elements that usually include an image, a short call-to-action message, and a link for more information. They are often created to be shared, and include HTML code that allows them to be posted on a Web site.

What is content syndication? Content syndication is a technical application that enables partner organizations to display current CDC health and safety content and allows visitors to the public health partner's website access to CDC content without leaving the partner website. This tool, provided by CDC, allows the communication and management of the latest science-based information online. View all of the Web pages available for content syndication on the topic of teen pregnancy.

For more information, visit the CDC website at www.cdc.gov/TeenPregnancy/SocialMedia/index.htm?source=govdelivery.

Does it Run in the Family? Toolkit Will Soon Be Available at Federal Health Centers Nationwide

The Genetic Alliance, in partnership with the Health Resources and Services Administration, selected six HRSA-funded health centers (including Siouxland Community Health Center) to integrate the *Does it Run in the Family?* toolkit into their clinical care and outreach practices. Selected centers will receive $40,000 each to implement and evaluate their programs, with the goal of creating and sustaining awareness and discussion of family health history among health center providers, staff and patients.

Over the course of 15 months, Genetic Alliance will work with the six centers to integrate family health history into their programs and processes as well as evaluate the impact of the toolkit on provider, staff and patient family history education and engagement. Sites will then suggest recommendations for dissemination of the toolkit into additional HRSA-funded health centers and other health care outlets across the country.

CDC Identifies 10 Public Health Achievements of First Decade of 21st Century

Maternal and Infant Health is Identified

Morbidity and Mortality Weekly Report, May 20, 2011

The past decade has seen significant reductions in the number of infants born with neural tube defects and expansion of screening of newborns for metabolic and other heritable disorders. Mandatory folic acid fortification of cereal grain products labeled as enriched in the United States, beginning in 1998, contributing to a 36 percent reduction in NTDs from 1996 to 2006 and prevented an estimated 10,000 NTD-affected pregnancies in the past decade, resulting in a savings of $4.7 billion in direct costs.

Improvements in technology and endorsement of a uniform newborn-screening panel of diseases have led to earlier life-saving treatment and intervention for at least 3,400 additional newborns each year with selected genetic and endocrine disorders. In 2003, all but four states were screening for only six of these disorders. By April 2011, all states reported screening for at least 26 disorders on an expanded and standardized uniform panel.

Newborn screening for hearing loss increased from 46.5 percent in 1999 to 96.9 percent in 2008. The percentage of infants not passing their hearing screening who were then diagnosed by an audiologist before age 3 months as either normal or having permanent hearing loss increased from 51.8 percent in 1999 to 68.1 percent in 2008.

For more information about the CDC's 10 public health achievements identified for the first decade of the 21st century go to www.cdc.gov/media/releases/2011/p0519_publichealthachievements.html.

To view the May 20, 2011 section of the Morbidity and Mortality Weekly Report, go to pages 6-10 of The UPdate.

Administration/Program Management

Informational Letter #1017: Transition to 5010 HIPAA Format

Important for all Iowa Medicaid Providers Billing Electronically

The Iowa Medicaid Enterprise has issued Informational Letter #1017 announcing that on **January 1, 2012 all electronic claims submitted to IME must be in the 5010 HIPAA format**. Iowa Medicaid's Electronic Data Interchange Support Services (EDISS) encourages all providers to enroll in Total OnBoarding (5010 HIPAA format) *well before* the January 2012 deadline. TOB replaces the 4010 format currently used. Providers not enrolled in TOB by January 1, 2012 will no longer be able to submit electronic transactions. At that time, the current 4010 format will be deleted from the EDISS system.

How to Transition to the 5010 Format:
Guidelines for transition to the 5010 format in the form of a checklist can be found on the EDISS website at www.edissweb.com/docs/shared/5010_checklist.pdf. The checklist is organized into three sections:

- Direct providers not using PC-ACE Pro32
- Direct providers using PC-ACE Pro32
- Providers sending files through a clearinghouse or billing service

Follow the section of the guidelines that is applicable to your agency to begin preparation for the transition.

EDISS will work closely with providers to ensure that all activities from claim submission to payment occur accurately. Providers are encouraged to enroll in TOB well in advance of the January 1, 2012 date to assure that the process is working smoothly.

See Informational Letter #1017 on page 11 of **The UPdate** for further detail. If you have questions, please contact IME Provider Services at 1-800-338-7909 (in the Des Moines area at 515-256-4609) or by email at imeproviderservices@dhs.state.ia.us.

Bureau of Family Health Grantee Committee Meeting

The next Bureau of Family Health Grantee Committee meeting will be held on June 16, 2011 from 9-11:30 via the ICN. A listing of ICN sites, meeting agenda and meeting minutes from the February 15, 2011 meeting can be downloaded from pages 12-19 of **The UPdate**. *This is a required meeting for Bureau of Family Health contract agencies*. If you have any questions, please contact Heather Hobert-Hoch at 515-281-6880.

Calendar

June 9, 2011

MCH Advisory Council Meeting, 1-3 p.m., Iowa Lutheran Hospital, Conference Room 1

June 16, 2011*

Bureau of Family Health Grantee Committee Meeting 9-11:30 a.m., ICN

* Required meeting

JUNE Contract Required Due Dates

15 - Due: Electronic expenditure workbooks

16 - BFH Grantee Committee Meeting

30 - Export WHIS records to IDPH

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Healthy Families Line: 1-800-369-2229
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Ten Great Public Health Achievements — United States, 2001–2010

During the 20th century, life expectancy at birth among U.S. residents increased by 62%, from 47.3 years in 1900 to 76.8 in 2000, and unprecedented improvements in population health status were observed at every stage of life (*1*). In 1999, *MMWR* published a series of reports highlighting 10 public health achievements that contributed to those improvements. This report assesses advances in public health during the first 10 years of the 21st century. Public health scientists at CDC were asked to nominate noteworthy public health achievements that occurred in the United States during 2001–2010. From those nominations, 10 achievements, not ranked in any order, have been summarized in this report.

Vaccine-Preventable Diseases

The past decade has seen substantial declines in cases, hospitalizations, deaths, and health-care costs associated with vaccine-preventable diseases. New vaccines (i.e., rotavirus, quadrivalent meningococcal conjugate, herpes zoster, pneumococcal conjugate, and human papillomavirus vaccines, as well as tetanus, diphtheria, and acellular pertussis vaccine for adults and adolescents) were introduced, bringing to 17 the number of diseases targeted by U.S. immunization policy. A recent economic analysis indicated that vaccination of each U.S. birth cohort with the current childhood immunization schedule prevents approximately 42,000 deaths and 20 million cases of disease, with net savings of nearly $14 billion in direct costs and $69 billion in total societal costs (*2*).

The impact of two vaccines has been particularly striking. Following the introduction of pneumococcal conjugate vaccine, an estimated 211,000 serious pneumococcal infections and 13,000 deaths were prevented during 2000–2008 (*3*). Routine rotavirus vaccination, implemented in 2006, now prevents an estimated 40,000–60,000 rotavirus hospitalizations each year (*4*). Advances also were made in the use of older vaccines, with reported cases of hepatitis A, hepatitis B, and varicella at record lows by the end of the decade. Age-specific mortality (i.e., deaths per million population) from varicella for persons age <20 years, declined by 97% from 0.65 in the prevaccine period (1990–1994) to 0.02 during 2005–2007 (*5*). Average age-adjusted mortality (deaths per million population) from hepatitis A also declined significantly, from 0.38 in the prevaccine period (1990–1995) to 0.26 during 2000–2004 (*6*).

Prevention and Control of Infectious Diseases

Improvements in state and local public health infrastructure along with innovative and targeted prevention efforts yielded significant progress in controlling infectious diseases. Examples include a 30% reduction from 2001 to 2010 in reported U.S. tuberculosis cases and a 58% decline from 2001 to 2009 in central line–associated blood stream infections (*7,8*). Major advances in laboratory techniques and technology and investments in disease surveillance have improved the capacity to identify contaminated foods rapidly and accurately and prevent further spread (*9–12*). Multiple efforts to extend HIV testing, including recommendations for expanded screening of persons aged 13–64 years, increased the number of persons diagnosed with HIV/AIDS and reduced the proportion with late diagnoses, enabling earlier access to life-saving treatment and care and giving infectious persons the information necessary to protect their partners (*13*). In 2002, information from CDC predictive models and reports of suspected West Nile virus transmission through blood transfusion spurred a national investigation, leading to the rapid development and implementation of new blood donor screening (*14*). To date, such screening has interdicted 3,000 potentially infected U.S. donations, removing them from the blood supply. Finally, in 2004, after more than 60 years of effort, canine rabies was eliminated in the United States, providing a model for controlling emerging zoonoses (*15,16*).

Tobacco Control

Since publication of the first Surgeon General's Report on tobacco in 1964, implementation of evidence-based policies and interventions by federal, state, and local public health authorities has reduced tobacco use significantly (*17*). By 2009, 20.6% of adults and 19.5% of youths were current smokers, compared with 23.5% of adults and 34.8% of youths 10 years earlier. However, progress in reducing smoking rates among youths and adults appears to have stalled in recent years. After a substantial decline from 1997 (36.4%) to 2003 (21.9%), smoking rates among high school students remained relatively unchanged from 2003 (21.9%) to 2009 (19.5%) (*18*). Similarly, adult smoking prevalence declined steadily from 1965 (42.4%) through the 1980s, but the rate of decline began to slow in the 1990s, and the prevalence remained relatively unchanged from 2004 (20.9%) to 2009 (20.6%) (*19*). Despite the progress that has been made, smoking still results in an economic burden, including medical costs and lost productivity, of approximately $193 billion per year (*20*).

Although no state had a comprehensive smoke-free law (i.e., prohibit smoking in worksites, restaurants, and bars) in 2000, that number increased to 25 states and the District of Columbia (DC) by 2010, with 16 states enacting comprehensive smoke-free laws following the release of the 2006 Surgeon

General's Report (*21*). After 99 individual state cigarette excise tax increases, at an average increase of 55.5 cents per pack, the average state excise tax increased from 41.96 cents per pack in 2000 to $1.44 per pack in 2010 (*22*). In 2009, the largest federal cigarette excise tax increase went into effect, bringing the combined federal and average state excise tax for cigarettes to $2.21 per pack, an increase from $0.76 in 2000. In 2009, the Food and Drug Administration (FDA) gained the authority to regulate tobacco products (*23*). By 2010, FDA had banned flavored cigarettes, established restrictions on youth access, and proposed larger, more effective graphic warning labels that are expected to lead to a significant increase in quit attempts (*24*).

Maternal and Infant Health

The past decade has seen significant reductions in the number of infants born with neural tube defects (NTDs) and expansion of screening of newborns for metabolic and other heritable disorders. Mandatory folic acid fortification of cereal grain products labeled as enriched in the United States beginning in 1998 contributed to a 36% reduction in NTDs from 1996 to 2006 and prevented an estimated 10,000 NTD-affected pregnancies in the past decade, resulting in a savings of $4.7 billion in direct costs (*25–27*).

Improvements in technology and endorsement of a uniform newborn-screening panel of diseases have led to earlier life-saving treatment and intervention for at least 3,400 additional newborns each year with selected genetic and endocrine disorders (*28,29*). In 2003, all but four states were screening for only six of these disorders. By April 2011, all states reported screening for at least 26 disorders on an expanded and standardized uniform panel (*29*). Newborn screening for hearing loss increased from 46.5% in 1999 to 96.9% in 2008 (*30*). The percentage of infants not passing their hearing screening who were then diagnosed by an audiologist before age 3 months as either normal or having permanent hearing loss increased from 51.8% in 1999 to 68.1 in 2008 (*30*).

Motor Vehicle Safety

Motor vehicle crashes are among the top 10 causes of death for U.S. residents of all ages and the leading cause of death for persons aged 5–34 years (*30*). In terms of years of potential life lost before age 65, motor vehicle crashes ranked third in 2007, behind only cancer and heart disease, and account for an estimated $99 billion in medical and lost work costs annually (*31,32*). Crash-related deaths and injuries largely are preventable. From 2000 to 2009, while the number of vehicle miles traveled on the nation's roads increased by 8.5%, the death rate related to motor vehicle travel declined from 14.9 per 100,000 population to 11.0, and the injury rate declined from 1,130 to 722; among children, the number of pedestrian deaths declined by 49%, from 475 to 244, and the number of bicyclist deaths declined by 58%, from 178 to 74 (*33,34*).

These successes largely resulted from safer vehicles, safer roadways, and safer road use. Behavior was improved by protective policies, including effective seat belt and child safety seat legislation; 49 states and the DC have enacted seat belt laws for adults, and all 50 states and DC have enacted legislation that protects children riding in vehicles (*35*). Graduated drivers licensing policies for teen drivers have helped reduce the number of teen crash deaths (*36*).

Cardiovascular Disease Prevention

Heart disease and stroke have been the first and third leading causes of death in the United States since 1921 and 1938, respectively (*37,38*). Preliminary data from 2009 indicate that stroke is now the fourth leading cause of death in the United States (*39*). During the past decade, the age-adjusted coronary heart disease and stroke death rates declined from 195 to 126 per 100,000 population and from 61.6 to 42.2 per 100,000 population, respectively, continuing a trend that started in the 1900s for stroke and in the 1960s for coronary heart disease (*40*). Factors contributing to these reductions include declines in the prevalence of cardiovascular risk factors such as uncontrolled hypertension, elevated cholesterol, and smoking, and improvements in treatments, medications, and quality of care (*41–44*)

Occupational Safety

Significant progress was made in improving working conditions and reducing the risk for workplace-associated injuries. For example, patient lifting has been a substantial cause of low back injuries among the 1.8 million U.S. health-care workers in nursing care and residential facilities. In the late 1990s, an evaluation of a best practices patient-handling program that included the use of mechanical patient-lifting equipment demonstrated reductions of 66% in the rates of workers' compensation injury claims and lost workdays and documented that the investment in lifting equipment can be recovered in less than 3 years (*45*). Following widespread dissemination and adoption of these best practices by the nursing home industry, Bureau of Labor Statistics data showed a 35% decline in low back injuries in residential and nursing care employees between 2003 and 2009.

The annual cost of farm-associated injuries among youth has been estimated at $1 billion annually (*46*). A comprehensive childhood agricultural injury prevention initiative was established to address this problem. Among its interventions was the development by the National Children's Center for Rural Agricultural Health and Safety of guidelines for parents

to match chores with their child's development and physical capabilities. Follow-up data have demonstrated a 56% decline in youth farm injury rates from 1998 to 2009 (National Institute for Occupational Safety and Health, unpublished data, 2011).

In the mid-1990s, crab fishing in the Bering Sea was associated with a rate of 770 deaths per 100,000 full-time fishers (*47*). Most fatalities occurred when vessels overturned because of heavy loads. In 1999, the U.S. Coast Guard implemented Dockside Stability and Safety Checks to correct stability hazards. Since then, one vessel has been lost and the fatality rate among crab fishermen has declined to 260 deaths per 100,000 full-time fishers (*47*).

Cancer Prevention

Evidence-based screening recommendations have been established to reduce mortality from colorectal cancer and female breast and cervical cancer (*48*). Several interventions inspired by these recommendations have improved cancer screening rates. Through the collaborative efforts of federal, state, and local health agencies, professional clinician societies, not-for-profit organizations, and patient advocates, standards were developed that have significantly improved cancer screening test quality and use (*49,50*). The National Breast and Cervical Cancer Early Detection Program has reduced disparities by providing breast and cervical cancer screening services for uninsured women (*49*). The program's success has resulted from similar collaborative relationships. From 1998 to 2007, colorectal cancer death rates decreased from 25.6 per 100,000 population to 20.0 (2.8% per year) for men and from 18.0 per 100,000 to 14.2 (2.7% per year) for women (*51*). During this same period, smaller declines were noted for breast and cervical cancer death rates (2.2% per year and 2.4%, respectively) (*52*).

Childhood Lead Poisoning Prevention

In 2000, childhood lead poisoning remained a major environmental public health problem in the United States, affecting children from all geographic areas and social and economic levels. Black children and those living in poverty and in old, poorly maintained housing were disproportionately affected. In 1990, five states had comprehensive lead poisoning prevention laws; by 2010, 23 states had such laws. Enforcement of these statutes as well as federal laws that reduce hazards in the housing with the greatest risks has significantly reduced the prevalence of lead poisoning. Findings of the National Health and Nutrition Examination Surveys from 1976–1980 to 2003–2008 reveal a steep decline, from 88.2% to 0.9%, in the percentage of children aged 1–5 years with blood lead levels ≥10 μg/dL. The risks for elevated blood lead levels based on socioeconomic status and race also were reduced significantly. The economic benefit of lowering lead levels among children by preventing lead exposure is estimated at $213 billion per year (*53*).

Public Health Preparedness and Response

After the international and domestic terrorist actions of 2001 highlighted gaps in the nation's public health preparedness, tremendous improvements have been made. In the first half of the decade, efforts were focused primarily on expanding the capacity of the public health system to respond (e.g., purchasing supplies and equipment). In the second half of the decade, the focus shifted to improving the laboratory, epidemiology, surveillance, and response capabilities of the public health system. For example, from 2006 to 2010, the percentage of Laboratory Response Network labs that passed proficiency testing for bioterrorism threat agents increased from 87% to 95%. The percentage of state public health laboratories correctly subtyping *Escherichia coli* O157:H7 and submitting the results into a national reporting system increased from 46% to 69%, and the percentage of state public health agencies prepared to use Strategic National Stockpile material increased from 70% to 98% (*54*). During the 2009 H1N1 influenza pandemic, these improvements in the ability to develop and implement a coordinated public health response in an emergency facilitated the rapid detection and characterization of the outbreak, deployment of laboratory tests, distribution of personal protective equipment from the Strategic National Stockpile, development of a candidate vaccine virus, and widespread administration of the resulting vaccine. These public health interventions prevented an estimated 5–10 million cases, 30,000 hospitalizations, and 1,500 deaths (CDC, unpublished data, 2011).

Existing systems also have been adapted to respond to public health threats. During the 2009 H1N1 influenza pandemic, the Vaccines for Children program was adapted to enable provider ordering and distribution of the pandemic vaccine. Similarly, President's Emergency Plan for AIDS Relief clinics were used to rapidly deliver treatment following the 2010 cholera outbreak in Haiti.

Conclusion

From 1999 to 2009, the age-adjusted death rate in the United States declined from 881.9 per 100,000 population to 741.0, a record low and a continuation of a steady downward trend that began during the last century. Advances in public health contributed significantly to this decline; seven of the 10 achievements described in this report targeted one or more of the 15 leading causes of death. Related *Healthy People 2010* data are available at http://www.cdc.gov/mmwr/preview/

mmwrhtml/mm6019a5_addinfo.htm. The examples in this report also illustrate the effective application of core public health tools. Some, such as the establishment of surveillance systems, dissemination of guidelines, implementation of research findings, or development of effective public health programs, are classic tools by which public health has addressed the burden of disease for decades.

Although not new, the judicious use of the legal system, by encouraging healthy behavior through taxation or by shaping it altogether through regulatory action, has become an increasingly important tool in modern public health practice and played a major role in many of the achievements described in this report (*55*). The creative use of the whole spectrum of available options, as demonstrated here, has enabled public health practitioners to respond effectively. Public health practice will continue to evolve to meet the new and complex challenges that lie ahead.

Reported by

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STATE OF IOWA

TERRY E. BRANSTAD, GOVERNOR
KIM REYNOLDS, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
CHARLES M. PALMER, DIRECTOR

INFORMATIONAL LETTER NO. 1017

DATE: June 1, 2011

TO: All Iowa Medicaid Providers Billing Electronically

ISSUED BY: Iowa Department of Human Services, Iowa Medicaid Enterprise (IME)

RE: Transition to 5010 HIPAA Format

EFFECTIVE: January 1, 2012

On January 1, 2012, all electronic claims must be in the 5010 HIPAA format. To ensure there is no disruption of claim submissions on this date, the Iowa Medicaid Electronic Data Interchange Support Services (EDISS) encourages all trading partners to enroll in Total OnBoarding (TOB) well before the January 2012 deadline. If the TOB profile has not been enrolled for 5010 as of January 1, 2012, the provider will no longer be active for electronic transactions because the current (4010) setup will be deleted from the EDISS system.

A common question EDISS receives is, "What exactly should I be doing for the 5010 transition?" To assist with the 5010 transition, follow the guidelines on the checklist on the EDISS website at http://www.edissweb.com/docs/shared/5010_checklist.pdf. The checklist is separated into three sections: Direct Providers (not using PC-ACE Pro32), Direct Providers (using PC-ACE Pro32), and Providers sending files through a Clearinghouse or Billing Service. Select the most appropriate section and follow the guidelines on the checklist to begin preparing for the transition.

On April 5, 2011, EDISS began selecting a subset of providers that successfully tested the 5010 errata format to move to a production status. During this transition, EDISS is working closely with trading partners to ensure all activities from claim submission to payment receipt are accurate.

As part of this transition, any additional electronic transactions users access in 4010 (i.e., 835, 270/271, 276/277) will need to be re-registered for the 5010 format through TOB. Re-registering will ensure electronic functionality is not removed at the time of 5010 cut over.

If you have any questions, please contact the IME Provider Services Unit, 1-800-338-7909, locally 515-256-4609 or by e-mail at imeproviderservices@dhs.state.ia.us.

BFH Grantee Committee Meeting
June 16, 2011
9-11:30 a.m.
ICN

*BFH Required Meeting

Agenda

9:00 a.m.	**Call to Order** Introductions & Roll Call	 *Michele Ross*
9:05 a.m.	**Announcements** Approval of Minutes FY12 Meeting Dates Vice Chair Position Fall Seminar	 *Michele Ross* *Michele Ross* *Michele Ross* *Andrew Connet*
9:15 a.m.	**Julie's Updates** • **BFH Transition** • **MCH/OH Listening Post** • **Budget/Legislative Update**	*Julie McMahon*
9:30 a.m.	**RFA Update**	*Andrea Kappelman*
9:50 a.m.	**Claims Processing**	*Andrew Connet/Juli Montgomery*
10:05 a.m.	**PREP (Personal Responsibility Education Program) RFP**	*Lindsay Miller*
10:15 a.m.	**Home Visiting Grant Update**	*Janet Horras*
10:25 a.m.	**CAReS Demographics**	*Erin Parker*
10:35 a.m.	**CH Presumptive Eligibility**	*Melissa Ellis*
10:45 a.m.	**Immunization & Counseling Codes 90460 & 90461**	*Janet Beaman/Sally Nadolsky*
11:00 a.m.	**Grantee Dialogue/Open Discussion**	*Michele Ross*
11:30 a.m.	**Agenda Items for Next Meeting/ Adjournment**	*Michele Ross*

*This is a required meeting for Bureau of Family Health contractors (Maternal Health, Child Health, and Family Planning).

BFH GRANTEE COMMITTEE MEETING
Date: February 15, 2011
Time: 9-11 a.m.
ICN

Members Present:

Allen Memorial Hospital: Sandy Kahler*

American Home Finding: Tracey Boxx-Vass *

Black Hawk County Child Health Department: Rhonda Bottke*, Arlene Prather-O'Kane

Community Health Services of Marion County: Kim Dorn*, Rachel Cecil

Crawford County Home Health Agency: Laura Beeck*, Jennifer Muff

Family Inc.: Sarah Zach*

Hawkeye Area Community Action Program: Kim Ott*, Ethel Levi

Hillcrest Family Services: Sherry McGinn*, Paula?

Johnson County Dept. of Public Health: Chuck Dufano*, Erica Wagner

Lee County Health Dept.: Margaret Cook*

MATURA Action Corporation: Mary Groves*

Mid-Iowa Community Action: Janelle Durlin*, Kate Pergande

Mid-Sioux Opportunity, Inc.: Cindy Harpenau*

New Opportunities: Paula Klocke*

North Iowa Community Action Org.: Lisa Koppin*

Northeast Iowa Community Action: Lori Egan*

Scott County Health Dept.: Tiffany Kennedy*

Siouxland Community Health Center: Sheila Martin*, Mona Scaletta, Linda Drey

Southern Iowa Family Planning: Vicki Palm*

St. Luke's Family Health Center: Val Campbell*

Taylor County Public Health: Joan Gallagher*

Trinity Muscatine: Mary Odell*

Visiting Nurse Assoc. of Dubuque: Molly Lammers*, Therese Maiers, Julie Ostwinkle

Visiting Nurse Services: Cari Spear*, Zoe Prevette, Julie Baker, Terry Walker

Warren County Health Services: Jodene DeVault*, Stacy Jobes, Shelley Jensen

Washington County PHN Service: Edie Nebel*, Jen Weidman

Webster County Public Health: Kari Prescott*, Jen Ellis

*Voting Representative

Minutes

Handouts included: Agenda, October 13, 2010 meeting minutes, Health Benefits Exchanges December 2010, Medicaid Expansion Under the Affordable Care Act, Prevention and Chronic Care Management Advisory Council Annual Report, Evaluation of the MCH/FP Grant Process 2010,

Michele Ross Chair Cari Spear, Vice Chair Notes Taken by BFH Staff

TOPICS	KEY DISCUSSION POINTS/OUTCOMES
Call to Order **Introductions & Roll Call**	***Cari Spear*** • Cari called the meeting to order at 9 a.m. • Roll call to identify voting members from each agency. • Cari Spear, Visiting Nurse Services, introduced as Vice Chair. Cari's bio was read. Welcome Cari.
Approval of Minutes	***Cari Spear*** • Motion made by Sarah Zach (Family Inc.) to approve the October 13, 2010 meeting minutes. Motion seconded by Tiffany Kennedy. Motion

Announcements	approved. • Jane reminds everyone to attend Board of Health meetings; contractual item. • Janet Beaman: call attention to recent email from Jane re: IME Program Integrity Unit of a preliminary report of overpayment from July 1, 2007 to June 30, 2010. So far, IDPH is aware of at least four agencies who have received this letter. If you receive the letter, be sure to read it very carefully. There is a short timeframe in which a request for reevaluation can be submitted. One agency asked how they were identified. IDPH does not know the answer to this question. Each agency must decide for themselves as to what action to take or not.
Legislation & Budget	***Julie McMahon*** • Julie McMahon provided an update on budget, legislation, transition. • New Health Policy Advisor: Michael Bushloe. • Dept. Directors: Palmer at DHS has been with DHS before; Roder at DOM, early childhood; Dr. Marrionette Miller-Meeks admits she is on a huge learning curve. Dr. MMM is "trainable; she listens; she reads a lot." Everyone should have received her bio. It will also be in the next edition of The UPdate. • General themes: less government at all levels; increase efficiencies and cost savings, do things smarter; eliminate duplication; and quality improvement. • Dr. Miller-Meeks still needs to be confirmed by the state legislators. Budget • Everyone should have received an e-mail from Dr. Miller-Meeks about $83.7M reduction. Existing contracts honored through January 31. IDPH' s portion of the budget reduction – every bureau chief has worked hard to lessen the impact on local agencies. Child health should see a minimal impact due to replacing state funds with federal funds. • There is a possibility of some restoration funds. However, for SFY12 &13 there is restoration of some funds projected in the areas of home care aid, child health, oral health and public health nursing. • SFY 12&13 IDPH budget takes on the Governor's budget. Nothing will really be known until after the legislative session. Federal budget: • State employees cannot advocate but can educate our legislators/congress representatives and senators. Talk about the impact of budget cuts in services to Iowans State Legislation • Lots of social issues, healthcare reform, budget. • Lynh Patterson has left. Beth Jones is doing a fantastic job as interim legislative liaison. Listening post • Julie will host this on Friday, Feb. 25; facilitator, 12 others with Julie. Watch for email from Julie announcing this session. Send comments to Julie or any of the panel members. Comments will be kept anonymous.

Health Care Reform	***Angie Doyle Scar*** • In a former position Angie did health "education training" for working with/talking to legislators. Remember that we, as constituents, are the most powerful voices they can hear. Angie now works with IDPH's Healthcare Reform team. • Angie provided an update on the Prevention and Chronic Care Management Advisory Council; Medical Home Advisory Council; and the health benefits exchange • The PCCM council has issued three issue briefs on Chronic Disease, Disease Registries and Prevention. They have also just released an annual report. All materials are available on IDPH's website. • Registries issue brief recommending one registry for chronic diseases. • The PCCM council was given two legislative charges last session. One was to look at data on health disparities in Iowa and the other is to create a Diabetes Care Coordination plan in Iowa with the Safety Net Providers. Health benefits exchange • Iowa has been awarded a planning grant for creating Iowa's health benefits exchange. IDPH is the lead on the grant. Have conducted five regional meetings and focus groups to get public buy-in. IDPH staff are conducting three more focus groups and will release a report of the findings. DHS is looking at what it will cost to update IT systems so that public programs can be part of the exchange. The insurance division is conducting an insurance market analysis. All this information will be collected and shared with an advisory committee who will make final recommendations to the legislature and governor. Medical Home • Annual report close to being released. The Medical Home Advisory Committee has been working to establish a multi-payor project, worked with DHS to establish medical homes within CHCs for Iowacare patients and is currently drafting rules for a medical home certification process in Iowa.
***hawk-i* Presumptive Eligibility**	***Melissa Ellis*** • Last week there was a subcommittee hearing to cut the eligibility level for ***hawk-i*** from 300% to 150%. The unanimous vote was to NOT ADVANCE the senate file. Family stories make a difference. They are very, very important. • Congrats to Title V agencies – Commonwealth Agency recently ranked Iowa as #1 in child care compared to the rest of the nation. Becoming a Qualified Entity: Others beyond ***hawk-i*** Outreach coordinators can now determine presumptive eligibility for children. • DHS contracts with IDPH for ***hawk-i*** outreach. • Once a family is deemed eligible for PE, the family is not responsible to pay for the services if subsequently determined not eligible. • PE is a temporary determination. A Qualified Entity must be a Medicaid provider. The lead agency applies to be a QE for children. • Who to call to become a QE? IME Provider Enrollment Unit at 800-338-7909, option 2. The QE must complete web-based training and then recertify annually. • Family income must be less than 300% of FPL. Under PE the family applies to Medicaid and if denied due to being over income, the application is screened for ***hawk-i*** eligibility.

	• QE (aka local agency) must maintain the application documentation for a period of three years. •
CAReS & WHIS Review Tools (Handout of slides available)	***Shelley Horak*** The CAReS and WHIS Review Tools survey and results • Provided an update on what has been happening since October. • We originally gathered information from C/W review participants through Survey Monkey. • Face-to-face visits will be conducted. Webster and Washington counties in-person. Crawford via e-mail, for now. • We received great feedback, giving our team a clear direction for improvements. • The CAReS and WHIS reviews ensure quality documentation of services billed to IDPH/ Medicaid. While they will not "go away," the process will continue to improve with a goal of satisfaction by all parties. • In the process of making revisions, plan to pilot the new tools in Spring 2011 and release the tools program-wide in Fall 2011.
RFP Evaluation Results (Handout of slides available)	***Shelley Horak*** • At the Fall Seminar evaluation tools were given out. The results that Shelley highlighted were made available to today's audience. • 76 individuals responded. 13 were executive directors; 21 were project directors; 18 were program coordinators. In general, 100% of the Executive Directors, 75% of the Project Directors, 60% of the Program Coordinators, and 80% of Other responded positively to writing a combined proposal. With regard to those that wrote all or most of the proposal, 4 wanted to write a separate proposal for each program, but 18 wanted to continue to write a combined proposal. (17.4% v. 78.3%). • Basically, the questions pertaining to logic models revealed that respondents were split with regard to how well they were understood and how useful they were. Therefore, a logic model training session is included in today's meeting. • Recommendations based on RFP evaluations: logic model training; clarify the criteria the proposal is based on as well as the guidance instruction; technical assistance related to the activity worksheets; reviewer training expansion; continue with simplifying the process and the documents and a user-friendly application. • The remainder of the presentation will be based on the responses of those who wrote the majority of the proposal. The team felt these responses were important to consider and would be most helpful in improving the RFP for the future.
Fee-for-Service Update (Handout of slides available)	***Shelley Horak*** • Fee for service and SharePoint challenges. • No paper GAX or expenditure reports • SharePoint is new to some, including most IDPH staff • The Medicaid QA Team (Juli, Renee, Shelley) are not SharePoint Administrators; we cannot fix your workbooks or participate in your

	workflows…this is Andrew Connet's territory. This is not negotiable at this time and we apologize for the inconvenience and the frustration.
WHIS Review Tool changes	***Steph Trusty*** • Two new WHIS reports will be coming. Karen Osenbaugh from SoftForce will be contacting agencies with technical assistance to help install the new reports in the next 30 days. The new reports are as follows: - WHIS Export Procedure to assist with submission of your required documentation of presumptive eligibility and care coordination to bill IDPH for these services. We will begin the new MH billing process in April once all agencies have the new report, a new procedure will be sent out in March to assist with April billing. - WHIS records for state audit – this new report will assist you in random selection and pulling the 5 percent of each type of service for the WHIS semi-annual summaries. • Healthy Start Grow Smart: no more funds for this initiative. The .pdf is available if you want to print your own.
Informing & Care Coordination	***Kari Prescott, Webster County Public Health*** • EPSDT Policies and Procedures: deferred to the next meeting due to time constraints
CCNC Update	***Analisa Pearson*** • CCNC Training is not yet completed. There probably are about 16-24 hours of preparation time remaining. Following that, the course will need to be evaluated for CEUs. It is expected the CEU process will take 30 days. • The memorandums of agreement with the regional nurses …. Starting July 1, 2010 the regional nurses no longer do training. • Question about potential funding for decreased ECI funding.
Agenda Items for Next Meeting/Adjournment	***Cari Spear*** Cari announced that Julie McMahon had to leave early. If there are questions for her, please send them to Julie McMahon or Heather Hobert Hoch. ***Topics for next BFH Grantee Committee Meeting:*** • If you have an agenda item you would like to have discussed at the next Grantee Committee meeting, please send you request to Michele Ross or Heather Hobert-Hoch. The next meeting will be held in conjunction with the Public Health Conference April 5-6th. • Kari Prescott made a motion to adjourn. Edie Nebel made a seconded the motion. Meeting adjourned at 11:10 a.m.

Bureau of Family Health Grantee Committee Meeting
June 16, 2011
9-11:30 a.m.
ICN Sites

Ames Iowa State University - 1 Lagomarcino Hall, Corner of Knoll Road and Pamel Drive, Room N147 Phone: 515-294-4111 Primary Local Site Contact: *Michelle Wilson* – 515-294-6293	**Dubuque** Dubuque Senior High School 1800 Clarke Drive, Room A-123 Phone: 563-552-5500 Primary Local Site Contact: *Deb Oleson* - 563-552-5521
Bedford Bedford Community High School 906 Pennsylvania Avenue, Fiber Optic Room Phone: 712-523-2114 Primary Local Site Contact: *Cheryl Fletcher* – 712-523-2114	**Fort Dodge** Fort Dodge Public Library 424 Central Avenue Phone: 515-573-8167 Primary Local Site Contact: *Deb Kern* – 515-573-8167 x232
Burlington Great Prairie AEA 3601 West Avenue Phone: 319-753-6561 Primary Local Site Contact: *Anne Aney* – 319-753-6561	**Iowa City** Iowa City High School 1900 Morningside Drive, Room 1001/1005 Phone: 319-688-1040 Primary Local Site Contact: *Jan Robertson* – 319-398-5452
Carroll DMACC – Carroll Campus 906 North Grant Road, Room 144 Phone: 712-792-1755 Primary Local Site Contact: *Jane Riley* – 712-792-8317	**Knoxville** Knoxville High School 1811 West Madison, Room 125 Phone: 641-842-2173 Primary Local Site Contact: *Paul Emerick*– 641-842-2173
Cedar Rapids Department of Human Services 411 3rd Street SE, 5th Floor, Room 550 Phone: 319-892-6700 Primary Local Site Contact: *Pat Lynch* – 319-892-6717	**Mason City** North Iowa Area Community College 500 College Drive, Activity Center, Room 106 Phone: 641-423-1264 Primary Local Site Contact: *Kathy Foster* – 641-422-4336
Columbus Junction Columbus Junction Public Library 232 2nd Street Phone: 319-728-7972 Primary Local Site Contact: *Cathy Crawford* – 319-728-7972	**Muscatine** Muscatine Community College 152 Colorado Street, Larson Hall, Room 60 Phone: 563-288-6001 Primary Local Site Contact: *Gail Spies*– 563-288-6005
Council Bluffs Iowa School for the Deaf - 1 3501 Harry Langdon Boulevard, Careers Bldg, 2nd Floor Phone: 712-366-3647 Primary Local Site Contact: *Christy Nash* – 712-366-3647	**Norwalk** Norwalk High School 1201 North Avenue, Room 102 Phone: 515-981-4201 Primary Local Site Contact: *Connie Thompson* – 515-981-4201 x30 *Gloria Fick* – 515-981-9871

Creston Creston High School 601 West Townline Road, Room 404 Phone: 641-782-2116 Primary Local Site Contact: *Jeff Norman* – 641-782-2116	**Ottumwa** Great Prairie AEA - 1 2814 N Court Street Phone: 641-682-8591 Primary Local Site Contact: *Shirley Walker* – 641-682-8591 x5220
Davenport Eastern Iowa Community College - 1 326 West 3rd Street, Kahl Educational Center, Room 300 Phone: 563-336-5200 Primary Local Site Contact: *Catarina Pena* – 563-336-5228	**Remsen** Remsen–Union High School 511 Roosevelt Phone: 712-786-1101 Primary Local Site Contact: *Stacey Galles* – 712-786-1101
Decorah Decorah Public Library 202 Winnebago Street Phone: 563-382-3717 Primary Local Site Contact: *Lorraine Borowski* – 563-382-3717	**Sioux City** West High School 2001 Casselman, Room 223 Phone: 712-279-6777 Primary Local Site Contact: *Jodie Larson* – 712-279-6784 Shelley Sweeney **–** 712-279-6784
Denison Denison High School 819 North 16th Street, Room 127 Phone: 712-263-3101 Primary Local Site Contact: *Nancy McCarville* – 712-263-3101 *Dennis Sychra* – 712-263-2176	**Waterloo** Department of Human Services 1407 Independence Avenue, Pinecrest Building, Phone: 319-291-2441 Primary Local Site Contact: *Vickie Westendorf* – 319-292-2430 *Michael Henrickson* – 319-291-2441
***Des Moines – Origination Site** State Library - 3 East 12th & Grand Avenue, Ola Babcock Miller Building (Old Historical Building) Phone: 515-281-4316 Primary Local Site Contact: *Toni Blair* – 515-281-8958	

*Origination site