



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Iowa**

**Application for 2015
Annual Report for 2013**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are provided as an attachment to this section.

An attachment is included in this section. IC - Assurances and Certifications

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

Public input was conducted in several different venues this year. A comprehensive method of public input was used for the Title V needs assessment. Stakeholders throughout the state were involved at three different levels. See the needs assessment section for more information. The needs assessment, state priorities, and proposed state performance measures with activities were posted via the IDPH website.

The Bureau of Family Health Grantee Committee is comprised of representatives from all 34 local MCH and Family Planning contract agencies. Local contract agencies are encouraged to provide input and influence bureau-related policy and quality assurance activities. Input from the committee was used to determine the Title V priority needs and performance measures.

There were about 150 hits to the IDPH Web site during the period of public input for the 2011 National and State Performance Measures (NPMs and SPMs). There were another 100 hits to the Public Input page for the period comment period for the needs assessment. Emails from local community partners provided input on the state priorities, performance measures, and activities within the performance measures. This input was reviewed and incorporated in to the application. Several comments pertained to the new state performance measures and the use of the Title V index.

The Iowa MCH Advisory Council also provided public comment via the IDPH website for the needs assessment and the state performance measures. The Council members represent a wide spectrum of providers, consumers, parents, and policy makers that are concerned about MCH issues. This input was provided prior to their June 16, 2010 meeting, and the council endorsed the state plan subsequent to that meeting via electronic vote.

Local MCH contract agencies provided input on the needs assessment, Title V priorities and the performance measures. See "Iowa 2015" for a complete description.

/2012/IDPH, in order to continually improve its services, establishes mechanisms to identify and clarify issues, strategize changes, and build improvements. One of these mechanisms IDPH

utilizes listening posts. A listening post is a deliberately planned opportunity for state program administrators to hear about the experiences of local program contractors and participants. In 2011, the Title V listening post was held to address MCH programming, including Oral Health. Services to communities are delivered through contracts with local MCH providers. The purpose for this meeting was to facilitate dialog to identify issues and concerns and to develop a set of group recommendations for action. This facilitated listening post had a workshop question: "Over the next five years, to better serve the needs of Iowa's MCH population, what must the IDPH and Local Contractors do?" The participants of the Title V Listening Post developed six recommendations to plan and implement process improvements:

1. Strengthen collaboration between contract holders and the Iowa Department of Public Health to evaluate and build a best practice consultation system that serves the needs of both. Create an effective two-way communication plan.
2. Create opportunities for provider collaboration. Grant holders are in a position to support and assist each other, as well as create program efficiencies, by sharing best practices and tools.
3. Access to data from multiple sources is difficult for local providers to find/access/identify, yet is required for programs across IDPH. The Department should work with local agencies and other partners in development of an integrated and user friendly web resource for necessary data.
4. Define, improve and streamline maternal child health services. Identify child health services and opportunities for quality improvements.
5. Evaluate and simplify the application process. Focus on the expected outcomes and identify changes to simplify and minimize the RFA process.
6. Fiscal support is critical as is timely payments for services. Delayed and time consuming resubmissions serve to increase local costs and create fiscal burdens for the agency.

A listening post with Bureau of Family Health staff will also be conducted in early August to gather input from staff on ways to improve state and local maternal health infrastructure. The Division Director and leadership staff from IDPH will be working on addressing recommendations from both groups in order to improve maternal and child health in Iowa.

Through the work of the MIECHV grant, staff conducted a series of five community forums in the selected targeted communities. The purpose of the community forums was to gather input from community members regarding their perspectives on the strengths and challenges present in their communities. Although the main function of the community forums was to help determine which evidence-based home visitation model the state would select for the MIECHV program, staff and participants discussed that status of programs for pregnant women and young children in the communities. Over 100 of community members and 25 families attended the forums.

IDPH also utilized a website to post the reports for the NPMs and SPMs. During the two week period established for public comment, over 330 hits were made to the Title V Public Input website. MCH stakeholders and interested public provided feedback on Iowa's proposed activities and performance measures via email and telephone. Iowa's Title V coordinator received 30 responses, offering support and providing suggestions to enhance the proposed activities. Feedback was reviewed and incorporated into the Title V application, as applicable. Several individuals requested that IDPH add more information on STI, specifically Gonorrhea and Chlamydia. Information was added into SPM #3 about how agencies address STIs in relation to the reproductive life plan. IDPH also received comments related to NPM #16 and how Iowa and local communities are addressing bullying/suicide. Information was added to this performance measure related to Iowa's Safe School legislation and a Department of Education initiative, Iowa Safe and Supportive Schools.

The Iowa Maternal and Child Health Advisory Council provided public comment both during the public comment period and during their June 9, 2011 meeting. The MCH Advisory Council endorsed the state plan through an electronic vote following the June meeting. The Council also regularly discusses Title V activities and emerging issues during their quarterly meetings. A list of MCH Advisory Council members is included in the attachment.//2012//

/2013/The IDPH used different methods to gain input related to MCH programming throughout FFY12.

In February 2012, the IDPH held a Listening Post for BFH staff members to identify issues and concerns at the state and local level and to develop a plan for addressing concerns. Through a consensus workshop with an outside facilitator, three priorities were identified and strategies were developed to improve the state and local infrastructure for MCH programs. The three priorities aligned with the Local Contractor Listening Post priorities identified in February 2011. Over the next year, state and local MCH staff will work on the following areas: 1) MCH consultation, 2) communication between the IDPH and local MCH agencies, and 3) core MCH services. A data integration workgroup will be added in 2013.

ECI hosted a parent summit in March 2012. A total of 52 parents attended and 22 signed up to be involved in next steps towards forming a parent council. Nearly half of the participants were from outside of central Iowa suggesting a truly statewide representation.

The consensus among parent summit organizers and facilitators was that the summit attracted a good turnout of very enthusiastic and engaged parents, and generated a sizable subgroup for follow-up. Planning committee members and summit partners who attended said that the summit was effective in empowering parents to assume more input regarding the services they use and value by inserting their voices into the process. The eleven primary issues raised by attendees were:

1. Improving WIC Services
2. Outreach and navigating the system
3. Child care reform: focus on quality
4. Government efficiency & customer service
5. Universal screening across programs and services
6. Child Care assistance, access and affordability
7. Transportation
8. Localized services (not regionalized)
9. Health and oral health
10. Parent involvement and engagement
11. Parent support, empowerment and education

Follow-up plans include a series of meetings with parents interested in pursuing these issues, hosting regional summits around the state and drafting a formal report. The IDPH intends to utilize the ECI Parent Council as an avenue to gain a parent perspective as it relates to MCH services.

IDPH utilized the IDPH website to post the reports for the NPMs and SPMs. During the two week period established for public comment, over 300 hits were made to the Title V Public Input website. MCH stakeholders and interested public provided feedback on Iowa's state priorities, proposed activities, and performance measures through an online survey. Iowa's Title V coordinator received 90 responses, offering support and providing suggestions to enhance the proposed activities. Feedback was reviewed and incorporated into the Title V application, as applicable. Several stakeholders shared the importance of supporting Child Care Nurse Consultants in relation to SPM #8, related to unintentional injuries. Other comments were related to parent awareness about services available for both child health services and those to children and youth with special health care needs. Overall, reviewers felt the activities were very thorough and addressed the NPMs and SPMs.

The Iowa MCH Advisory Council provided public comment during the public comment period and their March 2012 meeting. The Council endorsed the state plan at their June 2012 meeting. The Council also regularly discusses Title V activities and emerging issues during their quarterly meetings. A list of MCH Advisory Council members is included in the attachment.//2013//

/2014/During FFY13, the Iowa MCH Advisory Council provided input into the proposed goals and activities during their March 2013 meeting and also during the public comment period. The Council endorsed the proposed application in June 2013 through a virtual meeting and follow-up survey. A list of current MCH Advisory Council members is included in the attachment.

Iowa continued to utilize the IDPH website to post the NPMs and SPMs. IDPH allowed a two week period for interested MCH stakeholders and community partners to provide feedback on Iowa's state priorities, proposed activities and performance measures through an online survey. Along with email notifications to targeted groups, Title V staff used the IDPH Twitter account and several IDPH Facebook pages (I-Smile, WIC, and Preventing Iowa Youth Addiction) to advertise the public comment period.

During the public comment period, 75 individuals completed the online feedback survey. Nearly three-quarters of those that completed the survey supported the Title V plan, and offered no comments or questions. Many comments indicated the need for more family involvement in child health services and services for children and youth with special health care needs. Some respondents shared the need for better community collaboration among Title V agencies and other community resources. Overall, the public comment was favorable for the proposed activities.

IDPH is in the process of conducting focus groups with Title V clients to understand their experiences with care coordination, its benefits, and any gaps that exist in the services they have received. This information will help to support programs in effectively meeting the needs of clients, and provide an evidence base for care coordination as a community utility.//2014//

/2015/During FFY14, the Iowa MCH Advisory Council provided input into the proposed goals and activities during their June 2014 meeting and also during the public comment period. The Council endorsed the proposed application during the June 2014 meeting and follow-up survey for those who did not attend. A list of current MCH Advisory Council members is included in the attachment.

Iowa continued to utilize the IDPH website to post the NPMs and SPMs. IDPH allowed a two week period for interested MCH stakeholders and community partners to provide feedback on Iowa's state priorities, proposed activities and performance measures through an online survey. Along with email notifications to targeted groups, Title V staff used several IDPH Facebook pages to advertise the public comment period.

During the public comment period, there were 170 clicks on the website link advertising public comment. Forty-two individuals completed the online feedback survey. Nearly all of those that completed the survey supported the Title V plan, and offered few comments and/or questions. The comments that were received indicated the need for better community collaboration among Title V agencies and other community resources. Collaboration between MCH agencies and other community resources will be a focus over the next year. Overall, the public comment was favorable for the proposed activities.//2015//

An attachment is included in this section. IE - Public Input

II. Needs Assessment

In application year 2015, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

A. Any changes in the population strengths and needs in the State priorities since the last Block Grant application:

No update.

B. Any changes in the State MCH program or system capacity in those State priorities since the last Block Grant application:

1st Five Healthy Development:

During the 2014 Legislative session, IDPH received a \$300,000 increase for the 1st Five initiative. This funding is being used to move four community planning sites to implementation. 1st Five currently covers 49 of Iowa's 99 counties. The purpose of the program is to promote developmental surveillance and screening in the primary care office, using MCH agencies as a one-stop referral system for any developmental, family stress, or caregiver depression concerns.

Enhanced Care Coordination Screening Tool:

Over the past several years, Iowa has been trying to distinguish those families who may benefit from enhanced care coordination and monitoring services, provided by entities with medical expertise, such as Child Health Specialty Clinics (CHSC) from those that receive care coordination through the MCH program.

One suggested method for determining whether a child would be better served by the Title V CSHCN program is a combination of the CAHMI screening tool with an added measure of social or family circumstances, and an additional screen for children born before 37 weeks, or were drug exposed prenatally, or who are in the foster care system. The CAHMI screening tool has been validated for measurement of medical complexity.

The CAHMI screener utilizes consequences-based criteria to determine if a child has special health care needs. It broadly defines special health care need and is not condition specific. There is evidence that using algorithms to score the screening tool, children with more complex needs can be identified. There are 4 scenarios determined by CAHMI that meaningfully discriminate among CSHCN. The two algorithms listed here are the most appropriate of the 4 to meet the Iowa Title V need. The screening tool uses 5 basic concepts. Children, who meet any one of the criteria for a CONDITION that is expected to last AT LEAST 12 Months, are considered CSHCN:

1. Need or use medicine prescribed by a doctor
2. Need or use more medical care, mental health or educational services than is usual for most children of the same age
3. Limited or prevented in any way in his or her ability to do the things most children of the same age can do
4. Need or get special therapy, such as physical, occupational or speech therapy
5. Any kind of emotional, developmental or behavioral problem for which he or she needs or gets treatment or counseling

Because this tool was designed to identify special medical care needs only, it does not incorporate any of the social and family circumstances that might also lead a family to need enhanced care coordination or monitoring, an additional question has been added. The Iowa Enhanced Care Coordination Tool is a 6-item tool, designed to be completed by agencies or

providers. It follows two validated algorithms presented by the CAHMI medical complexity document. The tool is included in the attachment.

C. A brief description of any activities undertaken to operationalize the 5-Year Statewide Needs Assessment, such as 1) ensuring that the State addresses the findings and recommendations resulting from the Needs Assessment, 2) monitoring of timelines of the action plans, 3) reporting by a designated person or group responsible for accountability, and 4) linking the Needs Assessment process back into State program planning:

FFY16 Needs Assessment Process:

Iowa has developed a conceptual framework to implement the Title V 5-year Needs Assessment. This framework is broken into four areas/phases: assessing the population needs, assessing capacity (local and State) to address the identified needs, matching capacity to needs, and, finally, setting priorities for the state action plan.

Assessing Needs: Iowa is using both quantitative and qualitative methods to assess the MCH population needs. This includes a review of available data sources at the national and state levels. Staff are looking specifically for past performance in meeting national and state performance measures, progress towards Healthy People 2020 goals and various stratification to see where there are unmet needs.

To ensure that Iowa is in line with the newest Title V guidance, a crosswalk of the proposed straw measures, the current national and state performance measures and the Life Course Metrics was completed. This crosswalk is guiding the development of the broad topic areas for Iowa's data detail sheets, which will be used as a springboard for stakeholder input and priority setting. Each data detail sheet will include the following sections: Background; Health and/or Cost Impact; Relevant Data; What is being done in Iowa?; and Proposed Priority statements.

Focus groups are being conducted with clients from Iowa's MCH agencies throughout the state. Information obtained through the focus groups will be combined with the quantitative data into the DDSs to provide a more client focused perspective.

Assessing Capacity: Staff will be looking at capacity in the context of the MCH pyramid and how that relates to key measures of Accessibility, Quality, Affordability and Integration. Measures may change once the final Title V guidance is available. However, these are the 3 areas that were highlighted in the past.

IDPH and CHSC will be looking at capacity in terms of the organizational structure, workforce development and current capacity, as well as operational capacity (i.e. partnerships, resource availability, cultural competency).

Matching Needs to Capacity: In matching Iowa's needs to its capacity, staff will be determining Iowa's strengths and weaknesses, while determining the relative need to our current capacity. After completing the inventory, need and capacity will be ranked capacity according to: High Need/High Capacity, Low Need/High Capacity, High Need/Low Capacity, Low Need/Low Capacity.

Setting Priorities: The last step in the framework is to set Iowa's priorities for the upcoming 5-years. The data detail sheets will help to give stakeholders context for the situation and determine areas for prioritization. Criteria for setting priorities are being examined, as are methods for obtaining stakeholder input into the prioritization process.

D. A brief description of ongoing activities to gather information from a community and to evaluate implementation of the 5-Year Statewide Needs Assessment:

MCH Focus Groups:

The Iowa Department of Public Health is conducting focus groups to assess the quality of our care coordination activities in MCH programs. Specifically, we want to know, "How are we doing? What can we do to improve?" We are not assessing individual agency quality or practices, but rather, hope to create a state-wide snapshot of Care Coordination in our programs.

These data will be used to understand best practices for MCH programs in Iowa, as well as how MCH can be improved. IDPH is creating a best practices guide for MCH care coordination, as well as creating on-line trainings. These focus groups will be used to inform both. Additionally, these focus groups will serve as a pilot for future client-based qualitative data collection, including the Title V needs assessment.

An attachment is included in this section. IIC - Needs Assessment Summary

III. State Overview

A. Overview

Key factors that provide context for the state's Maternal and Child Health (MCH) annual report and state plan are highlighted in this overview. This section briefly outlines Iowa's demographics, population changes, economic indicators and significant public initiatives. Major strategic planning efforts affecting development of program activities are also identified.

Iowa's Land

Most of Iowa is composed of rolling prairies, covered with some of the world's most fertile soil and lies between the high bluffs of the Mississippi and Missouri Rivers. Iowa is one of the country's most important and prosperous agriculture states, and is known as the breadbasket of the US. The deep black soil yields huge quantities of corn, soybeans, oats, hay, and wheat, which help support cattle and hog industries, and supplies the large food processing industry. Manufacturing, especially agribusiness, is a large source of income for Iowans.

Changes in Demography

Iowa is a rural state with approximately 3.06 million people by 2011 estimates. With the continuing shift from rural areas to urban areas, more than half of Iowa's 99 counties are expected to decrease in population. However, Iowa's overall population increased by 2.6% from 2000 to 2009.

The state is 91% white; however, racial and cultural diversity is increasing. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 2.8% in 2000 to 5.0% in 2010. In 2000, live births to Hispanic women made up 5.6% of all births, double the population proportion in the same year. This ratio continued in 2008 (8.2% vs. 4.2%). Approximately 240,041 children are ages five and under and make up about 8.0% of the total population. Of the children between the ages of 0 -5, 8.9% are of Hispanic origin. There is another estimated 8.9% of children who have a special health care need. Children ages 19 and under had a higher rate of poverty (22.3%) than the general population (16.5%) in 2007.

The U.S. Census Bureau's 2008 American Community Survey shows that the percentage of Iowa's population that is Hispanic and/or Nonwhite is 17% in children ages 0 to 4, 15% in children ages 5 to 17, 9% in those 18-64 and 3% among those 65 and older.

Even with the influx of new citizens, Iowa's total population is projected to experience only modest growth between now and 2015. While the overall population remains stable, the minority populations are expected to grow in both absolute numbers and total proportion of the population.

Other key demographic data that paint the picture of Iowa includes 32% of families are single parent families, 14.2% of poor families have children, 17% of adults are without a high school diploma and 82.4% of 4th graders demonstrate reading at a proficient level.

//2013/The 2011 Census estimate results were released indicating each year Iowa's population is continuing to get more and more diverse. About 91% of the population is white and this number continues to decline each year. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 2.8% in 2000 to 5% in 2010. Iowa is a rural state with approximately 3.06 million people. Iowa's population continues to shift from rural areas to urban areas. More than half of Iowa's 99 counties are expected to lose population.//2013//

//2014/The 2012 Census estimates show that Iowa's population is approximately 3,074,186. The Hispanic population continues to grow at 5.2%.//2014//

/2015/The 2013 Census estimates show that Iowa's population is approximately 3,090,416.//2015//

Employment and Population

Changes in Iowa's unemployment rate has steadily increased since 2000. Iowa's seasonally adjusted unemployment rate was 6.8% in May 2010, one percentage point higher than May 2009 rate of 5.8%. The statewide estimate of unemployed workers dropped to 115,400 in May 2010 from 116,400 in April 2010. The number of unemployed persons stood at 96,200 a year ago.

The total number of working Iowans was 1,571,600 in May 2010, down from the previous year when it was 1,575,000.

/2012/Iowa's unemployment rate reached its highest point in the last 20 years in 2010 at 6.2%, representing approximately 102,600 individuals.//2012//

/2014/Iowa's unemployment rate dropped to 4.7%, the lowest point since 2008.//2014//

/2015/Iowa's unemployment rate has decreased to 4.3%.//2015//

Poverty

The 2008 data showed a decrease in the number of Iowa families living in poverty from 7.3% in 2006 to 6.1% in 2008. This is approximately 50,000 families defined as poor by the federal poverty level. In 2007, 13.3% of Iowa families with children ages 0 to 17 were living at or below the federal poverty level.

/2012/In 2010, 7.7% of families were living under the federal poverty level. At the same time, the percentage was higher for families with children; 15.9% for families with children less than 18 years old and 27.8% for families with children under the age of five.//2012//

FOCUSED STRATEGIC PLANS:

Early Childhood Iowa

Community Empowerment was created through legislation in 1998. The purpose of the legislation was to establish local community collaborations, create a partnership between communities and state government and improve the well-being of children 0 to 5 years of age and their families. Community Empowerment areas were designated to cover all 99 counties directly influencing community-based MCH services in Iowa.

The Early Childhood Comprehensive System initiative, Early Childhood Iowa (ECI), was established in 2003. ECI partners with the Iowa Department of Management's Office of Empowerment at the state and local level to improve and enhance the early childhood system including coordination and integration. The ECI Council of Stakeholders and six component workgroups developed and implemented various aspects of the early childhood system. ECI also focuses on building public and private stakeholder partnerships and relationships. After several years of working with policy makers, state departments and early childhood stakeholders, ECI was codified within the administrative rules in May 2009. The process was completed with input from the ECI Council and the six workgroups. The ECI governance structure was placed within the Department of Public Health.

Current economic conditions pushed recent legislative sessions to more thoroughly and intentionally look at efficiencies and accountability in state government. Community Empowerment often became a focal point in conversations during legislative discussions

regarding the efficiencies and effectiveness of Community Empowerment, both at a state and local level. In June 2009, the Department of Management's Office of Empowerment hosted a LEAN event to give leaders in early childhood the opportunity to reflect and build on what works in Iowa, while developing new models and strategies based on the latest early childhood research.

A diverse representation of state and local early childhood stakeholders came together for a week long process to identify first steps in improving the effectiveness and efficiency of the Early Childhood system. Four priority areas were identified and action plans were developed as follows:

1. Levels of Excellence
2. Regionalization and Re-define Empowerment Areas
3. State Structure
4. Marketing

Legislation passed in March 2010 combines the work of ECI and Community Empowerment and institutionalizes system building efforts within the Department of Management, effective July 1, 2010. The structure at the local and state level was named ECI. The Department of Management - Office of Early Childhood leads system level activities in partnership with state agencies and private stakeholders. There will continue to be an ECI Board, Early Childhood Stakeholder Alliance, six component workgroups and an Early Childhood Technical Assistance (TA) Team.

/2012/IDPH staff members are involved in all levels of the new ECI structure. A planning retreat was held in March 2011 to discuss the state-level structure of ECI and the relationship between the state and local structures (formerly Community Empowerment). The ECI TA Team developed the new Levels of Excellence rating system for local ECI areas and the criteria went into effect July 1, 2011. The ECI TA Team also assists local boards in their discussions around merging/regionalizing. //2012//

Over the past three years, cultural competency has been a priority for ECI. ECI hosted a diversity symposium and retreat in 2007 and 2008. As a result of these initiatives, a Diversity Workgroup was formed and a workplan was developed. The Diversity workgroup and several ad hoc workgroups were formed around specific areas of the workplan and have provided direction for addressing cultural competency.

/2014/IDPH in collaboration with ECI applied for the ECCS funds with a focus on developmental screenings through 1st Five and child care nurse consultants.//2014//

/2015/ECI is now in the third cycle of the Levels of Excellence process. This process is to measure the effectiveness and quality of the local boards and programs. ECI is working to focus efforts on high risk/high needs children.//2015//

Project LAUNCH

Fragmented systems, inadequate resources, lack of understanding and lack of accountability contribute to Iowa's failures to meet the mental health needs of Iowa's youngest citizens and their families. Iowa's Project LAUNCH seeks to develop the necessary infrastructure and system integration to assure that Iowa children are thriving in safe, supportive environments and entering school ready to learn and able to succeed. Iowa's Project LAUNCH targets children ages zero to eight and their families in a seven- zip code area of inner city Des Moines with a focus on low-income and minority populations who are traditionally underserved. The purpose of Iowa LAUNCH is to develop a sustainable, systemic community-approach to promoting social, emotional and behavioral health for young children and their families. Overall project goals are to: 1) Build state and local infrastructure to increase the capacity and integration of the children's mental health system into a comprehensive early childhood system of care to promote positive development for Polk County children ages zero to eight and their families; 2) Deliver family-centered, fully integrated evidenced-based services for children living in a targeted community at-

risk for poor social-emotional outcomes, and 3) Promote sustainability and statewide spread of best practices for system development. A state and local Project LAUNCH Strategic Plan was finalized in May 2010.

/2012/Project LAUNCH is in year two of a five year project with full implementation of the five direct service components. 1) Family Support - Nurse Family Partnership; 2) Parent Education - Positive Behavior and Intervention Support Case Management; 3) Developmental Screening - Ages and Stages and Ages and Stages - Social and Emotional; 4) Integration of Behavioral Health into Primary Care- 1st Five and Birth to Five Medical Home; and 5) Mental Health Consultation - School Mental Health Consultants. The State LAUNCH Council developed five workgroups: Health and Wellness, Family Support, Early Childhood Mental Health Consultation and Policy and Advocacy. A LAUNCH Interagency Coordinating Committee was developed to bring together Division Directors of early childhood programs and business leaders to implement recommendations from the state council through policy and program changes. The workgroups and Interagency Committee addressed activities from the Project LAUNCH Strategic Plan. Project LAUNCH is also involved in the state redesign of mental health in Iowa. There is a workgroup addressing the children's mental health system on which members of the Project LAUNCH council will serve.//2012//

/2013/Over the past year, VNS provided services to 116 families and 84 children participating in the Nurse-Family Partnership and Case Management/Positive Behaviors Interventions Support (PBIS) programs combined. A total of 1,027 home visits were completed, with an average of nine home visits per family. An additional 1,315 children were served through mental health consultation and training services.//2013//

/2014/Project LAUNCH is sustaining its work beyond the grant period by seeking additional funds, sharing best practices, advocating for policy change and strengthening workforce. A professional association was formed to support professional competence in children's social and emotional health.//2014//

/2015/Project LAUNCH continues to focus on professional development for children's social/emotional wellbeing by strengthening Iowa's infant mental health association. Efforts include identification of professional competencies, access to training, development of materials and creating awareness on the impact of childhood trauma.//2015//

Project Connect

Funded by the Office on Women's Health of the U.S. DHHS in conjunction with the Family Violence Prevention Fund, Project Connect is a two-year violence prevention initiative designed to find new ways to identify, respond to and prevent domestic and sexual violence, while promoting an improved public health response to abuse. Selected Project Connect grantees work with family planning, adolescent health, home visitation and other MCH and perinatal programs to develop policies and public health responses to domestic and sexual violence. Project Connect also supports the creation of continuing medical education materials designed to reach thousands of providers and health professional students. The project uses a Web-based platform to educate and promote clinical skills for medical and nursing students and providers. Participants receive continuing education credits while learning to assess, identify and provide support and intervention with victims of violence in a variety of health settings.

/2012/ In December of 2010, Iowa's first training on intimate partner violence and reproductive coercion (IPV/RC) was provided. Those in attendance were from maternal health, family planning and other sexual health disciplines. Comments from the training participants show the impact that these trainings made just one month later: "Just a simple question can start a conversation about healthy relationships." "I didn't know a lot of things about my client until I asked." "I was comfortable asking because I had resources to share and knew who I could call if the client

needed more help than I could give." Iowa has provided training to over 250 public health professionals.

In addition to provider training, there are five Project Connect pilot sites that are working to improve screening, professional and client education, supported referrals in relation to IPV/RC and linking public health services to women in shelters. Each site is in varying degrees of readiness.

1. MATURA Action Inc. is a maternal health agency that serves 10 counties in northwestern and southwestern Iowa. These counties are largely rural. MATURA works with clients to provide help in finding a medical home; prenatal and postpartum health education; transportation to medical visits; education about lifestyle decisions to improve pregnancy outcomes; breastfeeding education and support; psychosocial assessment including screening for perinatal depression; nutrition assessment and education; oral health assessment and help in finding a dentist to provide a regular source of oral health care; postpartum home visits by registered nurses to assess the health of both new mothers and their babies; family needs assessment and referral to community resources to help the family; and referral to family planning and child health agencies after delivery to support the family's ongoing health care needs.

2. Allen Memorial Hospital Women's Health Center is both a family planning service provider and maternal health agency located in northeastern Iowa serving a ten county area. Their maternal health services are similar to those listed for MATURA in addition to their family planning component. Allen is actively engaged in providing training for their hospital and clinic staff on the issues of DV/SA/RC. In April 2011, Allen provided training for all staff as well as community members.

3. Family Planning Council of Iowa sites (Hillcrest and Southeast Iowa) are also engaged in staff training and screening and protocol development. The Planned Parenthood of Southeast Iowa (PPSI) developed an excellent relationship with their local IPV shelter. PPSI has now made emergency contraception immediately available when needed for women in the shelter. PPSI has also provided basic training to shelter staff pertaining to emergency contraception and health.

4. Black Hawk County Health Department is Iowa's pilot site for integration of the STI program with DV/SA/RC. They have trained staff and are actively engaged in screening. Black Hawk has made extensive changes in their protocols and screening instruments and has developed screening questions which reflect the nature of the client's visit and needs. //2012//

//2013//Project Connect trained over 300 professionals in home visitation and family planning over the last year. Iowa also increased its reach to adolescent populations by conducting a sticker shock campaign in collaboration with family planning and domestic violence coalitions. The campaign distributed over 2,500 stickers pertaining to RC with the message, "Ask first. Respect the Answer." This message was strategically placed by youth on condom boxes during condom week to raise public awareness.

Five new pilot sites were added to improve screening, professional and client education, supported referrals in relation to IPV/RC, and linking public health services to women in shelters.//2013//

//2015//IDPH continued involvement with Project Connect as a consultant to states selected for Project Connect 2.0. 2014 activities:

- ***Hosting an Adolescent Health Conference on adolescent relationship abuse (80 participants)***
- ***Continuing to train home visitors on responding to domestic violence and providing safety cards to women seen in STD/HIV clinics***
- ***Training all Title V providers on how to screen, educate and refer for domestic violence (75 participants)//2015//***

Modernization of Public Health in Iowa

Public Health Modernization is a joint initiative of IDPH and local public health providers. Ongoing

since 2004 Public Health Modernization has achieved several milestones. In December 2007, the Iowa Public Health Standards were published after nearly two years of development. The first category of standards deals with public health infrastructure and includes criteria in the areas of governance, administration, communication and information technology, workforce, community assessment and planning and evaluation. The second category describes public health services provided including; preventing epidemics and the spread of disease, protecting against environmental hazards, preventing injuries, promoting healthy behaviors and preparing responses to and preparing for, responding to and recovering from public health emergencies.

In 2009 the Public Health Modernization Act was signed into law by the Governor of Iowa. The act called for the formation of a voluntary accreditation program for Iowa's local and state public health departments. Additionally, the law called for the formation of two advisory bodies to steer the Modernization initiative and make recommendations to the state board of health about accreditation and the Iowa Public Health Standards. The Public Health Advisory Council is responsible for identifying an accrediting entity for the state of Iowa, and for the review and revision of the Iowa Public Health Standards. The Public Health Evaluation Committee has responsibility for evaluating the public health system and the affect of the Iowa Public Health Standards. In 2010, further laws were passed updating Chapters 136 and 137 of the Iowa Code. These sections describe the roles and responsibilities of the state board of health and local boards of health, respectively. Both chapters were updated to align with the Public Health Modernization Act and the Iowa Public Health Standards. Finally, in 2010, Iowa was selected as a Beta test site for the Public Health Accreditation Board's pilot of the national accreditation system. Iowa was one of eight state health departments selected to participate. As part of the process, IDPH prepared for accreditation and began implementing quality improvement processes to address gaps in its ability to meet the standards and to improve work that already meets the standards.

//2012//In 2011, the Public Health Advisory Council will publish a revised version of the Iowa Public Health Standards that will be piloted by two counties testing the Iowa Accreditation Process. At the same time, the Public Health Evaluation Committee will conduct a survey of Iowa's governmental public health system so as to have an accurate baseline prior to the full scale implementation of the Iowa Accreditation Process and quality improvement processes. It is anticipated that the formal Iowa Public Health Accreditation Process will begin in 2012.//2012//

//2013//In 2012, the pilot of the Iowa Accreditation Process was completed. As a result of the pilot, subcommittees will address metrics and the accreditation process. A report detailing the results of the pilot was released to local public health partners. The Public Health Evaluation Committee's baseline of the governmental public health system (local and state) was completed. Findings describe strengths and weaknesses in Iowa's local and state public health infrastructure and service delivery. //2013//

//2014//The State Board of Health adopted the Iowa Public Health Standards with metrics. The standards will be in place until 2014, when changes may need to be made to align with the Public Health Accreditation Board's standards. IDPH is developing communication about meeting the standards and the relationship of standards to quality improvement.//2014//

//2015//Iowa is considering adopting the Public Health Accreditation Board (PHAB) standards for Iowa's governmental public health system. Public comments about the shift away from an Iowa based accreditation system and standards are being accepted through the Summer 2014. If Iowa adopts the PHAB standards, changes to the Public Health Modernization Act will need to occur.//2015//

Local MCH Agencies

Local maternal health and child health programs promote the development of community-based systems of preventive health care for pregnant women, children ages 0 through 21 and their

families. Goals of the MCH programs are to:

1. Promote the health of mothers and children by ensuring access to quality maternal (MH) and child health (CH) preventive health services (including oral health care), especially for low-income families or families with limited availability of health services
2. Reduce infant mortality and the incidence of preventable diseases and disabling conditions
3. Increase the number of children appropriately immunized against disease.

Local MCH contract agencies are charged with developing MCH programs that are responsive to the needs of the community. Contractors for the FFY 2011-2015 project period were selected through a competitive request for proposals (RFP) process. More information on local MCH agencies can be found in Section B: Agency Capacity.

/2012/Maternal, Infant, Early Childhood Evidence Based Home Visitation (MIECHV)

As part of the Federal Health Care Reform bill an appropriation is being made to states to implement evidence-based models of family support to targeted families in at-risk communities. Iowa completed all three steps of the application process by preparing an initial state plan, a comprehensive needs assessment and a final updated state plan. The state plan has identified two areas for program implementation: Black Hawk County and Appanoose and Wapello Counties.

IDPH issued an RFP to implement evidence-based home visitation program at the local level. The RFP solicited proposals that will enable the IDPH to select the most qualified applicant to provide Maternal, Infant and Early Childhood evidence-based home visitation services to at-risk young children to improve their health and development.

The program is designed to: 1) Strengthen and improve the programs and activities carried out under Title V and other community service providers; 2) Improve coordination of services for at-risk communities; and 3) Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

The state plans to implement or expand evidence-based home visiting models in two communities in Iowa. IDPH selected Black Hawk County as it is an urban community. The state intends to expand the home-based Early Head Start program and the Healthy Families Iowa program in Black Hawk County. The rural community that has been selected is a consortium of Appanoose and Wapello Counties to implement a Healthy Families Iowa program.

Iowa submitted an application for competitive MIECHV funds on July 1, 2011. Iowa proposed a two pronged approach in the expansion grant proposal. One prong will be the expansion of evidence-based home visitation in the remaining top 15 at-risk communities identified in our MIECHV Needs Assessment. The second prong will be aimed at enhancing the quality of existing infrastructure to support home visitation across the state.

Specifically IDPH proposed the following activities as part of the MIECHV competitive grant:

1. Expand Healthy Families America and home-based Early Head Start programming in targeted at-risk communities.
2. Develop and implement a statewide centralized intake system for family support programming including Iowa's Part C program that also includes transition and transfer services within and outside of the state.
3. Develop a required state certification system for all family support practitioners.
4. Explore innovative practices used in the medical field to bring specialized services to rural areas for applicability to the family support field, such as tele-health services. Specialized services include domestic violence, mental health and substance abuse counseling in addition to consultation services to home visitors from these professionals.
5. Complete an in-depth workforce study and create an action plan to address workforce

issues such as recruitment of a more ethnically diverse workforce and specialized tracks to increase worker competency in fields such as substance abuse, mental health and domestic violence.

6. Utilize the work of the marketing industry (the "q" rating or score) to complete a study of the personal attributes that families look for in-home visitors that cause them to stay engaged in the program. Create screening tools that will enable employing organizations to hire staff with personal attributes that will assist families in relating to the worker and will decrease drop-out rates.

7. Use social media to create a virtual home visitor program that will broaden the reach of home visiting services to include extended family members and other families not enrolled in a home visiting program.

With the expansion funds through the MIECHV competitive application, programs will target eligible families with children ages 0 to 5 residing in the targeted at-risk counties of: Buena Vista, Cerro Gordo, Clinton, Des Moines, Hamilton, Jefferson, Lee, Marshall, Montgomery, Muscatine, Page, Pottawattamie, Scott, Webster and Woodbury.

/2013/Iowa received a 20% increase in its MIECHV formula funding for the 2011 program year. The increase in formula funds allowed IDPH to expand the MIECHV program to Lee County for the Healthy Families program. IDPH issued a RFP to solicit the most qualified applicant to serve Lee County.

In March, Iowa received the competitive MIECHV expansion funds and IDPH is in the process of expanding evidence-based home visiting to the remaining top at-risk communities. This will allow the state to serve approximately 371 additional young children. The state will be able to serve approximately 4% of the families with children aged 0 -- 5 in the at-risk communities using MIECHV and existing funds.

In addition to these activities, IDPH will continue the following activities in collaboration with ECI:

1. The Iowa Family Support Credentialing (IFSC) Program. The IFSC supports the continuous quality improvement of family support programs that either do not follow a prescribed model, or programs that follow a prescribed model but the model developer does not provide an onsite review to ensure that the program is maintaining fidelity. Programs must demonstrate adherence to a set of basic standards in both practice and policy.

2. Alignment of reporting requirements across funding streams to increase the use of blended funding.

During the 2012 Iowa legislative session, the Iowa Home Visiting Campaign was signed into law. The Iowa Home Visiting Campaign has a goal of ensuring state general funds used to fund home visiting and family support programs are expended on programs that are "promising" or "evidenced-based" programs. This will ensure that scarce state resources are used for their highest and best purposes.

This goal will be accomplished by July 1, 2016, and will be phased in:

- By July 1, 2013, 25% of the funds expended for family support services are for promising or evidenced-based program models.
- By July 1, 2014, 50% of the funds expended for family support services are for promising or evidenced-based program models.
- By July 1, 2015, 75% of the funds expended for family support services are for promising or evidenced-based p models.
- By July 1, 2016, 90% of the funds expended for family support services are for promising or evidence-based practice models.
- The remaining 10% of funds may be used for innovative program models that do not yet meet the definition of promising or evidence-based programs.

Along with a greater understanding of home visiting services is an increased awareness of the

importance of investing our very limited tax dollars in programs that have proven to be effective. For the last three years we have collected uniform data measures across all program models. We have attempted to teach local decision makers how to use that data to dig deeper and find out more about the effectiveness of the programs they were funding.//2013//

/2014/Iowa continues to support the efforts of programs that have implemented or expanded evidence-based models of family support in the 18 targeted communities. Many of the state infrastructure building activities are well under way and the goals set forth by the 2012 Iowa Legislature are also on track for being met. One of the biggest endeavors over the past year has been the alignment of reporting requirements across funding streams to increase the use of blended funding. A family support data collection system was developed and piloted over the past year with a full roll out of the system in July 2014.//2014//

/2015/The family support web-based data collection system is fully operational but has not been without challenges. It has been a very difficult transition to learn a new system for many family support workers. Some infrastructure building projects are nearing completion while others are slated to be completed by September 30, 2016. Iowa has also noted some difficulty with reaching and maintaining full capacity in our Healthy Families America (HFA) model programs. The HFA model does have a very narrow window in which families may be enrolled. IDPH is exploring adding another home visiting model where HFA has been implemented so we can serve high risk families that missed the window to enroll in HFA.

Iowa continues efforts for all home visiting programs to be promising or evidence-based program models. The goal of 75% by July 1, 2015 is well on its way of being met by the MIECHV grantees in the state.//2015//

Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP)

In 2010 and 2011, Iowa's 99 counties successfully completed a comprehensive analysis of their community health needs, prioritized which needs would be included in a health improvement plan, and submitted this information to the Iowa Department of Public Health (IDPH). This process known as the Community Health Needs Assessment and Health Improvement Plan (CHNA & HIP), has more than a 20 year history and is a vital component of public health in Iowa. The CHNA & HIP process serves as a foundation for health planning in the state and subsequently, IDPH's ability to improve the health of Iowans.

IDPH enhanced the CHNA & HIP process this year by offering a more streamlined process and additional technical assistance. The 2010-2011 CHNA & HIP marks the first time a comprehensive analysis has been done of all the county needs assessments at IDPH. The goal of this analysis and report on the needs assessments is to provide a basis for understanding what health needs are most critical in the state, what needs are emerging and what needs are not being addressed at the local level.

In this installment of CHNA & HIP, the counties identified 1,240 needs in total, with 497 of those needs are being addressed through health improvement plans. This leaves 60% of the identified needs unaddressed by local public health agencies and their community partners. Counties cited multiple reasons for not addressing needs; however, a lack of human and financial resources emerged as a common theme.

Categorizing the health needs identified in the needs assessments by Iowa's counties is a challenging task. Many health needs are interrelated and crossover the focus areas of public health, as well as IDPH programmatic efforts, making natural categorical boundaries difficult to define. To respond to this, the analysis uses multiple levels of categorization. The broadest layer is categorization by IDPH focus area. The six focus areas and their short titles are:

1. Promote Healthy Behaviors (Healthy Behaviors)

2. Prevent Injuries
3. Prepare for, Respond to, and Recover from Public Health Emergencies (Emergency
4. Response)
5. Protect Against Environmental Hazards (Environmental Hazards)
6. Prevent Epidemics and the Spread of Disease (Prevent Epidemics)
7. Strengthen the Public Health Infrastructure (Health Infrastructure)
8. Access to MCH/FP Services (Health Infrastructure)//2012//

SIGNIFICANT PUBLIC INITIATIVES:

Newborn Hearing Screening Program

Iowa's Early Hearing Detection and Intervention (EHDI) program is a collaborative effort of two projects, one funded by the Centers for Disease Control and Prevention (CDC) and one funded by the Health Resources and Services Administration (HRSA). The two projects work together to achieve a comprehensive and coordinated statewide EHDI system. The CDC project, which is administered by IDPH is housed at IDPH's Bureau of Family Health. Under Iowa legislation regarding Universal Newborn Hearing Screening, IDPH is designated as the entity responsible for the collection of hearing screening and diagnostic information. The HRSA project is administered by Child Health Specialty Clinics (CHSC), Iowa's Title V program for children with special health care needs. The CHSC EHDI project focuses on assuring that all infants and toddlers that are deaf or hard-of-hearing receive timely and appropriate follow-up services. The CHSC EHDI project also provides family support including the statewide Guide By Your Side Parent Network.

Iowa's EHDI program goals include the following:

1. Develop and sustain a comprehensive coordinated system of care for Early Hearing Detection and intervention in Iowa.
2. Provide technical assistance to birthing hospitals, area education agencies and private practice audiologists relative to the hearing screening program and their responsibility under the law.
3. Implement a statewide Web-based surveillance system to assure all Iowa newborns are screened for hearing loss and receive follow-up services as needed.
4. Facilitate data integration linkages with related screening, tracking and surveillance programs to minimize infants "lost to follow-up".
5. Meet the National EHDI Goal of 1-3-6.
 - a. All infants are screened for hearing loss before 1 month of age, preferably before hospital discharge.
 - b. All infants who do not pass the screening will have a diagnostic audiologic evaluation before 3 months of age.
 - c. All infants identified with a hearing loss receive appropriate early intervention services before 6 months of age.
6. Review data to identify children with potential for hearing loss to ensure those children receive appropriate, timely early intervention services.
7. Collaborate with Early ACCESS (IDEA, Part C) to strengthen early intervention services for children who are deaf or hard-of-hearing.
8. Ensure families with children zero to three who are deaf, hard-of-hearing, or at risk of late-onset hearing loss will be linked to a medical home and receive family-to-family support.
9. Implement program evaluation that incorporates both process and outcome objectives which drives system development and program improvement.

//2015/IDPH will be the lead agency for HRSA funding in 2014-2017. The partnerships that were in place will remain and CHSC agreed to work with IDPH to transition the grant smoothly in the first quarter of 2014. At that time, IDPH EHDI will also assume all of the day-to-day responsibilities of follow-up and family support activities previously conducted by CHSC.//2015//

Barriers to Prenatal Care

Currently, IDPH sponsors the Barriers to Prenatal Care project, a 50 question survey of new mothers before hospital discharge. The survey identifies behaviors and experiences (e.g., nutrition, stress, weight, smoking, etc.) before and during pregnancy, as well as the mother's plans for baby care upon arriving home (e.g. sleep position, breastfeeding, etc.). In 2008, the March of Dimes funded a pilot project of the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS). This allowed Iowa to conduct I-PRAMS, a follow-up phone survey with new mothers four months after delivery.

I-PRAMS

I-PRAMS will provide information about moms' well being after pregnancy and the families' access to newborn/well baby care, as well as the new mother's ability to follow through with their initial plans for baby care and if not, why. Survey participants were randomly selected from among all new mothers in Iowa. The total survey sample size for the pilot was 1,800 with an overall response of 1,233 (68.4%). Preliminary data results based on calendar year responses are expected by late July 2010. In the future, the adequacy of the available data sets will be investigated to determine future data needs for MCH surveillance.

/2012/IDPH completed the I-PRAMS pilot, which prepared Iowa to submit a well-written application for the CDC-sponsored PRAMS surveillance system. The Iowa PRAMS application was approved, but not recommended for funding at this time. In an analysis using I-PRAMS data, IDPH examined the level of agreement for smoking quit rates during pregnancy between the Iowa birth certificate (I-BC) data and that reported via I-PRAMS. Both data sources ask for the number of cigarettes smoked in the three months prior to pregnancy and during the third trimester. Known responses to these questions were divided into three categories: smokers, non-smokers and quitters. Using SAS version 9.2, IDPH estimated quit smoking prevalence, kappa statistics and agreement, both overall and by maternal characteristics (e.g. age, race, education, Medicaid status).

The overall Kappa for the smoking categories suggests substantial agreement. However, the agreement levels for quit rates were substantially lower than for other smoking categories which suggest poor agreement. Public Health Implications: The I-BC provides new smoking measures during pregnancy including quit rates. Given the low level of agreement between I-BC and I-PRAMS, Iowa's quit rates should be used with caution.//2012//

/2013/In September 2011, IDPH was awarded CDC funding to implement PRAMS with data collection slated to begin in September 2012. The purpose of PRAMS is to collect state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. The goal of PRAMS is to improve the health of mothers and infants by reducing adverse outcomes such as infant low birth weight, infant mortality and morbidity, and maternal morbidity. PRAMS provides state-specific data for planning and assessing health programs and for describing maternal experiences that may contribute to maternal and infant health. The annual PRAMS sample of 1,800 women who have had a recent live birth is drawn from Iowa's birth certificate file. Women from some groups are sampled at a higher rate to ensure adequate data are available for higher risk populations. Selected women are first contacted by mail. If there is no response to repeated mailings, women are contacted and interviewed by telephone. Data collection procedures and instruments are standardized to allow comparisons between states.

PRAMS and Barriers will complement each other by allowing for comparisons between intentions versus actual behaviors. There are also a number of opportunities to conduct validity and reliability analyses across the surveillance systems.//2013//

/2014/Iowa PRAMS began collecting data in February 2013 starting with mothers of babies who were born in November 2012. As of June 2013, 711 were contacted to complete the PRAMS survey. Of the 711 contacted, 262 exceeded the 90 day participation period and 52% completed

the survey either by mail or phone interview. Of the remaining participants, 449 are still within the 90 day participation.

A data needs assessment was carried out to determine priority data requests and common themes among IDPH programs and the PRAMS Steering Committee. Primary areas of interest were reported as breastfeeding, depression amongst mothers, participation in a home visitation program and relation to experience of depression and other social stressors. Once a complete data set is available, priority will be given to these areas for analyses. State and national performance measures have also been identified for reporting priorities.

PRAMS participated in several community events to increase awareness of the survey and its importance to the health of Iowa moms and babies. Press releases, newsletter contributions and interviews were also completed. In June 2013, a PRAMS flyer was sent with the official birth certificate received by all Iowa moms to further raise awareness. Other activities planned include outreach at local farmers markets and fairs, flyers for church bulletins and a Spanish language radio interview.

The PRAMS Steering Committee remains active with the addition of three new members. The annual meeting was held in March 2013. Recommendations were made for community outreach and methods for increasing response rates.//2014//

/2015/Iowa PRAMS continues data collection according to the CDC PRAMS protocol. As of June 2014, 1,540 women have been contacted to complete the PRAMS survey. Of these 1,540 women, 1,329 have exceeded the 90 day survey participation period. For the closed batches, the overall response rate is 67.1%. Of the 1,329 women who responded to the survey, 65% responded by mail, while the remaining 35% responded by phone (preliminary, unweighted figures).//2015//

Iowa Child and Family Household Health Survey (IHHS)

The IHHS is a comprehensive, statewide effort to evaluate the health status, access to health care and social environment of children of children and families in Iowa. The first IHHS was conducted in 2000 and the second in 2005. Planning is underway for the implementation of the 2010 survey in the fall. The IHHS serves as a foundation for Iowa's five year needs assessment.

The IHHS is a collaboration between IDPH, the University of Iowa Public Policy Center and the CHSC.

The primary goals of the IHHS were to: 1) Assess the health and well-being of children and families in Iowa; 2) Assess a set of early childhood issues; 3) Evaluate the health insurance coverage of children in Iowa and features of the uninsured; and 4) Assess the health and well-being of racial and ethnic minority children in Iowa.

/2012/Data collection for the 2010 Iowa IHHS is complete, including oversamples for a racial/ethnic minority report and a LAUNCH grant report. A statewide report will be published in CY2011 after the survey data are cleaned, weighted and analyzed. Various topic specific reports and white papers will follow. Analysis of the 2010 IHHS will include trend data comparing the current survey results with data from the 2000 and 2005 IHHS. These population-based surveys are funded by the Iowa SSDI grants and other grant initiatives within IDPH and provide a wealth of data about children and families in Iowa.//2012//

/2013/The statewide report of the 2010 IHHS was published in April 2012. Dissemination of the report is underway utilizing multiple venues to reach the widest audience of state and local program partners. A series of webinars will be offered to present information on the 2010 IHHS statewide report and sample methodology.

Progress is underway to complete the analysis and reporting for the 2010 Iowa Child and Family Household Health Survey. During FFY2012 and FFY2013, the IDPH will plan and fund four major reports on early childhood, home visiting, health insurance and racial/ethnic disparities. During the same time period, at least four policy briefs will be published. Planned topics for these briefs include oral health; medical home/health home; access and need; and physical activity, weight and eating habits.//2013//

/2014/Four 2010 IHHS webinars were presented during FFY14 that focused on the data and programs addressing identified needs:

- Statewide Data Overview(Sept 2012)
- Adolescent Health (Oct 2012)
- Oral Health (Dec 2012)
- Nutrition/Physical Activity (June 2013)//2014//

/2015/Four 2010 IHHS reports were released during FFY15:

- **Insurance Report**
- **Medical Home Report**
- **Health Disparities Report**
- **Methodology**

Webinars were presented for the Insurance, Medical Home and Health Disparities reports. These reports and webinars are published and presented to help the public have a readable format of how our state is doing in terms of health. These reports and webinars are also used by other agencies for needs assessments and other reports.//2015//

State Child Health Insurance Program

Iowa's Covering Kids and Families (CKF) project, sponsored in part by the Robert Wood Johnson Foundation and led by IDPH's Bureau of Family Health, guided development of Iowa's SCHIP program. Iowa's CKF coordinated outreach and enrollment strategies, policy recommendations and sustainability. In response to the federal initiative of State Children's Health Insurance Programs (SCHIP), the 1998 Iowa Acts, Chapter 1196, authorized health care coverage for specified uninsured children in Iowa. Legislation created a plan that expanded Medicaid eligibility to children whose family incomes were up to 133% of the federal poverty level. Iowa also chose to establish a separate private insurance plan for children with a family income between 133 and 200% of the poverty level; this program is called hawk-i .

As part of the coordinated Iowa CKF efforts, the Bureau of Family Health became the Iowa Department of Human Services (DHS) contractor providing state level hawk-i outreach in 2002. A full-time state hawk-i outreach coordinator provides outreach coverage for state level initiatives and the local child health agencies provide outreach to all 99 counties at a community level. The local coordinators focus outreach on faith-based organizations, schools, health care providers and special populations while working with key stakeholders on outreach initiatives. In the upcoming year, local coordinators will provide leadership for implementing community-based presumptive eligibility described below.

In 2009, The General Assembly passed Senate File (SF) 389 directing the DHS to implement several initiatives that would expand coverage to children in both Medicaid and hawk-i and reduce barriers to enrollment. The intent of this legislation is to provide coverage for all children. The legislation 1) deemed hawk-i creditable coverage; 2) allows for the use of one pay stub as verification of income for Medicaid and hawk-i; 3) allows for the averaging of three years of income for self-employed persons to establish eligibility for Medicaid and hawk-i; 4) directs the state to complete the following for Medicaid and hawk-i; 5) utilize joint applications and the same application and renewal processes; 6) implement administrative or paperless verification at renewal; 7) utilize presumptive eligibility when determining a child's eligibility; 8) utilize the "express lane" option to reach and enroll children; 9) creates a dental-only option in hawk-i for children who have medical but not dental coverage.

Emerging from prior health reform legislation, effective July 1, 2009, eligibility for hawk-i was expanded to 300% FPL and Medicaid for pregnant women and infants less than one year of age to 300% FPL. As part of SF 389, also effective July 1, 2009, children in lawful permanent resident status may receive Medicaid or hawk-i coverage if they are otherwise eligible, regardless of their date of entry into the United States; thus eliminating the past five-year bar placed on this population. Effective March 1, 2010 hawk-i implemented the nation's first dental only program based on the CHIPRA legislation that allows states this option. The hawk-i Board unanimously approved a three tiered premium structure and assured that medically necessary orthodontia was provided under the dental only program.

Also effective March 1, 2010, Iowa DHS designed and implemented a presumptive eligibility for children program that will allow "qualified entities" to become certified to make presumptive determinations through a Web-based provider portal. The IME will assist in the enrollment and training of qualified entities. All presumptively eligible children will be enrolled in Medicaid until a formal eligibility determination is made. Upon determination, they will either remain in Medicaid or enroll in the hawk-i program.

//2012/ In January 2011, Iowa DHS released an informational letter to additional Medicaid providers. These providers included Iowa Medicaid hospitals, physicians, rural health clinics, local education agencies, maternal health centers, federally qualified health centers, family planning centers, screening centers, area education agencies, advanced registered nurse practitioners, Early ACCESS service coordinators and Indian Health Service providers. The letter announced that additional Medicaid providers could apply with Iowa DHS, IME to enroll as a qualified entities to make presumptive eligibility determinations for children.

As of May 2011, the Iowa DHS reported there are 159 providers enrolled as qualified entities. The Iowa DHS has received 1,064 applications for presumptive eligibility for children. Of these applications, 986 have been approved, 75 denied and 3 were cancelled. The most common reason for denying full Medicaid or hawk-i benefits is due to the failure of families to send the required documentation to DHS to verify income, child citizenship and identity.//2012//

//2013/ From October 1, 2010 to October 31, 2011, a total of 1,852 children were approved for presumptive eligibility. Enrollment of children in presumptive Medicaid is expected to continue to grow as the number of qualified entities determining presumptive Medicaid eligibility increases. All presumptive applications are automatically forwarded from the qualified entity to the DHS for a determination of whether the child qualifies for ongoing Medicaid or hawk-i. Of the 1,852 children approved for presumptive eligibility, 989 were approved for Medicaid, 141 were already eligible for Medicaid, 480 children were denied for Medicaid, 98 were approved for hawk-i coverage and 25 were denied for hawk-i coverage. The remaining 119 children are pending for final disposition.//2013//

//2015/Beginning January 1, 2014, income guidelines increased for both hawk-i and Medicaid, applications were updated to one single streamlined application for all health programs, and the process for applying for Presumptive Eligibility changed drastically. Pregnant women and children under age 1 below 375% of the Federal Poverty Level (FPL) and children ages 1-19 under 167% of the FPL now qualify for Medicaid, and children ages 1-19 between 167% and 302% FPL qualify for hawk-i and hawk-i dental only coverage.//2015//

Health Reform

As a result of the national and state level attention to health care, Iowa enacted a Health Care Reform bill (HF 2539) during the 2008 Iowa General Assembly. A Medical Home System Advisory Council was established from this legislation. The Council's charge is to advise and assist IDPH in implementing a medical home system for Iowa. HF 2539 provides a blueprint for

the future of Iowa's medical home system that defines medical home, outlines needs for the statewide structure and focuses on the joint principles of a patient centered medical home. The Health Care Reform bill also identifies phases for the medical home beginning with children enrolled in Medicaid. The proposed outcomes are to reduce disparities in health care access, delivery and health care outcomes; improve the quality and lower the costs of health care; and provide a tangible method to document if each Iowan has access to health care. For children, goals and performance measures will include childhood immunization rates, well-child care utilization rates, care management for children with chronic illnesses, emergency room utilization and oral health service utilization. The medical home system for children will coordinate and integrate with existing newborn and child health programs and entities including local MCH agencies, Community Empowerment and ECI.

//2012/The Medical Home System Advisory Council (MHSAC) developed an Initial Progress Report in 2009 with four high-level recommendations that continue to be top priority and can be found on their website: <http://www.idph.state.ia.us/MedicalHome/>. Four workgroups on certification, reimbursement, policy, and education have been created to advance these recommendations and plan for implementation of a comprehensive Iowa-based patient-centered medical home (PCMH) system. The MHSAC's most recent progress report includes six priority areas with recommendations for 2011, including primary care workforce shortage, accountable care organizations, IowaCare expansion, multi-payer collaboration, prevention and chronic disease management and health information exchange. IDPH is working on drafting and adopting rules for the certification of medical homes in Iowa to be completed through any nationally recognized certification tool. Iowa was chosen as one of eight states for the National Academy for State Health Policy Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program Participants. Iowa received a one-year program of TA. The MHSAC is collaborating with Medicaid in the development of the IowaCare Medical Home Model to phase in Federally Qualified Health Centers to provide primary health care services and to comply with certification requirements of a Medical Home. A Birth to Five Patient Centered Medical Home Pilot Project has been implemented to develop a model for a community-based utility that will comprehensively serve children 0-5 to address their specific needs by providing a PCMH.

The Prevention and Chronic Care Management (PCCM) Advisory Council is charged to develop a state initiative for prevention and chronic care management which integrates evidence-based strategies into public and private health care systems, including the patient-centered medical home system. The state initiative will address health promotion, prevention and chronic care management in Iowa.

The PCCM Advisory Council produced an initial report which gives seven broad recommendations needed to take a proactive approach by putting a major emphasis on prevention and wellness, along with chronic disease management. The Council's most recent progress report goes into detail on the key initiatives and advancements over the past year. Issue briefs have also been developed on a variety of topics related to prevention and chronic care management in Iowa. These reports can be found on the Council's website: <http://www.idph.state.ia.us/ChronicCare/>. The Council has broken into two subgroups to better focus on legislation charged to the Council. The Chronic Disease Management Subgroup is developing a plan to coordinate care for individuals with diabetes who receive care through safety nets. The Prevention Subgroup is submitting recommendations on strategies to collect and provide statistically accurate data concerning chronic disease in multicultural groups of racial and ethnic diversity in Iowa.//2012//

//2013/The Medical Home and Prevention and Chronic Care Management Advisory Council's 2012 Annual Report summarizes the Council's recommendations and the activities the Council has accomplished. The Council developed a number of issue briefs to educate stakeholders and policymakers on a variety of important topics including Patient-Centered Care, Social Determinants of Health, Community Utility, Chronic Disease Management and Prevention. The issue briefs also focus on pediatrics and highlight Iowa data and programs targeted at young

children.

The Council is collaborating with IME on implementing a Health Home model of care for Iowa's Medicaid population through the Affordable Care Act. There is a 90/10 Federal match rate for specific health home services for eight quarters for all individuals diagnosed with at least two chronic conditions, or one chronic condition and being at risk for a second chronic condition from the following list of categories: mental health condition, substance use disorder, asthma, diabetes, heart disease, overweight (BMI over 25 for adults and 85th percentile for children) and hypertension.//2013//

/2014/The PCCM and MH Advisory Councils combined into one Council. The staff who coordinate the Council have an expanded role and are now the Office of Health Care Transformation (OHCT), which is a key point-of-contact for ACA related initiatives at IDPH including Health Benefit Exchange, Accountable Care Organizations, Medical Home, chronic care management initiatives and care coordination. The goals of the OHCT are convening stakeholders, building relationships/partnerships, streamlining efforts, and offering technical assistance to organizations including Local Public Health Agencies and MCH grantees to prepare for ACA implementation.//2014//

/2015/The council changed its name to The Patient Centered Health Advisory Council to better illustrate the broad scope of its focus. In 2015, the council spent much of its time offering input to initiatives such as the Health Home program, which is funded through a Medicaid state plan amendment, the design of Iowa's Medicaid expansion program (Iowa Health and Wellness Program), the State Innovation Model grant, and various care coordination models being implemented across the state. The Office of Health Care Transformation continues to be the key point-of-contact for ACA-related initiatives at IDPH, it offers technical assistance to programs at IDPH, in addition to local public health and MCH agencies. This year brought a lot of changes to Iowa's healthcare environment with key ACA components being implemented such as the Marketplace and the Iowa Health and Wellness Plan. More than 29,000 individuals enrolled in the Marketplace, not including those who qualified for the Iowa Health and Wellness Plan.//2015//

Fit for Life

/2013/Iowans Fit for Life utilizes a strategic plan and an annual plan, to guide the work of the partners and staff team. Iowans Fit for Life works in community, worksites, healthcare clinics, and schools, as well as with specific age groups including early childhood, school age, working adults and older adults.

Significant Iowans Fit for Life resources include:

1. Eat and Play the 5-2-1 Way is a pediatric healthcare provider resource for the prevention of and treatment for childhood obesity
 2. Healthy Iowa Worksites is a collection of active and eating smart tools for building a worksite wellness program for small employers
 3. An Apple a Day and Other Small Steps is a school and community resource for implementing nutrition and physical activity improvements
 4. Asset Mapping is a facilitated conversation resource for coalitions to identify and map community assets for nutrition and physical activity
 5. Nutrition Environment Measures Survey-Vending (NEMS-V) is an assessment tool for healthy vending machines
 6. Walking With a Purpose is an assessment for communities, neighborhoods and other organizations to analyze the walkability or bike-ability of an area
 7. Making Worksite Wellness Work at Your School is a resource focusing on school as a worksite
- //2013//

/2014/Iowans Fit for Life will conclude June 29, 2013 as the funding comes to a close. IDPH has

received notice that the department received funding for the new heart disease, diabetes, nutrition and physical activity, and school health grant from the CDC. Many of the services will continue through the new grant program; however, some will not.//2014//

/2015/Iowans Fit for Life grant funding concluded in June 2013. Several nutrition and physical activity initiatives continue through other state and federal funding sources.//2015//

/2013/Community Transformation Grants

The Community Transformation Grant (CTG) is a signature program of the Prevention and Public Health Fund, made possible by the Affordable Care Act. The grant is intended to prevent leading causes of death and disability through evidence-based initiatives, environmental and systems change, and strengthening the health infrastructure.

A minimum of 50% of the grant funds distributed to 26 local boards of health must be used for four strategic directions: Tobacco free living, active living and healthy eating, healthy and safe physical environments, and increased use of high impact clinical prevention services. Funding from the CTG will not only improve infrastructure and health outcomes across Iowa, but will have immediate positive impacts on Iowans by fueling economic development in difficult economic times.

The principle of the Community Transformation Grant serves as a reminder that it all starts in a community. Communities shape people and impact all facets of their life, including their health outcomes. The CTG provides the infrastructure to enhance the linkages between the individual, their community, and the larger population. When an individual has access and makes the subsequent healthy choice it not only improves their well-being and health, but the impacts spillover to the entire population at an exponential rate.//2013//

/2014/The Iowa CTG counties continue to implement systems-level and environmental changes to improve healthy options. The following communities are improving access to healthy foods.

Using the NEMS-V assessment, a local theatre in Decatur County had only 8% of snacks and 12% of beverages meeting the yellow or green healthy status. From the local CTG recommendations, 42% of the theatre's snacks and 46% of the beverages are now considered healthy. In Marion County, the same assessment was conducted at a local aquatic center and healthy options went from 9% to 21%.

The Healthy Mills County Coalition worked closely with the Glenwood Giving Garden to develop new distribution methods for free produce. The Glenwood Giving Garden has distributed 2300 pounds of produce to 360 low-income and elderly families, an increase of 25% from the entire previous year.//2014//

/2015/Iowa's WIC and CTG teams implemented a new distribution system that expands farmer's market voucher access to eligible WIC participants in all counties. Many Iowa CTG counties now offer healthy options at concession stands.//2015//

Children with Special Health Care Needs

CHSC is Iowa's Title V Program for Children and Youth with Special Health Care Needs (CYSHCN). The CHSC administrative office is located at the University of Iowa in Iowa City. In addition to the Iowa City office, CHSC currently supports 13 regional centers throughout the state, four of which are primarily dedicated to building an improved family-driven, youth-guided system of care for children's mental health services under a cooperative agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA). Regional centers provide and

manage a number of services for CYSHCN, including direct care clinics, care coordination, family support and infrastructure building services, including core public health functions (assessment, policy development and assurance), training, program evaluation and continuous quality improvement. The CHSC Director, Debra Waldron, MD, MPH works collaboratively with the state MCH Director and Part C (of IDEA) Coordinator to implement and develop programs to meet the health-related needs of all Iowa children. The collaboration is enhanced by Dr. Waldron's 0.2 FTE appointment as Medical Director for IDPH's Division for Health Promotion and Chronic Disease Prevention. /2012/ It is also enhanced by CHSC's participation in the newly formed Partnership to Improve Child Health in Iowa (PI-CHI). PI-CHI seeks to improve the health of all Iowa children, including those with special needs. //2012// /2014/Dr. Waldron was appointed the Director for the University of Iowa's newly created Division of Child and Community Health. In this capacity she oversees the Center for Child Health Improvement and Innovation as well as CHSC. //2014//**2015/Contract ended.**//2015// Dr. Waldron is a board certified pediatrician with extensive public health experience in system development and quality improvement.

CHSC's organizational capacity is continually modified to respond to changing state and federal legislation and other external factors. CHSC's vision remains to assure a statewide system of care for Iowa's CYSHCN. The system is defined as containing four components: 1) direct clinical care; 2) care coordination; 3) family support; and 4) infrastructure building-systems building services. /2014/CHSC is transitioning to use the term "family-to-family" to differentiate peer to peer support from home visiting "family support"//2014//.

The process for developing CHSC priorities uses a combination of structured problem identification and prioritization activities, Web-based public input opportunities, and program leadership strategic planning efforts. In formulating program priorities, consideration is given to national priorities, emerging issues, financial circumstances, collaborative opportunities and overall environmental fluctuations. Input into program planning decisions is continually sought from CHSC program staff, state and community-based MCH stakeholders, and families of CYSHCN. Legislators, though generally not involved in program planning, are kept informed of major program activities that benefit their constituents. Program planning and priority setting has been supplemented by data from the 2005 Iowa Child and Family Household Health Survey (IHHS) and the National Survey of Children with Special Health Care Needs (2006). Both are random sample, population-based surveys and were repeated in 2010 and 2009, respectively. Repeated survey administration will provide information about changes in family experiences over time. //2012/ In keeping with current high-level interest in early childhood health and development, the 2010 IHHS included a special focus on early childhood issues. Data from both surveys will be available late summer/fall 2011.//2012//

/2013/CHSC has started analyzing data from both the 2010 IHHS and the 2009 National Survey of CSHCN.//2013//2014/A needs assessment targeting families and providers regarding ASD was completed and will be presented to stakeholders in FY 2014.//2014//

The population-based surveys, in combination with the problem identification and prioritization activities, identified a number of issues important to CYSHCN and their families. Consistent with national priorities, these include child and adolescent mental and behavioral health; medical homes for CYSHCN; organization and coordination of services for families; early identification and referral; transition systems for adolescents with special health care needs; family involvement in program activities; and adequate coverage for needed services. Underlying all these issues is the continuing challenge to define CHSC's roles in addressing identified priorities in a limited resources environment. Possible roles, for example, include leadership, facilitation, participation, direct service provision, resource support and advocacy. CHSC participates in the official budget request process used by the executive branch to guide its own budget priorities. CHSC staff participate on state boards to develop policy that impacts CYSHCN, including the State Board of Health, the Governor's Medical Assistance Advisory Board and ECI. /2012/ The University of Iowa Children's Hospital System of Care, Educational Research subcommittee is developing plans for the new children's hospital that will allow greater connectivity to local communities.

//2012//

/2013/CHSC has identified nutrition and obesity, bullying, child abuse and social determinant factors as additional areas of emphasis. CHSC Leadership conducted a strategic planning retreat in Spring 2012 and defined three focus areas for the next 3 years: 1) Reviving a Positive Team Culture; 2) Empowering Effective Leadership for Serving CYSHCN; and 3) Reformulating Our Organizational Structure.//2013// /2014/ CHSC will retain these focus areas. //2014//**2015/Five-year Title V Needs Assessment planning has begun.**//2015//

CHSC is dedicated to infrastructure building for the purpose of system development. Infrastructure building efforts currently receiving the greatest attention include improving access to pediatric mental and behavioral services, spreading the medical home model to improve quality of care for CYSHCN, developing and implementing standards for care coordination that best meet the needs of families, implementing quality improvement methodology within all CHSC programs and services, and developing statewide systems of care for 1) family to family support; 2) early hearing detection and intervention; and 3) infants born prematurely. CHSC will also focus on health service delivery and health status outcome issues related to cultural diversity and health literacy. Cultural brokering, cultural diversity technical assistance and culturally-relevant social determinants of health are also focus areas of organizational efforts. CHSC incorporates evaluation, health services research, economic analysis and partnership building strategies -- /2012/ with a goal of educating policymakers.//2012//**2015/CHSC is forming a Family Advisory Council.**//2015//

/2013/CHSC Director co-authored a literature review and study of the effects of environmental toxins on young children in Iowa. The study will provide a platform for future policy discussions. A statewide workgroup was also established.//2013// /2014/ CHSC is exploring new public/private partnerships with Hy-Vee and other community-based nutrition services throughout Iowa. //2014//

/2015/CHSC created an enhanced care coordination algorithm to guide providers in deciding when a CHSC care coordinator will benefit those they serve. CHSC has begun implementing Pediatric Integrated Health homes in additional counties to serve children on Medicaid with serious emotional disturbances. CHSC is also implementing Regional Autism Assistance Program teams at 14 sites and convening quarterly ASD expert panel meetings. Piloted tools with EPSDT on transition to adulthood.//2015//

B. Agency Capacity

In Iowa, Title V administration is the joint responsibility of the Bureau of Family Health (BFH) at IDPH and Child Health Specialty Clinics (CHSC) at the University of Iowa (UI). Iowa's MCH programs promote the development of systems of health care for children ages 0 to 21 years, pregnant women, and their families. Iowa strives for services that are collaborative, comprehensive, flexible, coordinated, culturally competent, developmentally appropriate, family-centered and community-based. The core public health functions of assessment, policy development and assurance are promoted.

/2012/The BFH work teams were restructured in the fall of 2010 to increase effectiveness, address emerging issues, adapt to change, and foster leadership for collaborative practice. The BFH moved from two work teams (CH Advocacy Team and Women's Health Team) to four teams (Title V/Early Childhood, Reproductive Health, Medical Home/EPSDT, and Epidemiology/Research and Development).//2012//

/2013/In April 2012, new leadership in the bureau continued to refine the work structure of the BFH. Four work units were developed to guide the work within the BFH:

1. Infrastructure and Performance Management
2. Reproductive, Maternal, & Women's Health

3. Early Childhood
4. Child and Adolescent Health//2013//

Women's Health

/2012/The Reproductive Health Team provides direction, oversight and monitoring for the 21 local MH and 8 family planning (FP) agencies.//2012// Systems development activities are coordinated with the IDPH FP Program, the FP Council of Iowa, hospitals, schools, local boards of health, providers of adolescent health programs, and statewide women's health initiatives. Technical support is provided to local MH and FP agencies. Contracts are managed with the University of Iowa Hospitals and Clinics (UIHC), Department of Pediatrics.

/2015/One family planning agency no longer had the capacity to provide family planning services, another family planning delegate agency has assumed responsibility for this service area.//2015//

Local Maternal Health (MH)

Local MH contract agencies are charged with developing programs that are responsive to the needs of the community. Contractors for the FFY 2011-2015 project period were selected through a competitive request for proposals (RFP) process.

A MH logic model provides the framework for MH programs to implement services that impact key performance measures. The goal of the MH program is to improve health outcomes for pregnant women and infants. Local MH contract agencies provide prenatal and postpartum care to low-income women and other women in need. Services include risk assessment, psychosocial screening, referrals, care coordination, education, delivery planning, oral health screening, postpartum visits and presumptive eligibility for Title XIX. Performance standards were developed to ensure the provision of quality MH service throughout the state. Local MH contract agencies also complete an annual direct care audit and semiannual review of the service documentation in WHIS.

/2015/Iowa Medicaid approved new billing codes to improve screening for alcohol and substance abuse, domestic violence, and depression. They also approved home visits by a nurse or social worker to do therapeutic listening to support women with mild to moderate depressive symptoms. Training was held in all six regions of the state on the evidence-based listening visit model.//2015//

Statewide Perinatal Care Program

The Statewide Perinatal Care Program provides training of health care professionals, development of care guidelines, consultation for regional and primary providers, and evaluation of quality of care through the state's 79 hospital facilities providing obstetrical and newborn services. The team consists of a neonatologist, a perinatologist, a dietitian, an obstetrics nurse, and a neonatal intensive care nurse. Through a contract with the UI, Department of Pediatrics, these services are provided to all birthing hospitals and more intensive services are directed toward Iowa's three tertiary care centers and 19 secondary care centers.

/2013/The IDPH plans to update its Guidelines for Perinatal Service, a reference for birthing hospitals intended to improve the quality of obstetrical and newborn care in birthing hospitals. IDPH will also be working with the Iowa Health Care Collaborative to improve the quality of obstetrics care through the Perinatal Review Team structure and other key partners.//2013//

/2015/The Perinatal Guidelines Committee plans to update the definitions to the levels of care within our regionalized system of perinatal care. This team will add medical expertise to Iowa's CoLIN team.//2015//

Abstinence Education

/2013/The Department hired a program coordinator and is working with Youth Shelter Services (YSS) as the local contractor to implement in five high risk communities. The priority population is youth ages 15-19 years who are living in institutional foster care and shelters.//2013//

/2014/IDPH selected YSS and Planned Parenthood of the Heartland (PPH) to provide Abstinence Education services. YSS is implementing Power Through Choices (PTC) in Boone, Marshall, Story and Polk Counties. PPH is implementing PTC in Linn County and the Teen Outreach Program (TOP) in Polk County.//2014//

/2015/Three school districts are now implementing TOP. These school districts are located in Marshall, Muscatine and Wapello counties.//2015//

Personal Responsibility Education Program (PREP)

Iowa's PREP program will provide comprehensive sexuality education to adolescents with medically accurate, culturally and age-appropriate, and evidence-based programming in order to assist them to reduce their risk of unintended pregnancy, HIV/AIDS, and other sexually transmitted infections (STIs). PREP programs will also address life skills to assist Iowa teens in making responsible, informed decisions and lead safe and healthy lives.

Iowa has identified three priority programs for implementation. Awards will be based on a competitive application process. The vision of PREP is: Iowa youth will be empowered to make positive decisions and healthy choices regarding sexual behavior as they prepare for a successful adulthood.//2012//

/2013/Iowa's PREP program awarded funding to 4 agencies. Agencies are implementing 1 of 2 evidence-based curriculum models in 5 counties. A second RFP was released in Spring 2012 to add four to five additional PREP local agencies.//2013// /2014/Completion of the second RFP expanded services and 5 agencies are delivering 1 of 3 models in 7 high-risk Iowa counties.//2014//

Preventing Shaken Baby Syndrome (SBS)

Comprised of representatives from IDPH, Prevent Child Abuse Iowa, Iowa Department of Management, and Blank Children's Hospital, the Iowa Prevent SBS team collaborated to plan and implement a statewide program to prevent SBS. The team attended the PREVENT Institute for Child Maltreatment at University of North Carolina which provided education and coaching toward the development of a plan for Shaken Baby Prevention.

Efforts by child abuse prevention advocates led to the passage and signing of a bill during the 2009 legislative session, directing IDPH to develop and implement a statewide SBS prevention plan. The foundation plan from PREVENT was used to further refine a plan and pilot implementation phase. Funds received have allowed this pilot to serve birthing hospitals, in a 12-county region in central Iowa. /2012/Additional hospitals throughout the state secured independent funding. Currently, 49 of the 79 birthing hospital implement the Period of PURPLE Crying curriculum developed by the National Center on Shaken Baby Syndrome.//2012//

/2013/For FFY13, the focus area will be schools so as to increase awareness and provide education on the prevention of SBS to 11-17 year olds, who may be siblings or babysitters of newborns. The target group will be family consumer science educators, area education agencies and Red Cross babysitting classes.//2013//

/2015/Currently, 58 of the 78 birthing hospitals implement the Period of PURPLE Crying

curriculum. IDPH plans to target education to emergency room nurses to reinforce that crying is normal and to never shake a baby.//2015//

Medical Home/EPSDT Work Team

For the child health (CH) program, the work team includes a focus on both the Medical Home Project and the EPSDT program. The Medical Home Project features a Medical Home System Advisory Council to make recommendations to IDPH on the plan for implementing a statewide, patient-centered medical home system. The initial phase will focus on providing a patient-centered medical home for children who are eligible for Medicaid. Included in a later phase is a focus on providing a patient-centered medical home to children covered by the hawk-i program.

This work team also focuses on quality improvement to promote effectiveness of the CH/EPSDT program. It addresses policy and practice to promote access to preventive health care services provided by CH contract agencies. Representatives on the team include those from CH, adolescent health, EPSDT, hawk-i outreach, oral health, and Medicaid fee-for-service, and quality assurance. Consultation is available from other key programs in the BFH and throughout IDPH.//2012//

/2013/The work team continued to focus on quality improvement to promote the effectiveness of the CH program. Due to a continued focus on care coordination services, this workgroup will transition to a Care Coordination Community of Practice and seek participation from others in the BFH and the IDPH.//2013//

Local CH Agencies

Local CH contract agencies are charged with developing programs that are responsive to the needs of the community. Contractors for the FFY 2011-2015 project period were selected through an integrated competitive RFP process for MCH and FP.

A CH Logic Model provides the framework for CH programs to implement services that impact key performance measures. The goal of the CH program is to improve health outcomes for children. CH contract agencies provide infrastructure building, population-based, and enabling services to assure that children have access to comprehensive well child-screening services including oral health services, based upon guidelines established under the EPSDT program. Agencies provide outreach to uninsured children, education on the importance of preventive health care, and access to medical and dental care. They promote linkage to medical and dental homes and referral to needed services. Service coordination under Early ACCESS (IDEA, Part C) is provided for children with blood lead levels of 20µg/dL or greater. Gap-filling direct care services are provided where access is limited.

/2012/Local CH contract agencies continue to provide programs that are responsive to the needs of the community. CH contractors selected during the FFY 2011 RFP process submitted continuation applications for the FFY 2012 contract year.//2012//

/2013/BFH and OH staff provide extensive technical assistance to local agencies, including working with those impacted by budget reductions to help prioritize focus areas.//2013// /2014/CH agencies continue focus on establishing medical and dental homes. Iowa's FFY 2012 EPSDT participation rate was 81% for children ages 0-20 (CMS 416 Report). 55.22% received a dental or oral health service.//2014//

/2015/CH agencies contribute to the Early ACCESS system through a focus on developmental testing and developmental monitoring for children with concerns who do not meet criteria for entry into Early ACCESS. CH agencies are implementing referral processes with Iowa's AEAs. Iowa Medicaid approved new billing codes to improve screening for caregiver depression, domestic violence, and alcohol and substance

abuse.//2015//

Oral Health Program

/2012/In January, the Oral Health Bureau merged with the IDPH Bureau of Health Care Access, forming the Bureau of Oral and Health Delivery Systems (OHDS). The new bureau includes three centers: Health Workforce, Rural Health and Primary Care, and the Oral Health Center (OHC).//2012//

OHC works to protect the health and wellness of Iowans through prevention and early detection of dental disease and through the promotion of optimal oral health and improved access to care. OHC staff offers consultation and assistance to local MCH contract agencies in assuring good oral health for the women and children they serve. An agreement with the DHS supports the I-Smile™ dental home initiative. I-Smile™ is the result of a state mandate that all Medicaid-enrolled children ages 0 to 12 have a dental home. The I-Smile™ program plan developed by OHC requires each CH agency have a dental hygienist serving as I-Smile™ coordinator, building support systems for families through work with dental providers, medical providers and community organizations. In addition to building local oral health infrastructure, the coordinators and other CH agency staff provide oral health promotion and education, care coordination and preventive dental services to ensure optimal oral health for children.

OHC partners with the Department of Education, school nurse organizations, and local public health to ensure compliance with the state's school dental screening requirement, enacted by the 2007 General Assembly. I-Smile™ coordinators are integral to the process, by coordinating local efforts to audit schools and helping families meet the requirement.

/2012/Using a Targeted Oral Health Service Systems (TOHSS) grant through HRSA, OHC is developing a surveillance system outlining oral health data resources available in the state. The TOHSS grant also allowed the OHC to conduct statewide promotion campaigns for oral health and I-Smile™. Health promotion efforts have been supported through a public-private partnership with the Delta Dental of Iowa Foundation, and have included broadcast of I-Smile™ public service announcements, radio spots, printed outreach materials, and distribution of children's oral health books to pediatric and primary care medical offices.

OHC has a new public-private partnership with Des Moines University to develop training for I-Smile™ Coordinators on the fundamentals of public health. Upon completion of the five modules, coordinators will be better aligned to build the I-Smile™ dental home system at the local level, creating an even stronger statewide oral health network.//2012//

/2013/As part of OHDS, additional state partners, such as the Rural Health and Primary Care Advisory Council and the Iowa Rural Health Association, are now involved in supporting OH programs and issues. OHC continues more limited health promotion efforts due to the end of the TOHSS grant in August. The partnership with DMU resulted in a dental public health training that I-Smile™ Coordinators are required to complete. OHC anticipates an improved understanding of public health systems-building once Coordinators complete the training.//2013//

/2014/In October 2012, an OHC dental hygienist position was vacated. Prior to filling the vacancy, both hygienist positions were changed to community health consultants (dental hygienist select); one is filled and OHC anticipates hiring the second in summer 2013, to assure maximum assistance to contractors.//2014//

/2015/A CDC grant allowed OHC to add three positions. Two are dental hygienists who provide technical assistance to MCH contractors, coordinate our expanded school-based sealant programs, and assist in coalition-building. The third, a statistical analyst, will join OHC in July, working to enhance oral health data collection, use, and reporting capabilities.//2015//

Healthy Child Care Iowa (HCCI)

/2012/Iowa has 50 Child Care Nurse Consultants (CCNCs) working a total of 24 FTE positions. Local MCH contract agencies are required to provide leadership for development of health and safety in child care. Key activities include securing funding, developing local agency capacity and structure for CCNC services, and establishing written agreements with Child Care Resource & Referral (CCR &R). Funding for CCNC positions comes from Child Care Developmental Funds, Early Childhood Iowa (ECI) funds, Title V funds, private and public foundations, businesses, and Head Start/Early Head Start.

Early care and education providers in Iowa have voluntary access to health and safety consultation through CCNCs. Early care and education providers participating in Iowa's Quality Rating Scale (QRS) are required to have a business relationship with a CCNC and for higher levels on the QRS are required to have onsite assessments and consultation provided. Due to a reorganization of Iowa's CCR&R system, regional CCNC positions were eliminated and will be replaced with a child care consultant with a health background.//2012//

/2013/Iowa has 45 Child Care Nurse Consultants (CCNCs) working a total of 25 FTE positions. Early care and education providers participating in Iowa's Quality Rating Scale (QRS) are not required to have a business relationship with a CCNC but the majority do. Fourteen of the 19 points available in the health and safety domain of the QRS are related to the CCNC, and 11 of those require onsite visits with the CCNC.//2013// /2014/ Iowa currently has 41 CCNCs working a total of 26 FTE positions.//2014//

Child Death Review Team

The Iowa Child Death Review Team (CDRT) reviews medical, investigative, and medical examiner records of all Iowa children from 0 through 17 years who died during the previous calendar year. In the 2009 General Assembly, CDRT responsibilities moved from BFH/Title V to the Iowa Office of State Medical Examiner. BFH staff worked with the Iowa Office of State Medical Examiner to transfer the program. The BFH continues to work with the CDRT but the Team has not been convened in the past year. /2013/The 2008 and 2009 CDRT Report was released. Five recommendations were included that related to safe sleep resources, drug/alcohol testing of care givers when a child death occurs, autopsy requirements, establishing community CDRTs, and child death prevention education/awareness.//2013//

Sudden Infant Death Syndrome(SIDS) Program Autopsies are required by Iowa Code on all children two years and younger who die unexpectedly. A contractual agreement with the Iowa SIDS Foundation covers printed information, community and professional presentations, grief counseling and referral services. A peer contact provides assistance to the family through the first year of grief following the infant's death. The Iowa SIDS Foundation operates eight grief support groups across the state. The contractual agreement with the Iowa SIDS Foundation is expected to continue in FFY2011.

/2014/The CDRT appointed a BFH staff member as an official member to collect data pertinent to the bureau and MCH programs. The data will be used to support educational and safety initiatives at the local level among MCH, early childhood, and adolescent programs. The 2010 CDRT Annual Report is set to be released by June 1, 2013. The report continues to support the 2008-2009 CDRT Annual Report recommendations as well as three new recommendations; enhanced and mandatory child abuse trainings, education related to relational and financial stressors determined to lead to increase chances for abusive behavior towards children by adults, and education related to consumer product safety versus proper supervision of children.//2014//

Center for Congenital and Inherited Disorders

/2012/The Center for Congenital and Inherited Disorders (CCID) at the IDPH is responsible for public health genetic and heritable disorder programming. This programming includes: Iowa Registry for Congenital and Inherited Disorders (IRCID) (birth defects, stillbirth and confirmed newborn screening cases), Regional Genetic Counseling Services (RGCS), Iowa Neonatal Metabolic Screening Program (INMSP), Maternal Prenatal Screening Program (MPSP), and the Neuromuscular and Related Disorders program.

The State Hygienic Laboratory at the UI is the designated testing laboratory for the INMSP and MPSP. The UI's Department of Pediatrics, Division of Medical Genetics, provides expertise and follow up services for the INMSP.

The CCID has developed a code of ethics to guide decision-making and policy development. Stillbirth prevention activities continue along with the stillbirth surveillance program at the IRCID. CCID has sustained family and health provider participation in the planning, implementation, and evaluation of the newborn screening programs. Iowa is leading a tri-state quality enhancement program implemented to support quality newborn screening programming in Iowa, North Dakota, and South Dakota.//2012//

/2013/To comply with recommendations from the Secretary for the U.S. DHHS, CCID is planning for the implementation of newborn screening for Severe Combined immunodeficiency (SCID) and Critical Congenital Heart Disease (CCHD). The IDPH partnered with the State Hygienic Laboratory and the UI Department of Pediatrics to develop screening protocols for each condition. CCID convened 2 expert work groups of health care providers, subspecialty care providers, parents of affected children and ancillary personnel to guide the planning and implementation of screening for these 2 additional conditions.//2013//

/2014/Iowa's newborn screening program is pilot testing for SCID and anticipate universal SCID screening by October 1, 2013. Newborn screening for CCHD was added to the newborn screening panel during the 2013 legislative session. 78% of Iowa hospitals are screening for CCHD.//2014//**2015/Iowa is universally screening for SCID.//2015//**

Early Hearing Detection and Intervention (EHDI) Program

Iowa continues to make substantial progress in development of a comprehensive EHDI system. The IDPH EHDI project partners with the CDD's Iowa's Leadership in Neurodevelopmental and related Disabilities (I-LEND) program for audiological training, technical assistance to EHDI screeners and audiologists, and assistance in developing EHDI protocols. The CHSC EHDI project partners with Iowa Hands and Voices, as well as other family support programs in the state to ensure families are connected to other parents and support services in their communities.

/2013/Iowa's EHDI program made significant progress in the last year in building a sustainable system and is working on further developments in the following areas:

- Participation in a pilot Individual EHDI (iEHDI) Database project with CDC
- Statewide implementation of eSPTTM in audiology clinics
- Disseminate quality assurance reports to assist hospitals in monitoring their progress towards state goals and improve data quality
- Create a Medical Home Implementation Team (MHIT) to engage primary care providers regarding EHDI best practices
- Integrate Guide By Your Side guides into statewide networks of family support
- Expand linkages with Early Head Start and other home visiting programs
- Explore data integration with vital records and the metabolic screening program
- Evaluate the effectiveness of hospital site visits//2013//

/2014/ Iowa's EHDI program was recognized by CDC EHDI for the quality and quantity of individualized data submitted as a part of the CDC iEHDI project.//2014//**2015/IDPH is piloting a process to find children the EHDI program was not able to locate through a partnership**

with local Title V programs.//2015//

Iowa Collaboration for Youth Development (ICYD) and the State of Iowa Youth Advisory Council (SIYAC)

/2012/In 2009, the Legislature passed House File 315 placing the ICYD Council and the SIYAC in the Iowa Code, Section 216A.140. Prior to becoming "formal" councils, both ICYD and SIYAC operated as non-statutory entities. The ICYD began in 1999 as an informal network of state agencies from ten departments serving as a forum to foster improvement in and coordination of state and local youth policy and programs. The ICYD has developed the following Youth Development Result Areas:

- All youth have safe and supportive families, schools, and communities
- All youth are healthy and socially competent
- All youth are successful in school
- All youth are prepared for a productive adulthood

The ICYD has historically participated in a variety of state and national youth initiatives and has been recognized nationally (e.g. National Conference of State Legislatures, National Governors Association, Forum for Youth Investment) for its work in coordinating youth development efforts. The legislation codifying the ICYD Council strengthens this network to improve results among Iowa's youth through the adoption and application of positive youth development principles and practices. The formalized ICYD Council provides a venue to enhance information and data sharing, develop strategies across state agencies, and present prioritized recommendations to the Governor and General Assembly that will improve the lives and futures of Iowa youth.

The SIYAC was established in 2001 as a vehicle for high school youth to inform legislators on youth issues and currently consists of 19 youth between 14-21 years of age who reside in Iowa. The ICYD Council is overseeing the activities of SIYAC and has sought input from these youth leaders in the development of more effective policies, practices, programs, and this Annual Report.

The prioritized issue, increasing Iowa's Graduation Rate to 95 percent by 2020, was selected due to its high visibility and as a summative measure of youth development efforts, and the many cross-agency issues that contribute to youth graduating from high school. Each of the agencies represented on the ICYD Council has a role in achieving this goal.//2012//

/2014/ICYD Council continues focus to increase Iowa's graduation rate to 95%. Key activities include; implementation of the Juvenile Justice Reform Project and the inclusion of positive youth development. SIYAC is working within education, health & wellness, and harassment awareness.//2014//

Improving Academic Achievement by Meeting Student Health Needs

/2012/The Departments of Education, Public Health, and Human Services work together to advance initiatives in coordinated school health. Priority actions are being addressed to improve student health and academic outcomes. The first goal of the interagency collaboration is to focus on school wellness. The Joint Statement and team members can be found at http://educateiowa.gov/index.php?option=com_content&task=view&id=583&Itemid=1614//2012//

Prevention of Youth Violence

Iowa's primary focus is to strengthen prevention of self-directed and interpersonal child and adolescent violence. These include such behaviors as suicide, child maltreatment, school violence, community violence and bullying. Comprehensive and sustained support of youth is necessary to improve youth outcomes and reduce suicide and interpersonal violence. The overarching theme of the violence prevention effort will be youth development. Youth

development goes beyond problem reduction and applies to prevention, remediation and treatment, participation and involvement and academic and workforce preparation.

Culturally Competent Care for MCH Populations

/2012/The Office of Minority and Multicultural Health (OMMH) is housed in the Division of Health Promotion and Chronic Disease Prevention. The Office is responsible for bridging communication, service delivery and practical approaches to issues encountered by organizations and communities working to address the needs of Iowa's diverse populations. Comprehensive strategies and actionable alliances are implemented to address culturally and linguistically appropriate services. These include strategic goals, plans, policies and procedures, arrangement of ongoing education and training for administrative, clinical and other appropriate staff, and identification of resources and programs to increase awareness of health equity and culturally sensitive and competent health care and service delivery.

The OMMH has formed numerous partnerships throughout the state MCH arenas by providing leadership, training, workshops, technical assistance and representation to assure health equity, and culturally sensitive and appropriate actions to impact and reduce identified disparities.//2012//

/2013/The OMMH provides a lending library of "Unnatural Causes" educational videos and discussion guides to address health equity within MCH agencies. The DHHS Office of Minority Health National Partnership for Action Plan to Reduce Racial and Ethnic Health Disparities initiative was implemented by disseminating 8,400 postcards explaining the initiative, toolkits and website information to all MCH agencies for distribution to staff and community partners. OMMH continues to provide cultural diversity education/awareness training and workshops as requested.//2013//

/2014/The OMMH continues to provide a lending library of "Unnatural Causes" educational videos and discussion guides to address health equity within MCH agencies. In partnership, OMMH will provide six scholarship awards for purchase of the videos by individual MCH agencies to maintain within their agencies to address health equity. OMMH will work with BFH to enhance training and activities to be provided to internal and external staff for health equity/health disparities inclusion within the delivery of services.//2014//

/2015/In partnership and collaboration with the University of Iowa and DHS Systems of Care Grant, the OMMH was successful in completing 6 statewide training sessions on the changing demographics of Iowa and the CLAS (Culturally and Linguistically Appropriate Services) standards. OMMH staff provided CLAS standard training at the MCH Fall Seminar and continues to provide cultural competencies training and awareness to MCH agencies when requested. IDPH will ensure that all MCH agencies have received training regarding these standards and become knowledgeable of the impact and need to incorporate these within service delivery to Iowa's diverse populations.//2015//

Children and Youth with Special Health Care Needs (CYSHCN)

CHSC uses an organizational structure of 13 regional centers to provide family-centered, community-based, coordinated services to Iowa CYSHCN and their families. CHSC also has an administrative office located in Iowa City.

CHSC's vision statement is to assure a system of care for Iowa's CYSHCN. Iowa's SPM #2 will assess the degree to which components of the system of care are present within CHSC. CHSC's system of care has been defined as having four components (direct clinical services, care coordination, family support, and infrastructure building-systems building). Descriptions regarding CHSC's capacity to assure each component of the statewide system are provided below. Key collaboration with community and state partners to maximize resources that contribute to the system of care are also described.

Direct Clinical Services

The term "CHSC Clinical Services" (CS) holistically refers to all clinical services CHSC provides. Any child or youth ages 0 to 21 years can be served through CHSC Clinical Services. Many children with behavioral and emotional health needs receive evaluations and recommendations. CS is an important platform for family access to intensive care coordination, as well as to child psychiatry consultation and nutrition services via telemedicine communication. CS regional center staffing includes some or all of the following: an Advanced Registered Nurse Practitioner, nurse clinician, Registered Dietitian and a Family Navigator, who is a caregiver of children with special health care needs. Collaborations may occur with an Area Education Agency, psychologist and/or speech and hearing professional and a contracted or DHS social worker. Many children seen in CS have complex behavioral or emotional problems that were not successfully addressed by parents, educators or primary care physicians.

CS also serves children in the early childhood system. CS provides developmental screening, assessment and follow-up for young children at-risk for developmental delay. Recommendations and family support are provided, as is care coordination, if desired. For children at risk for developmental delay in growth, motor skills, language and social interaction; children subjected to abuse or neglect; and children exposed to drugs during pregnancy or later at home, CS also connects families to Early ACCESS (IDEA, Part C).

CS currently performs essential surveillance functions regarding development, social-emotional skills, and nutrition. /2012/All CS screen for autism spectrum disorder using the Modified Checklist for Autism in Toddlers (M-CHAT). In 2010, CHSC's Regional Autism Services Program (RASP) reported a doubling of the number of autism spectrum disorder screenings of children 18–36 months seen in CHSC clinical settings. ARNP's, staff nurses and targeted Family Navigators are also trained in the evidence-based screening tools Ages and Stages Questionnaire (ASQ) and ASQ-Social Emotional (SE), and the Developmental Assessment of Young Children (DAYC). Registered Dietitians and other CS staff also implement the PEACH tool, a screening tool to detect feeding and nutrition needs of infants and toddlers. CHSC partners with Early ACCESS to promote statewide use of the tool. Work is also underway to use Family Navigators to conduct hearing re-screens in selected areas of the state for children who missed the birth screen. The Oelwein and Fort Dodge regional centers provide follow-up hearing screening for infants who did not receive the screening at birth or need a re-screen for other reasons./2015/***Training RNs and ARNPs to do Nutrition and Health Assessments for children. Trained ARNPs on STAT-MD tool, allowing those needing a mid-level assessment for ASD to receive it in their community. Transferred EHDl tasks to IDPH.***//2015//

CHSC registered dietitians (one full-time staff and two 0.5 FTE) provide specialized nutrition services via telehealth for infants and toddlers whose needs are identified on the PEACH tool. In addition, specialized nutrition services are available to children older than age 3 years, on a limited basis./2012//

/2013/The Oelwein Regional Center offers diagnostic ABR services via telehealth to infants and toddlers who did not pass their initial hearing screen. OAE equipment is also available to provide additional access to hearing screening for babies who did not receive the screening at the birthing facility, or for those who need a second screen. CHSC is developing a program to serve children who are obese by partnering with medical homes./2013//

/2014/ CS expanded and standardized screening and assessment tools for chronic condition to include, Autism Behavior Checklist, Social Responsiveness Scale, Vanderbilt Assessment, and Screen for Child Anxiety Related Disorders. CS provides health assessment and guidance and connections to primary care provider and medical specialists to the Part C team. CHSC dietitians and AmeriCorps HealthCorps member assembled nutrition education kits for use by CS team. Staff trained in motivational interviewing. //2014//

Care Coordination

/2012/CHSC provides care coordination services from multiple professionals throughout the program, targeting patient need to professional resources. The CHSC Family Navigator Network (FNN) is affiliated with the CHSC regional centers and utilizes parents and caregivers of CYSHCN to serve as community-based consultants to other parents and families. Two family participation coordinators, both FNN members, function as leaders who work to assure family participation in all aspects of program planning and policy development. They also provide family participation data, explore resources, participate in needs assessments, develop training materials, assure competencies of the FNN, promote collaboration, and organize family advocacy efforts.//2012// /2013/The CHSC Family Navigators continued to partner with other FNs via the Family to Family Iowa (F2F IA) family advocacy network. A website and shared competencies for learning were products of the network.//2013//

CHSC's Health and Disease Management (HDM) Unit, comprised of both nurses and Family Navigators is designed to help families evaluate a child's needs and obtain services. Since 1985, CHSC has had an agreement with DHS to assist with care coordination of CYSHCN eligible for the Medicaid Ill and Handicapped Waiver. Now, CHSC provides care coordination for children enrolled in Medicaid's consolidated Waiver Program.**/2015/IH Waiver is now the Health and Disability Waiver.//2015//**

/2012/Care coordination to connect subspecialty services is also available. ARNPs, staff nurses, social workers, and registered nurses also serve on the team of care coordinators to best meet families' needs as they evolve. Quality improvement techniques assure care coordination standards, staff training, and appropriate data tracking, including family impact data.//2012// /2013/Web-based training for care coordinators was introduced for new CHSC staff.//2013//**/2015/CHSC analyzes care coordination data quarterly. Created an enhanced care coordination algorithm to guide providers in deciding when a CHSC care coordinator will benefit children.//2015//**

A major care coordination initiative is facilitating linkages of all primary care practices in the state (pediatric and family medicine) to community-based care coordination resources, many of which are affiliated with the Title V Program. /2012/CS seeks to connect all children served by CHSC to medical homes with local primary care providers, while facilitating appropriate referrals to subspecialists through effective care coordination.//2012// /2013/CHSC is tracking the number of unduplicated patients served through external coordination.//2013//

The CHSC Family Navigator Network also provides staff to support Early ACCESS (IDEA, Part C). Selected CHSC Family Navigators function as service coordinators for medically complex children ages 0-3 years, those exposed to drugs, and those born prematurely, enrolled in Early ACCESS.

/2012/Community Circle of Care (CCC) provides care coordination to meet the needs of children and youth, birth to 21 years, who struggle with emotional/ behavioral challenges. CCC is a system of care initiative to build local resources, services, and supports to keep children in their own homes and communities, avoiding costly and inefficient out of home treatment or hospital placements. The CCC serves more than 550 newly enrolled youth in clinical services annually, providing medical assessment, treatment planning, care coordination, and medication management services for stabilization. Once stable, youth are transitioned back to their medical homes, while continuing supports and care coordination as needed to keep families successful. The CCC also provides parent to parent support, leadership and advocacy opportunities and group supports for youth and families.//2012//**/2015/ Using state funding to maintain CCC.//2015//**

/2014/ Expanded quality improvement tools for staff delivering care coordination and family

support.//2014//

Family to Family Support

CHSC obtained MCHB funds in 2009 to create Iowa's Family-to-Family Health Info Center (F2F HIC) which will enhance the mentoring, resource sharing, and parent-professional partnering of CHSC and other family advocacy efforts. //2012// Additionally, funds from Health and Human Services' Administration for Children and Families in 2009 were granted to the IDHS to conduct a Family Navigator 360 Project. DHS subcontracts with CHSC to collaborate with and supplement activities of Family to Family Iowa. The F360 five-year project will support the participation of 3 Family Navigators and the spread of effective navigation techniques and knowledge of family resources through a target network of 70 navigators. The two grant projects merged and the project has been renamed Family to Family Iowa (F2FIA). F2FIA's decision-making body is an interagency collaborative group comprised of more than 20 family advocacy groups.

Through F2FIA, families are matched with other families who can best provide peer support and teach skills to help them become their child's primary navigator and advocate.

A goal of F2FIA is that all Navigators will complete standardized training. In 2011, nearly all CHSC Family Navigators completed the training.//2012// //2013// Over 50 FNs have now received certificates of completion for completing the core competencies training. FNs can access shared resources through the F2F IA website.//2013//

Through a collaborative project with the Center for Disabilities and Development (CDD) at the UI, five CHSC Family Navigators have been trained to assist behavioral health professionals in teaching applied behavioral analysis techniques to parents of children with autism spectrum disorder. //2013// CHSC will partner with a new grant to the CDD that assists families in learning Applied Behavioral Analysis techniques within their home settings. FNs are integrating basic information about emergency preparedness into care coordination with families.//2013// **//2015// Participate in PrepKids project on emergency preparedness.//2015//**

Families also play a large role in system development activities. For example, CHSC community-based Family Navigators serve on the following state level groups: Medicaid's Medical Assistance Advisory Committee, Iowa Collaborative Safety Net Provider Network, Iowa Council on Early Intervention, Governor's Council on Developmental Disabilities, UI CDD's Community Partnership Advisory Council, the UIHC Family Advisory Committee, Family to Family Iowa, and local and county governance boards to guide Community Circle of Care (CCC). //2013// One FN for CHSC serves as Iowa's AMCHP Family Delegate and one FN completed the Family Scholars Program in 2012.//2013// **//2015// CHSC FNs continue to serve on local, state and national committees.//2015//**

//2014// Through a contract with Magellan of Iowa FN provides intensive family support services for children and youth with serious emotional disorders and their families. Leadership of F2F IA was transferred to family-run organization but CHSC continues to participate. //2014//

Infrastructure Building Services

CHSC is increasingly involved with a variety of activities to improve service system quality and capacity. CHSC is a leader and participant in efforts to both improve program-specific operations and meet larger scale community and state needs. The CHSC Public Health Division is the organizational structure that guides and facilitates CHSC's infrastructure building activities. The fundamental core public health functions of assessment, policy development and assurance have been strengthened in the programmatic and environmental awareness of leadership staff. Considered one of the four systems components of the statewide system of care for CYSHCN, infrastructure-building efforts will be monitored by the NICHQ Title V Index for the next five years.

Active projects of CHSC's infrastructure building efforts include:

- /2012/Participating as a state affiliate of Help Me Grow to assure healthy development of young children //2012// /2013/The Help Me Grow state leadership group became a subcommittee of Iowa's Project LAUNCH and is partnering with the Home Visiting program regarding a central point of intake and follow-up.//2013//**/2015/Partners with Iowa's 1st Five initiative to assure early identification and referral. Developing metrics for provider, child and family outcomes.//2015//**
- Implementing quality improvement methodology through all programs and services of CHSC
- Assisting with the design, development, implementation and evaluation of systems of care for children with autism spectrum disorder, hearing loss, and premature infants/**2015/Completed statewide ASD needs assessment.//2015//**
- Leading the PI-CHI
- Developing a new model to expand access to pediatric mental health services/**2015/Expanding Pediatric Integrated Health homes to additional counties to serve children on Medicaid with serious emotional disturbances.//2015//**
- Implementation and evaluation of the medical home and adolescent transition projects
- Developing a CHSC system for the delivery of effective, efficient care coordination that is data driven
- Serving on Early Childhood Iowa and other decision-making groups that determine policy for early childhood; memberships on public health conference planning committees to assure topics for CYSCHN are included in key agendas
- Facilitating use of innovative technology throughout all levels of CHSC to further communication among staff located throughout the state and to enable effective partnering between interagency partners at the state and local level
- Using social media to more effectively reach parents; and participating in the analysis of the state's 2010 Household Health Survey

CHSC also partners in system development efforts with the Early ACCESS program. A portion of federal ARRA funds distributed to CHSC through the Early ACCESS program was used to document the social determinants of health (SDOH) that increase the risk of negative outcomes for Iowa's early childhood population. Funds were also used to study the effects of environmental toxins in early childhood development and provide recommendations to policymakers. /2013/A state interagency workgroup has been formed to study the effects of environmental toxins on children.//2013//

/2012/CHSC is increasing attention to cultural diversity and cultural competence in several major program areas. CHSC will hire a bilingual Family Navigator to assist with translation and outreach to the Latino population, and a new Hispanic Early ACCESS service coordinator was hired in N.W. Iowa to serve eligible young Hispanic children and their families. CHSC will review the ARRA-funded white paper on social determinants of health to guide issues of cultural diversity and encourage policies promoting healthy outcomes for all of Iowa's early childhood target population. The cultural broker for the SAMHSA system of care mental health project will continue to focus on inclusion for Iowans living in rural poverty. The F2F IA project will identify and address cultural and linguistic competence technical assistance needs for its family information-sharing and mentoring initiatives. In addition, State Performance Measure #2 contains quality measures in each of the four systems of care components that address cultural competence, and the Public Health Division has assigned staff to renew the efforts to continually assure cultural competence in all program services and organizational structure. CHSC will also employ a paid consultant, the Director for Health Literacy from Iowa Health Systems, to advise on health literacy issues affecting all cultures.//2012///2013/Staff serve on the state Health Literacy Committee and presented at the April state conference on health literacy. Program materials are systematically reviewed for adherence to health literacy standards by program staff.//2013//

/2014/ SAMHSA 6-year funding for Community Circle of Care (CCC) ended. CHSC obtained \$1.5m state appropriation to sustain elements of CCC. CHSC advocates for system of care for children's mental health and disability and integrated health homes. CHSC collaborates on

American Board of Pediatrics Maintenance of Certification quality improvement projects. EHDI educates Audiologists, ENTs, Pediatricians, Family Practice Physicians and FQHCs on responsibilities of newborn hearing stakeholders. CHSC piloted "What to Do When Your Child Is Heavy" for potential incorporation into CS. CHSC secured state funding to improve system of care for children with ASD. //2014//

/2015/CHSC reorganized and is part of the University of Iowa Division of Child and Community Health. Implementing Regional Autism Assistance Program teams at 14 sites to assure a system of care for children with ASD and their families. Teams include ARNP's, RNs, and FNs who provide family-to-family support and care coordination. Convened expert panel to meet quarterly and created guidelines for the Iowa Autism Fund. Piloted tools with EPSDT on transition to adulthood and facilitated a state level transition workgroup. Partnering with national, state, and family organizations to create an enhanced FN training program.//2015

C. Organizational Structure

The Iowa legislature designated the Iowa Department of Public Health (IDPH), a cabinet level agency, as the administrator for Title V and maternal and child health (MCH) services. The legislature also directs IDPH to contract with Child Health Specialty Clinics (CHSC), based at the University of Iowa, Department of Pediatrics, as the state's Title V services for children and youth with special health care needs (CYSCHN) program. Statutory authority identified in the Code of Iowa (Chapter 135, Iowa Administrative Code 641, Chapter 76) provides further reference for the purpose and scope of Iowa's program. Legislative authorization for state expenditure of federal funding under the federal block grant is identified in Senate File 508 of the 2011 Session of the Iowa General Assembly. Contracts between IDPH and CHSC outline the responsibilities of both agencies for fulfilling the mandate for maternal and child health services. Copies of the contracts are available upon request. Additional State of Iowa statutes relating to MCH and CYSCHN programs are listed in the attachment.

The IDPH Division of Health Promotion and Chronic Disease Prevention includes the Bureau of Family Health (BFH), the primary MCH unit within the state. Responsibility for the administration of the Title V Block Grant lies within the BFH. Tables of organization illustrate the relationship of the division and the bureau within IDPH. It can be found in the Attachments. The bureau also administers a portion of the state's Title X Family Planning services. The organizational structure of the Bureau of Family Health has remained stable in recent years, while IDPH itself has experienced leadership change.

/2012/Terry E. Branstad became Iowa's governor in January 2011, and the Iowa House of Representatives changed from democratic to republican controlled, while the Iowa Senate remained under democratic control. Governor Branstad appointed Dr. Mariannette Miller Meeks, BSN, MEd, MD, as the director of the Iowa Department of Public Health in December 2010. Dr. Miller Meeks retained the existing IDPH organizational structure.//2012// /2013/ Director Miller Meeks appointed Gerd Clabaugh as the Deputy Director and Division Director for Acute Division Prevention and Emergency Response.//2013//

/2015/Dr. Miller Meeks resigned as the director of IDPH in January 2014. Gerd Clabaugh served as interim director from January 2014 until he was officially appointed as department director in May 2014. Brenda Dobson, bureau chief for the Bureau of Nutrition and Health Promotion, was named interim division director for the Division of Health Promotion and Chronic Disease Prevention until a permanent division director is hired.//2015//

Bureau of Family Health

Organizational structures within Bureau of Family Health (BFH) include the Women's Health Team (WHT) and the Child Health Advocacy Team (CHAT). Public health functions relating to the

health of mothers, children, and families are centered in the BFH. The BFH and Title V program provide support for the department's Office of Multicultural Health co-located within the Division of Health Promotion and Chronic Disease Prevention support integration of cultural competence into program development. Areas of work for these teams include system planning, standards of care development, contract management, and coordination of health-related services. Both teams collaborate with the Iowa Department of Human Services (DHS), the Iowa Department of Education (DE), and the Iowa Regents Universities. The BFH contracts with local child health and maternal health agencies and health care providers to manage MCH programs at the local level. Listings of current contractors are located in the attachment. The BFH collaborates with the Oral Health Bureau (also a branch of the Division of Health Promotion and Chronic Disease Prevention, IDPH) to issue a joint Request for Proposal (RFP). The RFP is issued to community-based organizations interested in providing public health services for MCH and Family Planning. The RFP requires contractors to link with the Bureau of Local Public Health Services, Bureau of Immunization and TB, Early ACCESS (IDEA, Part C), Healthy Child Care Iowa, hawk-i (S-CHIP) and the Lead Poisoning Prevention Program. Selection is based on applicant's ability to meet criteria in the areas of access, management, quality, coordination, and cost.

/2012/ The Bureau of Family Health restructured into four work teams, replacing the Child Health Advocacy Team (CHAT) and Women's Health Team (WHT). The four work teams include the Title V/early childhood team, reproductive health team, EPSDT/medical home team, and epidemiology/research and development team. The Oral Health Bureau was combined with the Bureau of Health Care Access to form the Bureau of Oral and Health Care Delivery Systems. The BFH continues to work with the Oral Health Center to administer programming through the combined RFP/RFA processes.//2012//

/2013/In April 2012, the new leadership in the BFH continued to refine the work structure. Four work units were developed to guide the work within the BFH:

1. BFH Infrastructure and Performance Management
2. Reproductive/Maternal/Women's Health
3. Early Childhood
4. Child and Adolescent Health

Because many of the projects done within the BFH and IDPH are cross cutting between teams and bureaus, BFH staff members are utilizing Communities of Practice (COP) as a work structure. The COP focus areas are Improving the Partnership with local MCH agencies including the MCH consultation and technical assistance structure and care coordination.//2013//

/2014/Based on feedback from local MCH agencies and BFH staff, technical assistance to local MCH agencies was restructured into a regional formation. Six regions were formed by the local agencies and each region was assigned a consultant to act as a single point of contact with the BFH. In the new formation, TA will be provided more consistently and in a timely manner.//2014//

/2015/The regional structure was evaluated in October 2013 and it was determined that this structure was an effective way of providing TA to the local MCH systems and will continue. Regions were charged with developing projects in a "Collective Impact" framework during the MCH Fall Seminar. Several regions developed regionalized referral protocols with Early ACCESS (IDEA, Part C). Other projects included communication with local ACOs , sharing of best practices, and training.//2015//

Administration of Programs Funded by Block Grant Partnership Budget IDPH is responsible for the administration of all programs carried out with allotments under Title V. A genetics coordinator of the Center of Congenital and Inherited Disorders (CCID) is housed in the Bureau of Family Health and coordinates with the Early Hearing Detection and Intervention program.

The lead program housed in the Division of Environmental Health partners with the BHF and local maternal and child health agencies on improving the incidence of lead poisoning among young children. The lead coordinator serves on the BFH CHAT team to improve system integration of

child health programs.

The Immunization program is part of the Bureau of Disease Prevention and TB and partners with the BHF and local maternal and child health agencies on improving immunization rates. A staff person from the immunization program serves on the BFH CHAT team.

/2012/Although CHAT is no longer meeting, BFH staff continues to involve the lead and immunization programs in program planning activities and to integrate activities into the child health program.//2012//

As part of the maternal health program there is support for the perinatal review team to help improve the perinatal infrastructure. The Team is led by at the University of Iowa. There is also support for the Barriers to Prenatal Care Survey through the Title V block grant and the HOPES home visiting project. This project is a cooperative venture of all of Iowa's maternity hospitals, the University of Northern Iowa Center for Social and Behavioral Research, and the Iowa Department of Public Health.

Child Vision Screening, Iowa KidSight, is currently one of 18 state-wide preschool vision-screening programs carried out by volunteer Lions Club members. The program is administered through the University of Iowa, Department of Ophthalmology and Visual Sciences. Any young child living in Iowa is eligible for the service. There is no cost to families to participate. State funds also support activities with Prevent Blindness Iowa.

/2012/State funds continue to support the activities related to children vision screening for SFY2012.//2012//

/2014/ In April 2013, Iowa signed into law Senate File 419. This legislation requires children to have vision screenings before entering kindergarten and again before entering third grade. Previously, a series of failed vision screening bills resulted in several legislators directing IDPH and other child vision advocates and stakeholders to focus on a collaborated effort to promote child vision screening across Iowa. The workgroup included members of the Iowa Academy of Ophthalmologists, Iowa Optometric Association, the Iowa Medical Society, and the Iowa School Board Association.//2014//

/2014/Iowa's 1st Five Healthy Development Initiative began as a state funded program in 2006, and was the result of a successful pilot ABCD II project funded by the Commonwealth Fund (2003-2006). The purpose of the 1st Five Healthy Development Initiative is to support and enhance models of service delivery that promote high quality well-child care, supporting healthy mental development for all children ages birth to five years. The primary focus of 1st Five is on children with less intense needs, for example, those who may only need preventive care; those who are identified as at-risk or in need of "low-level" interventions; and to assure that appropriate referrals, interventions, and follow-up will occur.

1st Five programs, administered through local Title V CH agencies, work with providers to ensure the three levels of developmental care through Iowa Medicaid's Early, Periodic Screening, Diagnosis and Treatment (EPSDT) program become standard practice. This relationship includes regular communication with medical providers on referral status and program maintenance. Visit www.iowaepsdt.org for more detailed information on the three levels of developmental care.

1st Five serves as a community utility, playing a crucial role in assisting primary care providers to deliver coordinated, comprehensive and family-centered care. Care coordination requires personal contact with families and providers that allows for individualization of care and family-centered decision making to meet the needs of each family. This communication may be carried out through face-to-face visits, telephone contacts, or written correspondence.

At the individual level, care coordination may involve providing information about available

services, assisting clients in making health care appointments, coordinating access to needed support services, coordinating access to health care services and following up to ensure that services were accessed.

In addition, successful applicants will serve as messengers about the importance of young children's healthy mental development to community stakeholders.

During the 2013 legislative session, 1st Five Healthy Development was given an increase in funding from approximately \$327,000 to \$1,327,000. The purpose of the increase was to fully operationalize existing 1st Five contractors and expand into new communities. Currently, seven 1st Five sites cover 13 counties. With the expanded funding, it is anticipated that local 1st Five sites will serve nearly half of Iowa's 99 counties.//2014//

/2015/During FFY2014, 1st Five expanded into 36 new counties, covering 49 of Iowa's 99 counties. Four new community planning sites were funded, bring the total number of Title V agencies with a 1st Five program to 11. During the 2014 Legislative session, 1st Five received an increase of \$300,000. This funding allows for the four community planning sites to move into implantation.//2015//

The BFH is represented on the Division of Health Promotion and Chronic Disease Prevention's Integration Team. The vision of this team is innovative integration through enhanced collaboration and use of our team's diverse skills and broad resources. The mission is to bring together a team to leverage opportunities, improve efficiencies and promote collaboration among all programs within the Division.

Child Health Specialty Clinics

Responsibility for coordinating Iowa's program for children and youth with special health care needs (CYSHCN) is administered by the IDPH Division of Health Promotion and Chronic Disease Prevention through a contract with the University of Iowa, Department of Pediatrics. Within the University of Iowa, Child Health Specialty Clinics (CHSC) has responsibility for administration of the contract. A table of organization for CHSC is located in the attachment.

Responsibility for family-centered, community-based, coordinated care for CYSHCN is placed in the CHSC statewide system of regional child health centers. Since 1976, the regional centers have provided multidisciplinary community-based resources for children with complex health and health-related problems. The regional centers support specialized diagnostic and evaluation services, care coordination services, family support, and infrastructure building efforts. The centers are permanently staffed by advanced registered nurse practitioners, nurse clinicians, Family Navigators, registered dietitians, and support staff. A map of the CHSC regional centers, in addition to other general program information is located at www.chsciowa.org. CHSC's Director is a pediatrician who also functions as chief medical officer.

CHSC has history of managing several federal grants and contracts that build systems of care for CYSHCN. In prior years multiple grants had fallen under the general heading of the Iowa Medical Home Initiative (IMHI), which ultimately strived to meet the national goal of enrolling all CYSHCN in a medical home. Another MCHB-funded grant, which ended in 2005, directed CHSC to build a system of adolescent transition services to promote, among other system improvements, the medical home model for adolescents with special health care needs. Although the grants have ended, CHSC will continue involvement in statewide spread of the medical home model by offering its care coordination expertise and service to community-based primary care providers serving CSHCN. CHSC implements the MCHB-funded Iowa Family-to-Family Health Information Center which is another resource to emerging medical homes seeking to become more family-centered. CHSC leads an MCHB grant to provide follow-up to infants and toddlers identified with hearing loss. In collaboration with IDPH's CDC EHDI funds, CHSC is developing Iowa's EHDI system of care. CHSC Family Navigators work with families of children with autism spectrum disorder to teach them applied behavior skills through a partnership with the University of Iowa's

Center for Disabilities and Development's NIH-funded project. CHSC collaborates with the DHS to create a statewide system of care for children and youth with serious emotional disorder through a SAMHSA Children's Mental Health Initiative.

New ARRA-supported contracts between CHSC and Iowa's Early ACCESS (Part C, IDEA) program have expanded CHSC's role in improving and influencing early childhood programs. Some examples are: increased service coordination for infants and toddlers enrolled in Part C; systems-building efforts such as quality improvement for infants born prematurely; evaluating the effects of environmental toxin exposure on early child development; promoting early childhood literacy; studying early childhood risk factors associated with selected "upstream" social determinants of health, exploring the use of telemedicine to deliver in-home nutrition services to infants and toddlers ages 0-3, and assuring critical health reviews are conducted on infants and toddlers served by Part C early intervention.

/2012/ CHSC is a new affiliate of the national Help Me Grow Center to assure the healthy development of young children. CHSC also receives funding from the Heartland Genetics and Newborn Screening Collaborative to connect families of children and youth with inheritable disorder through the use of social media. //2012//

/2013/CHSC will begin to transition the Family to Family (F2F) Health Information Center to a new grant recipient in June 2012. CHSC will remain an active collaborator in Iowa's network of F2F IA. The Help Me Grow Leadership Council became a subcommittee of Project LAUNCH, a SAMHSA funded systems of care project. CHSC received HRSA funds to implement Community Child Health Teams with new partners, including two state children's hospitals and two Federally Qualified Health Centers. Environmental Toxins studies supported by ARRA funds in FY 2012 are being analyzed by a newly formed interagency group to study the impact of environmental toxins on the health of children.//2013//

/2014/ Magellan contracted with UI Pediatrics' Center for Child Health Improvement and Innovation to create a team to develop and implement guidelines for treating children and youth with serious emotional disturbances in all counties and provide technical assistance for providers. CHSC is expanding external care coordination with primary care. CHSC leads coordination efforts for new ASD initiatives from DHS, DE, IDPH and ASD diagnostic and treatment centers. 1st Five, Home Visiting and CHSC are initiating new partnerships.//2014//

/2015/CHSC restructured and is now part of the University of Iowa Division of Child and Community Health in the Stead Family Department of Pediatrics. CHSC subcontracted EHDl tasks to IDPH from January 1 -- March 30, 2014. IDPH applied for and was awarded the HRSA EHDl funds for 2014-2017. The IH Waiver is now called the Health and Disability Waiver. CHSC implemented the Regional Autism Assistance Program teams at 14 sites to assure a system of care for children with ASD and their families. Teams include ARNPs, RNs, and FNs who provide family-to-family support, and enhanced care coordination and screening. CHSC is implementing the Pediatric Integrated Health program in additional counties to serve children younger than 19 years with Serious Emotional Disturbances on Medicaid. CHSC hired staff to partner with the IDPH 1st Five team, emphasizing practice transformation and child health metrics. CHSC is forming a Family Advisory Council.//2015//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Maternal and Child Health

The administrative office for Iowa's Title V program is housed within the Iowa Department of Public Health located on the State Capitol complex in Des Moines, Iowa. The IDPH employs the

Bureau of Family Health Chief and Title V Director, a Division Medical Director, and 26 professional and four support staff who manage the functions of Iowa's Title V program. In addition, Title V in cooperation with EPSDT, supports the State Dental Director (DDS) and four public health hygienists (RDH). This staff is based in the central office. The department contracts with 21 local maternal health agencies and 22 local child health agencies to provide community-based MCH services throughout the state. For additional information about the responsibilities and structure of the local contract agencies, see section IIIB Agency Capacity.

/2012/In April 2011, M. Jane Borst retired from the Iowa Department of Public Health. An interim Title V director was named until IDPH fills the position. Due to a hiring freeze, IDPH has not hired the bureau chief, but established a five member transition team to guide the work of bureau staff. The number of professional staff increased to 31, due to new funding awarded to the Bureau.//2012//

/2013/Gretchen Hageman was promoted to the Title V Director and Bureau Chief for the Bureau of Family Health in October 2011. The BFH has 32 professional staff, with an additional 6 vacancies due to staff turnover and new funding awarded to the Bureau.//2013//

/2014/The BFH has 32 professional and support staff members, with an additional 5 vacancies due to staff turnover and new funding awarded to the Bureau.//2014//

/2015/In May 2014, Gretchen Hageman resigned from the IDPH. Dr. Bob Russell was assigned interim Title V MCH Director and Randy Mayer was named interim Bureau Chief until the position can be filled. The BFH has 35 professional and support staff members, with an additional 4 vacancies due to staff turnover and new funding awarded to the bureau.//2015//

Bureau of Family Health (BFH) staff members provide the capacity for policy development, program planning, and evaluation functions. Data reporting and analysis functions are provided through the capabilities of staff in the IDPH Bureau of Information Management (BIM) and a senior statistician now assigned to the BFH. The IDPH Center for Health Statistics (CHS) was decentralized. The senior statistician provides the data as a CHS staff person will continue to perform analysis for Title V programs as a BFH staff member. A BIM staff member serves as liaison to the BFH and focuses on data integration efforts for the major MCH data systems in Iowa.

The Bureau of Family Health established an agreement with CDC to have an MCH Epidemiologist assigned to Iowa. Dr. Debra Kane will assist the Department by providing consultation, technical assistance, surveillance and analysis of epidemiological information for Iowa's MCH population. Initial activities have focused on needs assessment and data integration and data linkages.***/2015/The Bureau successfully recruited a doctoral prepared Council for State and Territorial Epidemiology Fellow. The CSTE Fellow will begin her 2 year tenure in July 2014. Dr. Kane will serve as her primary mentor.//2015//***

Medicaid Administrative Services: Due to changes in the federal definition of targeted case management (TCM), Iowa Medicaid submitted an amendment to their state plan to change EPSDT informing and care coordination and maternal health presumptive eligibility and care coordination from TCM to administrative services. Through a contract between Iowa Medicaid and the Bureau of Family Health, presumptive eligibility, informing, and care coordination are billed to the BFH on a fee-for-service basis with a full review of documentation done before payment is made. Four new staff members were hired to conduct quality assurance reviews of the service documentation provided with the billing. The new staff members also conduct technical assistance with local MCH agencies on documentation, other quality assurance activities, and billing processes.

Children and Youth with Special Health Care Needs

Iowa's Title V Program for CYSHCN, Child Health Specialty Clinics (CHSC), is an administrative responsibility of Iowa Department of Public Health (IDPH), Division of Health Promotion and Chronic Disease Prevention, managed through a contract with the University of Iowa, Department of Pediatrics. CHSC maintains an Iowa City administrative office, as well as 13 regional centers located in or near the state's population centers. /2012/ Of the total staff complement, 17 staff members are in Iowa City, while 110 staff members are located in the other 13 CHSC regional centers or in telecommuting status. //2012//

/2013/There are currently 23 staff members in Iowa City and 118 staff members located throughout the 13 regional centers. For the past six years, 4 of the 13 regional centers have received major financial support from the Community Circle of Care (CCC) System of Care Grant from the Substance Abuse Mental Health Services Agency (SAMHSA). The grant is slated to conclude in the fall of 2012. State appropriations will replace some of the funding, but may not supplant all the necessary financial resources needed to maintain all four of the CCC regional sites at their current staffing patterns.//2013// /2014/ There are currently 25 staff members in Iowa City and 100 staff members located throughout the 13 regional centers. All 13 regional centers will be maintained but with slight modifications to staffing patterns. //2014//**/2015/CHSC is using state funding to maintain the four CCC Regional Centers. CCC patients on Medicaid are being transferred to Pediatric Integrated Health providers.//2015//**

The capacity to perform core public health functions is shared among professional and support staff. Public Health Division Unit staff have education and experience in public health science and practice and science of improvement methodology, and take a lead role in coordinating core public health activities. Families of CYSHCN add program capacity through the Family Navigator Network (FNN), a community-based network of part-time Family Navigators affiliated with the regional centers. CHSC's family participation program is led by three experienced members of the FNN. They lead the FNN by advising on policy and program planning, recommending training, monitoring activity, and updating resource information. All Family Navigators undergo a structured basic training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports. In addition they are also trained to perform specific tasks related to their unique roles, e.g. autism, Early ACCESS (IDEA, Part C), Ill and Handicapped Waiver, Community Circle of Care, etc)./2013/One 0.5 FTE position was added in 2012 to oversee all quality improvement efforts within CHSC. CHSC currently has a roster of between 35-40 paid Family Navigators on staff, each working between 10-20 hours per week. The list of current FN is included in the attachment. The Iowa AMCHP Family Delegate led the F2F IA Health Information Center grant for the past 3 years. Administration for the F2F HIC grant will be transitioned to a nonprofit family-driven agency beginning June 1st, 2012.//2013//2014/The F2F HIC was transferred to ASK Resource Center, a family-driven nonprofit agency. The Iowa Family Delegate is participating in aspects of the Block Grant review this year, including participating in the on-site federal review. An additional FN position was created to provide support to children during the time period between positive screen for Autism Spectrum Disorder and time of appointment at diagnostic facility. An MPH was hired to assist CHSC in data analysis and program evaluation. The newly established University of Iowa Center for Child Health Improvement and Innovation will provide staff that will interface with local Title V to serve well child as well as CYSHCN populations.

/2015/The Center for Child Health Improvement and Innovation hired quality improvement advisors, program coordinators, social workers, registered nurses, and family navigators for the Pediatric Integrated Health program. CHSC Family Navigator continues to serve as an AMCHP Family Delegate and other Family Navigators serve on UI Health Care Family Advisory Council and other local, state and national committees. CHSC is partnering with other organizations to embed family centered principles in trainings for future health care providers (such as LEND) and current providers in clinical teams and 1st Five sites. This will increase the percentage of CYSHCN who receive family-centered care. CHSC is

partnering with the National Resource Center for Family-Centered Practice, University of Iowa Center for Child Health Improvement and Innovation, ASK Resource Center and NAMI Iowa to develop a Family Navigator training program. The training is required for new PIH Family Navigators. CHSC is contracting with Child Psychiatrists to utilize telehealth to assure access to care. A Family Navigator continues to provide family to family support for families in the Adolescent Health, Genetics, and Hemophilia Clinics at the University of Iowa Hospitals and Clinics. CHSC is exploring how to continue Family Navigator presence with other tertiary centers in central Iowa after grant funding ends for the HRSA Community Child Health Team grant.//2015//

External contracts and grants have increased CHSC's capacity to contribute to prescribed priorities. Contracts with the Iowa Department of Education Part C Program have expanded CHSC's participation in the areas of early intervention (especially system development and quality assurance) service coordination, and delivery of nutrition services. ARRA-supported contracts between CHSC and Iowa's Part C early intervention program increased CHSC's role as service coordinator for infants and toddlers enrolled in Part C as well as other projects that address eligibility (e.g. addressing early childhood risk factors associated with selected "upstream" social determinants of health and exposure to environmental toxins)./2013/A contract with the Iowa Chapter of the American Academy of Pediatrics allowed CHSC to coordinate state agency efforts and successfully become an affiliate state of the national Help Me Grow initiative. CHSC is coordinating new nutrition promotion and obesity prevention programs by coordinating resources and expertise from new community-based partners, University of Iowa health leaders, AmeriCorps students, IDPH initiatives and the Iowa Health Literacy Council.//2013///2014/A former Americorp worker became a full-time CHSC Registered Dietitian to assist with service provision to children ages 0-3 years and overall nutrition infrastructure activities. Magellan contracted with CHSC to implement an Integrated Health Home Project for children with specific mental health diagnoses who are also on Medicaid. Center for Disabilities and Development via EPSDT funding contracted with CHSC to provide technical assistance related to transitions tools for youth with special health care needs. De continues to contract with CHSC for the Regional Autism Assistance Program.//2014//***2015/CHSC hired a full-time Program Coordinator to coordinate the Regional Autism Assistance Program and another Program Coordinator to facilitate ASD activities required in a contract with the Iowa Department of Education. The Iowa Department of Education continues to contract with CHSC for one of these fulltime employees.//2015//***

Contracts with the Iowa Department of Human Services commit CHSC to provide care coordination to "medically fragile" children enrolled in Medicaid Waiver Programs and to develop a system of Family Navigators for the state. /2013/The DHS contract to develop the system of Family Navigators will be ending September 2012. Sustainability discussions are underway with key family advocacy leaders.//2013///2014/ CHSC contracted with Magellan for a pilot to employ FNs to work with families whose children have diagnosed mental health conditions.//2014//***2015/The pilot led to a continued contract with Magellan for Family Navigators to provide services to children with the highest need related to Serious Emotional Disturbances (SED).//2015//***

CHSC is contracted to lead the clinical care component of a major system improvement effort in ten counties of NE Iowa for children with severe emotional disorders. This six year effort, ending in 2012, is intended to produce a sustainable model that can successfully spread to the entire state. /2013/CHSC received state appropriations to sustain the Community Circle of Care model in a limited number of regions while continuing to spread the paradigm statewide through interagency partnering and exploration of additional funding streams and policy change.//2013// /2014/ State appropriations in the amount of \$1.4m were secured to support many of the functions at the four regional centers formerly designated at CCC sites. The project continues to collaborate with other state and local initiatives, including the Integrated Health Home project funded by Magellan which includes revenue-generating activities. //2014//***2015/CHSC staff in the PIH project network with providers from all Iowa counties to help create a seamless***

system of care and influence positive policy change.//2015//

Another significant element of program capacity relates to service billing. CHSC professional services are systematically billed at levels that accurately reflect the intensity and skill of the service. A sliding fee scale continues to be employed to determine family liability. /2012/Senior level management employees are Gretchen Hageman, interim Iowa Title V Director; Julie McMahon, interim bureau chief for the Bureau of Family Health; Dr. Bob Russell, Public Health Dental Director//2012//; and Dr. Debra Waldron, Director and Chief Medical Officer of Child Health Specialty Clinics./2015/***CHSC continues quality improvement efforts to assure appropriate charge capture regarding screening.//2015//***

/2013/Senior level management includes Gretchen Hageman, Iowa's Title V Director; Dr. Bob Russell, Public Health Dental Director; and Dr. Debra Waldron, Director and Chief Medical Officer of Child Health Specialty Clinics.//2013// Their qualifications appear in brief biographies attached to this section. Debra Waldron, MD, MPH, also serves as the medical director for the Iowa Department of Public Health's Division of Health Promotion and Chronic Disease./2014/ Dr. Waldron was appointed Director of the newly created Division of Child and Community Health at the University of Iowa Department of Pediatrics. The Division houses CHSC and the Center for Child Health Improvement and Innovation. //2014//2015/***Dr. Russell was appointed Interim Title V MCH Director for Iowa. Randy Mayer was appointed Interim Bureau Chief of the Bureau of Family Health in the Iowa Department of Public Health. Debra Waldron continues as Director and CMO of the UI Division of Child and Community Health.//2015//***

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

The following descriptions highlight significant organizational relationships within Iowa that enhance the capacity of the Title V program. These descriptions do not capture extensive coordination efforts undertaken by the state's Title V program. A complete listing of formal and informal organizational relationships is located in the attachment.

Special Supplementary Nutrition Program for Women Infants and Children (WIC)

WIC coordinates with MCH (Title V) services at the local level to provide comprehensive services to low-income women and children. /2012/Service models tend to vary in different localities, but to different degrees, staff members:

1. Collaborate to provide nutrition education focused on identified nutrition issues for women such as maternal gestational diabetes and breastfeeding.
2. Attempt to provide a consistent message to parents concerning the value to families of receiving both WIC and Title V Services.
3. Collaborate with oral health services to provide preventive oral health services by combining nutrition education and services from a Registered Dental Hygienist which can include oral health screening, application of fluoride varnish, and dental referrals.
4. Collect samples for lead screening for high serum lead when collecting a hemoglobin, an anemia screen for the WIC program. After the sample is tested, Registered Dietitians in the WIC program are available to provide nutrition counseling to families identified as positive for high serum lead.//2012//

The Bureau of Nutrition and Health Promotion coordinate the nutrition components of MCH projects and provide staff assistance. Training, consultation, and educational programs are available for all MCH programs.

/2013/A partnership between the Bureaus of WIC and BFH will result in Title V contract agencies having access to consulting on nutrition-related issues. Additionally, this partnership results in health and nutrition consultation for local MCH programs related to maternal nutrition,

breastfeeding, infant nutrition and child nutrition.//2013//

/2015/WIC coordinates with Title V in determining eligibility for Title XIX which makes women and children also eligible for WIC.//2015//

Family Planning

/2013/In 2011, Iowa completed the final year of the demonstration project for the Iowa Family Planning Network (IFPN) waiver. IDPH assisted DHS in the reapplication process. In 2012, the IFPN was renewed with expanded eligibility to include persons to age 55, males, persons with credible insurance that does not cover family planning services and persons with incomes at or below 300% of federal poverty level.

Because of the Iowa Initiative, long acting reversible contraceptive use by clients in the IDPH Title X project has risen to 16% from 3% in 2009. Although the number of clients seen in the IDPH Title X project dropped slightly in 2011, mirroring a national trend, the number of male, adolescent, African American and Hispanic clients has shown a steady increase. Of the total FFY 2011 IDPH Family Planning Program clients, Hispanics and African Americans made up 6% and 10% (respectively); adolescents were approximately 30% of the client, and 5% were male clients.

Title X family planning programming will interface with activities of the PREP and abstinence education projects, especially around outreach to males, teens and youth both in and aging out of foster care.//2013//

/2014/Title X providers are moving forward with participation in ACOs, transitioning to Electronic Health Records, and are working to develop formal linkages with FQHCs to expand Title X services through those agencies. Title X providers are working to improve coding and billing practices to respond to the changes of the ACA and promoting health homes for all Title X clients.

In 2012, the number of clients again dropped slightly, mirroring the rest of the country. The number of Hispanic and male clients continues to increase. In 2012 67% of clients seen were under 100% of the federal poverty level. Reproductive life plan counseling was completed at 19,541 client visits.//2014//

/2015/Six of seven Title X providers have transitioned to electronic health records. IDPH began working with an FQHC in Polk County to provide Title X family planning services and plans to expand access to other locations. Training on ICD -- 10 transitions will occur as necessary in 2015. Reproductive life planning trainings at birthing hospitals are scheduled to occur in 2015.//2015//

IDPH and Iowa DHS Agreements

Iowa DHS and IDPH work together to establish multiple agreements for initiatives that are mutually beneficial for the populations served. The following agreements initiated by DHS reflect the collaborative partnership between these state agencies.

DHS Cooperative Agreement

IDPH, Division of Health Promotion and Chronic Disease Prevention, maintains an ongoing cooperative agreement with DHS. The agreement defines coordinated efforts toward an integrated system of high quality, comprehensive, cost-effective, adequately financed health services for Medicaid members.

DHS Agreement for EPSDT -- Maternal Health -- Oral Health

EPSDT, maternal health, and oral health state agency coordination is necessary in order to

assure that families receive appropriate services. The IDPH provides services for the EPSDT program and the Maternal Health program under an intergovernmental agreement with DHS. Under this agreement, local CH contract agencies are approved as Medicaid Screening Centers, and local maternal health contract agencies are approved as Medicaid Maternal Health Centers. The I-Smile dental home initiative serves to improve access to Medicaid's dental prevention and treatment services for children and pregnant women. Local Title V agencies are able to bill Iowa Medicaid for covered services provided to Medicaid members.

Local CH care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the services available under the EPSDT program and the importance of regular well-child and dental exams. Care coordination services link children with needed medical, dental, and mental health services. DHS downloads information on Medicaid enrolled children into CARES, which is then available to local CH contract agencies.

Local MH agencies provide services for pregnant women according to standards established by the American College of OB/GYN for ambulatory obstetric care. MH services include medical and dental assessment, health and nutrition education, psychosocial screening and referral, care coordination, assistance with plans for delivery, and postpartum home visiting.

Assurance of medical and dental homes for regular preventive health care for children and pregnant women remains a cornerstone of the work accomplished by local contractors. Care coordinators partner with local practitioners to establish medical and dental homes. Local MCH contract agencies provide limited gap-filling direct care services based upon local need.

//2014/A component will be added to this agreement to incorporate infrastructure building activities for 1st Five. Local 1st Five contract agencies will be able to claim fee-for-service reimbursement for EPSDT medical provider consultation regarding the initiative and EPSDT provider and community partner trainings. It will also cover activities of the state coordinator and program evaluation.//2014//

DHS Agreement for Administrative Services

The administrative services agreement between IDPH and DHS provides funding for IDPH to pay fee-for-service claims for EPSDT informing and care coordination services as well as maternal health presumptive eligibility and care coordination provided by local contract agencies. This payment process began in February 2009 due to classification of these services as 'administrative' under Medicaid. IDPH implemented billing procedures and established parameters for quality assurance review of claims prior to payment. Technical assistance is provided as needed for local contract agencies.

//2013/Central to this agreement is a structure for payment by IDPH for these administrative services and a process for monitoring and quality review of the claims submitted to IDPH by local contract agencies.//2013//

DHS Medicaid Outreach Agreement

The purpose of this interagency agreement is to maintain the toll free 1-800 information and referral line known as the Healthy Families Line. The line distributes health information that meets the individual's needs. The service connects the caller directly to their local MCH contract agency where care coordinators can assist the caller to link with local resources.

DHS Medicaid and Vital Records Linked Data Agreement

In 1989, Iowa legislation directed DHS to evaluate the Medicaid program's effectiveness in serving low-income pregnant women. To examine the pregnancy and birth outcomes of women receiving Medicaid benefits, Medicaid claims data and birth certificate data are needed. An

annual inter-departmental agreement is executed by DHS to provide Medicaid claims data to the IDPH. IDPH staff link Medicaid claims data to birth certificate data. The results are used to examine access to prenatal care and preventive dental care for pregnant Medicaid women, as well as to compare birth outcomes of those on Medicaid to non-Medicaid members.

/2015/The four agreements with DHS, as described above, were established for 2015. The EPSDT, Maternal Health, Oral Health, 1st Five agreement was established for a new six-year project period. The other agreements operate under continuation amendments.//2015//

hawk-i (Healthy and Well Kids in Iowa)

For the past eight years, DHS has contracted with IDPH to provide grassroots outreach and enrollment for hawk-i. IDPH continues to contract with 22 local CH agencies to conduct grassroots hawk-i outreach and focus on children's enrollment. The successful collaboration between IDPH and DHS continues to guide successful outreach to uninsured families in Iowa. Outreach efforts focus on four areas: schools, health care providers, faith-based organizations and special populations. Additional efforts have included businesses, workforce development, chambers of commerce, insurance agents, tax preparation sites, and many other areas. /2012/ DHS has contracted with IDPH for the past nine years to provide grassroots outreach and enrollment for hawk-i.//2012//

As a result of the recent implementation of Iowa's hawk-i dental only program and the presumptive eligibility for children program, outreach has expanded to several new community partners. DHS and IDPH partnered with the Department of Education to provide training opportunities to Iowa's school nurses. School nurses in several of Iowa's school districts have been certified as qualified entities to determine children presumptively eligible for hawk-i or Medicaid. Other entities may include hospitals, primary care physician offices, rural health centers, federally qualified health centers, area education agencies, Early ACCESS service coordinators and Indian health providers.

In light of the recent reductions in the workforce and increasing unemployment rates, coordinators have focused on strengthening the collaboration with Iowa Workforce Development centers, temporary employment agencies and community job loss rapid response teams.

/2012/Most recently, DHS released an Informational Letter (No. 978) announcing their acceptance of applications for providers to enroll as qualified entities in determining presumptive eligibility for children. These providers include Iowa Medicaid hospitals, physicians, rural health clinics, local education agencies, maternal health agencies, federally qualified health centers, family planning centers, screening centers, area education agencies, advanced registered nurse practitioners, Early ACCESS service coordinators and Indian health service providers.//2012//

/2015/hawk-i outreach coordinators are experts on healthcare reform and the Health Insurance Marketplace and stay up to date on changes to the hawk-i program. Coordinators focused on educating communities on these changes and replacing outdated applications and information with new brochures to ensure families are aware of the hawk-i program. Coordinators began to utilize social media to better reach families and professionals who work with families. The local outreach coordinators began to play a much larger role in assisting families through the application process and ensuring they obtain coverage.

Iowa is interested in examining if the Health Insurance Marketplace will have an implications on hawk-i enrollment numbers, currently we are unable to get that data, since there have been system changes in Iowa. Hawk-i staff look forward to examining this in the next year.//2015//

Preventable Diseases Program

The Bureau of Immunization and Tuberculosis administers the program for vaccine preventable diseases. Vaccines are available to local health departments, CH agencies and private physician's offices for required childhood immunizations. The Immunization Registry Information System (IRIS), a web-based registry, now serves the state's public sector clinics and private providers. The BFH, Immunization and TB and DHS collaborate to promote statewide utilization of the registry in both public and private clinics.

Childhood Lead Poisoning Prevention Program

Since nearly 40 percent of the state's housing was built prior to 1950, IDPH recommends all Iowa children under the age of six receive routine blood lead testing. Local contract agencies, local health departments and private practitioners test children. IDPH educates private practitioners about the importance of testing children for lead poisoning. Case management of children with lead poisoning is a collaborative effort of the Childhood Lead Poisoning Prevention Program, the Bureau of Family Health, local contract agencies and local health departments.

Bureau of Local Public Health Services

The bureau was established to strengthen the public health delivery system in Iowa at both the state and local level through education, consultation, support and technical assistance for local boards of health and local health systems. The capacity of Iowa's local boards of health are increased through local health departments, public health agencies, programs and services. Increased capacity promotes healthy people in healthy communities. Regional community health consultants provide training and technical assistance to local public health agencies regarding assessment of their community's health needs and creation of health improvement plans. Technical assistance and education is also provided to local boards of health by the consultants to assist in preparation for meeting the Iowa Public Health Standards developed through Public Health Modernization in Iowa.

Iowa Center for Congenital and Inherited Disorders

The Center for Congenital and Inherited Disorders (CCID), in partnership with the University of Iowa and health care providers throughout the state, provides comprehensive genetics services. IDPH manages the five CCID programs with assistance from the Congenital and Inherited Disorders Advisory Committee (CIDAC). The five programs are the Iowa Neonatal Metabolic Screening Program (INMSP), the Expanded Maternal Serum Alpha-fetoprotein Screening Program (MSAFP), Regional Genetic Consultation Services (RGCS), the Neuromuscular and Related Disorders Program, and the Iowa Registry for Congenital and Inherited Disorders (IRCID). The INMSP, the RGCS, and the Neuromuscular and Related Genetic Disorders Program conduct statewide outreach clinics. Clinics offer diagnostic evaluation, confirmatory testing, medical management, education, case management, consultation and referral.

The IRCID mission is to maintain statewide surveillance for collecting information on birth defect occurrence in Iowa, monitor annual trends in birth defect occurrence and mortality, conduct research studies to identify genetic and environmental risk factors for birth defects and promote educational activities for the prevention of birth defects. In 2002, the IBDR developed a parental notification system that informs parents or guardians of children who are diagnosed with a birth defect and provide them with resource information. The parental notification system includes a resource brochure and a notification letter. The CCID works closely with the Early Hearing Detection Initiative to coordinate screenings for all newborns in the state.

In 2009, Iowa contracted with the North Dakota newborn screening program coordinator to implement a "regional" newborn screening coordinator position. This person is responsible for the coordination of both states' education, communication, and quality assurance efforts regarding

the newborn metabolic screening programs. Iowa also secured another CDC funded grant to expand the existing birth defects registry to include confirmed newborn screening cases. The Early Hearing Detection and Intervention (EHDI) program is included in this project, and work is underway to build a data dictionary necessary for EHDI reporting, based upon the completed work that established the variables and data dictionary for the metabolic screening reporting.

/2012/ The EHDI program is now under the auspices of the CCID. The state EHDI coordinator and the state genetics coordinator are exploring efficiencies and reduction of duplication through program integration. The tri-state newborn screening program is undertaking a quality enhancement initiative to integrate a culture of quality in NBS programming. //2012//

/2013/The CCID state genetics coordinator met with chronic disease prevention program managers representing colorectal cancer, breast and cervical cancer, cardiovascular disease, diabetes and environmental health to discuss collaboration on a life course plan for IDPH. The aim is to organize public health program planning, implementation and evaluation along the life course (rather than according to department table of organization or funding sources). A life course work group was developed and includes program managers, community members, and other state and academic partners. This workgroup will serve as the AMCHP Life Course Metric workgroup and includes the state genetics coordinator, the CDC-assigned MCH epidemiologist, and Iowa's Title V director and Iowa's Children with Special Health Care Needs Director. //2013//

/2014/ In May 2013, an intern from the UI College of Medicine worked with the state genetics coordinator to build an inventory of genetic services and programming offered across the state. This inventory was used to illustrate the provision of genetic programming across the life course. Strategic planning efforts are underway to align genetic programming across the life course to indicate time periods of optimal impact on health promotion and chronic disease prevention for the individual. //2014//

/2015/CCID is working to implement life course metrics.//2015//

Unintentional Injury Prevention

/2012/ Bureau of Family Health staff members continue to participate in the IDPH Statewide Injury Prevention Advisory Council and the IDPH Healthy Homes Initiative. In addition, the bureau has new funding from the Family Violence Prevention Fund for prevention of domestic violence. A statewide conference was held in December 2010 to educate providers of women's health services on identification and intervention in domestic violence situations.

Healthy Child Care Iowa (HCCI) continues to work through local and regional Child Care Nurse Consultants (CCNCs) to provide onsite injury prevention assessments of early care, health, and education providers at no cost to the provider. CCNCs are employed by or under contract with local CH agencies. Assessments utilize US Consumer Product Safety Commission recall notices, safety notices and guidelines to assess the environment for hazardous and recalled equipment, and site specific hazards. Additionally, CCNCs assess provider policies and practices related to injury risk such as use of age appropriate equipment, handling and storage of hazardous substances, and use of active, direct supervision. //2012//

/2013/BFH staff continue to implement Project Connect, which is designed to identify, respond to, and prevent domestic and sexual violence, as well as promote an improved public health response to abuse. BFH staff presented at the National Conference on Health and Domestic Violence featuring a photo voice project, developed in conjunction with a maternal health contract agencies.

BFH staff participates in the newly established Healthy Homes Advisory Committee. Members will participate in developing the Healthy Homes Strategic Plan, the first phase of implementing a 3 year Healthy Homes and Childhood Lead Poisoning Prevention Program grant awarded to IDPH

by the CDC.

Through HCCI, CCNCs provide 'Injury Prevention in Iowa Child Care' training throughout the state through Child Care Resource & Referral. 'Hazard Mitigation' and an 'Emergency Preparedness Planning' templates can be completed by child care providers to earn points in Iowa's QRS. The emergency preparedness plan must have MOAs with relocation sites and emergency transportation providers, and document that 24 hours of emergency supplies on hand in the facility.//2013//

/2014/ ServSafe Certification has been added as a point-able item to Iowa's QRS for child care providers, to encourage providers to become safe food handlers and prevent food-borne illness. Iowa will become an Eco-Healthy Child Care expansion state in 2014.//2014//

/2015/BFH staff worked with ISU Extension and Area Education Agencies (AEA) to disseminate an educational component for secondary level students designed by the National Center on Shaken Baby Syndrome. Program kits are available for use in schools to help middle school and high school students establish a foundation for good parenting by teaching that it is never okay to shake or otherwise harm a baby.//2015//

Early ACCESS

Early ACCESS (EA) is a federal program under the Individuals with Disabilities Education Act (IDEA, Part C). In Iowa, the program is an interagency collaboration among the Departments of Education, Public Health, Human Services and Child Health Specialty Clinics. The system is a partnership between families with young children ages 0 to 3 years and providers from the agencies listed above. The purpose of EA is to identify, coordinate and provide needed services and resources that will help families assist their infant or toddler to grow and develop. The Iowa Department of Education (DE) is the lead agency, as appointed by the Governor for the implementation and maintenance of the system. A state level multidisciplinary council, the Council for EA, advises and assists the DE in the implementation of Early ACCESS.

Signatory partners collaborate with the DE to address the needs of children ages 0-3 years with developmental delays or who have a high probability of delay and their families. Child Health Specialty Clinics provides service coordination to premature, medically fragile and drug exposed children, as well as provides nutrition services of all children enrolled in EA that require nutrition services. IDPH provides service coordination to children who have /2012/ venous lead levels of 20 ug/dl and above. //2012//

/2014/ Effective October 1, 2013 IDPH will no longer provide EA service coordination for children who have a venous lead level of 20ug/dl and above. IDPH will focus on child find activities for EA. In order to identify children, MCH agencies will: increase community awareness of EA by providing outreach and education; work with medical providers to understand the importance of early identification; provide developmental screening for children who are not being screened by their PCPs or other community partners; and implement a developmental screening system for children who are not eligible for EA. Currently EA does not have a system in place to follow up and/or provide education to families found not eligible. The developmental screening system will provide a safety net for families who may need ongoing monitoring or information on child development.//2014//

Federally Qualified Health Centers (FQHCs)

/2013/Iowa currently has 13 FQHCs:

1. Community Health Care in Davenport
2. Community Health Center of Fort Dodge, Inc.
3. Community Health Centers of Southeastern Iowa in West Burlington
4. Community Health Centers of Southern Iowa in Leon

5. Council Bluffs Community Health Center
6. Crescent Community Health Center in Dubuque
7. Linn Community Care in Cedar Rapids
8. Peoples Community Health Clinic in Clarksville
9. Primary Health Care, Inc. in Des Moines and Marshalltown
10. Proteus Employment Opportunities in Des Moines
11. River Hills Community Health Center in Ottumwa
12. Siouxland Community Health Center in Sioux City
13. United Community Health Center Inc. in Storm Lake//2013//

Primary Care Association

//2012//IDPH has a long-standing relationship with the Iowa Primary Care Association (IPCA). The Association provides technical and non-financial assistance to the community and migrant health centers of Iowa. These health centers offer comprehensive, physician-based "one-stop" primary care with a focus on prevention. The fourteen community health centers in Iowa are IPCA members. The Association works closely with the Iowa Department of Public Health, along with the Federal Bureau of Primary Health Care at the US Health Resources and Services Administration, and participates in collaborative activities promoting quality health care services.//2012//

Child Health Specialty Clinics

The Child Health Specialty Clinics (CHSC) administrative offices are located at the University of Iowa in Iowa City. Proximity to a major university health center provides a source of pediatric and public health expertise that is shared with CHSC's statewide staff and collaborating agencies. Continuing education programming occurs on-site in Iowa City, at community locations, over the statewide fiberoptic communication network, and via internet webcam connections. Health professionals and public health students -graduate and undergraduate -learn about community-based service delivery through observation and participation in direct care specialty clinics, care coordination services, family support and infrastructure building activities. CHSC's relationship with the University provides information technology resources, financial management services, public policy expertise, and research design and program evaluation consultation.

CHSC maintains interagency agreements with state entities. The following list indicates the agencies with which CHSC maintains agreements and summarizes the purpose of each agreement. CHSC has formal agreements with:

- 1) IDPH, BFH -to promote development of a cooperative and collaborative relationship at state and local levels through cross-referrals, sharing of staff, coordinating staff training, and interfacing data systems;
- 2) The Iowa Chapter of the American Academy of Pediatrics to provide staff to perform duties required of a state affiliate of Help Me Grow and to develop collaborative partnerships with the Iowa Chapter of American Academy of Pediatrics public health programs serving CYSHCN.**//2015//IDPH now contracts directly with Help Me Grow. CHSC contracts with Iowa Chapter of American Academy of Pediatrics for social media activities.//2015//**
- 3) IDPH to provide medical consultation to the Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health.**//2015//Contract ended.//2015//**
- 4) IDPH to provide community-based clinical consultation and care planning recommendations for children and youth with any combination of special needs. Provide core public health functions of assessment, policy development and assurance as applicable to system development and quality improvement for children and youth with special health care needs.//2013//Child health teams consisting of ARNPs, RNs and Family Navigators (parents or primary caregivers of CYSHCN)

team with primary care providers within the community and specialists located throughout the state, for most efficient use of resources. New initiatives are occurring with Blank Children's Hospital (Adolescent Clinic and Pediatric Clinic), the University of Iowa Hospitals and Clinics Adolescent Health Clinic and Federally Qualified Health Centers to assure care coordination, family support, and access to telehealth. Potential to co-locate selected CHSC regional offices at Title V grantee agencies is also being explored.//2013///2014/ Sioux City CHSC center co-located with local public health. //2014//

5) IDPH to provide a mechanism for sharing information to facilitate child find, follow-up, and quality assurance to further develop and enhance a quality EHDI surveillance system. Follow-up with families to ensure all children are screened and offered family support services is the primary focus. **/2015/CHSC transferred responsibility for the EHDI program to IDPH.//2015//**

6) Individual Area Education Agencies, using American Reinvestment Recovery Act (ARRA) funds, to provide service coordination and/or nutrition services, as defined in Iowa's IDEA rules and regulations, through a family-centered process to infants and toddlers and their families when eligibility is based on a health or medical condition./2013/ARRA funds expired in September 2011.//2013//

7) Iowa Department of Human Services (DHS) -to define responsibilities of the parties in assessment, planning, and care coordination activities for children with special health care needs who are recipients of the EPSDT Program of Title XIX (Iowa Medical Assistance Program) and applicants and recipients of the consolidated Waiver Programs of Title XIX. /2014/ CHSC will create or identify existing transitions tools to assist providers, care coordinators, youth, and families served by the EPSDT program. //2014// **/2015/EPSDT will make recommendations to the state regarding transition services. The Center for Child Health Improvement and Innovation/CHSC will conduct an evaluation for the SAMHSA System of Care Planning Grant, known as the Iowa Children's System of Care Initiative.//2015//**

8) DHS/Mental Health Disability Services --To support families of children with developmental disabilities in accessing services and supports by building and operating the Family Support 360 Iowa Navigation Network (Family 360-INN), a key component in the development of a family-driven statewide system of care for children in Iowa./2013/The FS 360 funds will expire September 30, 2012. Sustainability conversations are occurring, to continue Family to Family Iowa activities after the grant expires.//2013///2014/ CHSC collaborates with the new F2F-HIC grantee.//2014//

9) DHS --Funding through SAMHSA, Northeast Iowa Children's Mental Health Initiative. Develop and provide family-centered and community-based services for children with Severe Emotional Disturbances in a 10 county area./2013/SAMHSA funds will expire September 30, 2012.//2013///2013/Iowa's Statewide Systems of Care workgroup provides technical assistance, training, and support to providers regarding Systems of Care and wraparound services. Participants include representatives of mental health and health care providers, decategorization and county funded programs, and Systems of Care programs, with an interest in learning about Systems of Care, networking with other providers of children's mental health services, or integrating Systems of Care practice and principles into their program.//2013///2014/ DHS administers new Iowa Autism Support Fund with linkages to Title V. //2014///**2015/CHSC administers the Pediatric Integrated Health Home program for contracted counties serving children with serious emotional disturbances.//2015//**

10) Iowa Department of Education (DE) --Through ARRA funds, provide specific deliverables that will benefit infants and toddlers ages 0-3 years, e.g. white paper re social determinants of health; white paper on exposure to environmental toxins; nutrition services delivered in natural environments; quality improvement for Iowa's system of care for premature infants; promotion of early literacy through Reach Out and Read; training for professional working with children with autism spectrum disorder; service coordination for children in foster care. Activities will be

completed by September 30, 2011./2013/All projects were completed according to specifications by September 30, 2011, at which time ARRA funds were no longer available./2013//

11) DE -to delineate roles and responsibilities and provide technical assistance in the implementation of Early ACCESS (Part C, IDEA) including coordination and non duplication of services. To provide Early ACCESS service coordination and nutrition services for infants and toddlers who are born prematurely, drug-exposed, or medically fragile that contribute to a coordinated, statewide system of family-centered early intervention services./2015/CHSC trained **RNs to conduct health assessments to inform early intervention providers of health implications of interventions recommended.**/2015//

12) DE to provide consultative technical assistance and staff development in the area of Autism disorders to state and local agencies serving children and youth with Autism. /2014/ New state appropriations secured for ASD. The UI Hospitals and Clinics -- Leadership from CHSC also directs the UI Department of Pediatrics' new Center for CH Improvement and Innovation that promotes health system integration. Initial project spreads Pediatric Integrated Health Homes throughout Iowa./2014//2015/CHSC **participates in quality improvement activities directed by the UI Center for Child Health Improvement and Innovation.**

13) ChildServe was selected to serve as a new location for CHSC telehealth activities.

14) IDPH contracts with CHSC to administer the Regional Autism Assistance Program./2015//

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 08 - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	7000	6797	6970	7126	7207
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2013

Source: <http://childhealthdata.org/browse/titlev/state-ssi-data>. Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Tables produced by SSA/ORDP/ORES/DSSA. Contact Clark Pickett, (410) 965-9016 or clark.pickett@ssa.gov for further information. See Narrative for explanation of progress.

Notes - 2012

Source: <http://childhealthdata.org/browse/titlev/state-ssi-data>. Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Tables produced by SSA/ORDP/ORES/DSSA. Contact Clark Pickett, (410) 965-9016 or clark.pickett@ssa.gov for further information. See Narrative for explanation of progress.

Notes - 2011

Source: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table produced by SSA/ORDP/ORES/DSSA. See Narrative for explanation of progress.

Narrative:

Iowa's Title V definition of rehabilitative services includes a detailed discussion with each family of a child determined eligible for SSI. The discussion is offered to eligible families who are served by CHSC's Health and Disease Management staff (HDM). Annually CHSC's HDM staff serves approximately 2300 children and youth less than 16 years of age. These 2300 children include children that receive prior authorization for Medicaid Private Duty Nursing that are not on the Health and Disability Waiver (HDW) but are on the Intellectual Disability and Brain Injury waivers. The discussions reiterate the beneficiary's eligibility and encourages application for Medicaid, as well as describe additional Title V CYSHCN services that may be useful or of interest. The CYSHCN Program realizes that SSI eligibility discussions with families to request assistance from Title V are not precisely the same as providing "rehabilitative services;" however, that discussion does offer a connection between SSI beneficiary families and Title V services. Discussions occur with approximately 90% of families served by CHSC's HDM staff, under age 16 years who are approved for SSI. Discussions do not occur with 100% of families because a relatively small percentage of SSI-approved children reside in foster homes or other out-of-home placements and are in regular contact with DHS, the logical and more effective resource regarding rehabilitative services. For the large majority of SSI-approved children, CHSC reminds families to apply for Medicaid. Medicaid eligibility is automatic, but enrollment is not, so application is necessary. CHSC staff also provide other information regarding access to direct health care services, care coordination, and financing. Families are encouraged to contact the CHSC regional office nearest them if they feel CHSC might be of assistance.

In 2010 and 2011, CHSC requested assistance from the Disability Determination Services (DDS) in Iowa to potentially disseminate written communication to families. Due to several staffing changes within the DDS, the request was not fulfilled. In FY11 CHSC contracted with a consultant to train IHWP staff regarding transition from youth to adult. FY11, CHSC served 1702 children under age 16 who were either on or applying for the IHWP.

Twenty DHS SSI Field offices continue to display materials as requested by CHSC. CHSC continues to send supplies to the Field offices quarterly. In FY 2013, CHSC served 1878 children under age 16 years who were either on or applying for the HDW. DHS personnel indicated there were 1,183 children under age 16 with SSI income in FY 2013. In 2013, CHSC also revised the process for changing a Medicaid member from a Managed Health Care (MHC) Program to a non-MHC Program. The goal was to streamline the change process and improve standardization. CHSC provides care coordination for families who are approved to change from a Medicaid MHC Program to a non-MHC Program.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	No

Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2015

Narrative:

The Bureau of Family Health (BFH) Data Integration Project seeks to integrate currently siloed program data in two phases. An integrated data system will support the life course model by providing longitudinal tracking of clients as they transition through programs and to analyze data across the life span. Currently, multiple data systems within the BFH facilitate care management, resulting in redundant data entry and reporting and limited data accessibility and reduced long-term system viability. Additionally, some of the BFH data systems are not web-based, resulting in delayed access to data and risks for data loss. Phase 1 will produce an electronic data management system to include case management, referral management, risk assessment, billing, and client and population-level reporting. This system will replace existing separate systems to integrate data collection, case management, and reporting and analysis. Phase 2 will create an electronic repository to document screening, further testing, and follow-up/referrals for early childhood screening programs. Both systems will have high levels of interoperability and be able to access data from various sources such as EHRs and public health databases.

The estimated project duration once a vendor contract is in place is 24 months, and the estimated project budget is \$3.5 million for initial startup. Continued hosting and maintenance costs are estimated to be up to \$200,000 per year.

Based on information gathered through a needs assessment conducted with state and local partners as well as external stakeholders, a gap analysis of current systems, and a Request for Information (RFI) issued in Spring 2013, system requirements for both phases were developed. The top priorities reflected in the system requirements are 1) interoperability, 2) data element changes, 3) workflow/use improvement, 4) reports and query enhancement, and 5) future flexibility. An RFP was released for the "Phase 2" newborn screening portion of this project. A Commercial-Off-The-Shelf (COTS) product was selected and a contract will be executed for the development and implementation of this system in Summer 2014. Currently, funding sources are being explored for the "Phase 1" portion of the project, and an RFP is planned to be released in

Fall 2014.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The five-year plan for 2011-2015 places an emphasis on developing core public health functions and responding to changes in the health care delivery system. As a rural state with substantial shortages of medical services and maldistribution of existing services, Iowa is challenged to develop systematic approaches to population-based direct care services. In the past few years, program activities addressed improvement of access to services, identification of the needs of culturally diverse groups and recognition of changes brought about by managed care.

Additionally, activities for children and youth with special health care needs focus on assuring specialty services to children and families, integrating data systems, balancing private and public partnerships and integrating community-based services. The Title V CSHCN program continues to regularly discuss and debate how best to proportion its resources among the four service levels of the MCH pyramid. This exercise has served to help keep lively the broad expectations and potential influences of the CSHCN program.

B. State Priorities

Problem Statements

1. Need Statement: Lack of adoption of quality improvement methods within maternal and child health practice

Performance Measure: The degree to which Iowa's state MCH Title V Program improves the system of care measured through the MCH Title V Index.

The primary purpose of children's health care is to help children grow and develop. Well-child care encompasses health supervision, developmental surveillance and screening, psychosocial assessment, immunizations and care coordination. However, there is clear evidence that the quality of children's preventive care is lacking. One-quarter of families felt they were not always treated with respect. Only half (46 percent) of parents of young children in Iowa reported remembering having received preventive counseling about subjects such as seatbelts and nutrition. Only 31 percent of children ages 0-3 in foster care receive Early ACCESS services.

2. Need Statement: Lack of a statewide coordinated system of care for children and youth with special health care needs

Performance Measure: The degree to which components of a coordinated statewide system of care for CYSHCN are implemented.

A recent review of MCH literature revealed that "CYSHCN are at a greater risk for unmet health care needs, poorer dental health, and behavioral problems. Expenditures for their care are approximately three times higher than for other children, accounting for approximately 42% of all medical care costs for children." (Kogan MD, Strickland BB, Newacheck PW. Building Systems of Care: Finding from the National Survey of CSHCN, Pediatrics 124:S4, S333-S336, December 2009. "A comprehensive community-based system of services for CYSHCN has not yet been implemented. Moreover, to our knowledge, there has been no consensus to date on what constitutes a system of services. The absence of a broadly accepted definition has hindered progress in implementation of a systematic approach to delivering services." Perrin JM, Romm D, Bloom S, Homer C et al, "A Family-Centered, Community-Based System of Services for Children and Youth with Special Health Care Needs. Arch Pediatr Adolesc Med/Vol 161 (No 10, October 2007).

3. Need Statement: Lack of health equity in maternal and child health outcomes

Performance Measure: The degree to which Iowa's state MCH Title V program addresses health equity in MCH programs measured through the MCH Title V index.

Disparities related to lack of health care access or prevention services are associated with higher morbidity and mortality rates among racial minorities. Addressing health differences involves understanding social and economic circumstances experienced by minority families. Social determinants of health include job and food insecurity, inadequate housing and poor family environments. Barriers to care such as cost, lack of transportation, limited hourly access, lack of information about the system and language difficulties also contribute to disparities. African-American children were most likely to be in a household with high parenting stress and most likely to not weigh the right amount for their height. Hispanic children of families taking the survey in Spanish had the lowest overall health and were the least likely to be insured. African-Americans have nearly twice the occurrence of low birth weight babies compared to whites. 36 percent of African-American women were 10 or more pounds overweight a year after delivery, compared to only 29 percent of Whites.

4. Need Statement: Lack of coordinated systems of care for preconception and interconception care for high-risk and low income women

Performance Measure: Percent of women who are counseled about developing a reproductive life plan.

According to the 2000 US Census, Iowa has 353,129 women of childbearing age (15-44 years). Nationally, nearly half of pregnancies are unintended. Further, critical organ development begins just 17 days after conception, often before prenatal care has started. Preconception care encourages mothers to take folic acid daily to prevent spinal cord defects, adopting healthy lifestyle habits like avoidance of alcohol, tobacco cessation, and a nutritious diet and get information about the importance of prenatal care. Adequate prenatal care was received by 83.1 percent of pregnant women, including 77.5 percent on Medicaid. 6.7 percent of babies born are considered low birth weight (<2,500 grams). The birth rate for 15-17 year olds is 15.6 per 1,000.

5. Need Statement: Barriers to access to health care including mental health services for low-income pregnant women

Performance Measure: The degree to which the health care system implements evidence-based prenatal and perinatal care.

According to the 2000 US Census, Iowa has 353,129 women of childbearing age (15-44 years). Nationally, nearly half of pregnancies are unintended. Further, critical organ development begins just 17 days after conception, often before prenatal care has started. Preconception care encourages mothers to take folic acid daily to prevent spinal cord defects, adopting healthy lifestyle habits like avoidance of alcohol, tobacco cessation, and a nutritious diet and get information about the importance of prenatal care. Adequate prenatal care was received by 83.1 percent of pregnant women, including 77.5 percent on Medicaid. 6.7 percent of babies born are considered low birth weight (<2,500 grams). The birth rate for 15-17 year olds is 15.6 per 1,000.

6. Need Statement: Lack of access to preventive and restorative dental care for low-income pregnant women

Performance Measure: Percent of Medicaid enrolled women receiving preventive dental health services during pregnancy.

A woman's oral health impacts pregnancy outcomes as well as the oral health of her infant. Diet and hormonal changes during pregnancy may increase a woman's risk for developing tooth decay and gum disease. Bacteria associated gum disease can spread to the body, triggering

premature labor. Women who participate in Medicaid are significantly less likely to visit the dentist before, during and after pregnancy, compared to those with private insurance. Bacteria that cause cavities can pass from a mother's mouth to her baby's mouth, increasing the risk of cavities for that infant. Children whose mothers have poor oral health are five times more likely to have oral health problems than children whose mothers have good oral health. In Iowa, although there have been marginal gains in the past few years, less than one in four Medicaid-enrolled women received important preventive dental care in 2007.

7. Need Statement: Insufficient early and regular preventive and restorative dental care for children ages 5 and under

Performance Measure: Percent of Medicaid enrolled children 0-5 who receive a dental service.

Children need healthy teeth to eat food to nourish their bodies, speak properly, and build confidence. Cavities can develop as soon as teeth erupt (at around 6 months old) and can limit children's ability to eat and thrive, as well as their ability to concentrate and learn. Cavities can be prevented, but not enough children receive early preventive care. Children's oral health is addressed through the I-Smile™ dental home initiative. Fifty-five percent of Medicaid-enrolled children ages 1-5 do not receive dental services. In 2008, 99.6 percent of Medicaid-enrolled children did not receive an exam from a dentist prior to the age of one. The ADA recommends children have a dental exam by their first birthday. Forty-nine percent Iowa's general dentists always refer children younger than 3 to pediatric practices --there are 39 private-practice pediatric dentists in the state. Twenty-two percent of Iowa third graders have untreated decay, an increase from 13 percent in 2006.

8. Need Statement: High proportion of children ages 14 and under experiencing unintentional injuries

Performance Measure: Rate of hospitalizations due to unintentional injuries among children ages 0-14.

Injuries are a major public health concern in Iowa due to the large number of Iowans affected by them. Unintentional injuries are one of the leading causes of death for youth. Injuries can have long-term effects on quality of life due to physical impairment, memory troubles, emotional difficulties or learning disabilities and loss of ability to perform daily activities. Over 56,715 unintentional injuries occurred in children ages 14 years and under. Motor vehicle crashes accounted for the deaths of 4.6 children per 100,000. Five percent of children ages 0-5 had an injury requiring medical attention within the past year. From 1995-2007, 112 Iowa children under age 7 were victims of fatal child abuse with 49 percent of those dying from being shaken or slammed.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	95	53	176	56	55

Denominator	95	53	176	56	55
Data Source	CCID and INMSP	CCID and INMSP	CCID and INSP	CCID and INSP	CCID and INSP
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	100	100	100	100	100

Notes - 2013

FFY13 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program

Notes - 2012

FFY12 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program

Notes - 2011

FFY11 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program

a. Last Year's Accomplishments

The FFY13 performance objective of 100 percent was met. Data provided by the Center for Congenital and Inherited Disorders and the Iowa Neonatal Metabolic Screening program indicate that 100 percent of all eligible Iowa newborns that screened positive received short-term follow-up through to confirmatory diagnosis, and long-term follow-up for clinical case management and treatment.

Infrastructure Building Services:

The Center for Congenital and Inherited Disorders (CCID) is collaborating with staff of the Iowa Health Information Network (IHIN), Iowa's health information exchange, to include newborn screening reporting in the IHIN. CCID was informed that newborn screening won't be scheduled to participate in the IHIN until 2015

The tri-state Quality Improvement (QI) team continued monthly meetings to address cross-state quality assurance issues. Each state will develop its own QI and education plan based on state needs.

Parent and consumer membership on the Congenital and Inherited Disorders Advisory Committee (CIDAC) continued to expand and consumer's input and participation was solicited for policy development. Each CIDAC member is asked to provide a "spotlight" presentation based on the condition or disorder that is most familiar to them. This has been well received by members and has provided an opportunity for increased advocacy and awareness across programs.

The state genetics coordinator developed an Iowa genetics guide for primary care providers. The guide provides an interactive tool for PCPs to use that will help them find genetic services for their patients in their area, as well as a guide to genetic services across the life course.

Enabling Services:

The Regional Genetics Consultation Services (RGCS) continues its efforts to provide genetic consultation services via telehealth networks established by Child Health Specialty Clinics (CHSC). RGCS has expanded telehealth service delivery through the existing CHSC network.

Population-based and Direct Health Care Services:

The CCID implemented universal newborn screening for severe combined immunodeficiency (SCID) on July 1, 2014. The pilot project allowed laboratory and follow up staff to work with the medical consultants to build a comprehensive SCID screening program.

The Iowa legislature enacted legislation on July 1, 2013, requiring all newborns in Iowa to be screened for critical congenital heart defects (CCHD) using pulse oximetry. The state genetics coordinator contacted every birthing hospital in the state to inform them of the legislation, provide them with the screening protocol and algorithms, and recommended parent education materials. By October 2013, every birthing hospital reported doing universal screening on their babies in the normal newborn nursery, using the recommended protocols.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Development of integrated newborn screening data system				X
2. Provide home birth providers resources to conduct CCHD screening		X	X	
3. Develop CCHD screening protocol for NICU	X		X	
4. Promote life course model for newborn screening and genetic impact				X
5. Establish performance metrics as part of comprehensive QI program				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The state genetics coordinator (SGC) developed an Iowa genetics guide for primary care providers, providing an interactive tool that will help them find genetic services for their patients in their area, as well as a guide to genetic services across the life course. Information includes resources for genetic testing and consultation services for genetic issues. The guide will be distributed to health care providers on flash drives for "just-in-time" reference.

The SGC presented the life course model to representatives from the Divisions of Environmental Health and Health Promotion Chronic Disease Prevention within the Iowa Department of Public Health. Partnerships were established to link genetics and family health history throughout the life course with wellness and disease prevention efforts.

The Iowa Newborn Screening Team is prioritizing quality improvement projects after a needs assessment, and a work group is developing an education plan for providers and families.

Population-based and Direct Health Care Services:

The newborn screening for SCID pilot project will conclude in June 2015, with universal SCID screening implemented July 1, 2014. Follow-up protocols and procedures are in place, and report values are being evaluated and confirmed.

Every birthing hospital reports doing CCHD screening, as required by legislation. There is no reporting requirement, so reporting is voluntary.

c. Plan for the Coming Year

Infrastructure Building Services:

A request for proposals (RFP) was posted to develop an integrated newborn screening data system. Deliverables include automated data entry, imports/exports through electronic health records, follow up care coordination and case management and reporting capacity.

CIDAC CCHD work group will develop a recommended screening protocol for NICU babies.

The CCHD work group will work with midwives and home birth providers to enable babies born in out-of-hospital settings to receive timely CCHD screening. The SGC will work with large health systems to see if they have old or exchanged pulse oximeters available through their procurement agencies to distribute to home birth providers.

The life course model will promote newborn screening as part of recommended intervention to improve an individual's health trajectory. This is included in the genetics life course tool in the genetics guide distributed to providers.

A quality improvement plan will be developed that directs newborn screening program quality improvement efforts. Performance metrics will be established, and quarterly reviews by the Newborn Screening Team will monitor and evaluate compliance with performance goals.

TA will be requested from the HRSA-funded newborn screening technical assistance and evaluation program (NewSTEPS) to assist in a comprehensive needs assessment of newborn screening programming.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	39013					
Reporting Year:	2013					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	38512	98.7	3	1	1	100.0
Congenital	38512	98.7	348	26	23	88.5

Hypothyroidism (Classical)						
Galactosemia (Classical)	38512	98.7	1	0	0	
Sickle Cell Disease	38512	98.7	20	4	4	100.0
Biotinidase Deficiency	38512	98.7	15	1	2	200.0
Congenital Adrenal Hyperplasia	38512	98.7	12	1	0	0.0
Cystic Fibrosis	38512	98.7	62	12	11	91.7
Fatty Oxidation Disorders	38512	98.7	0	10	13	130.0
Maternal Prenatal Screening	0		0	108	0	0.0
First Trimester Only	327		0	35	0	0.0
Quad Screen	5982		0	2290	0	0.0
Integrated Screen	2495		0	79	0	0.0
NTD only	686		0	108	0	0.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	66.4	67.7	69.1	76	78
Annual Indicator	64.7	64.7	75.8	75.8	75.8
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	80	82	84	86	88

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC will wait until more information is released on the transformation of the Title V Block Grant to explore the need for an additional data source to provide information in the interim years.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted every 5 years by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC is exploring the potential to develop an additional data source that will provide information in the interim years.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The FFY13 performance objective of 78 was not met. The indicator value for Iowa of 75.8 percent was based on data from the 2009-10 National Survey of Children with Special Health Care Needs. The Iowa indicator of 75.8 percent is statistically better than the national mean of 70.3, though there is significant room for improvement.

Infrastructure Building Services:

CHSC collaborated with other Family to Family Iowa partners to develop a working definition of

family-to-family support to differentiate "family-to-family" peer support from "family support" as offered by home visiting programs.

CHSC community-based Family Navigators served on community and state advisory groups.

CHSC implemented a HRSA-funded System of Care/Evidence Based Practices grant that modeled Community Child Health Teams (CCHT) in medical homes by providing family-to-family support and care coordination.

Caregivers of children with hearing loss participated in the EHDl Medical Home Implementation Team.

CHSC expanded the role of Iowa's AMCHP Family Delegate to develop and monitor the MCH Block Grant application, as well as attend the on-site review. CHSC's AMCHP family mentor and AMCHP family scholars collaborated with family leaders from other states to share best practices.

CHSC served on the AMCHP social media committee to learn how to maximize use of social media with families.

CHSC collected family stories to show the value for CHSC programs, as well as to document needs and barriers to care.

Enabling and Direct Care Services:

CHSC received a contract to implement Pediatric Integrated Health (PIH) homes that provide care coordination, family-to-family support, and clinical services for children with Serious Emotional Disturbances (SED) in Dubuque County.

Select CHSC Regional Centers provided crisis intervention and a crisis line for families of children with SED that need assistance after office hours.

CHSC staff member ensured CHSC materials were written at 6th grade level or below and are available in other languages.

CHSC partnered with University of Iowa Autism Center to provide family-to-family support for families of children with Autism Spectrum Disorders (ASD), as well as serve as liaison with patients' schools and facilitate funding for services.

CHSC facilitated training for pediatricians and family practice physicians in two communities on how to recognize signs of child abuse and respond.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC received state funding to implement the Regional Autism Assistance Program (RAP) teams at 14 sites to assure a system of care for children with ASD and their families.		X		X
2. CHSC Family Navigator serves as an AMCHP Family Delegate and other Family Navigators serve on UI Health Care Family Advisory Council and other local, state and national committees.				X
3. CHSC is partnering to embed family centered principles in trainings for future health care providers (such as LEND) and current providers in clinical teams and 1st Five sites.				X

4. CHSC is developing a Family Advisory Council to provide feedback on how CHSC can better serve Iowa CYSHCN and their families.				X
5. CHSC is implementing a HRSA-funded System of Care/Evidence Based Practices grant that models community child health teams in medical homes by providing family-to-family support and care coordination.		X		X
6. CHSC surveyed families who received family navigation and is reviewing results.				X
7. CHSC is partnering with the National Resource Center for Family-Centered Practice, University of Iowa Center for Child Health Improvement and Innovation, ASK Resource Center and NAMI Iowa to develop a Family Navigator training program.				X
8. CHSC is working with state partners to expand the PIH program to additional counties.		X		X
9. CHSC partners with the University of Iowa Autism Center and University of Iowa Children's Hospital to provide family-to-family support for families of children with ASD and hemophilia.		X		
10.				

b. Current Activities

Infrastructure Building Services:

CHSC received state funding to implement the Regional Autism Assistance Program (RAP) teams at 14 sites to assure a system of care for children with ASD and their families.

CHSC Family Navigator serves as an AMCHP Family Delegate and other Family Navigators serve on UI Health Care Family Advisory Council and other local, state and national committees.

CHSC is partnering to embed family-centered principles in trainings for future health care providers (such as LEND) and current providers in clinical teams and 1st Five sites.

CHSC collects family stories to show the value of CHSC programs and remaining gaps and barriers.

CHSC is implementing a HRSA-funded System of Care/Evidence-Based Practices grant that models community child health teams in medical homes by providing family-to-family support and care coordination.

CHSC surveyed families who received family navigation and is reviewing results.

CHSC is partnering with the National Resource Center for Family-Centered Practice, University of Iowa Center for Child Health Improvement and Innovation, ASK Resource Center and National Alliance Mental Illness Iowa to develop a Family Navigator training program.

Enabling and Direct Care Services:

CHSC is working with state partners to expand the PIH program to additional Iowa counties.

CHSC partners with University of Iowa Autism Center and UI Children's Hospital to provide family-to-family support for families of children with ASD and hemophilia.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC Family Navigators will collaborate with the University of Iowa Center for Child Health

Improvement and Innovation and other state partners to expand the PIH program.

CHSC will continue to implement a robust Family Navigator training program, in partnership with the National Resource Center for Family-Centered Practice, University of Iowa Center for Child Health Improvement and Innovation, ASK Resource Center and NAMI Iowa.

CHSC will continue to collect family stories to show the value for CHSC programs, as well as to document needs and barriers to care.

CHSC will be a signatory partner in Iowa's System of Early Intervention services to assure families of children 0-3 years at risk or with developmental disabilities have individual family service plans.

CHSC will continue to partner with University of Iowa Autism Center and University of Iowa Children's Hospital to provide family-to-family support for families of children with ASD and hemophilia, as well as serve as liaison with schools and facilitate funding for services.

CHSC will enhance family navigation standards that specify what family navigation includes, frequency of contact with family, and procedures for families that no longer need Family Navigation.

CHSC will continue to develop a Family Advisory Council with youth members to provide feedback on how CHSC can better serve Iowa CYSHCN and their families.

Enabling and Direct Care Services:

CHSC Regional Centers will host community events to inform families how integrated health homes benefit CYSHCN, adults, and how to enroll.

CHSC staff will visit area Veterans Affairs office so staff is aware of our presence and ability to assist military families.

Select CHSC sites will provide crisis intervention and a crisis line for families that need assistance after office hours.

CHSC will survey families who receive family navigation services on their satisfaction levels and analyze results.

CHSC will begin a partnership with University of Iowa Children's Hospital Continuity of Care program to provide care coordination and family-to-family support for children returning to their homes across the state.

CHSC will continue to employ Family Peer Support Specialists, funded by Magellan, to provide intensive family-to-family support for families of children with SED.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	61.5	62.7	64	47	49

Annual Indicator	57.4	57.4	47	47	47
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	80	82	84	86	88

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC will wait until more information is released on the transformation of the Title V Block Grant to explore the need for an additional data source to provide information in the interim years.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted every 5 years by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this

performance measure. CHSC is exploring the potential to develop an additional data source that will provide information in the interim years.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The FFY13 performance objective of 49 was not met. The indicator value for Iowa of 47 percent was based on data from the 2009-10 National Survey of Children with Special Health Care Needs. The Iowa indicator of 47 percent is statistically better than the national mean of 43 percent, though there is significant room for improvement.

Infrastructure Building Services:

CHSC made its expertise available and positioned itself as a potential partner for any state or regional efforts to spread the medical home model, in accordance with the legislative requirements of Iowa's health care reform statute.

CHSC used MCH Navigator to provide web-based training for new staff on concepts such as Life Course, social determinants of health, and medical home.

Iowa Medicaid initiated its Health Home project through a state plan amendment, which was designed to increase the number of children and adults with certain chronic conditions that enroll in health homes. The University of Iowa Public Policy Center began an evaluation to determine if more individuals now receive care in a medical home and CHSC monitored progress.

CHSC trained family practice and pediatricians in two communities to recognize signs of child abuse and how to respond.

CHSC EHDI participated in the National Center for Hearing Assessment and Management Learning Community to share strategies and address challenges for providing diagnostic and audiologic tele-audiology.

CHSC EHDI participated in the National Center for Cultural Competence and the National Center for Hearing Assessment and Management Community of Learners to advance and sustain cultural and linguistic competence in EHDI programs.

CHSC implemented a HRSA-funded grant to implement community child health teams (CCHT) in two tertiary care centers that models family-to-family support in medical homes.

CHSC participated in Early Childhood Iowa, a state-level interagency systems and policy development group, whose mission is to improve the system of early care, health and education of young children, including access to medical and dental homes.

CHSC participated in Children's Mental Health and Disability System Redesign and other health reform committees.

CHSC explored providing telehealth consultation to primary care providers on new topics to increase their ability to serve children with chronic conditions.

CHSC staff participated in Iowa Primary Care Association, a network of safety net providers to support medical homes and vulnerable populations.

CHSC's SAMHSA-supported System of Care for children and youth with serious emotional disturbances (SED) program obtained state funding to continue to connect youth to their local medical home with care coordination and support services.

CHSC collaborated with the Iowa Leadership Education in Neurodevelopmental Disabilities (ILEND) program. This is an interdisciplinary leadership training program for graduate students with a commitment to providing culturally competent, family-centered, coordinated systems of health care and related services for children with special health care needs and their families.

CHSC participated in Help Me Grow, emphasizing coordinated intake follow-up processes that partners with home visiting, primary care, and early intervention.

Enabling and Direct Health Care Services:

Using community child health teams, CHSC Regional Centers provided care coordination and family-to-family support in partnership with primary care and neighborhood health providers.

EHDI provided followup for children at risk for delayed onset or progressive hearing loss.

CHSC received contracts to implement Pediatric Integrated Health (PIH) homes for children with Serious Emotional Disturbances (SED) in Dubuque County that provided care coordination, family-to-family support, and access to mental health services using a system of care approach.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC is completing a HRSA-funded grant to implement CCHT in two tertiary care centers, modeling family-to-family support in medical homes.		X		X
2. CHSC is vetting an enhanced care coordination algorithm to guide providers in determining when a CHSC care coordinator will benefit children they serve.				X
3. CHSC is implementing Regional Autism Assistance Program teams (RAPs) in 14 sites to assure as system of care for children with autism and their families.	X	X		X
4. Using Community Child Health Teams, CHSC Regional Centers provide care coordination and family-to-family support in partnership with primary care providers.		X		
5. CHSC is training RNs and ARNPs to do Nutrition and Health Assessments for young children while coordinating with medical homes.				X
6. CHSC partners to embed family-centered principles in trainings for future health care providers (such as LEND) and current providers in clinical teams and 1st Five sites.				X
7. CHSC is utilizing state funding to maintain the Community Circle of Care project that serves children with SED not on		X		

Medicaid.				
8. CHSC received funding to expand the Pediatric Integrated Health program to serve children and families with Serious Emotional Disturbances in additional counties.	X	X		X
9. CHSC convenes quarterly meetings of the Expert Panel for the Iowa Autism Fund to develop guidelines for the system of care for children with ASD, including telehealth.				X
10.				

b. Current Activities

Infrastructure Building Services:

CHSC received funding to expand the PIH program to serve children and families with SED in additional counties.

CHSC is completing a HRSA-funded grant to implement CCHT in two tertiary care centers, modeling family-to-family support in medical homes.

CHSC is developing Regional Autism Assistance Program (RAP) teams in 14 sites to assure a system of care for children with autism and their families. RAP teams include ARNPs trained on using the Screening Tool for Autism in Toddlers-MD (STAT-MD), RNs and Family Navigators.

CHSC convenes quarterly meetings of the Expert Panel for the Iowa Autism Fund to develop guidelines for the system of care for children with ASD, including telehealth.

CHSC partners to embed family centered principles in trainings for future health care providers (such as LEND) and current providers in clinical teams and 1st Five sites.

CHSC is vetting an enhanced care coordination algorithm to guide providers in determining when a CHSC care coordinator will benefit children they serve.

Enabling and Direct Health Care Services:

CHSC is training RNs and ARNPs to do Nutrition and Health Assessments for young children while coordinating with medical homes.

CHSC utilized state funding to maintain the Community Circle of Care project that serves children with SED not on Medicaid.

Using CCHT, CHSC Regional Centers provide care coordination and family-to-family support in partnership with primary care providers.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC staff will continue to participate in Iowa Primary Care Association, a network of safety net providers to support medical homes and vulnerable populations.

CHSC will collaborate with the ILEND, Iowa Chapter of the American Academy of Pediatrics, and other state partners to embed principles of care coordination and family-to-family support in trainings for future health care providers, as well as within clinical teams and 1st Five sites.

CHSC will collaborate with the University of Iowa Center for Child Health Improvement and Innovation to implement a robust Family Navigator training program that other programs and states may use. CHSC will determine the best way to assess gaps in services and identify the proper and accessible referral sources.

CHSC will continue to make its expertise available and position itself as a potential partner for any state or regional efforts to spread the medical home model, in accordance with the legislative requirements of Iowa's health care reform statute.

CHSC will use MCH Navigator to provide web-based education to new and existing staff on concepts such as Life Course, ethics, and medical home.

CHSC's Community Circle of Care for children with SED will maintain state funding to continue to connect children and youth to their local medical home, while providing care coordination and support services.

Using community child health teams, CHSC will provide care coordination and family-to-family support in partnership with primary care and neighborhood health providers.

CHSC's RNs and ARNPs will conduct Health and Nutrition assessments for children 0-3 years while coordinating with the medical home.

CHSC will convene quarterly meetings of the Expert Panel for the Iowa Autism Fund to update guidelines for the system of care for children with ASD.

CHSC will train health care providers on the enhanced care coordination algorithm to guide them in determining when a CHSC care coordinator will benefit children and families they serve.

CHSC will participate in Early Childhood Iowa, a state-level interagency systems and policy development group, whose mission is to improve the system of early care, health and education of young children, including access to medical and dental homes.

CHSC will continue to develop Regional Autism Assistance Program Teams (RAPs) across Iowa. RAP teams will contact service providers to update a directory of autism services.

CHSC Registered Dietitians will provide technical assistance to primary care providers of CYSHCN who are overweight or obese.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	73.4	74.9	76.4	66.6	68.6
Annual Indicator	68.6	68.6	64.6	64.6	64.6
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	70.6	72.6	74.6	78.6	80.6

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC will wait until more information is released on the transformation of the Title V Block Grant to explore the need for an additional data source to provide information in the interim years. Due to the full implementation of the Affordable Care Act in 2014, we recognize that changes in the benefit package for CYSHCN may result in the need to re-evaluate the targeted annual performance objectives.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted every 5 years by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC is exploring the potential to develop an additional data source that will provide information in the interim years. When the Affordable Care Act is fully implemented by 2014, we recognize the benefit package for CYSHCN may change resulting in the need to re-evaluate the targeted annual performance objectives.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

When the Affordable Care Act is fully implemented by 2014, we recognize the benefit package for CYSHCN may change resulting in the need to re-evaluate the targeted annual performance objectives.

a. Last Year's Accomplishments

The FFY13 performance objective of 68.6 was not met. The indicator value for Iowa of 64.6 percent was based on data from the 2009-10 National Survey of Children with Special Health Care Needs. The Iowa indicator of 64.6 percent is statistically better than the national mean of 60.6, though there is significant room for improvement.

Infrastructure Building Services:

CHSC staff assisted in reviewing proposals for essential health benefits packages for CYSHCN in health care reform, as requested by policymakers.

CHSC care coordination work group gathered data for presentations to Medicaid and other funders to advocate for payment for care coordination and family support activities.

CHSC maintained a collection of family stories to educate policymakers on the importance of adequate insurance coverage for CYSHCN and their families.

CHSC continued to participate in the Iowa Primary Care Association to assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured CYSHCN and their families.

A CHSC Family Navigator participated on a Governor-appointed statewide Medicaid Advisory Committee.

CHSC participated in learning events regarding the impact of the Affordable Care Act on CYSHCN and mobilized staff to respond to results of analysis during all phases of implementation.

CHSC staff participated on AMCHP Legislative Committee and other AMCHP committees to assist in developing educational materials for policymakers related to the unique health insurance needs of CYSHCN.

Enabling and Direct Care Services:

CHSC assisted families of CYSHCN to apply for Medicaid or SCHIP, and to be aware of new options under the Affordable Care Act (ACA).

CHSC provided guidance and care coordination for families of children enrolled in the Health and Disability Waiver and the Early Periodic Screening, Diagnosis, and Treatment programs.

CHSC partnered with University of Iowa Autism Center to provide family-to-family support for families of children with Autism Spectrum Disorder (ASD), which includes assisting families to find funding for ASD services.

A CHSC Registered Dietician submitted an article to the Iowa Chapter of the American Academy of Pediatrics fall newsletter educating primary care providers on the need for reimbursement for medical nutrition therapy for children who are overweight or obese.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. CHSC reaches out to non-profit hospitals, MCH grantees, and county boards of public health to share CHSC expertise in serving CYSCHN in a reformed health care system.				X
2. CHSC advises the state and Iowa Medicaid on quality measures for Accountable Care Organizations.				X
3. CHSC Family Navigators participate in research projects demonstrating the benefits of Applied Behavioral Analysis (ABA) for children with ASD to obtain data that will educate for potential policy changes regarding reimbursement for ABA.				X
4. CHSC staff educates policymakers regarding the continued need for public health programs, like Title V after the ACA is implemented.				X
5. CHSC is standardizing the process for Iowa Medicaid Members to change from a Managed Health Care Program to a non-managed Health Care Program and provide care coordination as requested.		X		X
6. CHSC is implementing Regional Autism Assistance Program (RAP) teams after legislation created the Autism Support Program to provide children with ASD access to ABA. RAP teams include ARNPs, RNs and Family Navigators.		X		X
7. CHSC convenes an Expert Panel for the Iowa Autism Fund to develop guidelines for the system of care for children with ASD, including reimbursement for telehealth.				X
8. CHSC Family Navigators inform families of changes in health benefit options due to the ACA.		X		
9.				
10.				

b. Current Activities

Infrastructure Building:

CHSC educates policymakers on the impact of the ACA on CYSCHN.

CHSC reaches out to non-profit hospitals, MCH grantees, and county boards of public health to share CHSC expertise in serving CYSCHN in a reformed health care system.

CHSC advises the state and Iowa Medicaid on quality measures for Accountable Care Organizations.

CHSC Family Navigators participate in research projects, as invited, demonstrating the benefits of Applied Behavioral Analysis (ABA) for children with ASD to obtain data that will educate payers for potential policy changes regarding reimbursement for ABA.

CHSC staff educates policymakers regarding the continued need for public health programs, such as Title V after the ACA is implemented.

CHSC is standardizing the process for Iowa Medicaid Members to change from a Managed Health Care Program to a non-managed Health Care Program and provide care coordination as requested.

CHSC is implementing Regional Autism Assistance Program (RAP) teams after legislation created the Autism Support Program to provide children with ASD access to ABA. RAP teams include ARNPs, RNs and Family Navigators.

CHSC convenes an Expert Panel for the Iowa Autism Fund to develop guidelines for the system

of care for children with ASD, including reimbursement for telehealth.

Enabling:

CHSC Family Navigators inform families of changes in health benefit options due to the ACA.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC staff will continue to participate in the leadership of the Iowa Primary Care Association network of safety net providers.

CHSC will explore ways to assure families of children with SED with private insurance have access to high quality services, regardless of funding source.

CHSC Family Navigators will continue to participate in research projects, as invited, that demonstrate the benefits of ABA for children with ASD to obtain data that will educate payers for potential policy changes regarding reimbursement for ABA.

CHSC staff will continue to educate policymakers regarding the system of care for children and families with ASD, SED, and other special health care needs.

CHSC staff will educate policymakers regarding the continued need for public health programs such as Title V even after the ACA is implemented.

CHSC will participate in educational efforts on the ACA's impact on CYSHCN.

CHSC will reach out to non-profit hospitals, MCH grantees, and county boards of public health to share CHSC expertise in serving CYSCHN in a reformed health care system.

CHSC leadership will provide its expertise related to Iowa's Essential Health Benefits package to meet the needs of CYSCHN.

CHSC will educate policymakers on the need for medical nutrition therapy provided by a Registered Dietician for children who are overweight or obese.

Enabling and Direct Health Care Services:

CHSC Family Navigators will inform families of changes in health benefit options due to the ACA, including for youth that are transitioning to adulthood.

CHSC RAP staff will continue to provide care coordination and family-to-family support to families enrolled in the Autism Support Program. CHSC will also provide these services to families who do not qualify for ABA through the Autism Support Program Fund.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	94.7	95.6	96.6	70	72

Annual Indicator	92.9	92.9	68	68	68
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	74	76	78	80	82

Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC will wait until more information is released on the transformation of the Title V Block Grant to explore the need for an additional data source to provide information in the interim years. The questions were revised extensively for the 2009-2010 CSHCN Survey. Thus, current indicator data is not comparable to surveys prior to the 2009-2010 CSHCN survey.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted every 5 years by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this

performance measure. CHSC is exploring the potential to develop an additional data source that will provide information in the interim years.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Although it is not the tool used to obtain the indicator data for NPM #5, the tools developed to capture data and drive processes for SPM #2 ("the degree to which components of a system of care for CYSHCN are implemented") also impact the community based service system for CYSHCN.

a. Last Year's Accomplishments

The FFY13 performance objective of 72 was not met. The indicator value for Iowa of 68 percent was based on data from the 2009-10 National Survey of Children with Special Health Care Needs. The Iowa indicator of 68 percent is statistically better than the national mean of 65.1, though there is significant room for improvement.

Infrastructure Building Services:

CHSC provided otoacoustic emission screening of newborns at two CHSC regional centers and offered Auditory Brainstem Response telehealth evaluation at one site.

CHSC participated in the Prep-Kids Emergency Preparedness program to assure families have knowledge to attain services in emergencies.

CHSC maintained the Child and Youth Psychiatric Project of Iowa (CYC-I) to provide consultation for primary care providers of patients with Serious Emotional Disturbances (SED).

Through F2F IA, CHSC trained a Spanish-speaking Family Navigator.

CHSC trained RNs at local agencies to conduct critical health reviews for children served by Part C IDEA, so families and providers know health implications for early intervention activities.

Through the National Improvement Partnership Network, CHSC improved knowledge of partnerships between pediatricians and subspecialty providers.

CHSC assessed written materials to assure they were at a 6th grade level or below and available in other languages.

CHSC leadership staff participated in statewide committees redesigning the children's mental health and developmental disabilities system.

CHSC educated stakeholders and policymakers about services for children and youth with special health care needs (CYSHCN).

Enabling and Direct Care Services:

CHSC provided telehealth services for children with SED, nutrition consultation, and auditory

brainstem response evaluation, and piloted services for those who are overweight/obese.

CHSC received a contract to implement Pediatric Integrated Health (PIH) homes for children with SED in Dubuque County that will serve as a single point of entry into mental health services, as well as provide care coordination with medical homes and family-to-family support.

CHSC's Health and Disability Management (HDM) Unit provided care coordination for families of children enrolled in Medicaid Waiver and EPSDT programs, while Family Navigators functioned as service coordinators for young children in Early ACCESS.

CHSC updated the Pediatric Resource Sheet listing key resources for children with special health care needs in plain language.

CHSC began to conduct a statewide needs assessment for children and youth with Autism Spectrum Disorder (ASD).

Table 4a. National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC trains RNs and ARNPs at community agencies to provide Early ACCESS health and nutrition assessments, while coordinating with medical homes.				X
2. CHSC maintains Child and Youth Psychiatric Project of Iowa (CYC-I) to provide consultation for primary care providers of children with SED.				X
3. CHSC Family Navigator is working with Johnson County NAMI to create a Roadmap to Services for children with SED.				X
4. CHSC's Health and Disability Management Unit provides care coordination for children enrolled in the Medicaid Waiver and EPSDT.		X		
5. CHSC Family Navigators function as service coordinators for young children in Early ACCESS.		X		
6. Regional Autism Assistance Program (RAP) teams will provide family-to-family support, care coordination and facilitate access to funding for applied behavioral analysis therapy through the Iowa Autism Fund.		X		X
7. CHSC is implementing Pediatric Integrated Health homes in additional counties to serve as a single point of entry into mental health services, as well as provide care coordination with medical homes and family-to-family support.		X		X
8. CHSC partners with community agencies to sponsor family support and awareness events on SED in local communities.		X		
9. CHSC partners with UI Autism Center and UI Children's Hospital to provide family-to-family support for families of children with ASD and hemophilia.		X		
10.				

b. Current Activities

Infrastructure Building Services:

CHSC trains RNs and ARNPs at community agencies to provide Early ACCESS health and nutrition assessments, while coordinating with medical homes.

CHSC maintains CYC-I to provide consultation for primary care providers of children with SED.

CHSC Family Navigator is working with Johnson County NAMI to create a Roadmap to Services for children with SED.

Enabling and Direct Health Care Services:

CHSC's HDM Unit provides care coordination for children enrolled in the Medicaid Waiver and EPSDT.

CHSC Family Navigators function as service coordinators for young children in Early ACCESS.

Regional Autism Assistance Program (RAP) teams of ARNP's, RNs, and Family Navigators provide family-to-family support, care coordination and facilitate access to funding for applied behavioral analysis therapy through the Iowa Autism Fund. RAP is creating a directory of autism services.

CHSC implemented PIH homes in additional counties to serve as a single point of entry into mental health services, as well as provide care coordination with medical homes and family-to-family support.

CHSC partners with community agencies to sponsor family support and awareness events on SED in local communities.

CHSC partners with University of Iowa Autism Center and UI Children's Hospital to provide family-to-family support for families of children with ASD and hemophilia.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC will partner with the University of Iowa Autism Center to provide family navigation for families of children with ASD.

CHSC will participate in the National Improvement Partnership Network to improve partnerships between pediatricians and subspecialists.

CHSC Family Navigator will continue as part of the University of Iowa Children's Hospital Hemophilia Treatment Center team, providing family-to-family support, serving as liaison with pediatric patients' schools, and facilitating funding for services.

CHSC RAP will contact service providers in their area to develop a directory of autism services.

CHSC Family Navigator will participate in Johnson County NAMI project to develop Roadmap to Services for persons with mental illness.

CHSC will collaborate with other community agencies to identify potential Family Navigators from minority backgrounds and who are bilingual.

CHSC leadership staff will participate in statewide committees improving the children's mental health and developmental disabilities system.

CHSC will analyze the Iowa Household Health Survey for disparities and create a plan to address issues, including building relationships with groups representing minority populations.

CHSC will explore ways to assure families of children with SED have access to high quality services, regardless of funding source.

Enabling and Direct Health Care Services:

CHSC will partner with the University of Iowa Children's Hospital Continuity of Care Program to provide family navigation and care coordination for CYSHCN as they return to their homes across the state.

CHSC care coordinators will share emergency preparedness materials with families to ensure they have knowledge to access services in an emergency.

CHSC staff member will inventory all written materials to assure they are written at a 6th grade level and available in other languages.

CHSC ARNPs will screen children for ASD using the Screening Tool for Autism in Toddlers-MD tool, allowing families to receive a mid-level assessment for ASD in their local community.

CHSC will partner with administrators of Autism Support Fund to assure families have information needed to enroll.

CHSC will continue to implement RAP teams in CHSC Regional Centers to improve the system of care for children with ASD. RAP teams will include ARNPs, RNs and Family Navigators. RAPs will provide care coordination, family-to-family support, and facilitate access to funding for applied behavioral analysis.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	50.7	51.7	52.7	45	47
Annual Indicator	47.3	47.3	45	45	45
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018

Annual Performance Objective	47	49	51	53	55
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Notes - 2013

For 2011-2015, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared. All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC will wait until more information is released on the transformation of the Title V Block Grant to explore the need for an additional data source to provide information in the interim years.

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted every 5 years by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

During the five-year interim, CHSC will continue to conduct activities that will impact this performance measure. CHSC is exploring the potential to develop an additional data source that will provide information in the interim years.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

a. Last Year's Accomplishments

The FFY13 performance objective of 47 was not met. The indicator value for Iowa of 45 percent was based on data from the 2009-10 National Survey of Children with Special Health Care Needs. The Iowa indicator of 45 percent is statistically better than the national mean of 40, though there is significant room for improvement.

Infrastructure Building Services:

CHSC's Medical Director led efforts to assure standards of care at CHSC Regional Centers for Clinical Services, including transition to adult care and focus on Life Course Development Theory (LCDT).

CHSC partnered with Family to Family Iowa (F2F-IA) to provide web-based transition resources.

CHSC provided care coordination and transition planning to youth with mental health needs, through a state appropriation.

CHSC collaborated with state partners to sponsor the Achieving Maximum Potential program for foster and adoptive youth transitioning to adulthood. The program assists participants to develop leadership and life skills, and provides the opportunity to share their perspectives on the foster care and adoption system with policymakers.

CHSC explored quality improvement projects regarding transition to adulthood with the Partnership to Improve Child Health In Iowa, a public-private partnership that works collaboratively to support clinicians in their efforts to improve children's health care by providing tested tools and techniques of quality improvement.

CHSC implemented a HRSA-funded System of Care/Evidence Based Practices grant that modeled community child health teams in medical homes by providing family-to-family support, care coordination.

CHSC facilitated a state level workgroup to align efforts of state stakeholders on transition and began developing a transition pilot program for CYSHCN over 12 years of age.

CHSC received technical assistance from AMCHP and Children's Medical Services to pilot evidence based transition practices and hosted a one-day transition conference for stakeholders. CHSC used feedback from youth, families, and health care providers to revise tools supporting evidence based transition practices.

CHSC employee completed a graduate-level certificate on integrating education and health care transition (HCT). CHSC hosted a live broadcast of 2012 Chronic Illness and Disability Conference for health care providers.

Enabling and Direct Health Care Services:

CHSC's Health and Disability Management (HDM) program helped families with eligible youth enroll in Medicaid Waiver and EPSDT programs and address transition issues using an age-based guide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC's Medical Director leads efforts to assure standards of care for Clinical Services at CHSC Regional Centers and focus				X

on Lifecourse Health Development Theory.				
2. CHSC collaborates with EPSDT to pilot tools and a web-based training for health care providers, care coordinators, and Family Navigators to facilitate HCT and is submitting recommendations to policymakers.		X		X
3. Staff attended the Developmental Disabilities Policy Council Summit and Iowa Transition Conference.				X
4. Presented at the Chronic Illness and Disability Conference on Transition from Pediatric to Adult Care, a HRSA-funded Systems of Care/Evidence-Based Practices grant that uses Community Child Health Teams in two primary care offices.		X		X
5. CHSC is integrating HCT tools into the electronic health record to allow sharing between facilities.				X
6. CHSC facilitates a state level workgroup to align state agencies' efforts on transition and partners with F2F-IA to distribute HCT resources.				X
7. CHSC is developing a Family Advisory Council with youth members.				X
8. CHSC staff participated in the Federal Partners in Transition National Online Dialogue: Participation Metrics to give feedback on transition barriers for CYSHCN.				X
9. CHSC is vetting an enhanced care coordination algorithm to guide providers in deciding when a CHSC care coordinator will benefit youth.				X
10. HDM Unit helps families with eligible youth enroll in Medicaid Waiver programs, EPSDT and address HCT with an age-based guide.		X		

b. Current Activities

Infrastructure Building Services:

CHSC's Medical Director leads efforts to assure standards of care for Clinical Services at CHSC Regional Centers and focus on LCDT.

CHSC collaborates with EPSDT to pilot tools and a training for health care providers, care coordinators, and Family Navigators to facilitate HCT and is submitting recommendations to policymakers.

Staff attended the Developmental Disabilities Policy Council Summit and Iowa Transition Conference.

Staff presented at the Chronic Illness and Disability Conference on Transition from Pediatric to Adult Care on using CCHT in primary care offices at two tertiary care centers to provide family-to-family support, care coordination, and transition planning.

CHSC is integrating HCT tools into the electronic health record to allow sharing between facilities.

CHSC facilitates a state level workgroup to align state agencies' efforts on transition and partners with F2F-IA to distribute HCT resources.

CHSC is developing a Family Advisory Council with youth members.

Staff partook in the Federal Partners in Transition National Online Dialogue: Participation Metrics to give feedback on

transition barriers for CYSHCN.

CHSC is vetting an enhanced care coordination algorithm to guide providers in deciding when a CHSC care coordinator will benefit youth.

Enabling & Direct Health Care Services:

HDM Unit helps families with eligible youth enroll in Medicaid Waiver programs, EPSDT and address HCT with an

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC will monitor transition planning Family Navigators do with families through quarterly reviews of electronic medical records.

CHSC's Medical Director will continue to lead efforts to assure standards of care for clinical services at CHSC Regional Centers and focus on LCDT.

CHSC will partner with F2F-IA to provide web-based transition resources.

CHSC will use feedback from the EPSDT Transition Pilot Project to revise and implement tools to facilitate transition planning statewide.

CHSC will collaborate with Family Navigators, youth, families, and stakeholder agencies to develop materials on transition to adulthood for youth and families.

CHSC will collaborate with partner agencies to train health care providers, educators, families, and youth on HCT, including how to integrate it with education. CHSC will present information in multiple formats to accommodate a variety of learning styles.

CHSC will continue to integrate transition tools into the electronic medical record to allow sharing between facilities.

CHSC will continue to work with the Partnership to Improve Childhood In Iowa to explore quality improvement projects on transition for CYSHCN.

CHSC will continue to facilitate a state level workgroup aligning state agencies efforts on transition to adulthood.

CHSC will maintain a Family Advisory Council with youth members to provide feedback on how CHSC can better serve Iowa CYSHCN and their families.

Enabling and Direct Health Care Services:

CHSC Family Navigators will assist youth and families in developing emergency plans as youth become more independent, as needed.

CHSC will continue to collaborate with state partners to support the Achieving Maximum Potential program for foster and adoptive youth transitioning to adulthood.

CHSC will expand use of transition tools resulting from the EPSDT Transition Pilot Project for use by all Family Navigators when providing family-to-family support or care coordination for youth ages 12-21 years and their families.

CHSC will explore partnerships with Area Education Agencies, state partners, and organizations

serving people with disabilities to access career exploration and educational options and support as youth become accustomed to their new jobs.

CHSC will update a plain language directory of resources on transition to adulthood and will distribute to families and stakeholders.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	74	73	74	65	72
Annual Indicator	72.8	73.9	63.9	71.0	71.1
Numerator	3930	15890	17511	19439	22426
Denominator	5395	21501	27402	27379	31539
Data Source	PSIA report	Immunization Annual Report	Immunization Annual Report	Immunization Annual Report	Immunization Annual Report
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	73	74	77	80	83

Notes - 2013

Data was obtained from the 2013 Immunization Program Annual Report, which includes county-wide immunization rates for 2013.

Notes - 2012

Data was obtained from the 2012 Immunization Program Annual Report, which includes county-wide immunization rates for 2012.

Notes - 2011

Data was obtained from the 2011 Immunization Program Annual Report, which includes county-wide immunization rates for 2011.

a. Last Year's Accomplishments

The FFY13 performance objective of 72 was not met. The indicator value for Iowa was 71.1 percent was based on data from the 2013 Iowa Immunization Program Annual Report. The indicator value has remained stable over the past several years, the Immunization program bases this rate from those children whose immunization records are in IRIS. The Immunization program will continue to work with private providers to enter their immunization data into IRIS.

Infrastructure Building Services:

Iowa received a grant award from the Prevention and Public Health Fund (PPHF) to assist in implementing billing programs in local public health agencies (LPHA) throughout the state. The award assisted LPHA in overcoming barriers identified with initiating a billing program. Funds were used to contract with HS Medical Billing for the following activities: provide one-on-one consultation to 45 Iowa's LPHA to establish successful billing programs; train LPHA staff on contracting, billing, credentialing, coding and other components of billing; and to continue the LPHA Billing Hotline.

Nearly 800 health professionals attended the 2013 Iowa Department of Public Health (IDPH) Immunization Conference in Des Moines on June 12-13, 2013. The two-day conference focused on current immunization information and vaccine education for health care providers. The conference has grown from a group of about 20 local public health agency staff in 1994 to more than 765 attendees this year from 14 states.

Throughout 2013, the Immunization Program worked with multiple health care providers to begin sending electronic files to IRIS. During this time, 224 organizations began exchanging electronic immunization data with IRIS.

The IDPH Bureau of Immunization and TB, completed the administrative rules process to require tetanus, diphtheria, and pertussis (Tdap) vaccine for students enrolling in 7th grade. The administrative rule change was effective January 16, 2013, and was implemented at the beginning of the 2013-2014 school year. The change requires a one-time booster dose of tetanus, diphtheria, and acellular pertussis-containing vaccine for applicants in grades 7 and above, if born on or after September 15, 2000, regardless of the interval since the last tetanus/diphtheria containing vaccine.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide a series of web-based trainings for VFC providers. Topics will include vaccine storage and handling, VFC program requirements and Vaccine 101.				X
2. Work towards increasing HPV vaccination rates in adolescents and adults.	X			X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

IRIS staff is working with Iowa pharmacies to enroll in IRIS. A law went into effect on September 1, 2013, that expands the types of immunizations and the age ranges of children that pharmacists can immunize. Previously pharmacists could administer pneumococcal and influenza to adults without having a physician order. With the new law they can administer the following:

- Influenza and other emergency vaccines to patients six years of age and older
- For adults 18 years of age and older, they can administer:
 - A vaccine on the ACIP-approved adult vaccination schedule, and;
 - A vaccine recommended by the CDC for international travel.

Pharmacies are playing an increasingly important role as vaccine providers for children, adolescents and adults. New laws are expanding the populations that can be served and the types of vaccinations that can be offered in the pharmacy environment. As a result, these once "non-traditional" immunization providers are assuming a greater role in increasing immunization coverage by targeting underserved populations and providing convenient access for more traditional audiences. The law also requires pharmacies to report the immunizations administered to the patient's provider. This can be accomplished through IRIS.

Immunization field staff is adjusting to a new CDC web-based assessment tool (PEAR). PEAR is a tool to assess VFC Providers compliance with VFC Program requirements.

Enabling Services:

Local CH contract agencies monitor their clients' immunization statuses and offer counseling to families. All 22 local child health contractors address immunizations as part of informing and care coordination services.

c. Plan for the Coming Year

Infrastructure Building Services:

Immunization staff will be providing a series of webinars for the VFC providers. Information will include vaccine storage and handling, VFC Program requirements, Vaccine 101.

The Immunization Program in cooperation with the Iowa Chapter of the American Academy of Pediatrics will be partnering to increase HPV vaccination rates in adolescents and adults. The activities will include co-branding of provider and patient education materials and using IRIS to calculate and distribute individual provider HPV vaccine coverage levels. Each provider will receive the clinic's adolescent vaccine coverage levels in addition to county and statewide rates for comparison.

Enabling and Direct Health Care Services:

All 22 local CH contract agencies developed action plans related to immunizations. Agencies' activities include providing community education on importance of immunizations, utilizing IRIS to identify children who need follow-up services, providing fact sheets in the newborn discharge package from hospital, and offering on-site immunizations at WIC clinics and other community settings.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	16	15.2	16	11.2	10.2
Annual Indicator	15.7	13.3	11.9	10.8	9.8
Numerator	945	804	707	635	581
Denominator	60016	60327	59558	59006	59161
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	9.7	9.6	9.6	9.4	9.2

Notes - 2013

FFY13 data were obtained from 2013 Vital Statistics data.

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

a. Last Year's Accomplishments

The FFY13 performance objective of 10.2 was met. 2013 Vital Statistics data indicates that the rate of birth (per 1,000) for teenagers aged 15 to 17 years was 9.8.

Infrastructure Building Services:

Iowa was awarded the formula grant program entitled the Personal Responsibility Education Program (PREP) in 2011. PREP provides comprehensive sexuality education to adolescents, ages 10-19, that is medically accurate, culturally and age-appropriate, and evidence-based. The program is implemented with the goal of assisting youth to reduce their risk of unintended pregnancy, HIV/AIDS, and other sexually transmitted infections.

During the first year, Iowa awarded funding to four contractors delivering education in five high risk counties in Iowa. A second competitive request for proposals was released and one additional contractor was awarded funding, while education to youth was expanded to two additional Iowa counties. The contractors, which consist of local public health agencies and private non-profits, have implemented one of three evidence-based teen pregnancy prevention programs to youth in their area through a mix of school and community-based settings, as well as after-school programs. One hundred thirty-four youth received PREP programming during FFY2012 pilot implementation.

In addition to education on abstinence and contraceptive use, PREP also addresses other topics to prepare young people for a successful adulthood. Iowa PREP chose to focus on healthy relationships, adolescent development, and healthy life skills to incorporate into the program. Lessons on suicide prevention, along with internet and social media safety, were delivered to youth through PREP.

Iowa was also awarded the Abstinence Education Funding (AEGP) and is working to develop a contract with Youth and Shelter Services to implement the TOP program for adolescent in foster care or after care programs in 4-5 communities. A state coordinator was hired and is working in collaboration with the PREP program.

Enabling and Direct Health Care Services:

Through Iowa's Title X family planning program, outreach plans to adolescents and males include:

- 1) Investigating and disseminating best practices for working with adolescents
- 2) Expanding the use of electronic media
- 3) Expanding the role of youth on the state FP committees
- 4) Informing Dept. of Education on Title X services for use in their HIV/STI and pregnancy prevention curricula
- 5) Developing partnerships between Title X agencies and foster care, intimate partner violence, and substance abuse resources
- 6) Collaborating with other agencies for increased funding for adolescent pregnancy prevention efforts.

Title X clinics have initiated efforts to ensure that all clients, including adolescents and males, are counseled about establishing a reproductive life plan (RLP) to set goals about having children. The concept of RLPs has also been expanded to WIC and maternal health clients.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assuring ongoing high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low income families.	X	X	X	
2. Expanding access to a broad range of acceptable and effective family planning methods and related preventive health services.	X	X	X	
3. Assuring compliance with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.			X	X
4. Emphasizing the importance of counseling family planning clients on establishing a reproductive life plan.	X	X	X	X
5. Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.		X	X	X
6. Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.	X	X	X	X
7. Continued PREP programming to youth residing in high risk areas of the State.			X	
8. Continued AEGP programming to youth in foster care, aftercare, reside in an out of home care setting or who reside in an area with a high teen birth rate.			X	
9.				
10.				

b. Current Activities**Infrastructure Building Services:**

PREP contractors will carry out Year 2 implementation and evaluation will be conducted. IDPH will provide ongoing training and technical assistance to local PREP contractors And outreach will be carried out so as to gather resources to complement the program and create sustainability.

IDPH will provide training and technical assistance to community agencies implementing POWER Through Choices and the TOP program through the AEGP.

The PREP and AEGP program coordinators have developed an adolescent health website (www.IAMincontrol.org) specifically for teens. From July 1, 2013 -- June 30, 2014 the website had 8,455 hits.

Enabling and Direct Health Care Care:

IDPH has implemented its objectives for Year 4 of the five-year Title X plan, including expanding services to minorities, adolescents, and males.

Continuing outreach efforts to adolescents and males using best practices, social media, and strengthening relationships with local and state partners.

Title X clinics have initiated efforts to ensure all clients, including adolescents and males, are counseled about the importance of establishing a RLP to set personal goals about having (or not having) children. RLP education has been expanded to WIC and MH clinic clients.

c. Plan for the Coming Year**Infrastructure Building Services:**

IDPH will continue to provide training and technical assistance to PREP and AEGP contractors, focusing on outreach activities and sustainability of the program. PREP and AEGP contractors will continue to recruit youth to participate in the program in a variety of settings.

Outreach plans to adolescents and males include: 1) continuing to investigate and disseminate best practices for working with adolescents; 2) expanding the use of social media to reach youth; 3) expanding the role of youth on the state family planning Information and Education committees; 4) continuing work with the Iowa DE staff informing them of Title X services for use in their HIV/STI prevention and pregnancy prevention curricula; 5) developing more formalized partnerships between Title X agencies and foster care, intimate partner violence, and substance abuse community resources; and 6) collaborating with other state agencies for increased funding for adolescent pregnancy prevention efforts in Iowa.

Four MCH contract agencies have action plans to address teenage pregnancy. Activities include utilizing a teen parent panel to educate high school students, distributing information, including the IDPH TEEN Line brochures, in both English and Spanish to middle and high schools, and collaborating with middle and high school staff, faith-based organizations, teen groups, and medical providers to educate individuals on teenage pregnancy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	50	50	50	47	47
Annual Indicator	48.5	49.7	45.6	45.6	45.6
Numerator	16962	17381	16111	16111	16111
Denominator	34972	34950	35332	35332	35332
Data Source	third grade survey	third grade survey	third grade survey	third grade survey	third grade survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	50	51	52	53	54

Notes - 2013

The data was collected through the OH survey of third graders in 2012.

The FFY13 performance objective of 47 was not met. The indicator value for Iowa of 45.6 percent was based on data from the 2012 Third Grade Oral Health Survey. Because schools that currently have an IDPH funded school-based sealant program were excluded from the survey, the state average may actually be higher than the survey results indicate.

Notes - 2012

The data was collected through the OH survey of third graders in 2012.

The FFY12 performance objective of 47 percent was not met. The indicator value for Iowa was 45.6 percent was based on data from the 2012 Third Grade Oral Health Survey. Because schools that currently have an IDPH funded school-based sealant program were excluded from the survey, the state average may actually be higher than the survey results indicated.

Notes - 2011

The data was collected through the OH survey of third graders in 2012.

a. Last Year's Accomplishments

The FFY13 performance objective of 47 was not met. The indicator value for Iowa of 45.6 percent was based on data from the 2012 Third Grade Oral Health Survey. Because schools that currently have an IDPH funded school-based sealant program were excluded from the survey, the state average may actually be higher than the survey results indicate.

Infrastructure Building Services:

I-Smile Coordinators and Oral Health Center (OHC) staff offered education regarding community water fluoridation (CWF) issues in order to maintain Iowa's current CWF systems. Dr. Russell, Iowa's State Dental Director, is on a CWF task force with several other state partners. Coalition efforts have resulted in retained CWF in Davenport, Des Moines, and other municipalities. OHC helped educate the Iowa Dental Board on the need to include child care as a setting for public health supervision of dental hygienists; a measure which was then passed. Based on the results of the 2012 survey of third graders and the Pew Foundation's report card, IDPH issued a Request for Proposal for a new School-Based Sealant Program (SBSP) project period. OHC staff provided

technical assistance to all Title V contractors who provide SBSP. OHC was awarded grant funding from the Centers for Disease Control and Prevention for capacity-building of state oral health programs, which includes a 0.5 FTE sealant program coordinator and expansion of SBSP.

Population-based Services:

SBSP contracts were in their third and final year. Seven new contracts were awarded. Prevention messages were shared with the public via Twitter and the I-Smile dental home Facebook page. The state requirement of dental screenings of kindergarten and ninth grade students also provided a means to encourage prevention.

Enabling and Direct Care Services:

Contract agencies used texting and email as billable forms of care coordination, improving I-Smile staff's ability to reach families who rely mostly on mobile communication.

All I-Smile projects must ensure that children age 0- 2 receive preventive services at WIC. Services for older children were encouraged based on data indicating gaps, and were most often provided in schools, preschools, and Head Start/Early Head Start centers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue public-private partnerships to increase preventive services for children.				X
2. Promote I-Smile™ and dental disease prevention.			X	
3. Administer local school-based sealant projects to provide preventive sealants to at-risk children.	X		X	X
4. Monitor marketplace dental insurance enrollment.				X
5. Advocacy and monitoring of community water fluoridation.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

OHC expanded SBSP from 7 to 18, through a partnership with Delta Dental of Iowa and a Centers for Disease Control and Prevention grant. OHC has maintained other activities, including participating in a task force supporting education efforts on the benefits of CWF and providing guidance for the state SBSP. State monitoring of water fluoridation data is transitioning to OHC staff.

Population-based Services:

FFY2014 is the first year of a new project period for SBSP, including the 11 new contracts. OHC supports local contractors through funding and guidance for health promotion to promote prevention of dental disease, as well as continuing to provide social media messages.

Enabling and Direct Care Services:

OHC staff works with staff from the Bureau of Family Health to respond to changing needs for provision of care coordination services, including consideration of client-specific letters to health providers as billable care coordination.

Gap-filling preventive services continue through local contractors and ensuring services for ages 0-2 at WIC is a requirement.

c. Plan for the Coming Year

Infrastructure Building Services:

OHC will continue collaboration with Delta Dental to support expansion of SBSP. Development of a new data system will include SBSP data, allowing improved ability to use data to drive preventive program development. A new epidemiological position with OHC will also assist in enhancing the Iowa oral health surveillance system to better determine need for and impact of preventive services. OHC will seek ways to identify if families enrolling through the health insurance marketplace are enrolling with a dental plan, to better understand program needs. Participation on the state's CWF coalition will continue, and OHC staff will assist in notification of "rapid response teams" for CWF issues that arise in the state.

Population-based Services:

An open mouth survey will be completed on third graders to measure progress toward advancing this performance measure and to better understand oral health status of Iowa children. Health promotion activities will continue, through local I-Smile projects and a state-coordinated approach from the OHC.

Enabling and Direct Care Services:

OHC will continue to monitor Title V contractors regarding quality of dental-specific care coordination services.

Preventive dental services will continue through local Title V contractors, due to data indicating specific gaps in access to care, particularly for children ages 0-2. This will be particularly important because dental insurance coverage is an option on the health insurance marketplace.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	3	3	2.3	2.1	2.3
Annual Indicator	3.1	2.5	2.3	2.5	1.5
Numerator	18	15	14	15	9
Denominator	589813	603673	601833	601376	602101
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018

Annual Performance Objective	2.7	2.6	2.5	2.4	2.3
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Notes - 2013

FFY13 data were obtained from 2013 Vital Statistics Provisional data.

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics provisional data.

a. Last Year's Accomplishments

The FFY13 performance objective of 2.3 percent was not met. The indicator value for Iowa was 3.0 was based on data from 2013 provisional Vital Statistics data.

Infrastructure Building Services:

IDPH Bureau of EMS and the Safe Kids Coalition:

- Conducted four National Highway Traffic Safety Administration Child Passenger Safety Seat technician certification trainings in Iowa
- Provided a yearly update on new trends and technology for currently certified child safety seat technicians. Maintaining the currently recognized Fitting Station locations as well as the state's child passenger safety seat website.
- Continued partnership and stakeholder work on graduated driver license and distracted driving projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Stay involved in state's injury prevention projects and initiatives.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The Bureau of EMS-Emergency Medical Services for Children (EMSC) Program works with Safe Kids Iowa and other nonprofit injury prevention organizations to support statewide child passenger safety check-ups at community events, as well as regularly scheduled child passenger safety inspection stations. Child passenger safety advocates work to provide outreach to physicians, health care agencies, and child care providers.

Population-based Services:

The BFH and EMS bureau are collaborating to provide outreach to childcare providers and families. The Bureau of EMS's EMSC program provides resources and information regarding recalls of child safety seats and bicycle safety, as well as other injury areas identified in the Iowa

Burden of Injury Report.

The IDPH Bureau of EMS-EMSC program is longer the grant recipient for the National Highway Traffic Safety Administrative funds from the state's Governor's Traffic Safety Bureau. Instead those funds will be expended on the Safe Kids Iowa program. Despite the lack of funding to support an Injury Prevention/Child Passenger Safety Coordinator the EMSC program manager continues to be actively involved in the state's injury prevention projects and initiatives, including the occupant protection projects, Love Our Kids program administration, Injury Prevention subcommittee of the state' trauma system, and the planning committee member for the state's injury prevention yearly conference.

c. Plan for the Coming Year

Infrastructure Building Services:

Although the IDPH Bureau of EMS-EMSC program is longer be the grant recipient for the National Highway Traffic Safety Administrative funds, the EMSC program manager will continue to be actively involved in the state's injury prevention projects and initiatives, including the occupant protection projects, Love Our Kids program administration, Injury Prevention subcommittee of the state' trauma system, and the planning committee member for the state's injury prevention yearly conference. Instead those funds will be expended on the Safe Kids Iowa program.

Two local CH agencies have specific action plans related to this measure. Agencies will utilize Safe Kids USA information and posting at immunization clinics, WIC clinics, schools, faith based organizations, libraries, physicians' offices, etc. One agency is seeking local funding to purchase car seats and will provide free car seat safety checks at various locations.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	20	19	16.5	17.5	18
Annual Indicator	18.1	16.4	17.3	17.7	18.7
Numerator	2692	2410	2412	3101	2645
Denominator	14871	14692	13913	17513	14166
Data Source	Pediatric NSS	Pediatric NSS	Pediatric NSS	IWIN Breastfeeding Duration Report	IWIN Breastfeeding Duration Report
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	19.5	20.5	21.5	22.5	23.5

Notes - 2013

FFY09 to FFY11 data obtained from PedNSS data. PedNSS data for the WIC Program was discontinued after 2011. Data for FFY12 and FFY13 obtained from IWIN Breastfeeding Report.

Notes - 2012

FFY12 data obtained from the IWIN Breastfeeding Duration Report. Analysis of PedNSS data for the WIC Program was discontinued after the year 2011. As a replacement, this measure will now utilize the breastfeeding duration report in the State database (IWIN). The results are compiled on an annual basis.

Notes - 2011

Data from 2011 PedNSS Data.

a. Last Year's Accomplishments

The FFY13 performance objective of 18 percent was met. The data show that 18.7 percent of mothers breastfed their infants at six months of age in 2013.

Infrastructure Building Services:

In FFY2013, the Bureau of Nutrition and Health Promotion (BNHP) co-sponsored the 24rd Annual Breastfeeding Conference on May 16, 2013. Staff from the BNHP provided technical assistance to WIC and local maternal and child health agencies on breastfeeding.

The BNHP updated the Breastfeeding Education for Iowa Communities training curriculum developed in 2012 through the Iowa Breastfeeding Coalition in conjunction with the Iowa WIC Program and USDA. Trainings held in 4 communities in FFY2013 with a total of 73 people trained.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Co-sponsor the annual Iowa breastfeeding conference				X
2. Bureau of Nutrition and Health Promotion require local WIC agencies to spend a minimum of 20% on nutrition education of which 3% needs to be spent on breastfeeding.				X
3. Bureau of Nutrition and Health Promotion provides support to the state breastfeeding coalition, Iowa Breastfeeding Coalition.				X
4. Bureau of Nutrition and Health Promotion has been receiving USDA Peer Counseling grant funds since 2004.		X		
5. Continue to provide technical assistance to local maternal and child health agencies.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The Bureau of Nutrition and Health Promotion (BNHP) co-sponsored the 25th Annual Breastfeeding Conference on May 15, 2014. Staff members are continuing to provide technical assistance to local maternal and child health agencies on breastfeeding. Staff also continues to promote and track the Breastfeeding Education for Iowa Communities training. One training has been held thus far in FFY14 with two more planned. BNHP continues to provide support to the Iowa Breastfeeding Coalition will current membership at approximately 80 people.

c. Plan for the Coming Year

Infrastructure Building Services:

The Bureau of Nutrition and Health Promotion (BNHP) will continue to co-sponsor the Annual Breastfeeding Conference in May 2015 and provide technical assistance to local maternal and child health agencies on breastfeeding. The BNHP will continue to update the training curriculum, Breastfeeding Education for Iowa Communities.

WIC and local MH agencies are addressing breastfeeding through their grant activities. Activities include providing breastfeeding education and support to mothers at each MH visit or home visit.

Local MH agencies collaborate with WIC agencies to provide education to WIC clients, counsel clients about infant feeding methods and give education about the benefits of breastfeeding.

Agencies will also promote "World Breastfeeding Week", August 1-7.

Six local MH agencies are addressing breastfeeding through their grant activities. Activities include providing breastfeeding education and support to mothers at each MH visit or home visit. Local MH agencies collaborate with WIC agencies to provide education to WIC clients, counsel clients about infant feeding methods and give education about the benefits of breastfeeding. Agencies will also offer Breastfeeding Support Groups.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	99.5	99.6	99.7	99.3	99.5
Annual Indicator	98.7	99.2	99.1	99.4	99.4
Numerator	38885	37838	37293	37799	38166
Denominator	39404	38151	37640	38022	38396
Data Source	eSP	eSP	eSP	eSP	Iowa EHD Database eSCREENER Plus
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2014	2015	2016	2017	2018
Annual Performance Objective	99.5	99.5	99.6	99.6	99.6

Notes - 2013

FFY13 data were obtained from the eSP™ newborn hearing screening database. The denominator represents the total number of children eligible for screening less those families that refused the birth screen or the infant died prior to hospital discharge. The numerator includes those infants eligible that received a hearing screen at birth. The data is provisional. The data will not be finalized until the final vital records file is released and the program is able to perform a one to one match.

Notes - 2012

FFY12 data were obtained from the eSP™ newborn hearing screening database. The denominator represents the total number of children eligible for screening less those children that transferred to a birthing facility outside of Iowa, home birth families contacted, but the department had no response back and therefore are considered "lost" and those families who refused to have their children screened at the hospital. The numerator are those children that were eligible and received a birth screen.

Notes - 2011

FFY11 data were obtained from the eSP™ newborn hearing screening database. The denominator represents the total number of children eligible for screening less those children that transferred to a birthing facility outside of Iowa, home birth families contacted, but the department had no response back and therefore are considered "lost" and those families who refused to have their children screened at the hospital. The numerator are those children that were eligible and received a birth screen.

a. Last Year's Accomplishments

The FFY13 annual indicator objective of 99.5 percent was not met. Provisional data from the eSP newborn hearing screening data system indicate that 99.4 percent of newborns were screened for hearing loss before discharge.

Infrastructure Building Services:

The EHDI program staff worked with individual birthing hospital personnel with high refer rates to implement strategies to decrease refer rates which in turn decreased the number of infants in need of follow up. Strategies included additional training on newborn hearing screening protocols and methods, data entry and the implementation of quality improvement goals.

The EHDI program continued to participate in training, outreach and public education opportunities with healthcare providers, audiologists, ENTs, early childhood providers and nurses. One educational outreach opportunity specifically targeted nurse midwives in an attempt to increase the number of infants born outside of a birthing facility who are screened for hearing loss. Following a targeted mailing to nurse midwives, the number of infants born outside a birthing facility screened increased and as well as inquiries about newborn hearing screening and appropriate follow-up to EHDI staff.

Iowa EHDI program completed additional analysis of infants being lost, including maternal demographics, refer rates of birthing facilities that use OAE versus AABR screening equipment and follow up rates for hospitals that offer hearing rescreens versus sending the families to another provider to have a hearing rescreen. Analysis was shared with birthing facilities and healthcare providers to educate providers on the important roles they play in follow up and reinforce best practices.

The Iowa EHDI program performed a one-to-one match with Vital Records reports for years 2010

through 2012. Iowa EHDI knows the outcome of every occurrent birth and finalized screening, assessment and early intervention enrollment data for each of those births in the Fall 2013. In May 2013, EHDI program staff was able to obtain approval through Early ACCESS (EA) through the Department of Education to obtain EA referral and enrollment data for any child diagnosed with a hearing loss.

The EHDI coordinator and follow up coordinator serve on a data integration committee within the Bureau of Family Health. It was determined the EHDI and dried blood spot screening programs were going to integrate their data systems. The team put out a request for information in April 2013 and viewed demonstrations in June 2013. The team then worked throughout the Summer and Fall 2013 completing a data dictionary for each database, gap analysis, business requirements. The goal is to complete a request for proposal for an integrated newborn screening database.

IDPH EHDI participated in the development of the Early Hearing Detection and Intervention (EHDI) PALS (Pediatric Audiology Links to Services), a web-based system to help parents, hospital personnel, and physicians find appropriate pediatric audiology facilities that will meet an individual child's needs.

Enabling and Direct Care Services:

IDPH EHDI followed up with families and healthcare providers for 5,043 infants that did not pass or missed the newborn hearing screening to ensure they received a hearing screen/rescreen and referral for a diagnostic assessment, as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to promote expansion of service delivery through telehealth.		X		
2. Implement integrated database (newborn hearing screening/dried blood spot) within birthing facilities and audiology facilities, healthcare providers, lab and vital records.				X
3. Monitor newborn hearing screening follow up program for referral patterns for infants in need of further screening and assessment to evaluate where children are being lost.				X
4. Evaluate maternal demographics to determine if they impact screening, assessment and timely follow-up				X
5. Evaluate maternal demographics to determine if they impact screening, assessment and timely follow-up				X
6. Continue to follow-up with families and healthcare providers for infants in need of a hearing screen, rescreen, diagnostic assessment or referral for early intervention and family support.		X		
7. Continue to participate in development of the EHDI PALS, web-based system to help parents, hospital personnel, and physicians find appropriate pediatric audiology facilities that will meet an individual child's needs.				X
8. Continue to use pediatric audiologists to provide technical assistance to facilities providing newborn screening and audiologist assessments.			X	X
9.				
10.				

b. Current Activities**Infrastructure Building Services:**

The EHDI and dried blood spot screening program issued a second request for information about an integrated data system in December 2013. The data integration team issued a request for proposal (RFP) in February 2014 and reviewed the proposals in April 2014. The team will issue a contract with the selected vendor in July 2014 to integrate the two databases. Following integration of the two databases, the EHDI program will provide training to birthing facilities, audiologists and other healthcare providers to ensure they continue to submit hearing screening and diagnostic assessments through the web-based data systems.

The EHDI program will work with birthing facilities to develop a ranking system which highlights facilities that are meeting/not meeting JCIH recommended EHDI best practices for screening and follow-up.

The program is in the process of developing protocols for follow-up of children in need of a hearing screen being served in the Title V programs. A pilot will be conducted within four Title V programs in rural and urban settings to assist families of children they serve who are in need of a hearing screen or assessment in finding the appropriate resources in their community.

Enabling and Direct Care Services:

IDPH EHDI will continue to follow-up with families and healthcare providers for infants in need of a hearing screen, diagnostic assessment or referral for early intervention and family support.

c. Plan for the Coming Year**Infrastructure Building Services:**

The EHDI program will evaluate the effectiveness of using Title V programs to assist families of children they serve who are in need of a hearing screen or assessment in finding the appropriate resources in their community. The program will then make adjustments and start to conduct a similar pilot in the local WIC and home visiting programs.

The EHDI program will assemble a focus group of prenatal educators (e.g. nurses) and explore the methods of outreach to increase parental knowledge of newborn hearing screening and timely follow-up prior to birth of their infant. The program will then provide education to the prenatal instructors and develop materials they can share in the prenatal period with parents and healthcare providers.

The EHDI program plans to assemble a workgroup and develop a checklist for audiologists to use when a child has been identified with a hearing loss to ensure all referrals have been made to appropriate providers including early intervention, parent support, ENTs and ophthalmology, etc. The program will then pilot the checklist and evaluate the effectiveness by comparing the timeliness of referrals between facilities that use the checklist and those that do not.

Other activities include the development of a hearing healthcare road map which outlines "next steps" for parents whose infants did not pass a hearing screen at birth and education and outreach to healthcare providers regarding timely referrals and appropriate follow-up.

Enabling and Direct Care Services:

IDPH EHDI will continue to follow-up with families and healthcare providers for infants in need of a hearing screen, diagnostic assessment or referral for early intervention and family support.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	2.8	2.8	2.8	2.8	2.8
Annual Indicator	2.8	2.8	2.8	2.8	2.8
Numerator	19969	20383	20321	20400	22974
Denominator	713155	727993	725767	728582	820510
Data Source	Household Health Survey	Household Health Survey	Household Health Survey	Household Health Survey	Household Health Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	2.8	2.5	2.5	2.5	2.5

Notes - 2013

FFY13 data were obtained from the 2010 Iowa Child and Family Household Health Survey for children 0-17 years.

Notes - 2012

FFY12 data were obtained from the 2010 Iowa Child and Family Household Health Survey for children 0-17 years.

Notes - 2011

FFY11 data were obtained from the 2010 Iowa Child and Family Household Health Survey for children 0-17 years.

a. Last Year's Accomplishments

The FFY13 performance objective of 2.8 was met. Data from the 2010 Iowa Child and Family Household Health Survey shows that 2.8 percent of children in Iowa are uninsured.

Infrastructure Building Services:

The state hawk-i Outreach Coordinator provided hawk-i materials and information during several conferences and events throughout the year, including the Iowa High School Wrestling and Basketball Tournaments, School Nurse Organization Conference, Iowa Governor's Conference on LGBTQ Youth, Risky Business Conference, and the Iowa Immunization Conference. The state coordinator provided training and ongoing technical assistance to the local hawk-i outreach coordinators for upcoming changes to the hawk-i and Presumptive Eligibility programs. Two statewide meetings were held for the local coordinators to share best practices for outreach and to provide professional development and ongoing technical assistance. Webinars were also held for the local outreach coordinators to ensure they have the most up to date information in order to

conduct successful outreach. The state coordinator also assisted the local agencies in implementing targeted outreach to teens through the CHIPRA II Outreach and Enrollment project.

Population-based Services:

The Department of Human Services (DHS) continues to contract with IDPH to provide oversight of the local hawk-i outreach program. During FFY13, child health agencies provided hawk-i outreach to their communities through schools, medical and dental providers, faith-based communities, and diverse ethnic populations. In addition to these four required populations, local agencies targeted community organizations that work with teens as well as children of all ages, and venues that reach families of all income levels, such as health fairs and other large community events. Through the CHIPRA Outreach and Enrollment project, many local agencies developed new and sustainable partnerships for referrals and information sharing about Medicaid and CHIP, in addition to existing community partnerships.

Enabling and Direct Care Services:

The local outreach coordinators directly assisted clients with applications for Medicaid and CHIP, in addition to assisting with the enrollment and renewal processes. Through presumptive eligibility for children, the local coordinators assist families in obtaining immediate coverage, and follow up with families to ensure they become enrolled in full Medicaid or CHIP.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhance outreach to special populations		X		X
2. Continue to oversee the hawk-i outreach contract with local child health agencies				X
3. Increase public awareness of the hawk-i program			X	X
4. Provide technical assistance to local child health agencies				X
5. Promote grassroots outreach activities		X		X
6. Utilize successfully established infrastructure and collaborations to implement outreach		X		X
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The state outreach coordinator continues to work closely with DHS and the local coordinators to ensure information and updates about program changes are communicated in a timely manner, and to ensure health insurance coverage for children despite recent large, system wide changes. Statewide meetings and webinars will continue to be held to distribute this information and facilitate best practice sharing among local coordinators. The state outreach coordinator will provide ongoing technical assistance regarding the new Presumptive Eligibility system, as well as the new application process for Medicaid and hawk-i.

Population-based Services:

Local coordinators continue to focus on increasing enrollment in Medicaid, hawk-i, and hawk-i Dental Only through Presumptive Eligibility for Children and increased awareness about the programs. The state outreach coordinator will be focusing on increasing awareness about Medicaid and hawk-i and ensuring accurate information about the program is distributed on a regular basis.

Enabling and Direct Care Services:

Local outreach coordinators continue to directly assist families with applications and enrollment in Medicaid and hawk-i through both Presumptive Eligibility for Children and regular applications. The local coordinators assist families in fully completing the application process to ensure children are covered.

c. Plan for the Coming Year

Infrastructure Building Services:

Promoting and maintaining the hawk-i and Presumptive Eligibility for Children programs will continue to be a priority in FFY 2015. In 2014, the hawk-i income guidelines increased from 300% of the Federal Poverty Level to 302%, and reaching families who may qualify for the program who did not previously will also be an outreach priority.

Local hawk-i Outreach Coordinators will be required to provide outreach to healthcare providers, schools, the faith-based community, and special populations. To ensure the local coordinators continue to use new and innovative strategies, they will also be required to include a new outreach activity for the FFY 2015.

Population-based Services:

The state coordinator and local coordinators will continue to focus on increasing enrollment in hawk-i and Medicaid through the Presumptive Eligibility for Children Program and increasing awareness about the programs and the importance of health insurance for children. Local coordinators will also focus on increasing enrollment in the hawk-i Dental Only program through increasing awareness and educating community partners.

Enabling and Direct Care Services:

Local coordinators will continue to provide Presumptive Eligibility Services for children, and those that are certified as Application Counselors will assist families with hawk-i and Medicaid applications. Those whose agencies are not Certified Application Counselor organizations will refer families to the appropriate agency that can assist with the applications. Outreach coordinators will also continue to assist families struggling with the enrollment process, and will elevate cases to the state coordinator to help identify barriers and ensure issues are resolved in a timely manner.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	32	30	29.8	31	21.5
Annual Indicator	32.5	31.9	31.7	21.9	19.3
Numerator	11773	11414	10911	16611	8314
Denominator	36225	35783	34420	75987	43137
Data Source	CDC PedNSS	CDC PedNSS	CDC PedNSS	IWIN Prevalence of Nutrition Risk	IWIN Prevalence of Nutrition Risk
Check this box if you cannot					

report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	19.1	19	18.9	18.8	18.7

Notes - 2013

The data source for this indicator is the Prevalence of Nutrition Risk from the IWIN data system. Children 2 to 5 years who were overweight (\geq 85th and $<$ 95th percentile BMI for age) or obese (\geq 95th percentile BMI for age) when certified were compared to the number of certifications of all children 2 to 5 years. In 2012, some of the children in the data set were duplicates. The certification of children was changed from 6 months to 12 months in 2013 which reflects 1 measurement per child per year.

Notes - 2012

Analysis of PedNSS data for the WIC Program was discontinued after the year 2011. As a replacement, this measure will now utilize risk criteria as identified by the Iowa WIC Program and recorded in the State data base (IWIN). The results are compiled on an annual basis. Data is defined as $>$ 85th percentile (At risk for becoming overweight) and $>$ 95th percentile (Overweight). These two groups were combined to tabulate the final percentage.

Notes - 2011

Data from 2011 PedNSS Data.

a. Last Year's Accomplishments

The FFY13 performance objective of 21.6 percent was met. Data from the 2013 Prevalence of Nutrition Risk report from the WIC data system show that 19.3 percent of children ages 2 to 5 years receiving WIC services had a BMI at or above the 85th percentile.

Infrastructure Building Services:

Local WIC programs continued to work with local vendors to increase the consumption of fresh fruits and vegetables. Through the Iowa Nutrition Network (INN) other food programs in Iowa continue to collaborate in this goal.

Local WIC agencies utilized the materials developed from a grant that focused on working with child care centers to limit screen time and encourage physical activity in nutrition education settings. These materials are often shared with other community programs.

Population-based Services:

The obesity rate is decreasing among children 2 to 5 in the United States due to the increase in encouraging healthy eating and exercise and encouraging breastfeeding. Currently, the WIC program in Iowa has experienced a decrease in obesity in this group and an increase in breastfeeding. This discussion is taking place with the emphasis on behaviors and benefits and not an overweight focus. Agencies were provided with the book written by Ellyn Satter entitled "Your Child's Weight- Helping Without Harming".

Enabling and Direct Care Services:

Local WIC agencies have concentrated on providing participants with materials and resources to encourage the following activities:

1. Emphasizing increasing the intake of fruits and vegetables and whole grains
2. Discussing limiting screen time to 1 hour per day
3. Increasing the awareness of proper serving sizes
4. Stressing the importance of exercise, both family and child
5. Eating family meals
6. Increasing breastfeeding

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Staff members will utilize participant-centered education		X		
2. Agencies will implement a physical activity model			X	
3. Agencies will increase access to community activity resources				X
4. WIC participants will have the tools to increase fruit and vegetable consumption				X
5. WIC participants will increase family meals			X	
6. More WIC mothers will choose to breastfeed their babies		X		
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The Iowa WIC Program is developing a module based on physical activity for children.

A survey was completed with all WIC agencies to determine if they needed materials for one-on-one counseling, group classes, or bulletin boards. Most agencies indicated they preferred materials for 1 on 1 counseling and bulletin boards. Resources were gathered to be included in the module: pamphlets and brochures, social media, video clips, and community resources (parks, playgrounds, summer programs). Draft copies will be shared with local agencies and the Nutrition Services Committee to test for effectiveness.

State and local staff are completing podcasts based on Participant-Centered Services. Each agency has a "champion" to act as a mentor. All mentors will participate in two webinars with Molly Kellogg to discuss challenges opportunities, and successes. Research indicates that working with participants in a person-centered way affects greater behavior change. Using these techniques in the discussion of diet and exercise will be a helpful tool in weight control counseling.

Population-based Services:

Plans are underway to increase the consumption of fresh fruits and vegetables by providing education concerning selecting, preparing, and storing produce when they receive the WIC Farmers' Market checks. This is a partnership with the Iowa Department of Agriculture and Land Stewardship, Iowa State University Extension, and the Iowa WIC Program.

c. Plan for the Coming Year

Infrastructure Building Services:

Agencies will be submitting nutrition education plans based upon the core nutrition messages. They are:

1. Role modeling: They learn from watching you. Eat fruits and veggies and your kids will too.
2. Cooking and Eating Together: Cook together. Eat together. Talk Together. Make mealtime family time.
3. Division of Feeding Responsibility: Let them learn by serving themselves, sometimes new foods take time, and patience works better than pressure.

Agencies will also focus on ways to increase the number of mothers who breastfeed which has proven to lower the chance of childhood obesity.

Person-centered services will continue to be a focus. All trainings will include more person-centered techniques. In this way, participants will be an integral part of the decision making involved in change.

Three local CH agencies have activities related to this measure. Activities include utilizing IDPH Family Support Nutrition Training Resource Manual to promote physical activity and nutrition at CH clinics in the service area, such as Pick a Better Snack and ACT handouts and posters.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	14	13	12	12	11.5
Annual Indicator	13.6	13.2	12.7	12.1	12.0
Numerator	5387	5085	4859	4666	4674
Denominator	39662	38514	38204	38645	38988
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	11	10.5	10	9	8.5

Notes - 2013

FFY13 data were obtained from 2013 Vital Statistics data.

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

a. Last Year's Accomplishments

The FFY13 performance objective of 11.5 percent was not met. Data from 2013 Vital Statistics indicates that 12.0 percent of women smoked in the last three months of pregnancy.

Infrastructure Building Services:

The smoking assessment tool being used by local MH programs assessed if tobacco products were presently being used. IDPH has expanded the tool to encourage conversation about second hand smoke from others in the infant's environment and encouraged methods to decrease this exposure.

Enabling and Direct Care Services:

Five local MCH agencies participated in activities related to reducing smoking during pregnancy. Activities included providing smoking cessation education to all MH participants at each prenatal and postpartum encounter, giving education about benefits of quitting smoking at any time during pregnancy, training staff on tobacco cessation, specifically using the Ask, Advise, Refer Quitline Iowa model. The staff also coordinated care by referring clients to the Quitline Iowa service.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education and outreach on the existence of Quitline Iowa.			X	X
2. Encourage MH agencies to have specific action plans related to smoking cessation.				X
3. Train MH staff in motivational interviewing.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities**Infrastructure Building Services:**

Pregnant women are provided education about the benefits of not smoking during pregnancy and the risks to both themselves and their unborn child if they continue to smoke. Local programs also refer members to the Quitline Iowa and local resources in their county that may be available.

The Medicaid IDPH maternal health taskforce continues to work together on strategies to reduce smoking during pregnancy for Medicaid women. This year a partnership with Medicaid was made to work on a Maternal Smoking Cessation Quality Improvement Project, activities included: a Perinatal letter (written by the Iowa ACOG chair to health care providers in Iowa about the importance of tobacco cessation counseling with pregnant and postpartum women), a chart record review was also done at three southern Iowa OB provider clinics through this project.

Enabling and Direct Care Services:

MH programs have continued to focus on encouraging women who are unwilling to quit to decrease the amount they smoke and not to smoke in the house and car to decrease the second

hand smoke exposure to their newborns.

c. Plan for the Coming Year

Infrastructure Building Services:

IDPH has a goal to focus on the education of OB providers about Quitline Iowa.

Continue to encourage MH agencies to have specific action plans related to smoking cessation

Encourage motivational interviewing techniques and training of MH staff in motivational interviewing when working with clients who use tobacco products.

Seven local MH agencies had specific action plans related to smoking cessation. Activities include providing smoking cessation education to all MH participants at each prenatal and postpartum encounter, giving education about the benefits of quitting smoking at any time during pregnancy, training staff using the Ask, Advise, Refer Quitline Iowa model and coordinate care by referring clients to Quitline Iowa.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	12.7	9.5	11	11	10.5
Annual Indicator	9.7	11.5	11.6	11.7	10.8
Numerator	21	25	25	25	23
Denominator	217380	216837	215834	213341	212508
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	10	9.5	9	9	9

Notes - 2013

FFY13 data were obtained from 2013 Vital Statistics provisional data.

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

a. Last Year's Accomplishments

The FFY13 performance objective of 10.5 was met. Provisional data from 2013 Vital Statistics indicates that the rate (per 100,000) of suicides among youths aged 15 to 19 years was 10.8.

Infrastructure Building Services:

Bureau of Family Health staff attended all regional MCH staff meetings in 2013 to bring adolescent health awareness and education to their communities. Topics identified include teen pregnancy prevention and STIs, substance abuse and tobacco, and mental health, including bullying and suicide. Title X agencies continued to screen for mental health as part of their intake process.

BFH continued its partnership with other IDPH bureaus and state agencies.

BFH strengthened their knowledge on adolescent mental health issues through educational opportunities, provided by the State Adolescent Health Resource Center and AMCHP.

Population-based Services:

PREP grantees continued to deliver the SOS Signs of Suicide Prevention Program (r) to Iowa youth.

IDPH, in partnership with Iowa State University Extension, launched the IAMincontrol website in November of 2012. The website continues to offer information and resources on a variety of topics affecting adolescents. The blog posts are mostly written by traditional college-aged students, with some posts written by young people and professionals around the state.

IDPH used the bullying and suicide prevention funding received during the 2012 Legislative session to implement and maintain a website specifically for bullying and suicide prevention. Your Life Iowa (www.yourlifeiowa.org) includes information, support and resources for teens and adults. BFH continues to partner with this initiative.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuation of the IAMincontrol website in providing age appropriate and medically accurate information to Iowa youth.			X	
2. BFH staff will continue collaborative efforts with key partners surrounding adolescent mental health.				X
3. Adolescent health staff will continue to bring awareness to MCH agencies on adolescent health issues, including mental health.				X
4. PREP grantees will continue to identify and provide effective suicide prevention education and referrals to Iowa youth.		X		
5. Adolescent health staff will continue to enhance their knowledge of adolescent mental health through professional development trainings.				X
6. Title X agencies will continue to screen for mental health through a coordinated intake process and provide necessary referrals.	X			
7.				
8.				
9.				

b. Current Activities**Infrastructure Building Services:**

BFH continues to solidify established relationships, strengthen MCH agencies on adolescent health issues through trainings, resources and technical assistance and continue to partner with new and existing youth serving agencies.

BFH adolescent health staff enhanced their relationship with internal IDPH staff through the formation of an Adolescent Health Collaborative, an intra-agency group within IDPH working to advance adolescent health efforts. Individuals who work with or oversee programming for youth participate in this group and represent various divisions and bureaus within the department. Adolescent health areas represented include, but are not limited to, tobacco and substance use prevention, violence prevention, teen pregnancy and STD/HIV prevention, family planning, immunizations, health insurance, brain injury and disability, and multicultural health.

BFH staff will continue involvement with the ACEs efforts by attending the statewide steering committee meetings. Staff will take the information from these meetings and work with local agencies and grantees to infiltrate the ACEs work in their communities. When local agencies are working as a collaborative effort, adolescent health staff will encourage them to invite mental health professionals to take an active role in their adolescent health coalitions.

Population-based Services:

PREP grantees address mental health and suicide prevention through programming with Iowa youth.

BFH maintains and promotes the IAMincontrol website through partnerships and outreach events.

c. Plan for the Coming Year**Infrastructure Building Services:**

IDPH received a Garrett Lee Smith State Youth Suicide Prevention Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The name of IDPH's project is Youth and Young Adult Suicide Prevention Program (Y-YASP). Y-YASP is a \$1.32 million, three-year project to implement the project across Iowa. The project includes specific steps to reduce suicides, suicidal behavior, and suicide risk among youth and young adults aged 10 to 24 years by: (1) implementing evidence-based screening for suicide risk at all IDPH substance abuse treatment programs (Patient Health Questionnaire-9) (2) Implement an evidence-based gatekeeper training program for middle and high school educators in all Iowa's middle/junior high and high schools and (3) reaching youth using social media.

Population-based Services:

BFH will continue to maintain and promote the IAMincontrol website.

PREP grantees will continue their efforts to address mental health and suicide prevention through programming with Iowa youth.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	96	97	95	93	83
Annual Indicator	93.7	83.1	75.9	82.4	85.1
Numerator	384	339	268	310	314
Denominator	410	408	353	376	369
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	2015	2016	2017	2018
Annual Performance Objective	85.5	86	86	87	88

Notes - 2013

FFY13 data were obtained from 2013 Vital Statistics data. In past years, infants born at level 2 and level 2 regional hospitals were inadvertently included in the data causing Iowa's percentage to be inflated. Missing data due to either missing hospital information or missing/improbable birth weight (<400 grams). The data collection was corrected for FFY12 and will be monitored for trends over the next several years.

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data. In past years, infants born at level 2 and level 2 regional hospitals were inadvertently included in the data causing Iowa's percentage to be inflated. Missing data due to either missing hospital information or missing/improbable birth weight (<400 grams). The data collection was corrected for FFY12 and will be monitored for trends over the next several years.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics provisional data.

Revised for 2012: In past years, infants born at level 2 and level 2 regional hospitals were inadvertently included in the data causing Iowa's percentage to be inflated. Missing data due to either missing hospital information or missing/improbable birth weight (<400 grams). The data collection was corrected for FFY12 and will be monitored for trends over the next several years.

a. Last Year's Accomplishments

The FFY13 performance objective of 83 percent was met. Data from 2013 Vital Statistics indicate that 85.1 percent of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates.

Infrastructure Building Services:

IDPH contracts with University of Iowa Hospitals and Clinics clinical experts the Statewide Perinatal Program staff they assist the Department in its role to maintain the Regionalized System of Perinatal Care in Iowa. Inter-hospital transports are encouraged if the necessary resources or personnel for optimal patient outcomes are not available at the facility currently providing care. When faced with preterm labor, transport of the mother in labor is recommended, if time allows.

There has been an increase in the number of Neonatologists practicing at Level II regional

hospitals in Iowa. Iowa code 641 chapter 150, which outlines Iowa's regionalized system of care, is being reviewed to consider changes to standardize levels of care to in light of newly published article by the American Academy of Pediatrics on Levels of Neonatal Care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage transfer of the mother prior to birth of a preterm infant when ever possible.				X
2. Amend 641-150 our rules for the regionalized system of care in Iowa.				X
3. Participate in the CoLIN.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

High risk infants have higher mortality rates when born outside hospitals with the most specialized care. This fact is well understood in Iowa and is continually reinforce by the Statewide Perinatal Program in Iowa. Multiple factors, including hospital volume in rural areas and a decline in the number of birthing hospitals in Iowa, have contributed to a slight increase in the travel time to a hospital with specialty care for some rural Iowans. This can cause an increased number of very low birth weight (VLBW) babies being deliver in rural Level I hospitals. IDPH will continue to monitor access to care for rural Iowans.

Iowa Code 641 Chapter 150, which outlines Iowa's regionalized system of care, is being reviewed a subcommittee has made recommendation to consider changes to standardize levels of care to in light of the article Levels of Neonatal Care published in the fall of 2012 by AAP. The Perinatal Guidelines Advisory Committee meeting to discuss levels of care definitions will be held on May 27, 2014.

c. Plan for the Coming Year

Infrastructure Building Services:

Statewide Perinatal Program staff has continued to reinforce the Regionalized System of Perinatal Care in Iowa. Inter-hospital transports are encouraged if the necessary resources or personnel for optimal patient outcomes are not available at the facility currently providing care. When faced with preterm labor, transport of the mother in labor is recommended, if time allows.

There has been an increase in the number of Neonatologists practicing at Level II regional and Level II Regional Neonatology Centers in the state. This may lead to improvements in infant survival in Iowa's birthing hospitals.

IDPH staff may need to amend Iowa Code 641 Chapter 150, which outlines Iowa's regionalized system of care based on the Perinatal Guidelines Advisory committee recommendation.

IDPH staff will begin participation in the Infant Mortality Collaborative Improvement and Innovation Network (CoIIN). We will be meeting with HHS Regions VII - X to build in the successes of the CoIIN for Regions IV, V and VI. Common priority topic areas driving infant mortality and poor birth outcomes will be discussed. State driven initiatives will be identified to improve our Regionalized system of care in Iowa. We will collaborate with other states in collaborative learning, sharing effective evidence based approaches.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective	76	77	78	86	85
Annual Indicator	74.3	75.5	84.5	84.0	84.1
Numerator	29469	29069	31883	32289	32583
Denominator	39662	38502	37746	38423	38766
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2014	2015	2016	2017	2018
Annual Performance Objective	87	89	90	91	91

Notes - 2013

FFY13 data obtained from FY13 Vital Statistics data.

Notes - 2012

FFY12 data obtained from FY12 Vital Statistics data.

The FFY12 performance objective of 86 percent was not met. Data from 2012 Vital Statistics indicates that 84 percent of infants born to pregnant women received prenatal care in the first trimester. The local maternal health agencies with the lowest percent of early entry into prenatal care have the highest minority populations in the state. The Hispanic population in Iowa increased by 83.7 percent in the past decade, according to US Census Bureau Data. Maternal health agencies continue to provide education to Hispanic women on the importance of prenatal care is being provided; however, some Hispanic women had the understanding that you only would see the health care provider early in pregnancy if you had problems. Non-citizen status has also been a barrier to getting some women into early prenatal care.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

a. Last Year's Accomplishments

The FFY13 performance objective of 85 percent was not met. Data from 2013 Vital Statistics indicates that 84.1 percent of infants born to pregnant women received prenatal care in the first trimester. The local maternal health agencies with the lowest percent of early entry into prenatal care have the highest minority populations in the state. The Hispanic population in Iowa increased by over 83 percent in the past decade, according to the US Census Bureau. Maternal health agencies continue to provide education to Hispanic women on the importance of prenatal care; however, some Hispanic women have the understanding that one would only see the health care provider early in pregnancy if she had problems. Non-citizen status has also been a barrier to getting some women into early prenatal care.

Infrastructure Building Services:

IDPH continues work with March of Dimes to create a link to Title V MCH agencies from their website. Twenty-five percent of the local maternal health agencies will have websites to assist with outreach. Several agencies are beginning to use Facebook and other social networking as effective outreach strategies. Many local agencies place PSAs about their services on their local radio stations.

Enabling and Direct Care Services:

IDPH continued to encourage local maternal health agency staff to improve collaborative relationships with providers who offer prenatal care. Local maternal health agencies worked with school nurses to keep nurses informed of agencies that provide free pregnancy testing. Outreach to all community sites that offer pregnancy testing to reach women as soon as possible will continue to be a primary focus. All local maternal staff completed training for presumptive eligibility.

All 21 local MH contract agencies have action plans related to early entry into prenatal care. Agencies' activities include providing care coordination services, partnering with local agencies/programs, developing public awareness campaigns, and working with vulnerable populations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Advocate for improved access for undocumented (immigrant) women				X
2. Continue outreach activities			X	X
3. Provide transportation to OB appointments	X			
4. Presumptive eligibility determination for pregnant women			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

IDPH encourages agency staff to improve collaborative relationships with family planning agencies and Primary Care Practices (PCPs) who offer pregnancy testing. IDPH is also encouraging partnerships with school nurses who can link pregnant teens to local MH programs.

Enabling Services:

As gas prices continue to rise, local maternal programs will also continue to focus on transportation services. Each agency will submit a transportation plan on what transportation resources are available locally.

Twenty-one local MH agencies have action plans related to early entry into prenatal care.

Agencies' activities include:

- Assisting clients with presumptive Medicaid eligibility determinations, if uninsured
- Collaborating with WIC clinics, medical providers, family planning agencies, free clinics to reach pregnant women
- Utilizing new and innovative methods for outreach and education to clients (e.g. social media and text messaging)
- Facilitating access to prenatal care for all pregnant women by providing care coordination that addresses geographic, cultural, socioeconomic, and organizational or transportation barriers unique to each county in the service area.

All maternal health agencies completed training in January on a new DHS system to enter presumptive eligibility information. Medicaid eligibility for pregnant women in Iowa was increased from 300% to 375% of the federal poverty level.

c. Plan for the Coming Year

Infrastructure Building Services:

About 50 percent of the local maternal health agencies have websites to assist with outreach. Agencies are expanding their use of Facebook and other social networking as effective outreach strategies. Many local agencies place PSAs about their services on their local radio stations this is especially effective with our Spanish speaking client. Some agencies are using self-service laundry sites and hair stylists to educate women about their Maternal Health services and encourage early prenatal care.

Enabling Services:

IDPH will continue to encourage local maternal health agency staff to improve collaborative relationships with providers who offer prenatal care. Local maternal health agencies are working with school nurses to keep nurses informed of agencies that provide free pregnancy testing. Outreach to all community sites that offer pregnancy testing to reach women as soon as possible will continue to be a primary focus.

All local maternal staff will complete training for presumptive eligibility.

All 21 local MH contract agencies have action plans related to early entry into prenatal care. Agencies' activities include presumptive eligibility determination, providing care coordination services to link women to a medical home, partnering with local agencies/programs, developing public awareness campaigns, and working with vulnerable populations.

D. State Performance Measures

State Performance Measure 1: *The degree to which the state MCH Title V Program improves the system of care for mothers and children in Iowa.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2009	2010	2011	2012	2013
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Performance Data					
Annual Performance Objective		10	16	21	21
Annual Indicator		16	20	20	21
Numerator					
Denominator					
Data Source		Title V Program Index	Title V Program Index	Title V Program Index	Title V Program Index
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	22	23	24	25	26

Notes - 2013

Data Source: Title V Program Index scored by local MCH agencies, MCH Advisory Council and BFH staff.

Notes - 2012

Data Source: Title V Program Index scored by local MCH agencies, MCH Advisory Council and BFH staff.

Notes - 2011

Data Source: Title V Program Index scored by local MCH agencies.

a. Last Year's Accomplishments

The FFY13 performance indicator of 21 was met. The Title V Program Index indicates a score of 21 was reached for this measure. A summary of results of the scoring tool is included in the attachment.

Infrastructure Building Services:

Strategic leadership: BFH and CHSC leadership monitored the implementation of the Affordable Care Act (ACA) and the implications for Title V. Iowa's Children and Youth with Special Health Care Needs (CYSHCN) Director serves on the Association of Maternal and Child Health Programs (AMCHP) Board.

Partnerships across public and private sectors: BFH and CHSC continue to establish new relationships with partners related to medical homes. Staff maintains partnerships with Early Childhood Iowa (ECI), Iowa Medicaid Enterprise (IME), Iowa Chapter of the American Academy of Pediatrics (IA-AAP), Iowa eHealth Project, and the PI- CHI.

Quality Improvement (QI): BFH and CHSC staff will continued to provide technical assistance to MCH and CYSHCN programs on incorporating QI into all Title V programming. The BFH has several staff members that are trained in QI methods that are available to IDPH and local contract agency staff in developing QI activities.

BFH staff worked on a QI project with one local CH agency. The project was related to issues of communication between programs, collecting and sharing accurate and current demographic information for clients, and confusion about defining care coordination and the responsibilities associated with it.

These issues were addressed by several staff in the BFH. First, staff from each local CH agency attended the child health one-day training, which includes modules specific to the database, informing, care coordination, and provision of direct care. Second, the local agency staff

received technical assistance from individual program staff in the Bureau. Finally, agency staff representing each Child Health program completed a 15-question crosswalk questionnaire to determine duplication in services among programs, opportunities for collaboration, and training needs. The crosswalk also provided the agency with information as to how each program was providing care coordination for children and their families. The action plan following this questionnaire included action steps to address care coordination issues along with issues in communication and other topics.

Use of available resources: BFH and CHSC discretionary grants coordinators continue to inventory available resources and identify leveraging opportunities.

Coordination of service delivery: Staff identified opportunities for coordinated service delivery with ECI, WIC, and family planning. CHSC programming will continue to be coordinated with family support programs, health care organizations, and health care systems. Staff continues to identify opportunities to provide services through telehealth.

Data infrastructure: BFH and CHSC staff identify examples of effective data sharing to benefit the MCH populations. The SSDI coordinator advocates the Iowa Health Information Network (IHIN) for inclusion of MCH data.

BFH staff continues to plan for an integrated data system. The system will include maternal, child, oral health, family planning, and MIECHV data.

An attachment is included in this section. IVD_SPM1_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue serving on AMCHP Committees.				X
2. Stay abreast of issues related to the ACA to ensure Title V programs are integrated into the health home and with accountable care organizations.				X
3. Utilize the MCH Navigator training portal for self assessment of the MCH Leadership Competencies in order to focus training and education opportunities.				X
4. IDPH staff will monitor of provision of services for special populations and care coordination services. CHSC will maintain service delivery improvements through telehealth.				X
5. The RFP for integrating MCH data systems will be released. As the system is developed, strategies to integrate with the IHIN and data systems within the Departments of Education and Human Services will be explored.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

Strategic leadership: BFH and CHSC Staff continue to communicate the goals of the Title V programs across the state. A workgroup was formed to develop materials to educating policy makers on the importance of the Title V program in reaching Iowa's most vulnerable populations and how Title V fits within the ACA. Title V Director and CYSHCN Director serve on the AMCHP

Board and several staff members serve on AMCHP Committees. Through these roles, Title V leadership help influence decisions made on behalf of the Title V program.

Partnerships across public and private sectors: Staff follows progress being made related to the ACA to ensure Title V programs are integrated into the health home and with ACOs.

QI: The MCH Fall Seminar focused on Collective Impact. MCH regions were encouraged to work on a project utilizing the collective impact framework.

Use of available resources: The Title V program will continue to seek out funding opportunities, as they relate to integration into the ACA.

Coordination of service delivery: IDPH staff will develop baseline assessment of services for special populations and care coordination services. CHSC will maintain service delivery improvements through telehealth.

Data infrastructure: The BFH embarked in a data integration project. A request for proposals (RFP) was released to integrate the newborn screening and newborn hearing program data systems. Work on a RFP for integration of MCH related systems is underway.

c. Plan for the Coming Year

Infrastructure Building Services:

Strategic leadership: The CYSHCN Director serves on the AMCHP Board and several staff members serve on AMCHP Committees. Through these roles, Iowa's Title V leadership will help influence decisions made on behalf of the Title V program.

Partnerships across public and private sectors: Staff continues to follow progress being made related to the ACA to ensure Title V programs are integrated into the health home and with accountable care organizations (ACOs).

QI: BFH and CHSC continue to work with local providers on integrating QI strategies into their work plans.

Use of available resources: Utilizing the MCH Navigator training portal, State and local Title V staff will conduct the self assessment of the MCH Leadership Competencies to focus training and education opportunities. Iowa's Title V program will continue to seek out new funding opportunities, especially as they relate to integration into the ACA.

Coordination of service delivery: IDPH staff will monitor of provision of services for special populations and care coordination services. CHSC will maintain service delivery improvements through telehealth

Data infrastructure: The RFP for integrating MCH data systems will be released. As the system is developed, strategies to integrate with the IHIN and data systems within the Departments of Education and Human Services will be explored.

State Performance Measure 2: *The degree to which components of a coordinated statewide system of care for CYSHCN are implemented.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013

Annual Performance Objective		26	45	70	83
Annual Indicator		44	66	81	88
Numerator					
Denominator					
Data Source		CHSC Tool	CHSC Tool	CHSC Tool	CHSC Tool
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	85	87	90	95	97

Notes - 2013

CHSC Tool (a 4-part tool, including Title V Program Index as Part 4) – See Attachment for completed tool. The 2013 score is the fourth annual measurement of performance using this tool. The CHSC Tool measures program progress of four components of CHSC's system of care for CYSHCN: direct clinical services, care coordination, family-to-family support, and infrastructure building. The intent is that progress on this measure will positively impact the larger CYSHCN population and therefore the national performance measures for CYSHCN. It is important to note, however, that since the CHSC Tool is not population-based, progress on this tool does not directly correlate to progress/lack of progress on achieving the national performance measures for CYSHCN (all national performance measures are tracked using the population-based national survey of CYSHCN).

Notes - 2012

CHSC Tool (a 4-part tool, including Title V Program Index as Part 4) – See Attachment for completed tool. The 2012 score is the third annual measurement of performance using this tool. The CHSC Tool measures program progress of four components of CHSC's system of care for CYSHCN: direct clinical services, care coordination, family-to-family support, and infrastructure building. The intent is that progress on this measure will positively impact the larger CYSHCN population and therefore the national performance measures for CYSHCN. It is important to note, however, that since the CHSC Tool is not population-based, progress on this tool does not directly correlate to progress/lack of progress on achieving the national performance measures for CYSHCN (all national performance measures are tracked using the population-based national survey of CYSHCN).

Notes - 2011

Data Source: CHSC Tool (includes Title V Program Index). The 2011 score is the second annual measurement of performance using this tool.

a. Last Year's Accomplishments

The FFY13 performance indicator of 83 was met. The CHSC Tool, which includes the Title V Program Index, indicates a score of 88 was reached for this measure. A summary of results of the scoring tool is included in the attachment.

Infrastructure Building Services:

CHSC reorganized so that CHSC is now a program within the Division of Child and Community Health Stead Department of Pediatrics at University of Iowa Health Care.

CHSC received technical assistance from AMCHP and Children's Medical Services to pilot evidence-based transition practices and hosted a one-day transition conference for stakeholders.

CHSC partnered with Project LAUNCH, Iowa Chapter of the American Academy of Pediatrics, 1st Five, home visiting, and others to maintain membership in Help Me Grow network of participating states and work toward core component goals.

CHSC staff participated in the National Improvement Partnership Network to improve

relationships between primary care and specialty providers.

CHSC trained staff on motivational interviewing and facilitator skills for family team meetings.

CHSC hired new staff to increase CHSC's capacity to capture, analyze and apply data.

CHSC participated in state committees that created recommendations for the children's mental health and disability system redesign and early childhood systems integration.

CHSC collaborated with interagency partners to assure adequate services for screening and evaluation of children suspected of child abuse

CHSC collaborated with AMCHP and 6 other states to identify new Life Course indicators.

CHSC coordinated presentations on identifying own biases and cultural competence and recorded for future staff training.

CHSC participated in AAP National Medical Home Project Advisory Council representing AMCHP and CYSHCN.

CHSC collaborated with IA-AAP and other state partners to develop webinars on early childhood brain development and a white paper on the effects of environmental toxins on children's health.

CHSC participated in the National Association of Health Policy's Advisory Council and Annual State Health Policy Conference.

CHSC ensured that communications reflect diverse populations of CYSHCN served by CHSC and are written in plain language at 6th grade level or below.

CHSC served as a planning partner for the Iowa Governor's Conference on Public Health, assuring inclusion of topics related to CYSHCN.

CHSC offered gap-filling direct clinical services, family-to-family support, and specialized care coordination for CYSHCN during the evolution of health care reform.

CHSC assisted with policymaking during the design and implementation of the new health care delivery system.

CHSC received contracts to implement Pediatric Integrated Health (PIH) homes for children with Serious Emotional Disturbances (SED) in Dubuque County to serve as a single point of entry into mental health services, as well as provide care coordination and family-to-family support.

CHSC maintained the Child and Youth Psychiatric Council project of Iowa (CYC-I) to support primary care providers (PCPs) serving youth with SED.

CHSC identified emerging clinical guidelines and screening tools to incorporate into clinical practice.

CHSC used MCH Navigator to train new staff on concepts such as life course, medical home, and ethics.

CHSC served as a host site for an AmeriCorps member who created resources in English and Spanish for families on portion size and feeding behaviors for families of infants and toddlers.

CHSC collaborated with the Iowa Leadership in Neurodevelopmental Disabilities program to ensure students' awareness of the need of children and youth with special health care needs and

to support the future maternal and child health workforce.

Direct and Enabling Services:

CHSC identified additional screening tools for CHSC clinicians to screen older children.

An attachment is included in this section. IVD_SPM2_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC is completing a HRSA-funded grant to implement CCHT in two tertiary care centers, modeling family-to-family support in medical homes.				X
2. CHSC is implementing the Regional Autism Assistance Program teams at CHSC's 14 sites to assure a system of care for children with ASD and their families.		X		X
3. CHSC is partnering with Iowa's 1st Five initiative to develop metrics to measure child and family outcomes.				X
4. CHSC is customizing the electronic health record to include transition data and other key clinical components for CYSHCN.				X
5. CHSC is reviewing data dashboards to respond with quality improvement efforts and communicate to stakeholders.				X
6. CHSC is vetting an enhanced care coordination algorithm to guide Title V practitioners in determining when a CHSC care coordinator will benefit children they serve.				X
7. CHSC trained ARNPs to use STAT-MD tool, allowing children who need a mid-level assessment for autism to receive it in their community.				X
8. CHSC is contracting with Family Medicine physicians and pediatricians to mentor 1st Five practice sites.				X
9. Select CHSC staff are piloting an expanded set of tools to facilitate transition planning with youth, families, and health care providers.		X		X
10. CHSC is implementing the Pediatric Integrated Health program for children with Serious Emotional Disturbances in additional counties.		X		X

b. Current Activities

Infrastructure Building Services:

CHSC surveys families to elicit feedback on all services provided in CHSC Regional Centers.

CHSC is implementing the Regional Autism Assistance Program teams at CHSC's 14 sites to assure a system of care for children with ASD and their families.

CHSC is partnering with Iowa's 1st Five initiative to develop metrics to measure child and family outcomes.

CHSC is customizing the electronic health record to include transition data and other key clinical components for CYSHCN.

CHSC is training employees in cultural competence and health literacy and is examining ways to improve them in care delivery.

CHSC is reviewing data dashboards to respond with quality improvement efforts and communicate to stakeholders.

CHSC is implementing the PIH program for children with SED in additional counties.

CHSC is vetting an enhanced care coordination algorithm to guide Title V practitioners in determining when a CHSC care coordinator will benefit children they serve.

CHSC is contracting with Family Medicine physicians and pediatricians to mentor 1st Five practice sites.

CHSC trained ARNPs to use STAT-MD tool, allowing children who need a mid-level assessment for autism to receive it in their community.

CHSC is developing a Family Advisory Council with youth members.

Enabling and Direct Care Services:

Select CHSC staff is piloting an expanded set of tools to facilitate transition planning with youth, families, and health care providers.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC will continue to customize electronic medical record to include data on transition to adult health care and other key clinical components for CYSHCN.

CHSC will collaborate with interagency partners to assure adequate services for screening and evaluation of children suspected of child abuse.

CHSC will survey families to elicit feedback on all services provided in CHSC Regional Centers and will use data to improve all aspects of care.

CHSC will continue to identify emerging clinical guidelines and screening tools and incorporate them into clinical practice.

CHSC will define crisis plans (behavioral vs. an emergency) for CYSHCN and assist families in planning for them.

CHSC will develop resources to assist families and youth in building self-advocacy skills, which may include handouts or social media.

CHSC will continue to serve as a planning partner for the Iowa Governor's Conference on Public Health, ensuring inclusion of topics related to CYSHCN.

CHSC will maintain a Family Advisory Council with youth members to gain input on transition to adult services and other CHSC programs.

CHSC's advocacy team will train staff on how to address bullying and will monitor legislative efforts.

CHSC will continue to collaborate with the IA-AAP to identify potential areas for collaboration with primary care providers.

CHSC will implement the Regional Autism Assistance Program to assure a system of care for children with ASD and their families, including care coordination, family-to-family support and access to funding for applied behavioral analysis.

CHSC ARNPs will use STAT-MD tool to allow children who need a mid-level assessment for autism to receive it in their community.

CHSC will review CHSC data dashboards to respond with quality improvement efforts and communicate with stakeholders.

CHSC will use Iowa-specific web-based tool to train staff in health care transition and use lessons learned from pilot project to revise and expand transition tools.

CHSC will survey PCPs and subspecialty providers referring patients to CHSC on the care of children seen in CHSC Regional Centers.

CHSC will ensure that communications reflect diverse populations and are written in plain language at 6th grade level or below.

CHSC will promote the use of trained Family Navigators to provide family-to-family support and care coordination among partners.

CHSC will train staff on serving children and families who are refugees and create a directory of services for this population.

CHSC staff will serve on community coalitions as available to build infrastructure for refugee populations.

CHSC will enhance family navigation standards that specify what family navigation includes, frequency of contact with family, and procedures for families that no longer need Family Navigation.

CHSC Registered Dietitians will provide technical assistance to primary care providers of CYSHCN who are overweight/obese.

CHSC will explore partnerships with faith-based communities.

State Performance Measure 3: *The degree to which Iowa's state MCH Title V program addresses health equity in MCH programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		5	15	19	19
Annual Indicator		13	18	18	19
Numerator					
Denominator					
Data Source		Title V Program Index	Title V Program Index	Title V Program Index	Title V Program Index
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	20	21	22	23	24

Notes - 2013

Data Source: Title V Program Index scored by local MCH agencies, MCH Advisory Council, and BFH Staff.

Notes - 2012

Data Source: Title V Program Index scored by local MCH agencies, MCH Advisory Council, and BFH Staff.

Notes - 2011

Data Source: Title V Program Index scored by local MCH agencies.

a. Last Year's Accomplishments

The FFY13 performance indicator of 19 was met. The Title V Program Index indicates a score of 19 was reached for this measure. A summary of results of the scoring tool is included in the attachment.

Infrastructure Building Services:

Iowa was one of four states selected for a Bay Area Regional Health Inequalities Initiative (BARNII) project with the National Association of Chronic Disease Directors'(NACDD) Organizational Self-Assessment for Addressing Health Inequities Toolkit and Guidance. The pilot study was conducted with Division of Health Promotion and Chronic Disease Prevention for a self-assessment of addressing health inequities. Based on recommendations from Iowa and the three other participating states, the NACDD will make revisions to and disseminate the toolkit and guidance and nationally.

The OMMH will continue to promote the Unnatural Causes lending library and funding for purchase to MCH agencies. Staff will continue to integrate health equity/health disparities awareness and education within MCH programs, activities and trainings and will continue to provide education regarding the goals and objectives of the DHHS OMH National Plan For Action.

IDPH staff will continue membership on DHHS OMH Regional Health Equity Advisory Committee. The OMMH continues to provide TA and training/workshops to MCH agencies, partners, and other stakeholders on targeted areas of health disparities, cultural awareness, health equity, and changing demographics in Iowa.

Provided technical assistance, workshops to agencies/partners/stakeholder on targeted areas of health disparities/health equity.

During the BFH Fall Seminar, OMMH staff presented on the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care. The CLAS Standards are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

Served on planning committee and key note speaker for Black Hawk County African American Clergy on disproportionate impact of adolescent STD's/HIV/AIDS in partnership with Allen's Together for Youth Programming. Provided 25 scholarships statewide to community and faith based organizations in partnership with local MCH programming to address health initiatives in the area of health/wellness and healthier life style choices especially within the child/adolescent/ and female populations within communities of racial/ethnic diversity.

An attachment is included in this section. IVD_SPM3_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Provide 1 presentation per each region for First 5 project on CLAS standards				X
2. Provide 1 session at MCH conference on SPM#3 - strategic agency strategies				X
3. Provide 2 displays at FSB conference on strategies for inclusion of relevant health equity information			X	
4. Provide 25 workshops/trainings on health equity to MCH agencies				X
5. Provide 2 in-service education sessions to FSB staff/CLAS				X
6. Sustain OMMH Advisory Council			X	
7. Sustain Latino Women Coalition - region 3			X	
8. Work in partnership with UNI Center on Health Disparities for data collection/race, ethnicity, changing demographics specific			X	
9. Serve on DHHS,OMH Regional Health Equity Advisory Council, Reg. VII				X
10. Serve on Adolescent Health Issues committee, IDPH				X

b. Current Activities

Infrastructure Building Services:

In partnership with U of I and DHS- SAMHSA Systems of Care award to provide 6 cultural competency trainings statewide inclusive of information on changing demographics and culturally and linguistically appropriate services targeting mental health in the child/adolescent populations and families. MCH agencies are allowed to participate and receive CEU's at no cost.

Staff in the OMMH will provide training to infuse CLAS standards into MCH agencies. OMMH will be requesting to attend regional meetings for at least half of the six MCH regions beginning August 2014.

Staff will continue to serve on Healthy Child Care Iowa committee, attend and provide in-service training on CLAS standards to new MCH staff and continue to support and encourage that all new staff review the Unnatural Causes video.

c. Plan for the Coming Year

Infrastructure Building Services:

Staff from the IDPH OMMH will discuss and develop a strategic plan on how to increase partnerships to address community based/agency based health initiatives and collaboration with MCH agencies to address targeted disparities.

Utilize web based learning for Unnatural Causes videos for an additional means of access to the information.

All local MCH agencies are required to address health disparities within their annual application. Activities include distribution of promotional materials in multiple languages, assisting with transportation and interpretation services, and other outreach activities. OMMH staff will work with individual MCH agencies in developing strategies/policies around addressing health disparities in their communities.

State Performance Measure 4: *Percent of family planning clients (women and men) who are counseled about developing a reproductive life plan.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		10	39	61	72
Annual Indicator		38.9	60.1	71.2	86.9
Numerator		2678	11254	12814	14611
Denominator		6881	18738	17996	16808
Data Source		Ahlers Family Planning Data	Ahlers Family Planning Data	Ahlers Family Planning Data	Ahlers Family Planning Data
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	75	76	80	85	88

Notes - 2013

FFY13 data were obtained from the Ahlers Family Planning data system.

Notes - 2012

FFY12 data were obtained from the Ahlers Family Planning data system.

Notes - 2011

FFY11 data were obtained from the Ahlers Family Planning data system.

a. Last Year's Accomplishments

The FFY13 performance indicator of 72 percent was met. Ahlers Data from 2013 indicates a score of 86.9 percent of family planning clients were counseled about developing a reproductive life plan.

Infrastructure Building Services:

Title X agencies expanded their counseling of family planning (FP) clients about reproductive life planning (RLP). This is evidenced by the change noted in the Annual Indicator above.

Another contractor transitioned to an electronic health record system (EHR) in 2013. Three of seven contractors are now documenting and receiving payment for meaningful use. Trainings continued to help contractors to improve coding and billing procedures and prepare for ICD-10 implementation. Three additional Title X contractors have purchased systems, built records and are planning to transition to EHR early in 2014.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand RLP counseling to include FP clients visiting a clinic for any purpose	X	X		
2. Offer materials to WIC program staff and clinics to advocate RLP occur at WIC clinics, and continue to promote the Iowa Family Planning Waiver to WIC staff		X		X
3. Expand PREP programming, identifying target communities and population risk factors as they emerge				X
4. Explore application of RLP in Iowa's abstinence education programming				X

5.				
6.				
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10.				

b. Current Activities

Infrastructure Building Services:

Three Title X contractors have Certified Application Counselors in their clinics and all received training on the importance of linking clients with navigators or other enrollers in their communities. All Title X contractors have contracts and have providers credentialed with the two Qualified Health Plans in Iowa. We have worked with ACOs to encourage inclusion of these essential community providers into their systems of care.

A website focused on adolescents was implemented during FY12-FY13. The website (www.iamincontrol.org) has an expanded focus on healthy teen living, incorporating Iowa's PREP and Abstinence Education programs.

A Reproductive Life Planning Kit is being developed for distribution to all Title X and Title V contractors. The kit will be appropriate for parents to use with their children to initiate the discussion of sexual health and life goals and for use in birthing hospitals.

The Iowa PREP and Abstinence Education programming continue in FY14. Iowa's programming use the curricula "Power Through Choices" to promote abstinence in Iowa's foster care youth residing in out of home placement situations. Both PREP and Abstinence Education programs also use the Teen Outreach Program Curriculum. In addition, PREP contractors are using the SiLHE and Wise Guys curricula to reach youth. Both PREP and Abstinence Education contractors will receive standardized RLP information. Five MH agencies have action plans addressing RLP.

c. Plan for the Coming Year

Infrastructure Building Services:

Iowa competed and was funded for Title X funding from the Office of Population Affairs last year. The priority populations are low-income minorities, adolescents and males. In addition, there will be continued focus on the Reproductive Life Plan work. Funding did not provide for consideration of an interactive website.

All Title X agencies will also be completing transitions to EHR and billing meaningful use indicators.

Work on effective, correct coding and billing activities will continue. ICD - 10 implementation efforts will continue.

One Title X agency is partnering with a Federally Qualified Health Center in Polk County. All will assist clients to navigate health care reform. Efforts will continue to make sure that all men and women attending family planning clinics receive preconception care and other health screenings as appropriate.

Seven local MH agencies have action plans related to RPL. Activities include providing care coordination and verbal referrals to women in need of further family planning education and/or counseling; providing education at third trimester and post-partum visits, including education about birth control methods; having birth control kits available at MH clinics, WIC clinics and local public health agencies, and at outreach/education classes; and training bi-lingual interpreters on

RPL protocol to avoid potential language barriers due to different terminologies across cultures. RLP information will be provided to Child Abuse Prevention advocates in the spring.

State Performance Measure 5: *The degree to which the health care system implements evidence-based prenatal and perinatal care.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective			9	14	24
Annual Indicator		8	13	23	22
Numerator					
Denominator					
Data Source		Title V Index	Title V Index	Title V Index	Title V Index
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	24	25	26	27	28

Notes - 2013

Data Source: Title V Program Index. The 2013 Title V Index was scored by the Perinatal Guidelines Committee.

Notes - 2012

Data Source: Title V Program Index. The 2012 Title V Index was scored by the Perinatal Guidelines Committee.

Notes - 2011

Data Source: Title V Program Index. The 2011 Title V Index was scored by the Perinatal Guidelines Committee.

a. Last Year's Accomplishments

The FFY13 performance objective of 24 was not met. The Title V Program Index indicates a score of 22 was reached for this measure. IDPH uses the Title V Program Index is structured around six core MCHB outcomes and was scored by the Perinatal Guidelines Committee. The summary of the Title V program Index is included in the attachment.

Infrastructure Building Services:

Strategic leadership: The Statewide Obstetrical Taskforce is collaborating to design an evidence-based strategy that engages providers, reduces adverse outcomes and improves care for mothers and babies. IDPH is participating in the Association of State and Territorial Health Officials (ASTHO) President's Challenge to decrease prematurity in the US by 8% by 2014. To achieve this goal, IDPH is partnering with the March of Dimes on the Healthy Babies are Worth the Wait campaign.

QI: BFH staff will continue to provide TA to MCH programs on QI methodology and to promote QI guidelines.

Use of available resources: BFH staff will collaborate with Iowa Medicaid Enterprise (IME) to advance evidence-based strategies into provider requirements and recommendations. The MH program will continue to leverage medical subspecialty TA/consultation available through the UI, partner with family planning to promote preconception care and RLP and March of Dimes to reduce preterm births. Coordination of service delivery: MH program staff will continue to assess

the availability of care coordination services and services to special populations to ensure services are provided equitably across the state.

Data infrastructure: IDPH is working to collaborate with the task force to link hospital discharge data and vital records birth files to track elective deliveries less than 39 weeks. The Medicaid Match Report also provides valuable data by linking Medicaid claims data and the birth file to monitor birth outcomes for Medicaid women.

An attachment is included in this section. IVD_SPM5_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Engage Iowa Medicaid and Wellmark to encourage providers to develop strategies for promoting evidence based practices				X
2. Implement Listening Visits an evidence based method to improve mental health support to women with depressive symptoms	X	X		X
3. Work on activities within the Statewide Obstetrical Task-force work plan				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

Strategic leadership: Statewide Obstetrical Task-force released its strategic plan. Their mission is to guide, monitor and improve obstetrical care in Iowa. The vision statement is to improve obstetrical and neonatal outcomes in quality, patient safety and cost. Goals include:

1. Deploy evidence-based best practices (reduce early elective deliveries, standardized progesterone treatment, tobacco cessation, avoid adverse OB events)
2. Ensure access to care
3. Increase providers and consumer awareness of available resources
4. Promote use of common metrics to measure our performance

QI: BFH staff will continue to provide technical assistance to MCH programs on QI methodology and to promote QI guidelines through the Perinatal Newsletter and the BFH update.

Use of available resources: BFH staff will collaborate with IME to advance evidence-based strategies into provider requirements and recommendations IDPH provided training and plan to implement therapeutic listening home visits

Partnerships across public and private sectors: The Medicaid Maternal Health Task Force will continue to partner with IDPH. They are exploring methods to improve quality of care for pregnant Medicaid eligible women. Needs are identified through a matched data set that included Medicaid claims data and birth certificate data. IDPH is working on strategies to link hospital discharge data to birth file to improve data tracking of elective deliveries prior to 39 weeks gestation.

c. Plan for the Coming Year

Infrastructure Building Services:

Strategic leadership: Statewide Obstetrical Task-force will begin to define activities to meet the goals in their work plan 1. To deploy evidence-based best practices (reduce early elective deliveries, standardized progesterone treatment, tobacco cessation, avoid adverse OB events) 2. Ensure access to care 3. Increase providers and consumer awareness of available resources 4. Promote use of common metrics to measure our performance.

Partnerships across public and private sectors: The Medicaid Maternal Health Task Force will continue to partner with IDPH. They are exploring methods to improve quality of care for pregnant Medicaid eligible women. Needs are identified through a matched data set that included Medicaid claims data and birth certificate data. IDPH is working on strategies to link hospital discharge data to birth file to improve data tracking of elective deliveries prior to 39 weeks gestation. Identify new partnerships to collaborate on the Infant Mortality collaborative Improvement and Innovation Network (CollIN).

QI: BFH staff will continue to provide technical assistance to MCH programs on QI methodology and to promote QI guidelines through the Perinatal Newsletter and the BFH Update.

Use of available resources: BFH staff will collaborate with IME to advance evidence-based strategies into provider requirements and recommendations. IDPH provided training in 2014 in therapeutic listening home visits. This will continue to be implemented in our Title V MH agencies in FFY 15. This is an evidence based method to provide mental health support for women with mild to moderate depressive symptoms.

State Performance Measure 6: *Percent of Medicaid enrolled women receiving preventive dental health services during pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		21	22	21	21
Annual Indicator		20.1	19.7	19.0	16.6
Numerator		3135	2970	2806	2529
Denominator		15582	15093	14786	15212
Data Source		Medicaid Match Report	Medicaid Match Report	Medicaid Match Report	Medicaid Match Report
Is the Data Provisional or Final?				Provisional	Provisional
	2014	2015	2016	2017	2018
Annual Performance Objective	23	24	25	25	25

Notes - 2013

FFY13 data were obtained from the 2013 Medicaid Match Report.

Notes - 2012

FFY12 data were obtained from the 2012 Medicaid Match Report.

The FFY12 performance objective of 21 percent was not met. 2012 provision Vital Statistics data indicate that 18.9 percent of Medicaid enrolled women received preventive dental health services during pregnancy. The main barriers for pregnant women on Medicaid receiving dental care included difficulty in finding a dentist that accepts Medicaid, low priority given to dental care,

misconceptions about the safety and appropriateness of dental care during pregnancy, and sporadic anticipatory guidance during prenatal care. In addition, dental providers are confused about which reimbursable services may be provided for pregnant women and also struggle with providers wanting to wait until after the pregnancy before providing services.

Notes - 2011

FFY11 data were obtained from the 2011 Medicaid Match Report.

a. Last Year's Accomplishments

The FFY13 performance objective of 21 percent was not met. The 2013 Medicaid match report indicates that 16.6 percent of Medicaid enrolled women received preventive dental health services during pregnancy. The main barriers for pregnant women on Medicaid receiving dental care included difficulty in finding a dentist that access Medicaid, low priority given to dental care, misconceptions about the safety and appropriateness of dental care during pregnancy and sporadic anticipatory guidance during prenatal care. In addition, dental providers are confused about which reimbursable services may be provided for pregnant women and also struggle with providers wanting to wait until after the pregnancy before providing services.

Infrastructure Building Services:

Oral Health Center staff continued to look for additional ways to integrate MH issues within current I-Smile strategies. For quality assurance, OHC staff participated in direct service chart audits for MH contractors who provide direct dental services to clients, and review and revise the chart audit tool as needed. Medicaid paid claims, WHIS, and Barriers to Prenatal Care Survey data are reviewed to assist in determining program direction. OHC staff also participated on the IDPH PRAMS workgroup, incorporating data measures for oral health within the new system. A Centers for Disease Control and Prevention grant was written and awarded, allowing OHC to build state program capacity, including hiring epidemiology/statistical staff.

Population-based Services:

Local I-Smile™ coordinators and the OHC include messaging about oral health and pregnancy within health promotion efforts. A new Facebook page that specifically targets moms continued to add followers. Other target populations include obstetricians and gynecologists, dentists, and family practice practitioners. OHC replicated a popular promotion for outreach to new parents in hospitals, initially funded through a foundation grant.

Enabling and Direct Care Services:

Twelve local MH agencies had action plans that address dental care for pregnant women. Agencies' activities include providing education on importance of dental care and referring clients to local dental clinics.

Nearly all MH contractors offered direct dental services to clients, including screenings, fluoride varnish applications, and counseling.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Data review, application, and monitoring for program development.				X
2. Oral health promotion.			X	
3. Integration of oral health within health reform.				X
4. Provide care coordination and gap filling preventive services.	X	X		
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

OHC continues to work toward building systems that address the oral health needs of MH clients and link with the existing I-Smile initiative for children. Oral health data from PRAMS and the Barriers to Prenatal Care Survey will be available and used by OHC staff to consider program impacts and considerations for future program directions.

Population-based Services:

OHC staff continues to offer preventive messages to moms on the I-Smile Facebook page. Other family health issues will also be incorporated. Funding for I-Smile health promotion includes MH as well as CH contractors.

Enabling and Direct Care Services:

OHC staff encourages contractors to assist MH clients to become enrolled on Medicaid or to find another payment source for dental care. I-Smile coordinators who are not yet qualified entities for presumptive eligibility are encouraged to do so. OHC monitor dental care coordination services provided to MH clients as part of quality assurance reviews.

Gap-filling preventive services may be provided by contractors as indicated by local need. Twelve local MH agencies have action plans related to dental care for pregnant women. Activities include discussing the importance of dental care and good oral health at each prenatal and postpartum visit, providing education to dispel the myth that dental care during pregnancy must be avoided.

c. Plan for the Coming Year

Infrastructure Building Services:

Hospital data indicating dental-related diagnoses will be used for a data portal on Iowa's data warehouse project. If possible, OHC will seek information on linkages to pregnancy diagnoses. A new epidemiologist will begin to identify data system needs and considerations for further evaluation of program impact on pregnant women. OHC staff will work with BFH staff on a new data system, including seeking funding resources and determining data elements. OHC staff will also consider new ways to better integrate oral health within health reform, through work with stakeholders and considering other state's successes. OHC staff will continue annual site visits to each MH contractor and participation in direct care chart audits to assure quality record-keeping and appropriate referral documentation.

Population-based Services:

I-Smile™ health promotion activities will continue at the state level as well as through local contractors. OHC anticipates providing specific funding to MH contractors again to conduct health promotion initiatives.

Enabling and Direct Care Services:

MH contractors will be required to identify dental care coordination services through the RFA process, allowing OHC staff better quality technical assistance and monitoring of those activities.

MH contractors who identify gaps in care for low income pregnant women will offer direct dental services of screenings, counseling, and fluoride application. This will be particularly important due to the lack of a requirement to have dental insurance as part of health insurance reform.

Eight local MH agencies have action plans related to dental care for pregnant women. Activities

include discussing with women the importance of dental care and good oral health at each prenatal and postpartum visit, providing education to dispel the myth that dental care during pregnancy is unsafe, and counseling Medicaid eligible women that dental care is a covered benefit.

State Performance Measure 7: *Percent of Medicaid enrolled children ages 0-5 years who receive a dental service.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		43.7	46	46.9	53
Annual Indicator		45.8	46.7	52.3	46.3
Numerator		48307	50848	57280	55149
Denominator		105429	108923	109479	119063
Data Source		CMS 4.16	CMS 4.16	CMS 4.16	CMS 4.16
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	47	48	49	50	51

Notes - 2013

FFY2013 data obtained from the 2013 CMS 4.16 report.

Notes - 2012

FFY2012 data were obtained from the 2012 CMS 416 report.

Notes - 2011

FFY2011 data were obtained from the 2011 CMS 416 report.

a. Last Year's Accomplishments

The FFY13 performance objective of 53 percent was not met. Data from the 2013 CMS 4.16 Report indicate that 46.3 percent of Medicaid-enrolled children ages 0-5 years received a dental service.

Infrastructure Building Services:

The I-Smile project is the basis for most of this measure's activities. Contract requirements included developing partnerships with businesses, business organizations, civic organizations, and/or faith-based organizations to build local infrastructure. To maintain quality and consistency, Oral Health Center staff conducted 3 required trainings for I-Smile Coordinators. OHC staff participated on the Early Childhood Iowa work group, identifying core health services for early childhood professionals. OHC staff provided education to the Iowa Dental Board about the importance of public health supervision of dental hygienists, leading to the addition of child care as an allowable setting. OHC staffs applied for a competitive 5-year capacity-building grant from the Centers for Disease Control and Prevention and were awarded. Funding began in September.

Population-based Services:

The OHC continues to promote early and regular dental care through its website, material distribution, and social media outlets. These activities are supported through other grants. Title V contract agencies are also required to conduct oral health promotion as part of I-Smile; OHC made specific I-Smile health promotion available to CH contractors.

Enabling and Direct Care Services:

ISC maintain and build local referral networks to ensure families are able to access services. To assist in this, OHC provides materials such as "first birthday" postcards that promote a child's initial dental visit and I-Smile ads that can be used in local newspapers.

Title V contract agencies were required to ensure that children are receiving gap-filling preventive services at WIC, based on data indicating children ages 0-2 are not getting into dental offices. Additional gap-filling services were also provided in other public health settings, based on need.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral health promotion.			X	
2. I-Smile™ coordinator professional development and training.				X
3. Dental care coordination and gap filling preventive services.	X	X		
4. Strengthen oral health coalition-building in the state.	X			
5. Open mouth surveillance, data monitoring, and evaluation.			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The bulk of activities targeting this performance measure are accomplished within the I-Smile project. A capacity-building CDC grant is allowing OHC to add epidemiological support, which will assist in data monitoring, program evaluation, and surveillance. OHC staff uses results of focus groups conducted in FFY2013 to guide program and policy development. OHC staff participates on the Community of Practice Care Coordination meetings, discussing strategies for expansion of 1st Five, MIECHV, and other health programs for children.

Population-based Services:

Health promotion activities continue, with an emphasis on "first visit by first birthday". OHC is providing funding for I-Smile health promotion to MCH contractors.

Enabling and Direct Care Services:

OHC and Family Health Bureau staff will work with local contractors to determine care coordination policy needs, and then work with IME to address those needs.

Gap-filling preventive services continue through local contractors. All will be required to ensure that children ages 0-2 at WIC are served.

c. Plan for the Coming Year

Infrastructure Building Services:

OHC staff will continue providing oversight of the I-Smile dental home initiative, including trainings for state coordinators, site visits, and policy development as needed. New OHC staff, hired as part of a CDC capacity-building grant will begin to visit local oral health coalitions, to consider ways to create a consistent approach statewide. OHC staff will work with FHB staff on development of a new data system, including seeking funding resources and determining data elements. OHC staff will also continue to manage the state's school screening requirement for children entering kindergarten; I-Smile coordinators coordinate the effort at the county level. OHC

staff will also consider new ways to better integrate oral health within medical health reform, through work with stakeholders and considering other states' successes.

Population-based Services:

Open mouth surveillance is planned for children at WIC and/or Head Start. Data will be compared to baseline surveys conducted in 2009 and 2010. OHC staff will work with I-Smile coordinators on statewide and local health promotion opportunities.

Enabling and Direct Care Services:

I-Smile coordinators and CH contractors will continue to offer care coordination, supported by OHC staff technical assistance. Coordinators will also advocate for selecting dental insurance for families enrolling with new health coverage via the marketplace.

CH contractors will continue to be required to ensure that children ages 0-2 are provided preventive care at WIC, due to data indicating a gap in care for this age group. Since dental insurance is not required as part of the health insurance marketplace, additional gap-filling care will also continue in other locations such as Head Start, based on need.

State Performance Measure 8: *Rate of hospitalizations due to unintentional injuries among children ages 0-14 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Performance Objective		12.2	6.3	11	14.5
Annual Indicator		12.4	19.9	15.6	10.3
Numerator		733	1199	936	623
Denominator		589813	603673	601376	602101
Data Source		Iowa Hospital Association inpatient data	Iowa Hospital Association inpatient data	Iowa Hospital Association inpatient data	IP files and census data
Is the Data Provisional or Final?				Final	Final
	2014	2015	2016	2017	2018
Annual Performance Objective	13.5	12.5	10.5	10	10

Notes - 2013

Reviewed and revised the data analysis strategy to more accurately determine the numerator values.

All numbers from the inpatient and outpatient files are down in 2013 compared to 2012. We are not sure why -for example, this number dropped from 936 to 623. We are investigating the issue.

Notes - 2012

FFY12 data were obtained from hospital inpatient data from the Iowa Hospital Association.

FFY 12 Update: Reviewed and revised the data analysis strategy to more accurately determine the numerator values.

Notes - 2011

FFY11 data were obtained from hospital inpatient data from the Iowa Hospital Association. Final data is available by the close of calendar year 2012. Data will continue to be monitored to track any shift in trends.

2011 Target was reset as part of the FFY12 application process, based upon provisional data. Final data was not obtained until after final submission, so the FFY11 target could not be reset.

FFY 11 Update: Reviewed and revised the data analysis strategy to more accurately determine the numerator values.

a. Last Year's Accomplishments

The FFY13 performance objective of 14.5 was not met. Data from the Iowa Hospital Association indicates that the rate of hospitalizations due to unintentional injuries among children ages 0-14 years was 15.6. IDPH staff reviewed and revised the data analysis strategy to more accurately determine the numerator value for FFY13. This data will be monitored and objectives will be realigned with the new analysis strategy.

Infrastructure Building Services:

BFH worked with the Bureau of Disability and Violence Prevention to conduct annual surveillance of statewide injury trends. Results of the injury prevention survey of local MCH contract agencies were used to share best practices at the local level. Three CH contract agencies developed specific action plans related to unintentional injuries. Activities included partnering with child care nurse consultants (CCNC) to evaluate child care facilities on health and safety issues, creating public awareness campaigns, providing health and safety education to families served, and car seat safety campaigns.

Best practice information on injury prevention for children was distributed to local Title V contractors, including numerous resources from the Children's Safety Network (CSN) and the Safe States Alliance. Staff also shared information on the Love Our Kids Grant designed to provide funding to rural areas to implement injury prevention initiatives for children. BFH also promoted the Annual Iowa Child and Youth Injury Prevention Conference.

IDPH submitted an application and was accepted into the Children's Safety Network (CSN) and Traumatic Brain Injury (TBI) Technical Assistance Center's (TAC) collaborative Community of Practice (COP) on the prevention of TBI. The Iowa Team joined an introductory conference call with 14 other participating states and made plans to develop an Iowa TBI initiative.

BFH continued to promote health and safety assessments in child care settings. Educational sessions were provided for consultants and providers of child care that addressed immunizations, Shaken Baby Syndrome (SBS), safe sleep, and playground safety. Recommendations were made to the Iowa DHS regarding injury surveillance in child care. It was proposed that DHS seek authority to make mandatory the reporting of child death and medically attended injuries in child care settings to DHS within 24 hours. Recommended interim strategies included voluntary web-based reporting or active surveillance by regulatory staff and CCNCs of incident reports when on-site in child care facilities.

BFH staff continued participation on the Prevent Iowa SBS Team. The team, comprised of representatives from IDPH, Prevent Child Abuse Iowa, Iowa Department of Management, and Blank Children's Hospital continued implementation of Iowa's statewide initiative to prevent SBS. The Period of PURPLE Crying is the educational program which helps parents and caregivers understand the features of crying in normal infants that can lead to shaking or abuse. Nurses in Iowa's birthing hospitals provided initial education to parents. They received a DVD and booklet

to help them understand the serious nature of SBS, as well as techniques to prevent it.

Population Based Services:

The Period of PURPLE Crying program was reinforced through parenting/birth classes, family physicians/pediatricians, social workers, licensed child care providers, and home visitors. An educational component designed by the National Center on SBS for secondary level students was planned. Program kits will be distributed to each AEA for use in schools. Information will be provided to school nurses and family consumer science teachers. This education can then be available for students in Middle School and High Schools to help instill a foundation for good parenting by teaching students that it is never okay to shake or otherwise harm a baby. It will help them to deal with the frustrations of infant crying which is often a trigger for maltreatment.

The public awareness campaign 'Click for Babies' coordinated by the National Center for SBS continued. Volunteers were solicited to knit purple hats for newborns with a note to reinforce key points of the SBS prevention project. Parents were encouraged to have their infant wear the hat and share the prevention message. In Iowa, knit-ins were held in Des Moines and Cedar Rapids. Over 6,000 caps were distributed to birthing hospitals across the state.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor unintentional injury trend data for children				X
2. Monitor legislation related to unintentional injury				X
3. Disseminate injury prevention information to local Title V agencies, school districts, child care centers, and new mothers			X	X
4. Promote education on Shaken Baby Syndrome			X	X
5. Continue to work with other IDPH bureaus, state agencies, and partners to promote unintentional injury prevention. This includes continued participation on the COP for TBI.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

BFH continues to track statewide data trends and monitor key legislation. BFH distributes educational resources to CH agencies addressing numerous types of unintentional injury.

FH staff continue participation on the TBI COP. Monthly educational sessions are held via webinar with other participating states. The Iowa Team meets monthly to advance a project which involves developing, piloting, and evaluating a Brain Care Guide to assist families with children who have sustained moderate to severe brain injury to provide information on available services.

Preventing injury and illness related to environmental impacts on children had a renewed focus with Iowa becoming an expansion State for Eco Healthy Child Care. The Injury Prevention Checklist was reviewed and is under revision. CCNCs continued to provide consultation and nursing assessments related to health and safety. An educational session was provided on chemical safety for consultants and child care providers.

Population-based Services:

The Period of PURPLE Crying continues via parenting/birth classes and service providers. IDPH

provided five school-based curriculum sets for each of Iowa's nine AEAs. Each curriculum contains an instructor's manual, DVD, handouts, a documentary entitled Elijah's Story, posters, brochures, and a demonstration doll. A CDC assigned Epidemic Intelligence Service Officer is investigating non-fatal abusive head trauma and child death review data to examine.

c. Plan for the Coming Year

Infrastructure Building Services:

BFH will continue annual surveillance of statewide trends and examine hospital inpatient data regarding unintentional injury among children. State level injury-related legislation will be monitored. Several Title V CH agencies will continue to implement specific plans to address unintentional injury.

BFH will continue its collaboration with the IDPH Healthy Homes and Lead Poisoning Prevention Program. Staff will promote the Annual Iowa Child and Youth Injury Prevention Conference. Best practice information on injury prevention for children will continue to be distributed to local Title V contractors and school districts. Key resources include those from Safe States and the Children's Safety Network.

Due to federal and state changes, it was determined the local CH contract agencies will be able to decide whether they will support a Child Care Nurse Consultant (CCNC) position. IDPH BFH will continue to work with local CCNCs promote health and safety assessments in child care settings. At the state level, BFH will continue to make improvements to Iowa's Training CCNC project. A small workgroup has been established and will be working to make changes. Iowa will also be using the Injury Prevention Checklist/Health and Safety Assessment that was developed from California. BFH will train all local CCNCs on the new tool.

Population-based Services:

BFH staff will continue to support messaging that families receive in the hospital about preventing Shaken Baby Syndrome (SBS). Dissemination of the Period of PURPLE Crying(r) program to new mothers both prenatal and postnatal will provide parents with information about the characteristics of normal infant crying, the dangers of shaking an infant, and techniques to soothe and cope with infant crying. CDC hospital discharge data will be examined for SBS related injuries. This data, in addition to Iowa child death data, will allow the EIS Officer to examine trends over time.

In FFY 2015, funding will dictate how many additional hospitals will receive the SBS DVDs and booklets. Currently 60 of the 78 birthing hospitals are participating. These 60 hospitals deliver 89% of Iowa's births. Outreach will continue to involve the remaining 18 hospitals. The goal is to get all Iowa birthing hospitals at a level of sustainability to continue this project. The public awareness campaign 'Click for Babies' will continue to be supported. Volunteers will be solicited to knit purple hats for newborns that contain a note reinforcing the key points of the SBS prevention project.

Three local CH agencies have action plans related to unintentional injuries. Activities include utilizing Safe Kids USA safety posters to display at immunization clinics, WIC clinics, schools, faith based organizations, libraries, and physician offices, conducting home safety checks for all families receiving home visits utilizing Safe Kids at Home Assessment Tool.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	6.7	7.0	6.5	6.6	6.5
Numerator	2674	2688	2499	2559	2536
Denominator	39662	38514	38204	38686	39013
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Narrative:

Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. For calendar years 2012 and 2013, the percent of infants born at a low birth weight remained stable at 6.6% and 6.5% respectively. This percentage has dropped from 7.2% in 2005 and 7.0% in 2010.

Low birth weight data are reviewed on an annual basis to identify trends and areas of concern. Because of the relationship between maternal smoking and infant low birth weight and the high proportion of pregnant Medicaid enrollees who smoke during pregnancy, IDPH in collaboration with our partners at Iowa Medicaid Enterprise (IME) conducted a Quality Improvement Project (QIP) to address the high rate of smoking among women with Medicaid reimbursed births. IDPH staff and IME staff collected data from a variety of source to assess provider awareness and use of smoking cessation strategies. We are in the process of identifying interventions to address the needs we identified. For example, some providers had not been aware of the Iowa Quit Line. Because the use of nicotine replacement products and other drugs to aide smoking cessation during pregnancy and lactation have not been sufficiently reviewed to determine their safety and efficacy, IDPH and IME have shifted their focus support provider use of smoking cessation counseling and referral to the Iowa QuitLine.

The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are receiving the appropriate level of care.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	4.9	5.1	4.7	4.9	4.8
Numerator	1888	1903	1752	1830	1820
Denominator	38246	37106	36902	37317	37670

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Narrative:

Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. The percent of singleton infants born at a LBW in 2013 was 4.8%. This is essentially equal to the percent of singleton infants born at a LBW in 2012 (4.9%). The percent of singleton infants born at a LBW in 2005 was 5.4% and 5.1% in 2010. Because of the relationship between maternal smoking and infant low birth weight and the high proportion of pregnant Medicaid enrollees who smoke during pregnancy, IDPH in collaboration with has been working closely with with our partners at Iowa Medicaid Enterprise (IME) conducted a Quality Improvement Project (QIP) to address the high rate of smoking among women with Medicaid reimbursed births. IDPH staff and IME staff collected data from a variety of source to assess provider awareness and use of smoking cessation strategies. We are in the process of identifying interventions to address the needs we identified. For example, some providers had not been aware of the Iowa Quit Line. Because the use of nicotine replacement products and other drugs to aide smoking cessation during pregnancy and lactation have not been sufficiently reviewed to determine their safety and efficacy, IDPH and IME have shifted their focus support provider use of smoking cessation counseling and referral to the Iowa QuitLine.

The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are receiving the appropriate level of care.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	1.1	1.3	1.1	1.1	0.8
Numerator	446	506	431	436	313
Denominator	39662	38514	38204	38686	37670
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Narrative:

The percentage of infants born at a very low birth weight percentage in Iowa has remained stable for the past several years. The percentage of infants born at a VLBW was 1.1% for calendar years 2012 and 2013. See #1 A and B for strategies that Iowa is implementing.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	2009	2010	2011	2012	2013
Annual Indicator	0.8	1.0	0.8	0.8	0.8
Numerator	310	358	307	305	313
Denominator	38246	37106	36902	37317	37670
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Narrative:

The percentage of infants born at a very low birth weight percentage in Iowa has remained stable for the past several years. The percentage of infants born at a VLBW was 1.1% for calendar years 2012 and 2013. See #1 A and B for strategies that Iowa is implementing.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
TOTAL POPULATION BY RACE								
Infants 0 to 1	38178	33709	1621	228	914	55	1651	0
Children 1 through 4	156548	136249	7721	1230	3671	223	7454	0
Children 5 through 9	205104	180147	9870	1360	4483	322	8922	0
Children 10	202271	180131	8972	1332	4327	256	7253	0

through 14								
Children 15 through 19	212508	190031	9771	1360	4877	220	6249	0
Children 20 through 24	226739	201065	11209	1405	8045	259	4756	0
Children 0 through 24	1041348	921332	49164	6915	26317	1335	36285	0

Notes - 2015

Narrative:

Historically, Iowa has been among the more homogenous states with respect to race and ethnicity, but the state is becoming notably more diverse, and young children are leading the way. Children of a race other than white and/or who are Hispanic or Latino represent 21 percent of Iowa's under-6 population and 17 percent of the 6-17 population in 2010, but only 2.9 percent of the 65-plus population. From 1990 to 2010, the young-child population in Iowa identifying as Hispanic or Latino more than doubled, and, in fact, people of Hispanic descent are now the largest minority group in the state. All other minority groups, including people who identify two or more races, have grown significantly as well. Iowa's population is projected to continue becoming more diverse over this decade, although at a slower rate than during the 2000s.

The growth of minority communities is a key component of overall population growth in Iowa. Without population growth among young children of color and/or of Hispanic or Latino descent, Iowa's young-child population would have declined statewide and in 70 of 99 counties. During the 2000s, a handful of suburban counties, primarily those around Des Moines, experienced very high growth rates among non-Hispanic white children, but the majority of counties experienced significant drops in this population.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	469240
Living in urban areas	474627
Living in rural areas	343591
Living in frontier areas	0
Total - all children 0 through 19	818218

Notes - 2015

Narrative:

Young people have left their farming communities behind and migrated toward urban centers in search of employment and other opportunities. According to data from the U.S. Census Bureau (2012), the population of urban counties in Iowa has increased 13.4 percent from 2000 to 2010. The population of rural counties in Iowa has decreased 3.1 percent during the same time period. In 2010, almost half of Iowa's population was located within ten urban counties with the remaining half spread over 89 rural counties.

F. Other Program Activities

The MCH Title V program has been extensively involved in providing leadership for changes in the service delivery system for children including but not limited to local Early Childhood Iowa Areas, the State Children's Health Insurance Program, Early Hearing Detection and Intervention, Newborn Metabolic Screening, Early ACCESS (IDEA, Part C), and the Iowa Medical Home Initiative. A list of formal and informal organizational relationships is located in the attachment for Organizational Structure section III-C. Contracts and memorandums of agreement are found in the attachment for this section, IV-F.

Family Planning activities are coordinated with the IDPH Family Planning Program and the Family Planning Council of Iowa, the Title X contractor for the state.

The following are other Child Health Specialty Clinic program activities:

1. State and regional staff is involved with planning and operation of local Early Childhood Iowa areas.
2. Staff contributes to course development and teaching for the University of Iowa College of Public Health MCH focus track students and other graduate students.
3. Staff participates in planning and providing experiences for leadership training in Iowa's Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program.
4. CHSC works with the Iowa Department of Human Services to assure quality care for CYSHCN enrolled in Medicaid and SCHIP programs and foster care.
5. Staff participates in planning and field-testing new approaches to delivering physical and behavioral health care services and consultation and nutrition services to community-based sites using telemedicine techniques.
6. CHSC partners with other Iowa public health professionals to co-plan and sponsor the Annual Iowa Governor's Conference on Public Health.
7. Staff participates in a Department of Human Services effort to assure appropriate screenings, evaluations and ongoing medical care for children enrolled in Iowa's foster care system.
8. Staff leads quality improvement efforts within Iowa's statewide system of early hearing detection and intervention for newborns and infants, based on principles obtained by participating in the National Improvement in Child Health Quality (NICHQ) learning collaborative.
9. Staff participates in an MCHB-supported Department of Public Health effort to establish a comprehensive early childhood system.
10. Staff participates in a Department of Human Services effort to assure healthy child mental development by improving early childhood screening practices among primary care providers.
11. Staff participates in IDEA Part C program planning and quality assurance projects and lead efforts to investigate the roles of social determinants of health, as well as home-based toxic exposures on early childhood development.
12. Staff serves in an advisory capacity to the Department of Public Health data integration initiative.
13. Staff serves in an advisory capacity for the Department of Public Health initiative to improve the "provider safety net" (community health centers, rural health clinics, and free medical clinics) for medically underserved Iowans, with a special emphasis on investigating the fit between the

medical home model and various safety net providers, especially free medical clinics.

14. Staff serves in an advisory capacity on the Children and Families Congenital and Inherited Disorders Advisory Committee, Iowa Council for Early ACCESS, Iowa Medical Home Advisory Committee, Council for Maternal and Child Health, Iowa Autism Council, and the Prevention and Chronic Care Management Advisory Council and Clinicians.

15. CHSC's Director is President of the Iowa Chapter of the American Academy of Pediatrics, AMCHP Treasurer, and on the AMCHP Board of Directors.

16. CHSC is represented on the Center for Disabilities and Development "Community Partners Advisory Committee" which seeks to improve community outreach, advocacy, and services to Iowa's citizens with disabilities.

17. The CHSC Regional Autism Assistance Program promotes training health care providers and educators in early detection and intervention strategies for children with autism and other disorders on the autism spectrum. CHSC Family Navigators assist families of children with ASD to apply for the Autism Support Program to access funding for Applied Behavioral Analysis.

18. To promote family involvement at all levels of the MCH pyramid, CHSC community-based family navigators serve on multiple state level advisory groups: Medicaid's Medical Assistance Advisory Committee, Iowa Collaborative Safety Net Provider Network, Early ACCESS (IDEA, Part C) Iowa Council on Early Intervention, Governor's Council for Prevention of Disabilities, University of Iowa Center for Disabilities and Development's Community Partnership Advisory Council, University of Iowa Hospitals and Clinics' Family Advisory Committee, the Maternal and Child Health Advisory Council, local and county governance boards to guide Community Circle of Care (CCC), and AMCHP Family Delegate.

CHSC promoted pre-service and in-service MCH workforce development. Staff presented at lectures and workshops reaching hundreds of University of Iowa students, staff, and faculty including at the College of Public Health, Stead Department of Pediatrics, Leadership Education in Neurodevelopmental Disabilities at the University Center for Excellence in Developmental Disabilities, and the College of Nursing. Staff also played key roles to facilitate the planning and execution of statewide learning events such as the Iowa Governor's Conference on Public Health and the annual Disabilities Prevention meeting.

CHSC promotes family involvement at all levels of the MCH pyramid. CHSC community-based Family Navigators serve on multiple state level advisory groups including: Medicaid's Medical Assistance Advisory Committee, Iowa Collaborative Safety Net Provider Network, Early ACCESS (IDEA, Part C) Iowa Council on Early Intervention, Governor's Council for Prevention of Disabilities, University of Iowa Center for Disabilities and Development's Community Partnership Advisory Council, University of Iowa Hospitals and Clinics' Family Advisory Committee, the Maternal and Child Health Advisory Council, local and county governance boards to guide the Pediatric Integrated Health Home program and other programs serving children with serious emotional disturbances, Iowa's Expert Panel on Autism. Iowa's AMCHP Family Delegate continually networks with other state and national family leaders to keep Iowa current in best practice and innovative ideas for family involvement.

A CHSC staff member serves on committees at the University of Iowa that identify and address health disparities. This staff member also reviews CHSC materials to assure they are culturally sensitive and written at a 6th grade level. CHSC also translates materials into Spanish and other languages as needed. All CHSC employees receive cultural competency training at orientation and throughout the year as needed. CHSC is also developing relationships with other organizations that serve minority families to expand our reach and better meet the needs of all families.

An attachment is included in this section. IVF - Other Program Activities

G. Technical Assistance

Iowa will be requesting technical assistance to develop strategies to increase the number of maternal health clients who receive dental care during pregnancy. The technical assistance will be used to address barriers Medicaid-enrolled women face in receiving dental care, such as finding dentists that accept Medicaid, low priority given to dental care, misconceptions about the safety and appropriateness of dental care during pregnancy and sporadic guidance given to pregnant women during prenatal care.

One major component of Iowa's Title V program at the state and local level is developing strategies to address cultural competency and working with diverse cultures. Iowa would like to work with staff from the University of Northern Iowa Project EXPORT to develop Iowa's capacity to assure Title V serves all ethnic minority groups and is working on system level strategies to address cultural competency.

Iowa recognizes the opportunity to build public health capacity for MCH through professional development focused on emerging issues and the changing political landscape, including the paradigm of ACOs and Medicaid Health Homes in care coordination/case or population management and the effects of those who work in Title V. Iowa may request technical assistance from Kay Johnson of Johnson Consulting and the MCH Workforce center to develop strategies to address these issues.

Iowa requests TA in reaching underserved and minority populations through the needs assessment process to address health disparities and promote health equity. Iowa has an increasing population of minority and underserved individuals, with health disparities and gaps in the service system and promoting health equity requires outreach to community leaders and organizations serving these groups. Iowa will seek technical assistance from the Center on Health Disparities at UC Davis.

Iowa has integrated the ACE survey questions into the BRFSS survey and will be getting the second year of data in the fall 2013. Technical assistance may be requested for analysis of the ACE survey questions. The technical assistance would be requested to do additional analysis that would drill deep into the data at a county level or regional level. Iowa is also interested in technical assistance from another state, such as Washington or Oklahoma on implementation at the community level.

Iowa is requesting technical assistance support to build capacity of data assessment and analysis related to child death review data. Support is needed to continue and expand analysis of the data from the child death review system. The focus would be on developing specific profiles, reports and measures for department maternal and child health programs and community-based initiatives. In addition, the department needs technical assistance in managing case files and entering data into the system. Iowa will use the data to inform the 2016 Title V needs assessment.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation (Line1, Form 2)	6442068	5960821	6536122		6477854	
2. Unobligated Balance (Line2, Form 2)	0	0	0		0	
3. State Funds (Line3, Form 2)	5350187	5128803	5670857		6214124	
4. Local MCH Funds (Line4, Form 2)	0	0	0		0	
5. Other Funds (Line5, Form 2)	3852092	4604294	5558142		7162830	
6. Program Income (Line6, Form 2)	350000	354382	472000		430000	
7. Subtotal	15994347	16048300	18237121		20284808	
8. Other Federal Funds (Line10, Form 2)	13566821	12880039	12517428		11487702	
9. Total (Line11, Form 2)	29561168	28928339	30754549		31772510	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	1641918	1498875	1683481		1652122	
b. Infants < 1 year old	301710	296455	268698		356076	
c. Children 1 to 22 years old	9056884	8995907	10694019		11762849	
d. Children with	4387297	4640507	4984385		5907223	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	606538	616556	606538		606538	
g. SUBTOTAL	15994347	16048300	18237121		20284808	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	150000		0		140000	
d. Abstinence Education	860594		823680		808000	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	190000		635045		665046	
j. Education	156400		588326		599780	
k. Home Visiting	7740642		7345869		7124800	
k. Other						
HRSA			294399		250000	
Iowa DHS			547076		547076	
OPA					1253000	
OPA			1333033			
SAMHSA			850000			
Autism	154326					
CCHT-Intgr. Comm.	86489					
CDC Stillbirth	270000					
CHIPRA	324766					
Early ACCESS-CHSC	211376					
EPSDT - HCBS IS	547076					
Family Planning	1333033					
Newborn Hearing-HRSA	270000					
PRAMS	190046					
Prjct LAUNCH/Connect	982073					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2013		FY 2014		FY 2015	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	4691978	4403112	4426360		4592778	
II. Enabling Services	2963776	3362426	3581960		4259499	
III. Population-Based Services	1476974	1597167	1782376		1695395	
IV. Infrastructure Building Services	6861619	6685595	8446425		9737136	
V. Federal-State	15994347	16048300	18237121		20284808	

Title V Block Grant Partnership Total						
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A. Expenditures

Form 3, State MCH Funding Profile, shows \$5,960,821 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 12 award.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY13 in the amount of \$16,048,300. Of this amount, \$5,960,821 was funded by federal Title V. Figure 1 in the attachment displays the distribution of Title V expenditures by population served. The state match is reported at \$5,128,803. This exceeds both the state match requirement of \$4,745,632 and the maintenance of effort requirement of \$5,035,775. Federal Title V funds expended for infant and child health primary and preventive care was \$2,036,079 or approximately 34.1 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at \$2,124,518 or 35.6 percent of the federal block grant funds expended for the year. Administration expenditures of \$605,431 represent 10.1 percent of the federal Title V expenditures to date.

In the attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to infrastructure continue to increase for MCH compared to the proportional of funds directed to direct services. Continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state partnership.

The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with OMB Circular A-133. The most recent report is for the period July 1, 2012 to June 30, 2013. The Iowa Department of Public Health had one finding in the 2013 audit related to internal controls; however, these findings were not related to Title V expenditures. The report is submitted to the federal clearinghouse by the state Auditor's Office.

An attachment is included in this section. VA - Expenditures

B. Budget

The FFY15 Title V appropriation is projected to be \$6,477,854, based on the final Notice of Grant Award for FFY14. As itemized in the budget attachment, this expected allocation is budgeted as follows: \$1,346,040 (20.8%) for maternal health services; \$284,113 (4.4%) for infant health services; \$2,068,776 (31.9%) for child health services; \$2,172,387 (33.5%) for services to children with special health care needs; and \$606,538 (9.4%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. In the attachment, Figure 5 illustrates the budget plan for the FFY13 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is \$6,214,124. Iowa continues to exceed the state maintenance of

effort of \$5,035,775, established in 1989 and exceeds the required match of \$4,848,188.

The total budget for the federal-state partnership is projected to be \$20,284,808. Attachment, Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of service, as well as population group served.

Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Infrastructure Building Services

Estimated budget for continuing development of core public health functions and system development are \$9,737,135 or 48.0 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 36 percent of the funding for local child health agencies and 23 percent of local maternal health funds. In addition, it will include contract services with the University of Iowa, Departments of Pediatrics, Perinatal Review Team, Healthy Child Care Iowa, EPSDT dental and IDPH 1st Five Initiative. CHSC's budget for infrastructure building services is estimated at \$2,081,980 (35.3 percent of the CYSHCN budget).

Population-based Services

The federal-state partnership expenditures for continuation of population-based services are estimated at \$1,695,395, which represents approximately 8.4 percent of the total partnership budget. IDPH funds budgeted in this category include state funds for STD testing, immunization, lead poisoning prevention, and birth defects and audiological services. This category also includes 9 percent of the funding for local child health agencies and 10 percent of local maternal health funds. IDPH projects expenditure of \$1,456,677. CHSC's budget for population-based services is estimated at \$178,065 (3.0 percent of the CYSHCN budget).

Enabling Services

The federal-state partnership expenditures for continuation of enabling services are estimated at \$4,259,499 representing 21.0 percent of the partnership budget. This category includes 41 percent of the funding for local child health agencies and 37 percent of local maternal health funds. Healthy Families toll free information and referral line, TEEN Line, hawk-i Outreach, and EPSDT are included in this category. CHSC's budget for enabling services is estimated at \$2,127,159 (36 percent of the CYSHCN budget). CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Direct Health Care Services

The federal-state partnership expenditures for continuation of direct care services are estimated at \$4,592,778. This represents approximately 22.6 percent of the partnership budget. The amount includes 14 percent of the funding for local child health agencies and 30 percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment, and dental sealant projects; OB indigent program, and child vision screening. CHSC projects a direct care budget of \$1,520,019 or approximately 25.7 percent of the CYSHCN budget.

Other federal funds directed toward MCH include:

- State Systems Development Initiative (HRSA/MCHB)
- Early Childhood Comprehensive Systems Grant (HRSA/MCHB)
- Title X Family Planning
- Early ACCESS (IDEA, Part C)
- Iowa Stillbirth Surveillance Project (CDC)
- Iowa Newborn Screening Surveillance Project (CDC)
- Early Hearing Detection and Intervention (CDC and HRSA)

Project LAUNCH (SAMHSA)
Personal Responsibility Education Program--PREP (ACF)
Maternal, Infant, Early Childhood Home Visiting (HRSA/MCHB)
Pregnancy Risk Assessment Monitoring System (PRAMS) (CDC)
Abstinence Education (ACF)

An attachment is included in this section. VB - Budget

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.