Maternal and Child Health Services
Title V Block Grant

State Narrative for Iowa

Application for 2013
Annual Report for 2011

Document Generation Date: Wednesday, September 12, 2012

Table of Contents

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 Iowa Department of Public Health Web site.

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. 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 Maternal and Child Health Advisory Council also provided public comment via the IDPH Web site 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/ The Iowa Department of Public Health, 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 is 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 February 2011, the Title V listening post was held to address Maternal Child Health programming, including Oral Health, funded in part through the Title V Block Grant. Services to communities are delivered through contracts with local maternal and child health 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. The six recommendations that will guide work for the Bureau of Family Health's work are:

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 (RFP/RFA competitive selection). 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 Maternal, Infant, Early Childhood Home Visitation (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 communities members and 25 families attended the community forums.

IDPH also utilized a website to post the reports for the National Performance Measures and State Performance Measures. During the two week period established for public comment, over 330 hits were made to the Title V Public Input website (http://www.idph.state.ia.us/hpcdp/title_v.asp). MCH stakeholders and interested public provided feedback on Iowa's state priorities, 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.

Early Childhood Iowa (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 National Performance Measures and State Performance Measures. During the two week period established for public comment, over 300 hits were made to the Title V Public Input website (http://www.idph.state.ia.us/hpcdp/title_v.asp). 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//

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

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/Changes in the population strengths and needs in the State priorities since the last Block Grant application:

The 2011 Census estimate results were released indicating that each year Iowa's population continues 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.

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

Legislative Session: During the 2012 legislative session, the IDPH lost minimal state maternal and child health funding. While the cuts were minimal, they still continue to affect the Title V MCH foundation at the state and local level. The economy seems to be picking up slowly and revenue projections indicate an expected increase.

MCH Restructure: Over the past two years, Iowa's Title V MCH program has been evaluating the state and local structure and putting together workgroups to address the needed changes. As part of the follow up from two MCH Title V Listening Post evaluations, February 2011 with local MCH contracts and January 2012 with state MCH partners, the MCH Consultation and Technical Assistance Leadership Team was developed. The Leadership Team is a partnership between local MCH partners and state MCH staff. The following three workgroups were identified to provide input and oversight into the changes for the following areas:
1. Consultation and Technical Assistance Structure
2. Communication
3. Core MCH Services and Contracting Process

Adverse Childhood Experience (ACE): IDPH, along with many other stakeholders, are very involved in building broad based education, awareness, and support for Iowa's involvement with the ACE study. The overarching goal is to engage as many partners across a variety of disciplines as possible, both at a state and local level. An ACE Steering Committee was developed to spearhead efforts.

The ACEs Steering Committee made the following initial recommendations around ACEs:

1. Increase understanding among our policy makers on the prevalence of ACEs in our state which can inform Iowa's mental health redesign.

2. Integrate trauma-informed professional development across all departments & systems serving families.

3. Infuse high quality, evidence-based practices into family-based programming.

4. Increase public/private co-investment partnerships around a shared understanding and common language about ACEs and align missions for a greater, collective impact.

5. Improve effectiveness by refining public health awareness campaigns strategies.

Iowa received funding from a variety of sources to integrate the ACE survey questions in the BRFSS survey. Preliminary results will be available in the fall 2012.

Life Course: Iowa was selected to participate as a team in AMCHP's Life Course Metric Project. Iowa has been working over the last six months on focusing efforts and aligning programs around the life course. The staff focused efforts on BFH programs and hopes to move the focus to the Division level. The Life Course Metric Team will help educate other bureaus and private organizations stakeholders.

Social Determinants of Health: Iowa's Title V program for children and youth with special health care needs, CHSC commissioned a study to examine the body of knowledge around the life course model for Iowa's children ages 0 to 3 years. The project included: 1) completion of a literature review on social determinants of health; 2) application of the literature to conduct an assessment of social determinants of health for infants and toddlers in selected Iowa communities; 3) sharing the results of the assessment with policymakers and stakeholders; and 4) creation of a white paper that includes transforming policy recommendations to practice -- "The Health Practitioner's Role in Healthy Young Child Development: Taking a Life Course Approach in Iowa." The white paper is being presented to the Iowa Department of Education, the Iowa Department of Public Health, and the Iowa Department of Human Services.

Maternal, Infant and Early Childhood Home Visiting (MIECHV) Project: Iowa submitted an application for a four-year competitive MIECHV expansion funds on July 1, 2011. IDPH was originally denied funding but were subsequently awarded funds on March 31, 2012 to implement the expansion proposal in a three-year time frame. IDPH is in the process of expanding evidence-based home visiting to the 15 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 four percent of the families with children aged 0-5 years in the at-risk communities with MIECHV funding and existing funding.

IDPH will also be implementing the following infrastructure building activities with the MIECHV expansion grant:
• 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.
• Develop state competency requirements and a validation system for all family support practitioners.
• 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.
• 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.
• Utilize the work of the marketing industry to complete a study of the personal attributes that families look for in home visitors that cause them to stay engaged in the program. In the marketing industry this is called the "q" rating or score. Create screening tools that will enable employing organizations to hire staff that has the personal attributes that will assist families to be able to relate to the worker and will decrease drop-out rates.
• 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.

A brief description of ongoing needs assessment activities, such as data collection and analysis, evaluations, focus groups, surveys, that enable the State to continue to monitor and assess, on an ongoing basis, its priority needs and its capacity to meet those needs:

State and local MCH stakeholders continue to review data and discuss ways to address the NPMs and SPMs. The MCH Advisory Council meets quarterly and tracks progress on SPM and NPM. The MCH Advisory Council also provides significant input in March on activities that are reported on. BFH staff also take input from local MCH agency grant applications to determine what activities they are doing that relate to the SPM and NPM.

A brief description of any activities undertaken to operationalize the 5-year Needs Assessment, such as establishing an advisory group to monitor State progress in addressing the findings and recommendations resulting from the Needs Assessment:

The Bureau of Family Health established a Quality Improvement team to ensure a continuous effort to enhance quality and consistency of services provided to Iowans. Members of the QI team were trained in the use of various tools that promote implementation of quality services and effective decision making. The group reviewed tools such as the Radar Chart, Root Cause Analysis, Flowcharting, and Fish Bone Diagram. The goal of this initiative will be to promote regular and ongoing quality improvement processes throughout the bureau.

MCH staff provides technical assistance to local MCH programs on QI methodology. During FFY12 and FFY13, BFH staff members are providing local MCH programs with tools and strategies to conduct service note reviews for documentation in CAReS and WHIS to assure that all services provided through the MCH program are properly documented. EPSDT staff provides regularly scheduled trainings related to the CH/EPSDT and MH program. These trainings are open to new and existing staff at the local level.

The Child and Family Iowa Household Health Survey (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, the second in 2005 and the third in 2010. The IHHS serves as a foundation for Iowa's Title V five year needs assessment and other program related needs assessments.

The IHHS is a collaboration between IDPH, the University of Iowa Public Policy Center and the Iowa Child Health Specialty Clinics (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.

The statewide report of the 2010 IHHS was published (www.ppc/uiowa.edu). Dissemination of the report is underway utilizing multiple venues to reach the widest audience of state and local program partners. Communications with early childhood program partners is nearly complete in preparation for distribution of the second 2010 report focusing on the health of Iowa's early childhood population. A series of webinars will be offered to present information on the 2010 IHHS statewide report, sample methodology, and early childhood report.//2013//

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, wheat and barley, 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 percent of the population is white and this number continues to decline each year. Resident of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 2.8 percent in 2000 to 5 percent 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//

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//

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.

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//

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//

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//

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//

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
2. Detection and intervention in Iowa.
3. 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.
4. Implement a statewide Web-based surveillance system to assure all Iowa newborns are screened for hearing loss and receive follow-up services as needed.
5. Facilitate data integration linkages with related screening, tracking and surveillance programs to minimize infants "lost to follow-up".
6. Meet the National EHDI Goal of 1-3-6.
7. All infants are screened for hearing loss before 1 month of age, preferably before hospital discharge.
8. All infants who do not pass the screening will have a diagnostic audiologic evaluation before 3 months of age.
9. All infants identified with a hearing loss receive appropriate early intervention services before 6 months of age.
10. Review data to identify children with potential for hearing loss to ensure those children receive appropriate, timely early intervention services.
11. Collaborate with Early ACCESS (IDEA, Part C) to strengthen early intervention services for children who are deaf or hard-of-hearing.
12. 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.
13. Implement program evaluation that incorporates both process and outcome objectives which drives system development and program improvement.

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//

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//

State Child Health Insurance Program

Iowa's Covering Kids and Families (CKF) project, sponsored in part by the Robert Woods 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 (Healthy and Well Kids in Iowa.)

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 Iowa Medicaid Enterprise (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//

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 maternal and child health 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 Councils' 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//

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//

/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//

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// 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.

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//

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//

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//

/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//

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. 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 (Child Health 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. BFH Infrastructure and Performance Management
2. Reproductive, Maternal, and 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 maternal health (MH) and 8 family planning (FP) agencies.//2012// Systems development activities are coordinated with the IDPH Family Planning Program, the Family Planning Council of Iowa (FPCI), 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.

Local Maternal Health

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 the electronic data base (WHIS).

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 University of Iowa, 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//

Abstinence Education

/2013/The Department hired a program coordinator and is working with Youth Shelter Services 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//

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//

Preventing Shaken Baby Syndrome

Comprised of representatives from IDPH, Prevent Child Abuse Iowa, Iowa Department of Management, and Blank Children's Hospital, the Iowa Prevent Shaken Baby Syndrome (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(r) 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//

Medical Home/EPSDT Work Team

For the child health 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 Child Health/EPSDT program. It addresses policy and practice to promote access to preventive health care services provided by child health contract agencies. Representatives on the team include those from child health, 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 Child Health 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 Child Health 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 request for proposals (RFP) process for MCH and family planning.

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. The CH Logic Model continues to be the framework that contractors design their child health program, implement services, and impact key performance measures.//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//

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//

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//

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.

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 University of Iowa is the designated testing laboratory for the INMSP and MPSP. The University of Iowa'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 University of Iowa 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//

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 Center for Disabilities and Development'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 eSP™ 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//

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//

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 maternal and child health 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//

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.

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//

Care Coordination Services

/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, comrised 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.

/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//***

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//

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 (F2F IA). F2F IA's decision-making body is an interagency collaborative group comprised of more than 20 family advocacy groups.

Through F2F IA, 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 F2F IA 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 at the University of Iowa, 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 Center for Disabilities and Development 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//***

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, University of Iowa Center for Disabilities and Development's Community Partnership Advisory Council, the University of Iowa Hospitals and Clinics' 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//***

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//***
- 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
- Leading the Partnership to Improve Child Health in Iowa

- Developing a new model to expand access to pediatric mental health services
- 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//***

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//***

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//

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 Immunization 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.

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.//2012//

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//

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). These staff are 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//

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.

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//

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 HICH grant will be transitioned to a nonprofit family-driven agency beginning June 1st, 2012.//2013//***

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//***

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//***

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//***

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.

/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 Prevention.

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 maternal and child health (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//

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 percent from 3 percent 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 6.0 and 10.0 percent (respectively); adolescents were approximately 30 percent of the client, and 5.0 percent 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//

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 Care for Kids , 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 Care for Kids program and the Maternal Health program under an intergovernmental agreement with DHS. Under this agreement, local child health 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 the Child and Adolescent Reporting System (CAReS), which is then available to local child health 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.

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.

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//

Preventable Diseases Program

The Bureau of Immunization and Tuberculosis administers the program for vaccine preventable diseases. Vaccines are available to local health departments, child health 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 Early Hearing Detection and Intervention (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). Aife 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//

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 to provide onsite injury prevention assessments of early care, health, and education providers at no cost to the provider. CCNC's are employed by or under contract with local CH agencies. Assessments utilize U. S. Consumer Product Safety Commission recall notices, safety notices and guidelines to assess the environment for hazardous and recalled equipment, and site specific hazards. Additionally, CCNC's 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 Quality Rating System. The emergency preparedness plan must have Memorandum of Agreements with relocation sites and emergency transportation providers, and document that 24 hours of emergency supplies on hand in the facility.//2013//.

Early ACCESS

Early ACCESS 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 Early ACCESS 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 Early ACCESS, 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 Early ACCESS that require nutrition services. IDPH provides service coordination to children who have /2012/ venous lead levels of 20 ug/dl and above. //2012//

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 (Iowa PCA), formerly known as the Iowa/Nebraska Primary Care Association or IANEPCA. 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 Iowa PCA 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.

3) IDPH to provide medical consultation to the Division of Health Promotion and Chronic Disease Prevention, Iowa Department of Public Health.

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//***

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.

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.

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 occuring, to continue Family to Family Iowa activities after the grant expires.//2013//***

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//***

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.

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.

F. Health Systems Capacity Indicators

HSCI 08

Our Iowa 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 Ill and Handicapped Waiver Program (IHWP). Annually IHWP serves between 1700-1800 children and youth less than 16 years of age. 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 Title V CYSHCN Program realizes that SSI eligibility discussions with families to request assistance from Title V is not precisely the same as providing "rehabilitative services." We do, however, believe that the discussion does offer a potential connection between SSI beneficiary families and Title V services. Discussions occur with approximately 90% of families served by IHWP under age 16 years who are approved for SSI. The reason discussions do not occur with 100% of families is because a relatively small percentage of SSI-approved children reside in foster homes or other out-of- home placements and are in regular and close contact with Iowa's Department of Human Services (DHS). For those children, DHS is the logical and more effective resource regarding rehabilitative services. For the large majority of SSI-approved children that are not in foster care or other out-of-home placement, CHSC reminds families to apply for Medicaid services. 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. This would then begin a more formal service relationship between the SSI-approved child, their family, and the State Title V CYSHCN Program.

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 by the Center for Disability Programs in Kansas City. In FY 2011 CHSC contracted with a consultant to train IHWP staff regarding transition from youth to adult (e.g. guardianship,etc.) CHSC queried Social Security Field offices in Iowa requesting they display CHSC brochures, contact information and a resource sheet to assist families of a CYSHCN. No Field offices responded in 2011./2012/ Twenty-one DHS SS Field offices are displaying materials as requested by CHSC. CHSC sends supplies to the Field offices quarterly. In FY 2011, CHSC served 1702 children under age 16 who were either on or applying for the IHWP. CHSC staff sought advice from John Reiss of the University of Florida regarding this indicator. DHS personnel indicated there were 1,178 children under age 16 with SSI income in FY 2011.//2012//

HSCI 9A
Programs within the Bureau of Family Health (BFH) are aware of the aging of current MCH data systems, which provided a catalyst for a quickened pace of planning for data integration. The BFH established the Data Integration Committee whose goal is to plan the actual integration of MCH-related data systems within a timeframe of two -- three years. Activities of the Committee include:
• Implementing quality improvement methods with participants about potential data system integrations.
• Facilitating discussion about the potential data system integrations
• Prioritizing data system integration(s) to be pursued in subsequent years
• Writing business requirements for integrated data system(s)
• Creating a timeline for system integration

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 interconceptioncare 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 perinatalcare.

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 2006.6

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	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	184	73	95	53	176

Denominator	184	73	95	53	176
Data Source		CCID and INMSP	CCID and INMSP	CCID and INMSP	CCID and INMSP
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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	100	100	100	100	100

Notes - 2011
FFY11 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program

Notes - 2010
FFY10 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program. The sharp decrease in the number of cases is due to data being obtained directly from the follow-up program, which interprets a definitive diagnosis differently than in previous years.

Notes - 2009
FFY09 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

a. Last Year's Accomplishments
The FFY11 performance objective of 100 percent was met. Data provided by the Center for Congenital and Inherited Disorders (CCID) and the Iowa Neonatal Metabolic Screening Program (INMSP) indicate that 100 percent of all eligible Iowa newborns that screen positive receive short-term follow-up through to confirmatory diagnosis, and long-term follow-up for clinical case management and treatment.

Infrastructure Building:
A quality improvement program was initiated for the tri-state area -- Iowa, North Dakota, and South Dakota (the University of Iowa State Hygienic Laboratory (SHL) conducts dried blood spot newborn screening for all three states). Monthly teleconferences and webinars are used to discuss QA activities, issues that require review for improvement, performance measures/metrics targets and status, and instruction on use of various QI tools.

The CCID uses proprietary data-matching software to match birth records with screening records. Staff members are able to assure that every child born in Iowa receives the newborn screening, unless the parents have waived the screening.

The CCID is in the last year of a CDC grant aimed at expanding the existing Iowa Registry for Congenital and Inherited Disorders (IRCID) to include confirmed newborn screening cases. Implementation began via case identification by the SHL and Iowa Early Hearing Detection and Intervention (EHDI) programs, Iowa's long-term follow-up programs. A neonatal metabolic screening program regional coordinator was hired to provide coordination, education and quality assurance services to Iowa and North Dakota.

Population-based:

The INMSP is a fee-for-service program that provides laboratory, follow-up, consultative, and educational services. The SHL at the University of Iowa (UI) is responsible for the neonatal metabolic screening testing. UI Newborn Metabolic Screening staff members provide follow-up on positive screens. All newborns are screened for medium chain acyl Co-A dehydrogenase deficiency, phenylketonuria, and other amino acid, organic acid, and fatty acid oxidation disorders detectable by tandem mass spectrometry, as well as hypothyroidism, galactosemia, hemoglobinopathies, congenital adrenal hyperplasia, biotinidase deficiency, and cystic fibrosis.

Enabling:
Regional Genetics Consultation Services (RGCS) is exploring a partnership with the regional Title V Child Health Specialty Clinics (CHSC) to use telehealth services located in the CHSC clinics. Telehealth will be used for genetic consultations and basic exams, in collaboration with the child's medical home provider.

Direct Health Care:
CCID, SHL, families, and expert partners are planning for pilot testing to add critical congenital heart disease, and severe combined immunodeficiency to the state's newborn screening panel.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Explore expansion of service delivery through telehealth		X		
2. Promote development of data integration/linkages with birth certificate, laboratory, healthcare providers, and newborn hearing screening program				X
3. Continue to engage communities and healthcare providers in the planning, implementation and evaluation of newborn screening programs				X
4. Monitor newborn metabolic follow up program for referral patterns and linkages with medical home				X
5. Evaluate conditions for addition to the universal newborn screening panel	X		X	
6. Develop and implement a comprehensive quality improvement program				X
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
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.

The tri-state QI team is continuing its monthly meetings, addressing quality assurance issues, and working on an education plan.

Parent and consumer membership on the Congenital and Inherited Disorders Advisory Committee continues to expand and consumer opinion/feedback is encouraged. The state genetics coordinator is in contact with families and consumers regularly to solicit advice for program planning, implementation and evaluation.

Enabling:

The RGCS is continuing its efforts to provide genetic consultation services via telehealth networks established by CHSC. RGCS is meeting to expand telehealth service delivery through the existing CHSC network.

Direct Health Care and Population-based:
CCID is continuing planning for the implementation of newborn screening for SCID and CCHD. A SCID advisory committee is guiding the planning and implementation efforts, and the SHL is securing equipment and beginning staff training for SCID testing. The CCHC advisory committee for newborn screening was convened, and has developed screening protocols and algorithms. The CCHD advisory committee is working with other states to develop educational materials, and the UI's Department of Pediatrics, Division of Pediatric Cardiology is providing medical expertise.

c. Plan for the Coming Year
Infrastructure Building:
CCID will begin work with all birthing hospitals in the state to encourage newborn screening documentation in electronic health records, in order to improve provider access to information, and results reporting for surveillance activities through the IHIN. The newborn screening programs and SHL will also participate in the IHIN.

The tri-state quality improvement team held a quality summit in spring 2012. This two-day summit convened newborn screening program staff from Iowa, North Dakota, and South Dakota. The aims of the summit were to prioritize activities and establish program metrics, and to plan activities to integrate a culture of quality throughout newborn screening programming. The results of this summit was shared with the regional genetics and newborn screening coordinating center.

The state genetics coordinator will work with the Iowa Department of Public Health (IDPH) wellness and disease prevention programs to link genetics and family health history throughout the life course with wellness and disease prevention efforts.

Direct Health Care/Population-based:
CCID plans to begin implementation of newborn screening for SCID and CCHD. Parents of children with SCID/CCHD will be recruited for CIDAC membership, in addition to the ad hoc advisory committees for SCID and CCHD screening planning.

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:	**38049**					
Reporting Year:	**2011**					
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)	37772	99.3	10	2	2	100.0
Congenital Hypothyroidism (Classical)	37772	99.3	14	1	1	100.0
Galactosemia (Classical)	37772	99.3	1	0	0	
Sickle Cell Disease	37772	99.3	12	6	6	100.0
Biotinidase Deficiency	37772	99.3	26	2	2	100.0
Congenital Adrenal Hyperplasia	37772	99.3	14	1	1	100.0
Cystic Fibrosis	37772	99.3	42	9	9	100.0
Fatty Acid Oxydation Disorders	37772	99.3	52	13	13	100.0
First Trimester Only	337		47	0	0	
Quad Screen	6452		306	0	0	
Integrated Screen	2421		100	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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	62	65.1	66.4	67.7	69.1
Annual Indicator	64.7	64.7	64.7	64.7	75.8
Numerator					
Denominator					
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	76	78	80	82	84

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Annual indicator value is from '05-'06 NS-CSHCN. Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to partner in decision making.

a. Last Year's Accomplishments
The FFY11 performance objective of 69.1 percent was met, however the data is not comparable due to changes in survey design. The indicator value for Iowa was 75.8 percent based on data from the 2009-10 National Children with Special Health Care Needs Survey. The Iowa indicator of 75.8 is statistically better than the national mean of 70.3, though there is significant room for improvement.

Infrastructure Building Services:

One CHSC Family Navigator served on the CHSC Leadership Council, and Family Navigators also serve on multiple state level advisory groups. One Family Navigator served as Iowa's AMCHP Family Delegate and completed the AMCHP Family Leadership Training. CHSC's Director of Public Health served on AMCHP's Family and Youth Leadership Committee. Family leaders implement the quality improvement process for the family support component of State Performance Measure #2.

The F2F IA continued to implement training modules for all Family Navigators to assure competency and consistency of family support throughout the state. CHSC continued to work with a Home Visitor technical assistance mentor to earn the Iowa Family Support Credential, a state-endorsed credentialing process for Iowa's family support programs. CCC Family Navigators and EHDI Guide by Your Side staff increased support services in rural Iowa.

CHSC continued to maintain approval from UI Institutional Review Board (IRB) to implement a family impact survey, to be given to all families receiving family support/care coordination. Family stories are collected to be used for advocacy efforts throughout the year.

Conducted May 2011 F2F IA Conference featuring cultural competency, medical home, health literacy, and youth transitions.

Family Navigators developed the core competency training that is used by all FNs hired by CHSC and many from additional family advocacy groups participating in F2F IA.

CHSC developed protocols for Family Navigators to enter family support data into the electronic medical record. CHSC established quarterly chart review protocols to monitor quality of selected elements of family support.

Enabling and Direct Care Services:

CHSC's vision identifies family support and care coordination as two components of Iowa's system of care for CYSHCN. CHSC maintained paid Family Navigators to work in CHSC regional clinics and with primary care providers in local communities. Created personnel guidelines for all CHSC Regional Center Family Navigators.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC will continue to implement Family to Family Iowa through May 31, 2012 and will mentor new F2F HIC grant recipient.				X
2. CHSC will continue to receive clinical assistance to fulfill the requirements to become a credentialed agency under the Iowa Family Support Standards.				X
3. CHSC will continue to subcontract with the Iowa Department of Human Services through September 30, 2012 to implement care coordination and other components of the Iowa's Family 360 grant (awarded from US Dept of HHS-ACF).		X		
4. Family Navigators will receive ongoing training to fulfill specific care coordination and family support functions within CHSC's system of care for children and youth with special health care needs.				X
5. Family support in CHSC will continue to maintain a roster of Family Navigators working in several program areas.		X		
6. Family Navigators will receive ongoing training regarding cultural competence and health literacy.				X
7. Family Impact data will be collected for CHSC care coordinators by Family Navigators to assure continuous quality improvement.				X
8. Family leaders will develop new web-based trainings for sharing among F2F Iowa, as training needs are identified.				X
9. CHSC will implement Community Child Health Teams in pilot sites through a HRSA System of Care/Evidence Based Models grant demonstrating important role of family support within medical homes and prepare for statewide replication.				X
10.				

b. Current Activities
Infrastructure Building Services:

CHSC's Family Navigators participate at all levels of the MCH pyramid and on state, local and federal committees.

One Family Navigator is completing the AMCHP Family Scholar Training and attended AMCHP.

CCC Family Navigators conduct parent support groups.

CHSC will implement Community Child Health Teams in two pilot sites through a HRSA System of Care/Evidence Based Models grant modeling important role of family support within medical homes.

CHSC assures standard skills and competencies of Family Navigators and is pursuing the Iowa Family Support Credential process. CHSC is collecting family impact data for continuous quality improvement.

CHSC is implementing the activities in the Heartland Genetics grant to connect families with children and youth with inheritable disorders to information and peer-to-peer support using social media.

Enabling and Direct Care Services:

Family Navigators are paid staff and receive ongoing training. CHSC trains 15 additional Family Navigators from F2F Iowa each year.

CHSC serves on the Iowa Health Literacy Board and ensures CHSC formats that meet health literacy and cultural needs of families.

Caregivers of children with hearing loss participate in the EHDI Systems of Care's Medical Home Implementation Team.

CHSC conducted the third annual F2F IA Conference on April 22-23, 2012.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC will continue to support and expand CHSC's family participation across all levels of the MCH pyramid. The CHSC community-based Family Navigators will continue to serve on multiple state level advisory groups..

CHSC will apply to have additional Family Navigators participate in the AMCHP Family Scholar and Family Mentor Programs. CHSC family scholars will collaborate with scholars from other states to share best practices.

CHSC and Iowa Department of Public Health Title V will discuss ways to utilize Family Navigators to advise regarding components of MCH in addition to those for cyshcn.

CHSC will mentor the new recipient of the F2F IA Health Information Center federal funds. CHSC will continue to subcontract with the Iowa Department of Human Services to implement components of Iowa's Family 360 grant through September 30, 2012.

CHSC will increase its collection of family stories for use in program marketing and stakeholder education. CHSC will link to the F2F IA website to promote easier access to peer-to-peer support and web-based resources.

CHSC will complete the application process to the Iowa Family Support Credential process for Family Navigators to achieve credentialing.

CHSC will analyze family impact data for continuous quality improvement of the Family Navigator Network.

CHSC will serve on social media committees of AMCHP, the Iowa Department of Public Health, and the University of Iowa to learn how to maximize use of social media with families. Data collected in FY 2012 regarding family satisfaction with social media will be analyzed to determine future communication mechanisms with families.

CHSC will implement Community Child Health Teams in two remaining sites (Federally Qualified Health Centers) through a HRSA System of Care/Evidence Based Models grant modeling important role of family support within medical homes.

Enabling and Direct Care Services:

CHSC will continue to employ Family Navigators working in several program areas. Family navigators will continue to receive ongoing training to fulfill specific care coordination and family support functions within CHSC's system of care for CYSHCN. A minimum of 15 additional family support workers from Iowa's family support groups will be trained in Family 360 Navigator skills and deliver family navigation services.

CHSC staff members will serve on the Iowa Health Literacy Board and ensure CHSC staff are using formats for care coordination and clinical services that meet the health literacy and cultural needs of families served.

Caregivers of children with hearing loss will continue to participate in the EHDI Systems of Care's Medical Home Implementation Team to assure primary care practices recognize the important role families play in their child's care plan and ongoing follow-up.

CHSC will co-plan a fourth annual F2F IA Conference, in collaboration with the new recipient of F2F HIC funds.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	63	60.3	61.5	62.7	64
Annual Indicator	57.4	57.4	57.4	57.4	47
Numerator					
Denominator					
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	47	49	50	52	54

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the medical home model.

a. Last Year's Accomplishments
The FFY11 performance objective of 64 percent was not met. The indicator value for Iowa was 47 percent based on data from the 2009-10 National Children with Special Health Care Needs Survey. The indicator ranks Iowa statistically better than the national mean of 43.0, but leaves room for significant improvement.

Infrastructure Building Services:

The Pediatric Clinical Consultant oversaw all aspects of CHSC's clinical care and serves on the Iowa Medical Home Advisory Council. CHSC's Clinical Care Division conducted quality improvement activities to monitor that CYSHCN seen in CHSC Regional Centers are appropriately referred back to their primary care physicians.

CHSC provided leadership to implement Partnership to Improve Child Health in Iowa (PI-CHI) in collaboration with the Iowa American Academy of Pediatrics (IA-AAP) to improve child health outcomes. PI-CHI collaborates with Project LAUNCH to improve quality.

CHSC coordinated efforts with PI-CHI for Iowa to be recognized as a National Improvement Partnership Network (NIPN) state. CHSC conducted a project using funds from the American Recovery and Reinvestment Act in cooperation with PI-CHI, to assure Neonatal Intensive Care Unit graduates receive high quality care within medical homes and neighborhoods.

CHSC implemented the electronic medical record system, EPIC, including a care coordination module.

The SAMHSA supported System of Care for youth with SED kept youth connected to their medical home with care coordination and support services.

EHDI staff met with primary care practices to share information regarding the importance of family support to families of children with hearing loss.

CHSC became a state affiliate agency for Help Me Grow (HMG) and organized a State Advisory Council that identified central point of contact as a key focus area for Year 1 activities of HMG. CHSC Pediatric Clinical Consultant was also the consultant for a related IDPH project, 1st Five Healthy Mental Development. In this capacity she encouraged PCPs to inquire about social determinants of health and adverse childhood experiences and encourages the use of standardized developmental screening tools with health maintenance visits.

CHSC Quality Improvement Advisors, in partnership with the IA-AAP PI-CHI, developed a

Maintenance of Certification (MOC) application to the American Board of Pediatrics. The application was successful and will implement the project "Ensuring followup for children at risk for delayed onset or progressive hearing loss." The project will work with PCPs to assure all children ages 0-30 months that passed their Newborn Hearing Screening and have risk factors for delayed onset or progressive hearing loss receive followup that is consistent with the Joint Committee on Infant Hearing recommendations.

CHSC applied for and received an "Innovative Evidence Based Models for Improving System Services for CYSHCN" grant from HRSA. The 3-year project will implement community child health teams within medical home settings serving youth with serious emotional, mental health, and behavioral health needs, including Blank Children's Hospital, University of Iowa Children's Hospital, and two federally qualified health centers (FQHCs) in rural areas of the state.

Enabling and Direct Care Services:

CHSC staff members provided care coordination activities for CYSHCN in partnerships with primary care providers using a community utility model.

CHSC Care Coordination work group and Family Support work groups focus on continuous quality improvement on ways to partner with PCPs for improved support for all families, including those not seen by CHSC direct clinical services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC maintains a 0.6 FTE Pediatric Clinical Consultant position to facilitate and oversee CHSC Clinical Services and develop standards for all aspects of CHSC's clinical care.				X
2. CHSC is implementing a vision statement to assure a system of care for CYSHCN. The systems contains two key components of a medical home: care coordination and family support. Quality improvement occurs re implementation.				X
3. CHSC maintains a care coordination workgroup to develop, implement and evaluate standardized procedures for the delivery of care coordination to CYSHCN within medical homes.				X
4. CHSC continues to 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.				X
5. CHSC is initiating a Maintenance of Certification project with the American Board of Pediatrics to assure children at risk for late onset hearing loss receive appropriate follow-up care within medical homes and neighborhoods.				X
6. CHSC will implement Community Child Health Teams in pilot sites through a HRSA System of Care/Evidence Based Models grant demonstrating important role of family support within medical homes and prepare for statewide replication.				X
7. CHSC is collaborating with IA-AAP to conduct a Maintenance of Certification (MOC) project for PCPs with the American Board of Pediatrics to assure children identified with risk for late onset hearing loss are appropriately followed within medical hom				X
8.				

9.				
10.				

b. Current Activities
Infrastructure Building Services:

CHSC is analyzing data from the 2010 Iowa Household Health Survey and 2010 National CYSHCN surveys re medical home.

CHSC partners with IA-AAP to conduct EHDI Chapter Education and Training grant to improve EHDI System of Care.

CHSC is building relationships with FQHCs to emphasize care coordination and family support.

The SAMHSA supported System of Care for youth with SED continues to link youth to a local medical home, coordinated care and support services.

Iowa is an affiliate of Help Me Grow, identifying ways to improve interface of early identification with medical homes.

CHSC is employing EHDI MOC project re late onset hearing loss.

CHSC continues to participate in National Improvement Partnership network.

Enabling and Direct Care Services:

CHSC provides care coordination for CYSHCN, partnering with primary care and community health providers.

An internal CHSC workgroup is identifying ways to serve children and youth who are overweight, partnering with medical homes. An AmeriCorps member is completing a 1 year term of service regarding this effort.

A CHSC workgroup is piloting activities to assure children exposed to abuse receive appropriate evaluations and services.

CHSC serves on Children's Mental Health and Disability System Redesign subcommittee, Iowa Medical Home - Prevention and Chronic Care Management Advisory Council.

CHSC is executing a HRSA-funded grant to deploy community child health teams in 2 tertiary children's hospitals and 2 FQHCs

c. Plan for the Coming Year
Infrastructure Building Services:

CHSC will 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 data obtained from the 2010 Iowa Household Health Survey and the 2010 National CYSHCN surveys to guide quality improvement efforts regarding medical homes for CYSHCN in Iowa.

CHSC will continue to 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 review web-based learning opportunities from the MCH Navigator to educate staff regarding concepts of social determinants of health.

The SAMHSA supported System of Care for youth with SED will seek alternate funding opportunities so it can continue to connect youth to their local medical home with care coordination and support services.

Iowa will continue to participate as a state affiliate of Help Me Grow to apply lessons learned from the national network to Iowa practices regarding intake care coordination, long-term follow-up care coordination, and the interface of both types of care coordination with medical homes.

Enabling and Direct Care Services:

CHSC Family Navigators, staff nurses, dietitians, social workers and Advanced Registered Nurse Practitioners will provide care coordination for CYSHCN in partnership with primary care and neighborhood health providers.

A CHSC work group will implement a pilot in selected CHSC regional centers to assure children exposed to child abuse receive appropriate and timely evaluations and timely services.

CHSC Leadership will participate on Children's Mental Health and Disability System Redesign subcommittee.

CHSC will implement a HRSA-funded grant to implement community child health teams in two tertiary children's hospitals in Iowa and two FQHCs.

CHSC will explore potential expansion of telehealth consults to PCPs regarding additional topics for children with special health care needs, to increase PCP ability to serve children with chronic conditions.

CHSC care coordinators, Family Navigators, and Registered Dietitians will partner with PCPs to direct families to information and resources for children who are overweight or obese.

Iowa Medicaid initiated its Health Home project through a State Plan Amendment on July 1. It is anticipated that an increased number of children and adults with certain chronic conditions will be enrolled in health homes. Over time this measure should show that more individuals will be receiving care in a medical home.

Results from various 2010 Iowa Child and Household Health Survey reports revealed disparities for children with components of medical home, affecting CYSHCN and children with low incomes. CHSC will further analyze the data for future program planning.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	74.7	72	73.4	74.9	76.4
Annual Indicator	68.6	68.6	68.6	68.6	64.6
Numerator					
Denominator					

Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	66.6	68.6	70.6	72.6	74.6

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the families ability to have adequate public and/or public insurance.

a. Last Year's Accomplishments
The FFY11 performance objective of 76.4 percent was not met. The indicator value for Iowa was 64.6 percent based on data from the 2009-10 National Children with Special Health Care Needs Survey. The indicator is higher than the national mean of 60.6, though there is still room for significant improvement.

Infrastructure Building Services:

CHSC participated on the IAPCA Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans. CHSC was represented on Iowa's ECI Stakeholders Alliance, which contains strategic goals to assure adequate health and dental insurance coverage.

CHSC's care coordination work group began collecting data that may be used for discussions with Iowa Medicaid to illustrate the benefits of care coordination to CYSHCN and advocate for

Medicaid policy that reimburses for care coordination. A CHSC Family Navigator served on a Governor-appointed Medicaid Advisory Committee.

CHSC collected data on the appropriate use of billing codes.

Enabling and Direct Care Services:

CHSC regional centers worked with families of CYSHCN to apply for Medicaid or SCHIP. CHSC's Health & Disease Management unit provided guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing. CHSC conducted quality improvement measures to assure billing codes were maximized for all services delivered.

Family Navigators worked with children with autism spectrum disorder to collect data on a NIH-research grant that seeks to demonstrate the benefits of Applied Behavioral Analysis, for potential future use to educate private and public insurers for potential policy changes.

CHSC reviewed white paper from Child and Family Policy Center, Des Moines (contracted in 2010-11 by CHSC using funds from the American Reinvestment and Recovery Act) regarding social determinants of health in Iowa and implications for the system of care, including public and private payors.

CHSC contracted with Magellan Behavioral Health for Family Navigators from Community Circle of Care to provide family support services to families of children and youth with severe emotional disabilities. Data from the pilot will be analyzed for potential payment reform.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CHSC participates on the Iowa-Nebraska Primary Care Association Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.				X
2. CHSC's care coordination work group is collecting data that will be used for discussions with Iowa Medicaid to illustrate the benefits of care coordination to CYSHCN, to advocate for Medicaid policy that reimburses for care coordination.				X
3. CHSC regional centers work with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process.		X		
4. Family Navigators are working with children with autism spectrum disorder to collection data on a research grant that seeks to demonstrate the benefits of Applied Behavioral Analysis.	X			
5. The Family to Family Iowa network of Family Navigators includes the topic of resources for public/private insurance in its training modules for all Navigators.				X
6. CHSC is conducting quality improvement measures to assure billing codes continue to be maximized for all services delivered.				X
7. CHSC is participating in learning events and discussions regarding the impact of the Affordable Care Act on benefits to cyshcn.				X
8.				

9.				
10.				

b. Current Activities
Infrastructure Building Services:

CHSC is analyzing data from the Iowa 2010 Iowa Child and Family Household Health Survey and NSCYSHCN 2009-10 re financing issues. CHSC care coordination work group is gathering data to present to Medicaid to advocate for payment for care coordination activities and maintains collection of family stories to educate policymakers on the importance of adequate insurance coverage for CYSHCN and their families.

CHSC is represented on the IAPCA Committees to assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

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

CSHC is participating in learning events regarding the impact of the Affordable Care Act.

Enabling and Direct Care Services:

CHSC assists and enables families of CYSHCN to apply for Medicaid or SCHIP. CHSC provides guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing.

CHSC Family Navigators work with children with autism spectrum disorder to collect data for a NIH-research grant that demonstrates the benefits of Applied Behavioral Analysis (ABA). Data will educate payors for potential policy changes regarding reimbursement for ABA. CHSC is participating in Phase II of the research that will deliver the services inside the family's home.

c. Plan for the Coming Year
CHSC will develop quality improvement activities based on analysis of data from the Iowa 2010 Iowa Child and Family Household Health Survey and NSCYSHCN 2009-10 re financing issues. CHSC care coordination work group will continue to gathering data to present to Medicaid to advocate for payment for care coordination activities.

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

CHSC will continue to be represented on the IAPCA Committees to assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

A Family Navigator will continue to participate on a Governor-appointed statewide Medicaid Advisory Committee.

CSHC is participating in learning events regarding the impact of the Affordable Care Act and will mobilize staff as needed to respond to results of analysis during all phases of implementation.

Enabling and Direct Care Services:

CHSC will continue to assist and enable families of CYSHCN to apply for Medicaid or SCHIP, or new options under the Affordable Care Act. CHSC will provide guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care

financing.

CHSC Family Navigators will assist families to install computer equipment in their homes so families can participate in Phase II of a NIH-research grant that demonstrates the benefits of Applied Behavioral Analysis (ABA). Data will educate payors for potential policy changes regarding reimbursement for ABA.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	86	93.8	94.7	95.6	96.6
Annual Indicator	92.9	92.9	92.9	92.9	68
Numerator					
Denominator					
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70	72	74	76	78

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.

Notes - 2010
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and

the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve community-based service systems.

a. Last Year's Accomplishments
The FFY11 performance objective of 96.6 percent was not met and it should be noted that the surveys are not comperable due to changes to survey design. The indicator value for Iowa was 68 percent based on data from the 2009-10 National Children with Special Health Care Needs Survey. The Iowa indicator of 68.0 is higher than the the national mean of 65.1, but there is still room for significant improvement.

Infrastructure Building Services:

Iowa EHDI System of Care expanded lessons learned from a 2010 a NICHQ project focused on improving the service system for parents to more easily access services. CHSC participated in the National Improvement Partnership Network to identify and integrate new quality improvement strategies in its programs and services.

CHSC staff participated in a SAMHSA-supported System of Care system improvement effort to develop a coordinated, family-driven system of care for children with SED. The F2F IA Network provided advice to medical homes regarding the importance of family support services and approaches to organizing services. Through Heartland Genetics project, CHSC worked with families of selected genetics conditions to promote use of social media, including with minority populations, to access resources and communicate with care providers.

CHSC researched social determinants of health and environmental toxins and their potential impact on the needs of Iowa's families, with emphasis on children ages 0-3 years. Iowa Household Health Survey results were produced for analysis with emphasis on ages 0-3 years.

CHSC improved the care coordination portion of the electronic medical record and worked with University of Iowa Hospitals and Clinics to roll out MyChart to families served so families could feel empowered to obtain their own patient information.

Applied for HRSA-funded Innovative Models for a System of Care grant that would fund implementation of community health teams providing families access to family support and care coordination.

CHSC developed a Family Satisfaction Survey and attained Institutional Review Board approval.

Enabling and Direct Care Services:

CHSC Family Navigators and Care Coordinators helped families of children with complex health care needs enroll in Medicaid Waiver and EPSDT Programs and taught them skills to locate services they need.

Telemedicine consultations provided access to selected direct services (i.e. child psychiatry, nutrition, and Applied Behavioral Analysis for ASD). Surveyed EA providers regarding how to improve telehealth nutrition services.

Through Help Me Grow, CHSC led efforts to identify single point of entry resources for children at risk.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC is communicating with primary care practices regarding the importance of family support and care coordination to ultimately improve health outcomes and systems outcomes.				X
2. CHSC continues to play a major role in a SAMHSA-supported System of Care project to improve access, delivery, and coordination of mental health services for children with severe emotional disorders and will explore ways to continue and/or spread les				X
3. CHSC continues to use telehealth technology to improve families' access to clinical services, especially for children with behavioral problems and nutrition consultation.	X			
4. The CHSC Health and Disease Management Unit continues to provide care coordination to children with complex health care needs enrolled in Medicaid Waiver and EPSDT Programs under a contract with the Iowa Department of Human Services.		X		
5. CHSC workgroups implement the four components of its system of care: gap-filling direct clinical, care coordination, family support and infrastructure building and initiated quality improvement efforts.				X
6. The Iowa EHDI System of Care continues to spread lessons learned from its participation in a National Improvement in Child Health Quality (NICHQ) project that improved the quality of care elements of the service system in AEA 12.				X
7. CHSC collects family impact data to use for continuous quality improvement.				X
8. Through Heartland Genetics project, CHSC worked with families of selected genetics conditions to provide family support through social media, including with minority populations.				X
9. CHSC partners with primary care physicians to serve families of children and youth who are overweight or obese.				X
10. CHSC participates in PrepKids Emergency Preparedness project to assure families have knowledge to attain services they need even in times of emergency.				X

b. Current Activities
Infrastructure Building Services:

CHSC staff use health literacy and cultural competence standards to review program elements. CHSC educates policymakers regarding needs of families.

CHSC implements quality improvement efforts to actualize the vision statement "Assure a system of care for CYSHCN," Special emphasis is placed on meeting the needs of the family over the child's life course.

Pilot projects are occurring with child abuse agencies to utilize CHSC ARNPs for selected elements of evaluation for children suspected of being abused.

CHSC maintains F2F HIC website with family resources. CHSC Latino liaison advised CHSC prior to June 2012 resignation.

CHSC maintains the Child and Youth Psychiatric Consult Project of Iowa (CYC-I), to provide consultative and supportive services for primary care providers caring for children and youth with mental and behavioral health needs.

CHSC participates in Emergency Preparedness project (PrepKids)) to assure families will cope in times of emergency. CHSC is using AMCHP Learn the Signs Act Early funding to increase awareness of autism resources.

Enabling and Direct Care Services:

CHSC provides family support, care coordination, and telemedicine and is conducting critical health reviews for children served by Part C, IDEA so families/providers understand implications of health condition for early intervention activities. Children overweight or obese will be additional focus area.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC will continue to implements quality improvement efforts to actualize the vision statement "Assure a system of care for CYSHCN," Emphasis is placed on meeting the needs of the family over the child's life course. Through the National Improvement Partnership Network, CHSC will improve partnerships between pediatricians and subspecialty providers.

Pilot projects will occur with child abuse agencies to utilize CHSC ARNPs for some elements of evaluation for children suspected of child abuse.

CHSC will collaborate to maintain and link to web-based resources via F2F HIC so families and providers can access them easily, including implementation of social media when appropriate.

CHSC will continue to provide otoacoustic emission screening of newborns at two CHSC regional centers to ensure access and to offer ABR telehealth evaluation services at one site.

CHSC will continue to be a state affiliate of Help Me Grow.

CHSC will continue to collaborate with the Community Circle of Care and the University of Iowa Child Psychology Department to maintain the Child and Youth Psychiatric Consult Project of Iowa (CYC-I) and to seek alternate funding when SAMHSA funds end.

CHSC will participate in Pre-Kids Emergency Preparedness project) to assure families have knowledge to attain services they need even in times of an emergency

CHSC will finalize activities for one-year AMCHP Learn the Signs Act Early funding to increase provider knowledge of autism resources they can share with families.

Enabling and Direct Care Services:

The CHSC Health and Disease Management Unit will continue to provide care coordination to children with complex health needs enrolled in Medicaid Waiver and EPSDT. CHSC Family Navigators will function as service coordinators for young children in Iowa's Early ACCESS

program. F2F IA Family Navigators will provide family support, and receive training regarding new standards and procedures for delivering care coordination and family support.

Telemedicine services will be provided for Serious Emotional Disturbances, nutrition consultation, and ABRs. Services to children who are overweight or obese will be piloted.

CHSC RN's will spread ability to conduct critical health reviews for children served by Part C, IDEA so families/providers understand implications of health condition for early intervention activities.

EHDI staff will evaluate remote ABR evaluations for children suspected of having a hearing loss and will relocate equipment if analysis indicates less than optimal usage.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	7.7	49.7	50.7	51.7	52.7
Annual Indicator	47.3	47.3	47.3	47.3	45
Numerator					
Denominator					
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	45	47	49	51	53

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.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009
Annual indicator value is from the '05-'06 NS-CSHCN.

Although the data source for this NPM (National Survey for CSHCN) is only repeated every five years, we feel responsible to raise the annual target objective by a modest percentage as motivation to remain involved in system development efforts designed to improve the transition services.

a. Last Year's Accomplishments
The FFY11 performance objective of 52.7 percent was not met. The indicator value for Iowa was 45 percent based on data from the 2009-10 National Children with Special Health Care Needs Survey. The Iowa indicator of 45.0 is statistically higher than the national indicator of 40.0, though still leaves significant room for improvement.

Infrastructure Building Services:

CHSC's Pediatric Clinical Consultant served as the Director of Adolescent Medicine Program at the University of Iowa's Department of Pediatrics. CHSC staff coordinated youth feedback to the F2F IA Governance Council and the Iowa Autism Council. CHSC co-led a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.

Youth Transition was a key topic at the F2F IA conference in May 2011.

Enabling and Direct Care Services:

CHSC's Health and Disease Management (HDM) Unit continued to assist families with eligible adolescents to enroll in Medicaid Waiver programs. CHSC developed a tool to guide Health and Disease Management staff when discussing transition issues with families with a child eligible for Medicaid waiver programs, beginning by age 14. The tool targets program information to a youth's age and provides tasks that teens can do to begin taking responsibility for their own health care. The Family 360 Navigator/care coordinator training included topics relevant to youth and life course development

CHSC obtained a HRSA-funded grant to implement Community Child Health Team in four sites throughout Iowa between March 2012 and August 2015. Emphasis is on youth with behavioral and mental health needs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC's Pediatric Clinical Consultant is the Director of Adolescent Medicine Program at the University of Iowa Department of Pediatrics, and CHSC will capitalize on her expertise to infuse needs of adolescents into its programs and services.				X
2. Youth will continue to advise the F2F IA Governance Council and the Iowa Autism Council.				X

3. CHSC will spread lessons learned from SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.				X
4. CHSC's Health and Disease Management Unit will continue to assist families with eligible adolescents to enroll in Medicaid Waiver programs and, when relevant, to address transition issues, e.g. linking adolescents to Vocational Rehabilitation service		X		
5. Training for CHSC employees, Family Navigators and other applicable UI Health Care staff will include topics relevant to youth transition and life course development.				X
6. Protocols for direct clinical care, care coordination, and family support will include processes to address the needs of youth who are transitioning to adult services (on or before age 14).		X		
7. UI Health Care transition workgroup will develop policies on several transition issues.				X
8. Community Child Health Team (HRSA grant) for youth with behavioral, emotional and mental health concerns emphasizes the need for transition planning among this population. Family Navigator will address these issues with participating families.				X
9. CHSC staff member is enrolled in a Education-Health Care Transition Certificate program through the University of Florida to advance knowledge throughout the program regarding transition services.				X
10.				

b. Current Activities
Infrastructure Building Services:

CHSC's Pediatric Clinical Consultant is leading efforts to assure standards of care for CHSC Clinical Services, including transition to adult care. She will educate UI Health Care Staff regarding the needs of transitioning CYSHCN. CHSC formed a workgroup to align efforts of state health organizations.

Standardized care coordination at CHSC and Family 360/F2F IA Navigators address youths' needs using Life Course Health Development theory. Youth advise F2F IA Governance Council and Iowa Autism Council. F2F IA provides web-based transition resources.

CHSC works with the National Health Care Transition Center (NHCTC), providing an idea exchange and technical assistance. The NHCTC works with CHSC to promote policy changes enhancing access to transition services, such as improved reimbursement for providers.

CHSC co-leads a SAMHSA-supported mental health System of Care project to aid transition to adulthood, providing care coordination and building support services. ELEVATE is a support group for foster and adoptive youth wanting to connect with others and share personal stories.

CHSC works with PI-CHI to explore quality improvement projects on transition for CYSHCN. PI-CHI leaders interface with the CCHT HRSA-funded grant.

Direct and Enabling Services:

CHSC's HDM Unit helps families with eligible adolescents to enroll in Medicaid Waiver programs and address transition issues of those over age 12. All care coordinators use the age-based discussion guide.

c. Plan for the Coming Year
CHSC will facilitate UI Health Care Transition workgroup to develop a comprehensive health care transition program for CYSHCN, beginning by age 14. Workgroup will also raise awareness of transition issues among adult health care providers.

Conduct focus groups with youth, providers, and parents on transitioning to adult care.

CHSC will develop policies on transition issues, such as when transition begins and ends, when a youth is seen without a parent, assessing youth intellectual age and addressing needs of those with severe intellectual disabilities, and legal consent if parent has guardianship.

Coordinate the training of CHSC employees, Family Navigators, and other applicable UI Health Care staff on transition issues.

CHSC will coordinate development of an interactive and web-based transition program that encourages youth to begin building skills for transition in early adolescence. The initial pilot program will include CYSHCN ages 12-21 served by CHSC, University of Iowa Children's Hospital, and those on the Health and Disease Management Waiver program. Project staff will use existing materials from other states and develop Iowa-specific resources when necessary. Youth and families may connect with their care coordination team and other supportive individuals (as desired by the youth), use audiobooks and videos to learn transition skills, and access tools to identify needs and help them be successful. A care coordinator will work with families to create a post-transition plan addressing areas that require assistance. CHSC will take measures to assure families without in-home internet access receive transition planning services.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	95	90	74	73	74
Annual Indicator	88.4	72.8	72.8	73.9	63.9
Numerator	5116	3930	3930	15890	17511
Denominator	5786	5395	5395	21501	27402
Data Source		PSIA report	PSIA 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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	65	68	71	74	77

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

Notes - 2010
Data was obtained from the 2010 Immunization Program Annual Report, which includes county-wide immunization rates for 2010.

Notes - 2009
Iowa is reporting 2008 data from the PSIA report for 2009 due to lack of data. Iowa is exploring the implementation of a county level survey for immunization status data.

a. Last Year's Accomplishments
The FFY11 performance objective of 74 percent was not met. Data from the 2011 Immunization Program Annual Report indicate that 63.9 percent of 19-35 month olds received the full schedule of age appropriate immunizations. As Iowa continues to add providers and children into IRIS, education with providers is needed to increase provider awareness on the importance of the full schedule of age-appropriate immunizations.

Infrastructure Building:
IDPH hosted a statewide immunization conference for over 800 participants. The conference focused on current immunization information and vaccine education for health care providers.

The Immunization Program received an American Recovery and Reinvestment Act (ARRA) grant for innovative projects to improve reimbursement in public health department clinics. The program contracted with HS Medical Billing to develop a billing system for local public health agencies (LPHAs) to save program revenue, reach additional populations, provide vaccines not currently offered and to take on new immunization initiatives to reach special under-vaccinated populations with reduced access to vaccination services. The Immunization Program and HS Medical Billing held four comprehensive billing training programs attended by 149 representatives of LPHAs. Seventy-seven of Iowa's 99 counties were represented at the meetings.

The Immunization Program contracted with ZLRIGNITON, a marketing communication firm based in Des Moines, Iowa to develop "The Flu Ends With U" mass media social marketing campaign.

In 2011, the Immunization Program developed and published an Annual Report which included a report for childcare/school audits, county immunization rates for 2-year olds and adolescents, and a summary of the different components of the Immunization Program.

IDPH established a contract with Hewlett Packard (HP) to upgrade Iowa's immunization registry (IRIS).

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Recruit new private practice physicians to use the IRIS data system.				X
2. Provide immunization training and in services for VFC providers.				X
3. Continue to provide technical assistance to local maternal and child health, WIC, and public health agencies.				X
4. Collaborate with the Dept of Education on data exchanges to assure complete immunization records.				X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
IRIS staff are working to increase the number of private providers using IRIS through a variety of outreach mechanisms. The new version of IRIS was rolled out the first week of June. The new IRIS system includes an Immunization Billing Program. The upgrade also interfaces with the vital statistics database and includes the ability to link with electronic medical records.

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

c. Plan for the Coming Year
Infrastructure Building:
The IDPH Immunization Program will continue to work with primary care providers and other public health providers on technical assistance or data needs related to the new version of IRIS. Staff members are also participating in the CDC bar-coding pilot project for IRIS.

Through funding from the CDC, Immunization Program staff are developing policies that will allow an exchange between IRIS and electronic medical records.

IDPH will provide immunization education to Vaccine for Children Providers through 11 different regional trainings.

Enabling and Direct Health Care:
All local CH contract agencies developed action plans related to immunizations. Agencies' activities include providing gap-filling direct care services, partnering with WIC, child care and other community partners, providing care coordination, addressing vulnerable populations, and implementing quality improvement strategies.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	16	15	16	15.2	16
Annual Indicator	15.6	16.8	15.7	13.3	11.9
Numerator	973	1025	945	804	707
Denominator	62364	61192	60016	60327	59558
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11.2	11	10.8	10.5	10.2

Notes - 2011
FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010
FFY10 data were obtained from 2010 Vital Statistics data.

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics provisional data.

a. Last Year's Accomplishments
The FFY11 performance objective of 16 was met. 2011 provisional vital statistics data indicates that the rate of birth (per 1,000) for teenagers ages 15 through 17 years was 11.7.

Infrastructure Building:
The overall family planning objectives remained focused on improving the quality and quantity of services to Iowa's three priority populations (minorities, adolescents and males), increasing the number of pregnancies in Iowa that are intended, promoting long acting reversible contraceptive use, and developing sustainable IDPH family planning clinics positioned to serve an increased number of clients.

IDPH family planning (FP) programs ensured 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. Programs investigated ways to expand access to a broad range of family planning methods and related preventive health services.

Enabling Services:
Local agencies continued to emphasize the importance of counseling FP clients on establishing a reproductive life plan (RLP). They encourage participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services. They also provided counseling to minors on how to resist attempts to coerce them into engaging in sexual activities.

Family planning agencies addressed comprehensive FP and other health needs of individuals, families, and communities. They accomplished this through outreach to hard-to-reach and/or vulnerable populations and partnerships with other community-based health and social service providers.

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. Addressing the comprehensive family planning and other health needs of individuals, families, and communities through outreach to hard-to-reach and vulnerable populations, and partnering with other community-based health and social service programs	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building:

Iowa awarded the Personal Responsibility Education Program (PREP) funding to 4 local agencies. The selected agencies will implement 2 evidence-based curricula to teens ages 10-19 in 5 high-risk counties. The goal of PREP is to reduce teen pregnancy, reduce the prevalence of HIV/AIDS, including STIs, and preparing them for a successful future.

Iowa was also awarded the Abstinence Education funding and is working to develop a contract with YSS 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 Care:

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 will initiate efforts to ensure that all clients, including adolescents and males, are counseled about establishing an RLP to set goals about having children. In the upcoming year, the concept of RLPs will be expanded to WIC and MH client

c. Plan for the Coming Year

Infrastructure Building:

IDPH will ensure training is provided to any agencies that are successfully awarded funding through the second PREP RFP. Local PREP agencies will carry out Year 2 implementation and evaluation will be conducted. IDPH will provide ongoing training and technical assistance to local PREP agencies throughout this period to ensure program fidelity. Iowa will continue to maintain and develop the marketing campaign for PREP. Outreach to other state agencies and local

organizations will be carried out so as to gather resources to complement the program and create sustainability.

IDPH will ensure training and technical assistance is also provided to community agencies implementing the TOP program through the Abstinence Education Funding. The PREP and Abstinence Education program coordinators will be developing a Teen website and working with adolescents on design and content.

Enabling and Direct Care:
IDPH will implement its objectives for Year 4 of the five-year Title X plan, including expanding services to minorities, adolescents, and males. Minorities and adolescents are disproportionately affected by reproductive health issues and the role of males in family planning remains underestimated.

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.

Title X clinics will initiate efforts to ensure that all clients, including adolescents and males, are counseled about the importance of establishing an RLP to set personal goals about having (or not having) children. The RLP will also describe plans to achieve those goals. In the upcoming year, the concept of RLP will be expanded to WIC and MH clinic clients. Provider coding initiatives began and will continue in 2012 to promote clinic sustainability, especially in light of the ACA.

Five MCH contract agencies have action plans to address teenage pregnancy. Activities include building or participating in local pregnancy prevention coalitions and partnering with schools to present pregnancy. Local staff will work with middle and high school staff, faith based, teen groups, and medical providers to educate individuals on teenage pregnancy prevention strategies.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	45	47	50	50	50
Annual Indicator	44.5	49.2	48.5	49.7	45.6
Numerator	15446	17336	16962	17381	16111
Denominator	34709	35235	34972	34950	35332
Data Source		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?				Provisional	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	47	48	49	50	51

Notes - 2011
The data was collected through the OH survey of third graders in 2012.

Notes - 2010
Based upon the results of the 2009 3rd grade survey conducted by OHB, a data consultant for Iowa's Title V application used a forecast formula to estimate the sealant rate for 2010.

Notes - 2009
Based upon the results of the 2009 3rd grade survey conducted by OHB, a data consultant for Iowa's Title V application used a forecast formula to estimate the sealant rate this year.

a. Last Year's Accomplishments
The FFY11 performance objective of 50 percent was not met. Data from the 2012 third grade sealant survey indicate that 45.6 percent of third grade children have received protective sealants on at least one permanent molar tooth. Because schools that currently have a school-based sealant program were excluded from the survey, the state average may actually be higher than the survey results indicate.

Infrastructure Building:
IDPH met with Delta Dental of Iowa to discuss potential collaborations to expand the current school-based sealant program in Iowa. IDPH has been unable to expand the Oral Health Center's (OHC) sealant program due to state budget cuts and lack of other funds to pay for additional program expenses. Delta is considering how its Foundation may be able to play a role in purchasing equipment and supplies.

The OHC completed improvements to Child and Adolescent Reporting System (CAReS) that provide local agencies methods to evaluate the oral health status and accessibility of preventive care for children. Agency staff members are now able to generate reports, helping them assess their population, determine program effectiveness, and assist in planning future services and projects. I-Smile™ Coordinators continue to promote prevention via community-based activities, along with media and radio public service announcements (PSAs).

Population-based:
In addition to the seven IDPH-funded school-based sealant programs, I-Smile™ Coordinators in nine other agencies coordinated or assisted with programs in their service areas. For the IDPH-funded programs, the rate of free/reduced lunch participation for targeted schools was increased to 40 percent this year, in order to target higher-risk children for dental disease. The sealant programs are also encouraged to include fluoride varnish applications as part of their routine services.

In FFY2011, 979 preventive services (professional cleanings, fluoride applications, and sealant applications) were provided to children using Title V funds through referrals to dental offices. Also, 46,810 fluoride varnish applications were provided to low-income children at public health settings, such as WIC clinics, schools, and Head Start centers.

As part of the HRSA TOHSS grant, the I-Smile™ Dental Home website was revised and updated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Further develop 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. Oversee retention checks within school-based sealant projects to assure quality of services.				X
5. Continue advocacy for community water fluoridation.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building:
OHC staff are continuing discussions with Delta Dental, to determine ways to expand school-based programs via equipment purchasing assistance, and also determining methods that may improve upon the number of children enrolled in hawk-i who receive dental sealants. OHC-funded school-based sealant programs are required to do retention checks during this school year as a quality assurance measure. OHC staff and local I-Smile™ Coordinators are involved in advocacy for community water fluoridation (CWF) as communities make decisions regarding the continuance of this important public health measure.

Population-based:
School-based sealant programs are in their second year of a three-year project period. Improvements to the I-Smile™ website (www.ismiledentalhome.iowa.gov) include slide shows that promote dental sealants and fluoride varnish. The changes made to the site are intended to increase website traffic and improve users' understanding of the importance of good oral health for children.

Enabling:
Several I-Smile™ Coordinators have become Qualified Entities, enabling them to determine presumptive eligibility for maternal and child health clients. This will improve access to care for at-risk children.

Direct Health Care:
Gap-filling preventive services are provided in the schools, as well as for very young children at WIC, Head Start/Early Head Start centers, preschools, and child care locations.

c. Plan for the Coming Year

Infrastructure Building:
I-Smile™ Coordinators and OHC staff will remain involved in CWF issues as they arise. Maintaining Iowa's current CWF system is important to ensure that Iowans of all income levels and ages receive the benefit of primary prevention to dental disease. OHC staff will consider results of the oral health survey of third graders to determine whether any program or policy changes are needed. Based on the I-Smile™ strategic planning done in October 2011, OHC staff will begin to consider how to incorporate school-based preventive services in all Iowa counties, which may include oral health education, sealant programs, and/or fluoride applications.

Population-based:
OHC will oversee the third year of its school-based sealant program project period. A competitive RFP will be developed for the following year, if funding is available. Health promotion efforts will also focus on disease prevention, as the budget allows.

Enabling and Direct Care:
OHC will consider ways to share prevention messages electronically -- including the use of social media and reminder text messages as part of care coordination.

Direct Health Care:
Based on I-Smile™ data, Title V CH agencies will be required to ensure that gap-filling preventive services are provided for children at WIC and if indicated by needs assessments, for older children.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	2	4.5	3	3	2.3
Annual Indicator	4.6	2.9	3.1	2.5	2.3
Numerator	25	17	18	15	14
Denominator	543571	586749	589813	603673	601833
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.1	2	1.9	1.8	1.7

Notes - 2011
FFY11 data were obtained from 2011 Vital Statistics provisional data.

Notes - 2010
FFY10 data were obtained from 2010 Vital Statistics data.

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

a. Last Year's Accomplishments
The FFY11 performance objective of 2.3 was met. Data from the 2011 provisional vital records data indicate that the rate (per 100,000 children) of deaths to children aged 14 years and younger caused by motor vehicle crashes was 2.3.

Infrastructure Building:

Community outreach activities included "Spot the Tot" training, which teaches drivers to keep their eyes on children while backing up. Updated car seat safety inspection cards were developed. The car seat safety inspection cards were distributed at community events. Through feedback from the car seat safety technicians who do check-up events and community inspection stations, the Bureau of Emergency Medical Services (EMS) assessed of the needs of local communities. This assessment allowed the bureau staff to address the areas where education is still needed. This education involved demonstrations of proper booster seat installation and booster seat checks.

The EMSC program initiated the "Love Our Kids" project in 1997 and continues to administer the project which provides community based funding for injury prevention projects at the community level. During FFY2011, a total of 24 $1,500.00 service agreements were granted to 24 communities throughout Iowa.

Population-based:
IDPH conducted activities to decrease the mortality rate, including a campaign focusing on pedestrian safety. The plan was designed to educate children on safe street crossing and proper utilization of sidewalks. IDPH and the Iowa Safe Kids Coalition also planned targeted interventions to encourage booster seat usage.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct outreach activities, including "Spot the Tot" training.			X	
2. Conduct activities to decrease mortality, including a campaign focusing on pedestrian safety.				X
3. Provide education and demonstration of proper car seat and booster seat installation.		X	X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
IDPH, through funding from the Governor's Traffic Safety Bureau, offers Certified Passenger Safety Technician courses, with a minimum of four classes per year throughout the state. The Bureau of EMS and the Safe Kids Coalition continues to host inspection stations held on a regular basis. The state's Child Passenger Safety coordinator will provide the Annual Technician Update to provide continuing education for technicians on new trends in occupant protection.

c. Plan for the Coming Year
Infrastructure Building:
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. Physician outreach promoting child passenger safety continues. Physicians have the opportunity to educate families with young children about appropriate child passenger safety systems, with materials provided at no cost. Outreach in childcare settings and schools ensured that a broad population receives education on appropriate occupant protection.

Population-based:
The Bureaus of Family Health (BFH) and EMS 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. One local contract agency focuses on decreasing child mortality related to motor vehicle accidents. The agency will focus on the distribution of car seat safety materials, and certified car safety seat inspectors will provide education and demonstrations at community events.

The IDPH Bureau of EMS-EMSC program will no longer be 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 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.

Two local child health agencies' action plans focus on performing car seat safety checks in their communities.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	35	46	20	19	16.5
Annual Indicator	20.1	20.0	18.1	16.4	17.3
Numerator	2903	2927	2692	2410	2412
Denominator	14444	14633	14871	14692	13913
Data Source		Pediatric NSS	Pediatric NSS	Pediatric NSS	Pediatric NSS
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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	17.5	18	18.5	19	20

Notes - 2011
Data from 2011 PedNSS Data.

Notes - 2010
FFY10 data was obtained from the 2010 PedNSS. The data show that 16.4 percent of the 14,692 infants in the data set were breastfed at six months of age. The decrease was caused by a change in documentation procedures by WIC staff to calculate this measure.

Notes - 2009
2009 data is from the 2009 Pediatric Nutrition Surveillance Survey. The data show that 18.1 percent of the 14,871 infants in the data set were breastfed at six months of age.

a. Last Year's Accomplishments
The FFY11 performance objective of 16.5 percent was met. Data from the 2011 PedNSS data indicate that 17.3 percent of mothers breastfed their infants at 6 months of age.

Infrastructure Building:
The Bureau of Nutrition and Health Promotion (BNHP) staff continued to provide technical assistance to local maternal and child health agencies on breastfeeding. State and local Nutrition Program for Women, Infants, and Children (WIC) staff continued to be involved in the Iowa's Fit for Life Early Childhood work group that focused on implementation of family friendly policy recommendations on breastfeeding. BNHP continued to support local agencies as they work with businesses, schools, and colleges to become breastfeeding friendly.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide technical assistance to local maternal and child health agencies on breastfeeding.				X
2. Co-sponsor the annual breastfeeding conference.				X
3. Continue to be involved with the Iowans Fit for Life Early Childhood workgroup to implement family friendly policy recommendations on breastfeeding.		X		X
4. Continue to be involved with the Health and Human Services Business Case for Breastfeeding to help implement worksites becoming breastfeeding friendly.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
The IDPH BNHP requires local contract agencies to expend a minimum of 20 percent of the total allocated WIC funds on nutrition education, including a minimum of three percent to be spent on breastfeeding promotion and support.

Population-based:
All 20 WIC agencies, including those that integrate Title V services, implemented action plans targeting community-based breastfeeding promotion and support. Planned activities of local WIC contract agencies include: breastfeeding fairs for pregnant women, breastfeeding education and support to communities, and continuing education to community partners and contacting businesses to discuss worksite lactation policies throughout the state.

Enabling:
BNHP has been receiving USDA Peer Counseling grant funds since 2004. The purpose of the grant was to start and then maintain a peer counseling program. A pilot project was started in a local WIC agency in 2005. In 2008, four additional agencies started peer counselor programs. Two additional peer agencies were added in March 2010 for a total of seven breastfeeding peer counseling agencies with a total of 28 peer counselors. An updated peer curriculum was made available through USDA in November 2011 and more agencies will be trained and start using the new curriculum in 2012.

c. Plan for the Coming Year
Infrastructure Building:
BNHP staff will provide technical assistance on breastfeeding to the local contract agencies. Local MH contract agencies will continue to develop and implement community-based strategies for breastfeeding. IDPH will support the agencies that have WIC breastfeeding peer counselor programs. The WIC program at the state and local level helped the state breastfeeding coalition (Iowa Breastfeeding Coalition) develop a four-hour breastfeeding training for communities. BNHP intends to evaluate the training after it has been in 2012 and make any necessary changes based on the training and current research on breastfeeding.

The Healthy, Hunger-Free Kids Act of 2010 an October 1, 2020 mandate for WIC Programs to implement EBT, an electronic system replacing paper food checks with a card for food benefit issuance and redemption at authorized WIC grocery stores. The first step states must take toward WIC EBT is to prove affordability and feasibility. Through a planning contractor's analysis of current WIC state systems and key stakeholders, the Iowa WIC Program determined that WIC EBT is affordable. The Iowa WIC Program further concluded that either a magnetic stripe card system processing transactions in real-time, or an embedded chip smart card system processing offline would be an acceptable alternative to paper check instruments for benefit issuance and redemption. Based on these findings, the Iowa WIC Program is in the process of preparing a proposed plan for proceeding to implementation for review and approval by the USDA.

Seven local MCH agencies' action plans address breastfeeding. Activities include providing outreach, education, and support on benefits and the act of breastfeeding.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	99.8	99	99.5	99.6	99.7
Annual Indicator	98.2	98.7	98.7	99.2	99.1
Numerator	39684	39545	38885	37838	37293
Denominator	40414	40052	39404	38151	37640
Data Source		eSP	eSP	eSP	eSP
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	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	99.3	99.4	99.5	99.6	99.6

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.

Notes - 2010
FFY10 data were obtained from the eSP newborn hearing screening database. The total number screened may not include children that were not screened by the birth hospital because they were transferred to another facility before screening, missed, or the family refused. The total eligible for screening is birth by occurence.

Notes - 2009
The 2009 data were obtained from the eSP newborn hearing screening data base. The total number screened may not include children that were not screened by the birth hospital because they were transferred to another facility before screening, missed, or the family refused. The total eligible for screening is birth by occurrence.

a. Last Year's Accomplishments
The FFY11 annual indicator objective of 99.7 percent was not met. Provisional data from the eSP™ newborn hearing screening data system indicates that 99.1 percent of newborns were screened for hearing loss before hospital discharge. Reasons that children may not have been screened by the birth hospital include: transfer to another facility for a higher level of care prior to screening, missed cases by the birth hospital because of early discharge or equipment, child death or family refusal. The number in the newborn hearing screening database also includes home births, which accounts for the greatest number of children that either never receive a hearing screen or refuse the screen.

Infrastructure Building:
The Iowa EHDI program staff began conducting site visits to Iowa birthing hospitals (82 total) in 2009 and continued in 2010 and 2011. The hospital site visits resulted in a decrease in referral and missed rates for hospitals not meeting state goals; in some cases as much as a 15 percent decrease. The EHDI program staff developed quarterly reports that were emailed to each birthing hospital, detailing their progress in the last quarter, as well as their progress or lack of progress year to date. The reports have been an effective quality assurance tool as they have led to additional training, hospitals developing quality assurance goals related to their screening and follow-up rates and hospitals ensuring their equipment are functioning properly.

The EHDI program continued to participate in a number of outreach and public education opportunities.

Iowa was one of two states successful in obtaining a grant, iEHDI, from the CDC in 2010.Through iEHDI, Iowa's program assists in assessing the feasibility of providing individual-level data beyond the aggregate data currently provided through the annual CDC Screening and Follow-up Survey. Iowa's EHDI database currently provides individual level data along with aggregate data for screening and diagnosis and the program is working to include more comprehensive early intervention and family support data.

The EHDI program has continued their evaluation of the newborn hearing screening and follow-up program. As a result of the evaluation of the EHDI database, the program identified an

increased need to capture early intervention and family support data. The program has worked with the eSP to add a case management system that will more accurately capture this data. The second area evaluated was parent's report of the education and support they received throughout the screening and diagnostic assessment process.The information obtained from the parent survey was shared with hospitals through individual hospital site visits to educate them about parent experiences and reinforce best practices in communication with parents and scheduling follow up visits. This information was also used to modify short term follow up processes for children who were missed and did not pass their final birth screen.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to hospital, Area Education Agencies, health care providers and private practice audiologists.				X
2. Continue to monitor eSP™ data.				X
3. Use pediatric audiologists to provide technical assistance to facilities providing newborn screening.			X	X
4. Provide training to health care providers and early childhood professionals on childhood hearing loss and the importance of timely follow up.			X	X
5. Program evaluation completed for data base usability, parent experience regarding screening and follow up (screen, re-screen, diagnosis, family support).				X
6. Provide care coordination to families of children who did not pass their hearing birth screen to ensure they receive an outpatient hearing rescreen or diagnostic assessment.		X		
7. Public education regarding newborn hearing screening and importance of timely follow up (newsletters, conferences, presentations)			X	
8.				
9.				
10.				

b. Current Activities

Infrastructure Building:

EHDI began planning for the third phase of its evaluation plan, which assesses the processes being used by hospitals, physicians, and audiologists to move children through screening and needed follow-up and family support.

EHDI audiology technical assistants provide training to reduce the number of children that are referred on the initial birth screen. EHDI team members are completing site visits to all birthing hospitals and are planning for site visits to audiology clinics.

A new data team was assembled to identify data sharing mechanisms between EHDI, Early ACCESS, Area Education Agencies (AEA), and DE to identify common data elements and possible data sharing strategies.

Population-based:

EHDI provides public education regarding newborn hearing screening and the importance of timely follow-up through newsletters, conferences, and presentations.

Enabling:

The EHDI program contacts families and medical homes of children that did not return for a hearing re-screen and/or obtain a diagnostic assessment to reinforce the importance of follow-up at well-child appointments and contact those with risk factors for hearing loss to provide guidance regarding the recommended follow-up. EHDI continues to provide family support services to families of children with hearing loss through the Iowa Guide by Your Side program.

c. Plan for the Coming Year
Infrastructure Building:
EHDI staff will continue efforts to educate midwives, PCPs, audiologists, and ENTs about the importance of timely screening and follow-up for children who do not pass the initial screen or have risk factors for late-onset hearing loss.

The EHDI staff will continue to evaluate the EHDI program's System of Care, including hearing screening and follow-up processes, referral, early intervention and family support. Evaluation results will be shared with the EHDI Advisory Committee and other partners to help guide policy and program development.

IDPH and CHSC will continue to work with Center for Disabilities and Development (CDD) audiologists to provide training or technical to hospitals, AEA staff, private audiology clinics and healthcare providers. Training will emphasize the importance of decreasing "refer" and "miss" rates and lost to follow-up numbers, as well as increase timely follow-up, including referral for diagnostic assessments, Early ACCESS and family support. EHDI program staff will recruit additional private practice clinics to report all screening or diagnostic assessment results to IDPH through the EHDI web-based data system versus paper reports.

Population-based:
All birthing hospitals will provide universal newborn hearing screening services as required by law. The EHDI program will continue to work with birthing facilities that have NICUs to implement AABR screening as a standard of care as recommended by the Joint Committee on Infant Hearing Screening. The EHDI program will participate in outreach and public education opportunities regarding the program.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	2.7	2.6	2.8	2.8	2.8
Annual Indicator	2.8	2.8	2.8	2.8	2.8
Numerator	19919	19852	19969	20383	20321
Denominator	711403	709000	713155	727993	725767
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	2.8	2.8	2.8	2.8	2.8

Notes - 2011
FFY11 data were obtained from the 2010 Iowa Child and Family Household Health Survey for children 0-17 years.

Notes - 2010
FFY 10 data were obtained from the 2010 Iowa Child and Family Household Health Survey for children 0-17 years.

Notes - 2009
The annual indicator reflects the results of the 2005 Household Health Survey as noted in previous years. It remains difficult to estimate the percent of uninsured children in Iowa. Data from the most recent (2008) Census Population Survey (CPS) conflicts with this estimate, which errors in measurement and the use of differing data sources.

a. Last Year's Accomplishments
The FFY11 performance objective of 2.8 percent was met. Data from the 2010 Iowa Child and Family Household Health Survey shows 2.8 percent of children in Iowa are uninsured.

Infrastructure Building:
At the state level, the state hawk-i outreach coordinator exhibited hawk-i outreach information to self-employed farm families at the Iowa Farm Progress Show and other large venues, including events such as Iowa's Midwest Rural Agricultural Safety & Health Forum, school nursing conferences, Iowa's Nurse Practitioner's Conference, and a training event for Iowa State University Extension Healthy Families Line staff. The state coordinator was active in providing education and training on presumptive eligibility for children to school nurses across the state, as well as newly hired school nurses.

Population-based:
In 2011, the Iowa Department of Human Services (DHS) continued to contract with IDPH to provide oversight of the local grassroots hawk-i outreach across the state. CH agencies continued to provide localized outreach to four required focus areas: schools, medical providers (including dentists), faith-based communities, and diverse ethnic populations. Outreach coordinators received trainings throughout the year assisting them with their outreach efforts. Specifically, coordinators participated in two outreach taskforce events where best practices were shared and new training was provided.

Each year, outreach coordinators go beyond these four required focus areas to reach families who may have children eligible for Children's Health Insurance Program (CHIP) or Medicaid coverage. In light of recent reductions in the workforce and increasing unemployment rates, local outreach coordinators continued to focus on strengthening the information link to workforce development centers, temporary employment agencies, and community job loss rapid response teams. Coordinators also focused outreach efforts on retail businesses that patrons frequent as a result of a slow economy. These include laundry-mats, low-cost hair salons, and low-cost fast food chain restaurants.

Iowa was the first state in the nation to implement a dental only program under its CHIP in March 2010. The hawk-i dental program is a supplemental dental only program designed for families who may already have health care coverage for their children but lack dental health coverage. Outreach coordinators continued their efforts to inform and provide information to families and community partners about the new dental option available to eligible children.

Enabling:
Outreach coordinators were instrumental in assisting the Iowa DHS in the implementation of Iowa's Presumptive Eligibility for Children program.

DHS designed presumptive eligibility to allow qualified entities (QEs) to become certified to make presumptive determinations through a web-based provider portal. Initially, DHS limited the number of QEs to a select number of local hawk-i outreach coordinators as a pilot project. To date, Iowa has gradually expanded qualified entities, and continues to add qualified entities in provider categories including Head Start programs, WIC clinics, physicians, rural health clinics, general hospitals, FQHC, local area education agencies, maternal health centers, and birthing centers. There are a total of 205 QEs, including all hawk-i outreach coordinators, which have access to sign children up for the presumptive eligibility program.

According to DHS, from October 1, 2010 through October 31, 2011, a total of 1,852 children were approved for presumptive eligibility. Enrollment of children in presumptive Medicaid is expected to grow as the number of QEs determining presumptive Medicaid eligibility increases.

All presumptive eligibility applications are automatically forwarded from the QE to DHS for a determination of whether the child qualifies for ongoing Medicaid coverage. Of the 1,852 children approved for presumptive eligibility, 989 were approved for Medicaid, 141 were already eligible, 480 children were denied, 98 were approved for hawk-i coverage, and 25 were denied hawk-i coverage. The remaining 119 children were pending at the time of report for final disposition.

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. Promote the public awareness campaign for hawk-i.			X	X
4. Provide technical assistance to local child health agencies.				X
5. Promote grassroots outreach activities related to Presumptive Eligibility for Children.		X		X
6. Utilize successfully established infrastructure and collaborations to implement targeted grassroots outreach to uninsured teens with funding from the CHIPRA II Outreach grant		X		X
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
Iowa's focus for Medicaid and CHIP continues to support efforts to align policies of multiple programs to allow for simplified and streamlined application processes. After the implementation of the dental only program and the presumptive eligibility for children, IDPH continues to be successful in collaborating with DHS and CMS to strengthen CHIP quality improvement activities

related to increasing access to care and the use of preventative care.

IDPH was awarded the CHIPRA II Outreach and Enrollment grant in August 2011. The grant proposed that the funding be used to direct a statewide program ensuring that eligible teens are enrolled in health care coverage and that they remain covered until the age of 19.

Population-based:
Local outreach coordinators continue to educate families, community partners, and PCPs about Iowa's health insurance options for children. Local coordinators continue to focus efforts on four primary areas. Specifically, they continued to focus efforts on recruiting Medicaid providers to become QEs to enroll children in the Presumptive Eligibility for Children Program.

Enabling:
Iowa's local outreach coordinators have the capacity to enroll children in the Presumptive Eligibility for Children Program. They focus on assisting families to enroll in Medicaid or hawk-i through the presumptive eligibility program and assist families in navigating the Medicaid and hawk-i enrollment and renewal processes.

c. Plan for the Coming Year
Infrastructure Building:
Iowa's CHIP administrators indicated the program's primary focus for FFY2013 will be maintaining the CHIP program and the Presumptive Eligibility for Children Program. DHS is designing and implementing an Express Lane Eligibility (ELE) process that will enroll children who receive Food Assistance, but not Medicaid, into the Medicaid program. It is anticipated that the ELE will be expanded to include programs outside of DHS in years to come.

Local hawk-i outreach coordinators will be required to continue outreach to health care providers, schools, the faith-based community, and diverse ethnic populations. Outreach coordinators will also focus on continuing to recruit QEs to become certified in making presumptive eligibility determinations for children in their communities.

Through the CHIPRA II Outreach and Enrollment, IDPH will design and implement targeted grassroots outreach to uninsured teens using the following methodology: 1) engage teens and their families through creative activities that reflect the interests and needs of teenagers, including the "Get Covered. Get in the Game Campaign."; 2) create a teen media, marketing, and text messaging campaign; 3) utilize a statewide outreach network to disseminate outreach materials; 4) build the capacity of local coalitions and create teen advisory councils; 5) conduct comprehensive project evaluation; and 6) ensure sustainability. IDPH's CHIPRA II project will utilize successful, previously established infrastructure and collaborations to rapidly advance the objectives of the project.

Population-based:
The primary focus of outreach across Iowa will be to increase enrollment of Iowa's children in Medicaid and hawk-i by utilizing the Presumptive Eligibility for Children Program. The focus of all outreach will continue to be on hawk-i enrollment, the hawk-i dental only program, and presumptive eligibility for children.

Enabling:
All hawk-i outreach coordinators will continue their certification as QEs and local outreach efforts will focus on enrolling children in Medicaid and hawk-i through the Presumptive Eligibility for Children Program. As a result of the hawk-i dental only program, outreach workers will also assist families in enrolling in the dental only option offered by hawk-i. Coordinators will continue to identify barriers through the use of occurrence reports and other forms of established

communication.

All 22 local CH contract agencies have action plans related to enrolling children in health insurance through hawk-i. Activities include developing community partnerships, providing outreach to schools, health care providers, faith-based organizations, and vulnerable populations, providing public education, providing presumptive eligibility, and care coordination services.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	30	30	32	30	29.8
Annual Indicator	32.5	32.6	32.5	31.9	31.7
Numerator	9802	10936	11773	11414	10911
Denominator	30161	33548	36225	35783	34420
Data Source		CDC PedNSS	CDC PedNSS	CDC PedNSS	CDC PedNSS
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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	31	30.5	30	29.5	29

Notes - 2011
Data from 2011 PedNSS Data.

Notes - 2010
Data from 2010 PedNSS Data.

Notes - 2009
Data obtained from 2009 PedNSS Data.

a. Last Year's Accomplishments
The FFY11 performance objective of 29.8 percent was not met. Data from 2011 PedNSS data shows 31.7 percent of children ages 2 to 5 years receiving WIC services had a BMI at or above the 85th percentile and has been declining for the past 4 years. Iowa continues to implement the Healthy Kids Act of 2008, which is a collaboration between the Departments of Education, Human Services and Public Health.

Infrastructure Building:
Local MCH and WIC vendors were given materials to promote fresh fruit and vegetable vouchers from the WIC program. BNHP staff developed snack recipes using WIC foods for use in local agencies.

BNHP staff promoted Live Healthy Iowa Kids, a free 100 Day Challenge for youth. BNHP staff

also participated in the Iowa Governor's Council on Physical Fitness and Nutrition.

IDPH received a CPPW grant that focuses on working with child care centers to limit screen time and encourage physical activity. IDPH worked with DHS Child Care Bureau, Early Childhood Iowa, WIC, and Healthy Child Care Iowa to implement activities in the grant.

I-WALK participants conducted walkability assessments in 12 communities using GPS units to map routes taken by students and identify barriers to walking or bicycling to school.

Population-based:
Twenty-two BASICS contractors worked with elementary and preschools to increase fruit and vegetable consumption, drinking one percent and fat-free milk, and being physically active every day in children.

Enabling:
Six BASICS contractors worked directly with parents of young children through Storks Nest and in-home visitation programs. In FY 2011, these contractors served families to promote good nutrition and food preparation skills.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Local agencies were provided with displays to promote the usage of the WIC Farmers Market Checks and the WIC Cash Value Vouchers at the local markets.			X	
2. Local WIC agencies were provided with posters, electronic handouts, and public service announcements regarding a topic to discuss designed to decrease childhood obesity each quarter. This information is being shared with community partners to provid			X	
3. The Annual Breastfeeding Conference did address the link of breastfeeding to decrease in obesity. Also, local WIC agencies received a 2-day training on “Grow and Glow” in which this same topic was discussed.				X
4. The Live Healthy Iowa Kids/Governor’s Challenge promoted a free 100 Day Challenge for youth teams in 2011. Data shows: 549 teams from 200 schools participated including 10,941 students.			X	
5. Trained hospital personnel state-wide to help promote the Baby-Friendly Hospital initiative				X
6. The I-Walk project (a partnership between Iowan’s Fit for Life and the Iowa Department of Transportation) also partnered with 12 local school districts to find safe routes to school to promote exercise.			X	X
7. Iowans fit for Life trained 37 nurses in Motivational Interviewing after which these nurses conducted height and weight assessments on over 6,000 7th and 8th graders in Iowa schools.				X
8. SNAP Education and the Iowa WIC Program partnered to promote the consumption of 1% and skim milk in children over 2 years of age marketing it as “I’m a big kid now and do not drink little kid’s milk”.			X	X
9.				

10.				

b. Current Activities
WIC local agencies are currently providing counseling to families who indicate that their children watch more than 2 hours of TV/videos per day. The total number of families counseled will be tabulated by May 30, 2012.

Iowans Fit for Life are partnering with UI to produce a video on assessing body mass index (BMI) for children with special healthcare needs.

Local WIC agencies continue to participate with local partners in the poster, PSA, and handout campaign. A survey will be conducted via surveymonkey.com at the end of the project.

Iowa continues to implement the Healthy Kids Act which outlines the following requirements:
1. Established nutritional content standards for food and beverages sold or provided on school grounds during the school day.
2. Requires school districts and accredited non-public schools to ensure every student in grades K-5 has 30 minutes per day of physical activity and every student in grades 6-12 has 120 minutes per week of physical activity.
3. Requires every student to complete a course that leads to certification in cardiopulmonary resuscitation (CPR) by the end of grade 12.
4. Requires Iowa's Area Education Agencies (AEAs), or a consortium of two or more AEAs, to contract with a licensed dietitian.

I-Walk is in the process of adding 16 more school districts to the safe route to school project.

c. Plan for the Coming Year
Local WIC agencies are in the process of submitting action plans for the coming year. Some will focus on childhood obesity in children under 5 years old.

The Wellmark BMI project has added 30 additional nurses to complete assessments for 9th graders.

WIC breastfeeding peer counselors will continue to receive training including the relationship of breast feeding and reduced childhood obesity.

A new project with IDALS is being planned by the Iowa WIC Program to continue to increase redemption of Farmers Market checks.

Iowa's Community Transformation Grant activities include increasing the number of school districts and child care centers with healthy food procurement practices and increasing opportunities for physical activities in schools and child care facilities.

Five MCH agencies will promote and educate families around the topics of nutrition and physical activities, as indicated in their 2013 action plans.

The primary activities funded under the Iowa Healthy Weight Collaborative is to form a Learning Collaborative, a quality improvement initiative that brings together a diverse collection of people and organizations as a team in order to accomplish a common goal. Over a set period of time--approximately one year--the team works together to test, share, and implement strategies to bring about improvement.

The Iowa team is well-positioned to build on existing efforts to promote the integration of public health, primary health care, and community resources. The primary focus for the Iowa Healthy

Weight Collaborative team is the dissemination of an enhanced referral system and consistent messaging to achieve healthy weight goals among community residents. An enhanced primary care referral system to integrate local resources, using Eat & Play the 5-2-1 Way, will be pilot tested in each targeted community. Additionally, the Iowa team will promote motivational interviewing through a structured training of a cadre of community, public health, and primary care direct care workers. Participating in the Collaborative enhances identification of efficient and effective processes in a local community referral system, plus applying existing state and local resources and programs, to increase the number of Iowans at a healthy weight.

An essential partner on the team will be the county-level LPH agency in six counties in northeast Iowa. Located in all counties, LPH staff function as community change agents by engaging in active outreach to assess local family and child needs, identifying community resources, and facilitating the implementation of child and family programs responsive to identified needs. The LPH agency, the practice entity of the Local Board of Health (LBOH), is generally agreed to provide effective leadership with a sophisticated set of skills and support for community-based staff.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	18	14	14	13	12
Annual Indicator	14.9	14.5	13.6	13.2	12.7
Numerator	6075	5846	5387	5085	4859
Denominator	40788	40221	39662	38514	38204
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	12	11	10	9	8

Notes - 2011
FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010
FFY10 data were obtained from 2010 Vital Statistics data.

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics data.

a. Last Year's Accomplishments
The FFY11 performance objective of 12 percent was met. Data from 2011 provisional vital statistics indicates that 12.6 percent of women smoked in the last three months of pregnancy.

Infrastructure Building:
The IDPH Division of Tobacco Use Prevention and Control continued to reach out to women's health providers through an existing contract with the Iowa Tobacco Research Center. The Division also developed new Quitline Iowa outreach materials focusing on tobacco cessation for women.

Maternal health agencies continued to expand the use of dental hygienists to provide tobacco cessation counseling in order to build capacity for maternal oral health services.

According to IDPH data, Iowa mothers enrolled in Medicaid smoke during pregnancy at a higher rate than the national average. A taskforce of IDPH and Iowa Medicaid Enterprise (IME) staff explored strategies to reduce tobacco use in pregnant women.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train on the tobacco intervention model to local agencies				X
2. Expand tobacco cessation training to dental hygienists, local I-Smiles coordinators, and WIC staff		X		X
3. Work with Medicaid leadership to decrease the number of Medicaid women smoking during pregnancy				X
4. Utilize Iowa PRAMS pilot which will allow a second year of improved data collection				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
IDPH staff and IME task force members continue to use the Medicaid Match report to develop strategies to address ways to decrease the number of women who smoke during pregnancy. The taskforce has developed a streamlined report and is focusing on tobacco use in women of child bearing age as well as reduce exposure to second hand smoke.

The Iowa Tobacco Research Center will continue to offer provider trainings on tobacco cessation and motivational interviewing to health care providers. Through these trainings, providers are encouraged to ask every client about tobacco use, advise them to quit if they are using tobacco, and refer them to tobacco cessation counseling.

Nine local MH contract agencies have action plans related to smoking cessation for pregnant women. Activities include referring clients who smoke to Quiteline Iowa, providing smoking cessation education, and preparing public awareness campaigns. In 2012, a new vendor was selected for Quitline Iowa and is processing prior authorization requests. This information is communicated to our MH and family planning agencies to assist pregnant Medicaid eligible women to access nicotine replacement therapy when needed.

c. Plan for the Coming Year

Infrastructure Building:
The smoking assessment tool local MH programs use asks only if the client currently use tobacco products. IDPH plans to expand the assessment to include assessment of others who might be smoking in the home. 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 QuiteLine Iowa and local resources in their county that may be available.

Enabling:
MH programs plan to continue 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.

Seven local MH agencies have specific action plans related to smoking cessation. Activities include screening all clients for tobacco use and referring those who smoke 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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	10	9.8	12.7	9.5	11
Annual Indicator	10.1	12.9	9.7	11.5	11.6
Numerator	22	28	21	25	25
Denominator	217502	216795	217380	216837	215834
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11	10.5	10	9.5	9

Notes - 2011
FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010
FFY10 data were obtained from 2010 Vital Statistics data. The variation in the rate is due to the low numbers of suicides among youth aged 15-19 years.

Notes - 2009
Data were obtained from 2009 Vital Statistics data.

a. Last Year's Accomplishments

The FFY11 performance objective of 11 deaths per 100,000 was met. 2011 provisional vital statistics indicates that the rate (per 100,000) of suicide deaths among youths aged 15 through 19 was 11.5.

Infrastructure Building:
IDPH and Iowa's Suicide Prevention Strategy Steering Committee composed a draft plan for Suicide Prevention in Iowa for 2011 to 2014. The plan addresses the magnitude of the problem in our state and identifies key risk and protective factors associated with suicide. There are six goals within the plan, outlining details for interventions and evaluation of suicide prevention efforts. At the time of this report, suicide was the second leading cause of death for all Iowans 15-40 years of age.

In 2011, IDPH did not receive the funding it anticipated from SAMHSA for a 3-year Youth Suicide Prevention Grant. With the loss of this funding, the IDPH Suicide Prevention Coordinator position was lost, as were the expanded state-wide interventions that were planned and proposed in last year's report on this Performance Measure. The retirement loss of our Adolescent Health Coordinator in BFH further limited our ability to address this important public health issue to any effective degree.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Encourage parents to seek early treatment for children with behavior problems, possible mental disorders and substance abuse problems.			X	
2. Encourage health care plans to cover mental health and substance abuse on the level physical illnesses are				X
3. Schools should implement mental health screening programs for children. Teachers should be educated about suicide risk factors and resources to which they may refer children for assistance.				X
4. Children who have attempted suicide or displayed other warning signs should receive aggressive treatment services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
In the 2012 legislative session, bullying and suicide prevention became a focus because of several current bullying accidents that resulted in adolescents committing suicide. IDPH received $50,000 to develop a needs assessment related to suicide prevention services and to hire a coordinator to focus on bullying and suicide prevention at a state level. The BFH will be working with the Division of Behavioral Health on the implementation.

Although IDPH was not funded for the IYSPP grant, suicide prevention services in Iowa continue through other agencies and means. Some school districts continue to use the Teen Screen Schools tool but do not report results to IDPH. Other services may be offered though county health departments or local programs.

The planning process of the Iowa DE Safe and Supportive Schools program is completed. Implementation of the study and programming continues through the DE. The annual surveys of grades 9-12 in the selected schools was aligned with the Iowa Youth Survey. Data from the selected school surveys will be analyzed though DE.

BFH continues its relationship with the Iowa Council on Youth Development and its collaboration with the partnering agencies within this Council. BFH staff is involved in the state's Mental Health Redesign efforts and will continue to support screening young children for social and emotional development through Project LAUNCH, 1st Five Health Mental Development, EPSDT, and Early ACCESS.

c. Plan for the Coming Year

Infrastructure Building:
IDPH will begin to partner with the Iowa DE Safe and Supportive Schools program and other initiatives. such as school climate/bullying and positive behavior supports. BFH staff will encourage local CH coordinators to work with local initiatives in their service area.

Through Iowa's PREP, BFH will provide program planning for a state-level project to improve the quality of health care for adolescents. This work will begin with convening an Adolescent Mental Health Advisory work group. The work group will design and implement a comprehensive needs assessment of the status of mental health screening for adolescents within the PREP project period.

The BFH is pursuing efforts about the Adverse Childhood Experiences (ACE) Study and is supporting the inclusion of the ACE questionnaire in Iowa's BRFSS. This information will serve as a guide for programs designed to prevent risk behavior in youth and instill quality in efforts to address the effects of ACE events on youth and adults.

Currently, one MCH agency has an action plan related to this measure. The agency will promote and educate clients on awareness of depression, suicide ideation, and positive coping skills.

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	2007	2008	2009	2010	2011
Annual Performance Objective	96	97	96	97	95
Annual Indicator	94.2	95.0	93.7	94.1	91.5
Numerator	468	420	384	430	355
Denominator	497	442	410	457	388
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	93	95	97	97	97

Notes - 2011
FFY11 data were obtained from 2011 Vital Statistics provisional data.

Notes - 2010
FFY10 data were obtained from 2010 Vital Statistics provisional data. Although the 2010 objective of 97 percent was not met, the rate has been stable since 2005.

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics provisional data.

a. Last Year's Accomplishments
The FFY11 performance objective of 97 percent was not met. Iowa's 2011 provisional Vital Statistics data indicates 91.5 percent of very low birth weight (VLBW) infants were delivered at facilities for high-risk deliveries and neonates. Over the past 10 years, 16 small community Iowa hospitals stopped providing obstetrical care. This represents a decline of over 20 percent in perinatal services available to rural Iowans. In 2011, five VLBW infants delivered outside a hospital setting. Travel distance for women in rural Iowa may prevent Iowa from reaching our goal for the number of VLBW infant delivering at an appropriate facility.

Infrastructure Building:
The Statewide Perinatal Care Team continued to provide ongoing education about the importance of transferring women to appropriate facilities for birth when they are stable enough for transport and will continue to travel to birthing hospitals each year. During their site visits, the team continued to stress the importance of the regionalized system of care in light of the decreased total number of hospitals that provide birthing services.

In October 2010, St. Luke's Hospital in Cedar Rapids went from a level II regional center to a level II regional neonatal center. This increased the level of neonatal services that are available in eastern Iowa.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase the number of Level II Regional Neonatal Centers				X
2. Increase access to a higher level of care for the very low birth weight infants		X		
3. Publish the Iowa Perinatal Newsletter on a quarterly basis			X	X
4. Strategize with key officials on quality improvement for premature and low birth weight babies on Medicaid				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building:
IDPH continues to monitor the access to high risk care for both pregnant women and their infants in rural parts of the state, as community hospitals struggle to continue their birthing services and to maintain obstetrical, surgical, anesthesia, and round-the-clock coverage needed. The Statewide Perinatal Program continues to conduct hospital site visits, individual education, and quality improvement initiatives. IDPH staff will evaluate and consider any needed updates to the Guidelines to Perinatal Care 8th edition that were published in 2008.

c. Plan for the Coming Year
Infrastructure Building:
Statewide Perinatal Program staff will 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.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective	87	80	76	77	78
Annual Indicator	77.7	75.9	74.3	75.5	84.5
Numerator	31740	30513	29469	29069	31883
Denominator	40835	40221	39662	38502	37746
Data Source		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
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	86	87	88	89	90

Notes - 2011
FFY11 data were obtained from 2011 provisional Vital Statistics data.

Notes - 2010
FFY10 data were obtained from 2010 Vital Statistics data.

Notes - 2009
2009 Data were obtained from 2009 Vital Statistics data.

a. Last Year's Accomplishments
The FFY11 performance objective of 78 percent was met. 2011 provisional Vital Statistics data indicates that 84.5 percent of infants were born to women receiving prenatal care beginning in the

first trimester.

Infrastructure Building:
BFH staff continued working with FQHCs to encourage the provision of prenatal care. This relationship improves access to prenatal care for low income women who are not Medicaid eligible.

IME contracted with a new transportation vendor, TMS Management Group, Inc. The new vendor improved access to transportation for clients outside the agency's city limits.

Enabling:
BFH staff and local MCH contract agencies continued to focus on an assessment of health care coverage for each client and assisting those who are uninsured, or underinsured, with the presumptive eligibility application. IME converted the paper presumptive eligibility application to an online application, allowing an immediate determination of presumptive eligibility status.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase outreach presentations to churches, schools, and community centers			X	
2. Promote communication and collaboration among local maternal health agencies and other local agencies				X
3. Integrate maternal health services with WIC, child health programs, family planning services, and DHS programs				X
4. Advocate for improved access for undocumented (immigrant) women		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
IDPH is also working 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 Health Care:
IDPH will encourage agency staff to improve collaborative relationships with family planning agencies and PCPs who offer prenatal care. Local MH agencies are working with school nurses to keep nurses informed of agencies that provide free pregnancy testing. This relationship helps to increase the early identification of adolescent pregnancies. 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 MH staff will complete training for the online presumptive eligibility application through the Iowa Medicaid Portal Access, which will streamline the application process.

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 such as Storks Nest, developing public awareness campaigns, and working with vulnerable populations.

c. Plan for the Coming Year
Infrastructure Building:
IDPH will encourage agency staff to improve collaborative relationships with family planning agencies and PCPs who offer pregnancy testing. IDPH is also encouraging partnerships with school nurses who can link pregnant teens to local MH programs.

Enabling:
As gas prices continue to rise, local MH programs will also continue to focus on transportation services. Each agency will submit a transportation plan on what transportation resources are available locally.

Twenty local MH agencies have action plans related to early entry into prenatal care. Agencies' activities include providing outreach to mothers using, fliers, quick fact sheets, and brochures; and collaborating with WIC clinics, medical providers, family planning agencies, and free clinics to reach pregnant women.

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 Performance Data	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				10	16
Annual Indicator				16	20
Numerator					
Denominator					
Data Source				Title V Program Index	Title V Program Index
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	21	22	23	24	25

Notes - 2011
Data Source: Title V Program Index scored by local MCH agencies.

Notes - 2010
Data Source: Title V Program Index. The 2010 score is the first measurement of performance and is considered a baseline.

a. Last Year's Accomplishments
The FFY11 performance objective of 16 was met. The indicator value is based on the average score of MCH programs scoring the Title V Program Index. Iowa's local MCH programs scores averaged 20 (out of 30) points. Iowa's MCH program will continue to find strategies that improve the system of care for Iowa's mothers and children.

Infrastructure Building:

The Iowa Department of Public Health (IDPH) and Child Health Specialty Clinics (CHSC) use the Title V Program Index as an instrument for measuring progress. The Title V Program Index, adapted from the National Initiative for Children's Healthcare Quality (NICHQ), is structured around six core Maternal and Child Health Bureau (MCHB) outcomes:

Strategic leadership: BFH and CHSC staffs are synthesizing existing strategic planning activities into a formal written plan. The Getting to the Core strategic planning process identifies the most important functions of the Bureau of Family Health and designs strategies to maintain those functions.

Partnerships across public and private sectors: MCH staff carries out strategies to establish effective private/public partnerships. Staff maintains partnerships with Medicaid, Iowa Chapter of the American Academy of Pediatrics (IA- AAP), Iowa eHealth Project, and the Partnership to Improve Child Health (PI-CHI).

Quality Improvement (QI): MCH staff provides technical assistance to local MCH programs on QI methodology. The BFH and CHSC embed QI initiatives into MCH programming at the state and local levels.
At the MCH Fall Seminar, participants focused on the Life Course Perspective and Adverse Childhood Experiences (ACEs).

Use of available resources: The BFH and CHSC monitor new funding opportunities to support programming in Iowa. Last year, IDPH applied for 18 grants (CHSC six) to support the work of Title V.

Coordination of service delivery: BFH and CHSC staff are developing assessments of services to special populations and care coordination to ensure that services are being provided equitably across Iowa.

Data infrastructure: BFH staff monitor the development of a health information exchange and advocate for inclusion of MCH public health 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. Conducted internal strategic planning, "Getting to the Core", to identify the most important functions to BFH.				X
2. Maintain partnerships with Iowa Medicaid, IA-AAP, Iowa eHealth, and other agencies/program				X
3. Provide TA to local MCH and CYSHCN programs				X
4. Monitor the development of the Iowa Health Information Network (IHIN)				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:
Strategic leadership: BHF is measuring how the Title V state plan is used in program planning at the local level. CHSC leadership is working with state partners to develop trust and embrace the system of care for the CYSHCN strategic plan.

Partnerships across public and private sectors: BFH and CHSC continue to establish new relationships with partners related to medical homes. Staff maintains partnerships with Iowa Medicaid, IA-AAP, Iowa eHealth Project, and the PI- CHI.

QI: BFH and CHSC staff will continue to provide technical assistance to MCH and CYSHCN programs on incorporating QI into all Title V programming.

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 Early Childhood Iowa (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 Health Information Exchange (HIE) for inclusion of MCH data.

BFH staff is involved in projects related to data integration of maternal, child, oral health, and MIECHV data.

c. Plan for the Coming Year

Infrastructure Building Services:
Using the Title V Program Index as a dashboard for measuring progress, the Iowa MCH program is focused on the strategies listed below in FFY2013. In each category the Iowa MCH program will attempt to move one step higher in the Title V Program Index scoring grid.

Strategic leadership
• Continue to communicate the goals and objectives of the Title V programs across the state.
• Educating policy makers on the importance of the Title V program in reaching Iowa's most vulnerable populations and how the goals of Title V fit within the Affordable Care Act (ACA)
Partnerships across public and private sectors
• 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)
• Establish and reinforce effective relationships with public and private partners related to medical homes
• Monitor/maintain effective partnership with Iowa Medicaid Enterprise (IME), IA- AAP, Iowa eHealth Project, and the PI-CHI

Quality Improvement
• Continue to work with local providers on integrating quality improvement strategies into their work plans

Use of available resources
• Continue to seek out new funding opportunities, especially as they relate to integration into the ACA
• Conduct a self assessment of the MCH Leadership Competencies for state and local Title V

staff and use the results to focus training and education for personnel

Coordination of service delivery
• Develop baseline assessment of provision of services for special populations
• Develop baseline assessment of care coordination services
• Maintain service delivery improvements through telehealth

Data infrastructure
• Monitor development of HIE for inclusion of MCH public health data
• Advocate for use of available funding for inclusion of MCH public health data in Iowa HIE
• Identify examples of effective data sharing to benefit the MCH populations
• Continue planning for an integrated MCH data

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	2007	2008	2009	2010	2011
Annual Performance Objective				26	45
Annual Indicator				44	66
Numerator					
Denominator					
Data Source				CHSC Tool	CHSC Tool
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	70	75	80	85	90

Notes - 2011
Data Source: CHSC Tool (includes Title V Program Index). The 2011 score is the second annual measurement of performance using this tool.

Notes - 2010
Data Source: CHSC Tool (includes Title V Program Index). The 2010 score is the first measurement of performance and is considered a baseline.

a. Last Year's Accomplishments
The FFY11 performance objective of 46 was met. Iowa's CYSHCN program scores averaged 66, utilizing the CHSC Scoring tool (which includes the Title V Program Index).

Infrastructure Building Services:

Defined expectations for four work teams for Iowa's System of Care for CYSHCN (direct clinical care; care coordination; family support; and infrastructure.)

For direct clinical care component, defined protocols and selected standardized tools for early and continuous screening within CHSC Regional Centers. For care coordination component, defined protocols and trained staff on delivering care coordination and family peer support services. Established processes and standards to refer CYSHCN served by CHSC Regional Centers back to medical homes. Created an age-based transition to adult services planning tool to guide care coordinators' discussions with families.

Lead the SAMHSA System of Care mental health project, with continued focus on rural Iowans in poverty.

Encouraged and financially supported Family Navigators to attend trainings aimed at transition planning, health literacy, and cultural competence.

Worked with Iowa Home Program staff to begin 3-year application process to obtain family support credentialing for CHSC Family Navigators.

Developed information repositories for sharing clinical care guidelines, clinical practice standards, and family support resources.

Trained staff regarding electronic medical record protocols and reporting standards. Implemented chart review procedures for ongoing quality improvement.

Provided Spanish screening tools and encouraged use of interpreter telephone line to all CHSC staff. CHSC hired a staff member to review CHSC plans to ensure service delivery in appropriate health literacy levels and cultural platforms.

Targeted ARRA funds from Early ACCESS to provide "Reach Out and Read" materials to primary care practices that serve high numbers of minorities. Used ARRA funds to subcontract with Child and Family Policy Center to analyze existing data and produce a report on the impact of social determinants of health on early child development and subcontract with independent consultant to produce report on effects of environmental toxins on development of young children.

CHSC collaborated with the Iowa Chapter of the American Academy of Pediatrics for Iowa to become member of National Improvement Partnership Network (NIPN) to promote quality improvement and established Partnership to Improve Child Health (PI-CHI) as Iowa's local NIPN chapter.

Purchased and circulated DVD's regarding social determinants of health to all CHSC staff.

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. Modify electronic medical records to accommodate care coordination data that can inform clinical care and also be used for quality improvement tracking.				X
2. CHSC Quality Improvement Advisors will train staff and implement ongoing processes to apply science of improvement techniques from National Initiative in Children's to multiple projects.				X
3. Train staff regarding new public health paradigms such as life course and social determinants of health, using MCH Navigate resources from HRSA whenever possible.				X
4. Maximize reimbursement mechanisms and policy for care coordination and family support activities.				X
5. Maintain CYSHCN advocacy/education plan that incorporates family stories and data that is accessible and current and used to educate and advocate.				X
6. Assure mentoring plan is developing new leaders within CHSC as staff age and retire.				X
7. Continue at least quarterly meetings for each of the four work groups of the System of Care to assure ongoing progress.				X
8. Analyze data from 2010 Iowa Household Health Survey and				X

2009-10 NSCSHCN and incorporate into ongoing CHSC strategic planning discussions.				
9. Maximize use of technology to improve internal and external communication.				X
10. Develop web-based resources for future training of Family Navigators and Care Coordinators.				X

b. Current Activities
CHSC Liaison to Family Navigator for Hispanic families assisted with outreach to the Latino populations, prior to June 2012 resignation.

CHSC staff use age-based checklist to assist youth/families in transition planning, beginning by age 14 and emergency preparation booklets with selected families.

CHSC staff are beginning to use MCH Navigator as resource for ongoing staff development.

CHSC is collaborating with Federally Qualified Health Centers to implement community utility model using funding from HRSA for Innovative Evidence Based Models for Improving System Services for CYSHCN project.

CHSC is developing virtual communication resources and use of social media to maximize internal and external communication.

CHSC is one of 16 affiliate groups of national Help Me Grow network.

CHSC is pursuing the family support credential for Family Navigators serving families in the CHSC Regional Centers and continues to lead Family to Family Iowa.

CHSC is developing a care coordination training webinar that orients new staff to care coordination processes and tracking log, web-based modules for CDC-materials related to Learn the Signs Act Early materials, and other Family Navigator required training elements.

Family impact data is being collected from families receiving comprehensive care coordination from CHSC Regional Center or Family Support 360 Family Navigators.

Obesity workgroup has been established to better coordinate efforts of University of Iowa, CHSC, and IDPH.

c. Plan for the Coming Year
Infrastructure

CHSC will review materials for cultural competence and appropriate health literacy levels.

CHSC staff will utilize a newly created age-based checklist to assist youth/families in transition planning, to adult health services.

CHSC will begin new partnerships with Federally Qualified Health Centers to implement community utility model in underserved regions (Fort Dodge and Sioux City).

CHSC will expand virtual communication resources to maximize internal and external communication (e.g. SharePoint, Windows Live Messenger, websites, and social media).

CHSC will partner with Project LAUNCH, IA-AAP, and others to continue implementation of the PI-CHI, focusing on continuous quality improvement. CHSC is one of 16 affiliate groups of the

national "Help Me Grow" network to assure healthy development.

CHSC will continue to pursue the family support credential for Family Navigators and will continue to participate in Family to Family Iowa.

CHSC Family Navigators will provide technical assistance to families as they learn Applied Behavioral Analysis in their homes.

CHSC clinical staff will identify additional screening tools to use with older children,

Quality improvement project will decrease time required to complete CHSC referrals to external services and track when services are received by the families as result of those referrals. CHSC will survey PCPs regarding their perceptions of communication with CHSC.

CHSC will expand social media presence.

CHSC will customize electronic medical record to include data elements regarding transition to adult health services.

Family Navigators and other direct care providers will receive training on motivational interviewing and facilitator skills for family team meetings.

CHSC will analyze data from 2009-10 NSCSHCN and 2010 Iowa Household Health and use for program planning. CHSC will increase its capacity to use Epic data for multiple quality improvement efforts, including family impact data.

Increase coordination of CHSC services with others working with similar populations such as: 1) Department of Human Services to assure adequate services are available for screening and evaluation of children expected of abuse; 2) PCPs and IDPH providers regarding decrease prevalence of overweight/obese children and youth; 3) Research institutions regarding effects of environmental toxins on child development and assuring families are aware of emergency services for cyshcn; 4) IDPH epidemiologist to help identify potential roles of CHSC in projects that seek to improve pregnancy outcomes; 5) Children's Mental Health redesign subcommittee participation; 6) Blank Children's Hospital, UIHC, and Federally Qualified Health Centers to use community health team approach.

Implement MCH Navigator tools into staff orientation and ongoing training to assure staff have baseline competencies and keep abreast of current information and practice implications.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				5	15
Annual Indicator				13	18
Numerator					
Denominator					
Data Source				Title V Program Index	Title V Program Index
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	19	20	21	22	23

Notes - 2011
Data Source: Title V Program Index scored by local MCH agencies.

Notes - 2010
Data Source: Title V Program Index. The 2010 score is the first measurement of performance and is considered a baseline.

a. Last Year's Accomplishments
The FFY11 performance objective of 15 was met. The indicator value is based on the average score of MCH programs scoring the Title V Program Index. Iowa's local MCH programs scores averaged 18 (out of 30) points. Iowa's MCH program will continue to find strategies that address health equity.

Staff of the Office of Minority and Multicultural Health (OMMH), in partnership with BFH staff provided 16 workshops to MCH/public health agencies and academic institutions on the subject of health equity and those differences in population health that can be traced to unequal economic and social conditions which can be systemic and avoidable. In partnership with Kirkwood Community College, IDPH held a health summit for African women. The summit focused on education and awareness on breast health issues that disproportionately affect African American women.

IDPH obtained additional videos and information to implement and to ensure the effective utilization of the "Unnatural Causes" lending library.

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**			
	DHC	**ES**	**PBS**	**IB**
1. Provided workshops to MCH agencies, academic institutions and public health agencies on cultural awareness/health equity inclusive of technical assistance in planning and implementation				X
2. Provide leadership in implementation within the OMMH Advisory Council and partnerships health equity agenda		X		X
3. Sustain region 3 Latino's Women's Health Coalition		X	X	X
4. Developed and implemented Unnatural Causes lending library and resources				X
5. Increased partnerships to address health equity and disparities		X		X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
IDPH staff provided a workshop at the fall MCH seminar on the utilization of the lending library/resources within MCH staff meetings and staff development. Appointed to the Region VII Regional Health Equity Council. Obtained funding for marketing to incorporate Department of Health and Human Services (DHHS), Office of Minority Health National Plan for Action to reduce racial and ethnic health disparities.

The OMMH partnered with Mercy Medical Services of Central Iowa to provide disparities grant

funding to conduct cancer screening within the African American community of Polk County. The OMMH partnered with Cornell University to provide two workshops on health morbidity and mortality in college-age students of diversity. Staff also continues to provide assistance to current and developing health coalitions within communities of diversity and public health service regions.

c. Plan for the Coming Year

Staff of the OMMH, in partnership with BFH staff, will:

- Continue to serve on planning committees, provide workshops, resources and technical assistance to entrench actionable alliances with MCH contractors, Mercy Medical Services of Central Iowa, UI, University of Northern Iowa Center on Health Disparities and other entities for strategies needed in addressing health equity in Iowa.
- Meet regularly with MCH staff members to develop assessment, strategies and action plans for increased awareness, interventions, and reporting in order to decrease the negative health impacts within Iowa's diverse population.
- Develop, manage, and implement grants awarded to statewide entities through OMMH state partnerships funds to assist in programs, projects or partnerships that will reduce health equity/disparities.
- Establish an inventory of best practices from the field for our partners in addressing health equity.
- Work with oral health programming on developing a webinar to promote health equity.
- Begin to identify and address how IDPH can develop a data set of social determinates that contribute to health inequity in Iowa.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				10	39
Annual Indicator				38.9	60.1
Numerator				2678	11254
Denominator				6881	18738
Data Source				Ahlers Family Planning Data	Ahlers Family Planning Data
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	61	63	65	67	69

Notes - 2011

FFY11 data were obtained from the Ahlers Family Planning data system.

Notes - 2010

FFY10 data were obtained from the Ahlers Family Planning data system.

a. Last Year's Accomplishments

The FFY11 performance objective of 39 was met. Data provided by the Ahlers Family Planning data system indicate that 60.1 percent of family planning clients are counseled about developing

a reproductive life plan.

Reproductive Life Planning (RLP) was successfully introduced into Title X family planning programming. IDPH's BFH contractors received training on the Life Course Theory of Health and how the RLP fits into that concept at the Spring Conference. Contractors were encouraged to consider implementing RLP counseling in WIC, MH, and CH programs where appropriate. A competitive Request for Proposal for community-based implementation of evidence-based curricula and strategies in schools, clinics, and community settings was issued and contracts have been executed.

Project Connect, an initiative by the Family Violence Prevention Fund and the Office of Women's Health, continued to promote screening for reproductive coercion and intimate partner violence, including birth control sabotage, in reproductive health settings. Trainings provided to MH, family planning (FP) and domestic and sexual violence advocates promoted partnerships and expanded universal education about the effects of violence on health.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expand RLP counseling to include FP clients attending a clinic visit for pregnancy testing only	X	X		
2. Offer materials to WIC program staff and clinics to advocate RLP occur at WIC clinics		X		X
3. Conduct statewide needs assessment for PREP, identifying target communities and population risk factors for Iowa's PREP program				X
4. Explore application of RLP in Iowa's abstinence education programming				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY2012, Title X agencies expanded their counseling of FP clients about RLP. This is evidenced by the change noted in the Annual Indicator above. Contractors for the Iowa Personal Responsibility Education Program (PREP) project began program implementation in spring 2012. Abstinence Education programs will begin program implementation in fall 2012.

A photo voice project has been initiated in one Title X agency to encourage youth participants to capture their interpretations of domestic and sexual violence through pictures. The project summary will be shared with the youth, IDPH contractors, and staff.

In response to the ACA, funding was made available to Title X agencies to assist them in the implementation of electronic health records, to improve coding and billing procedures, and to improve documentation to achieve meaningful use. Efforts continue to assist Title X agencies in navigating health care reform.

c. Plan for the Coming Year

A website focused on male involvement in family planning decisions was designed and will be implemented during FY12-FY13. The website will have an expanded focus on healthy teen living, incorporating Iowa's PREP and Abstinence Education programs.

Iowa was awarded funding for implementation of PREP to promote comprehensive sexuality education to teens ages 10-19. The goal of PREP is to reduce teen pregnancy, reduce the prevalence of HIV/AIDS and STIs, and to educate teens on adulthood preparation subjects/life skills to prepare them for a successful future. Iowa PREP facilitators will receive standardized RLP information and materials, including directions for documentation.

Iowa also received funding for Abstinence Education programming during FY12. Iowa's programming will use the curricula "Teen Outreach Program" (TOP) to promote abstinence in Iowa's foster care youth residing in out of home placement situations. Iowa Abstinence Education contractors will receive standardized RLP information and materials, including directions for documentation.

Five local MH agencies have action plans that address RLP. Activities include providing RLP to all clients in the MH program.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective					9
Annual Indicator				8	13
Numerator					
Denominator					
Data Source				Title V Index	Title V Index
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	14	15	16	17	20

Notes - 2011
Data Source: Title V Program Index. The 2011 Title V Index was scored by the Perinatal Guidelines Committee.

Notes - 2010
Data Source: Title V Program Index. The 2010 score is the first measurement of performance and is considered a baseline.

a. Last Year's Accomplishments
The FFY11 performance objective of 9 was met. The indicator value is based on the average score of the Perinatal Guidelines Committee members scoring the Title V Program Index. Iowa's local MCH programs scores averaged 13 (out of 30) points.

Infrastructure Building Services:
IDPH used the Title V Program Index as an instrument for measuring progress. The Title V Program Index, adapted from the NICHQ, is structured around six core MCHB outcomes:

Strategic leadership: MH program staff will work with leadership within IDPH, MH contractors, the Statewide Perinatal Care Program and the Perinatal Guidelines Committee to develop a strategic plan.

Partnerships across public and private sectors: IDPH will continue to support the work of the Perinatal Guidelines Committee, which is represented by public and private sectors.

QI: MH staff provides technical assistance to MCH programs on QI methodology. IDPH requires that QI be embedded into MCH programming and grantee proposals/applications.

Use of available resources: IDPH identifies potential community-based resources for MH programming in the MH and FP logic models. Logic models are included in the competitive RFP/RFA for local MCH/FP programming.

Coordination of service delivery: Care coordination is included as a core service for MCH programs. Local contract agency staff coordinates care for clients between the hospitals and other health providers. BFH staff are currently assessing care coordination services to ensure equitable services across the state.

Data infrastructure: Iowa's SSDI coordinator monitors the development of MCH public health data and advocates for the use of available funding for inclusion in the Health Information Exchange.

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 other third party payers in developing strategies for promoting evidence-based practices.				X
2. Continue to provide technical assistance to MCH programs on quality improvement methodology				X
3. Partner with Title X Family Planning to promote preconception care and reproductive life planning and March of Dimes to reduce preterm births.				X
4. Monitor community based performance indicators for early entry into prenatal care and medical home for prenatal care				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building:

Strategic leadership: BFH staff assessed the willingness of the Statewide Perinatal Team and the Perinatal Guidelines Committee to provide leadership on a strategic plan. Once complete, the updated strategic plan will be endorsed by the Committee and local MH contract agencies.

Partnerships across public/private sectors: During the development of the strategic plan, BFH gathered input from key partners and engaged IME and other third party payers in developing strategies for promoting evidence-based practices.

QI: BFH staff will continue to provide technical assistance to MCH programs on QI methodology. MH program staff coordinate system improvement activities with IME.

Use of available resources: BFH staff will collaborate with IME to advance evidence-based strategies into provider requirements/recommendations. The MH program will continue to

leverage medical subspecialty technical assistance through UI.

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: MCH surveillance expanded through a CDC grant to fund the Iowa PRAMS surveillance system. Iowa lacks the mechanisms and methods for monitoring changes and trends in a manner that reliably supports the use of "data to action." IDPH hired a project coordinator and has initiated a Steering Committee.

c. Plan for the Coming Year

Infrastructure Building:
Using the Title V Program Index as a dashboard for measuring progress, the Iowa MCH program is focusing on the following strategies in FFY2013:

Strategic leadership: Statewide Perinatal Team and the Perinatal Guidelines Committee will participate in a development of strategic plan.

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.

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 UPDATE.

Use of available resources: BFH staff will collaborate with IME to advance evidence- based strategies into provider requirements and recommendations (i.e., screening & risk assessment tools, physician education, and policy development). The MH program will continue to leverage medical subspecialty TA and consultation available through the UI Carver College of Medicine. IDPH will continue to partner with Title X Family Planning to promote preconception care and reproductive life planning 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: The Iowa PRAMS will employ a mixed model approach for data collection. The mixed model approach combines two modes of data collection: mail and telephone. Up to three self-administered surveys are mailed to a randomly selected sample of women who gave birth to a liveborn infant in the Iowa. Women who do not respond to the mailings are contacted by telephone and encouraged to complete a telephone interview. Data collection will begin in September 2012.

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	2007	2008	2009	2010	2011

Annual Performance Objective				21	22
Annual Indicator				20.1	19.7
Numerator				3135	2970
Denominator				15582	15093
Data Source				Medicaid Match Report	Medicaid Match Report
Is the Data Provisional or Final?				Provisional	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	21	22	23	24	25

Notes - 2011
FFY11 data were obtained from the 2011 Medicaid Match Report.

Notes - 2010
FFY10 data were obtained from the 2010 Medicaid Match Report.

a. Last Year's Accomplishments
The FFY11 performance objective of 22 percent was not met. Data from the 2011 Medicaid Match Report indicate that 19.7 percent of Medicaid enrolled women received preventive dental 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 still struggle with providers wanting to wait until after the pregnancy before providing services.

Infrastructure Building:
IDPH made changes to the Women's Health Information System (WHIS) in order to learn more about clients' oral health. Oral health questions were also added to the Iowa's Barriers to Prenatal Care survey, and that data will be available in 2012. A breakout session at the 2011 Governor's Conference on Public Health focused on data that shows increases in preventive dental care services for Medicaid-enrolled pregnant women in Iowa. The session, led by BFH and Oral Health Center (OHC) staff, also reviewed MH program outreach efforts. Participants then discussed ideas to improve the oral health of at-risk pregnant women, such as offering trainings for dental and medical offices about oral health and pregnancy, and possible policy changes to the MH program.

Population-based:
A poster targeting pregnant women was developed by OHC. The "Your baby will love your healthy smile" posters were shared with MH and CH contract agencies, to be distributed and posted in locations where pregnant women would see them. In addition, public service announcements (PSAs) ran on Iowa Public Television that explained the transfer of decay-causing bacteria from a mother's mouth to her child's mouth. Many local I-Smile™ Coordinators offered promotion materials (toothbrushes, floss, and tobacco cessation information) to hospitals for new moms and OB/GYN offices for their patients.

Enabling:
OHC staff clarified care coordination policy guidelines for Title V agencies, assisting them to provide quality care coordination for dental services. Staff also provided guidance on appropriately documenting and billing the care coordination services.

Direct Care:
Gap-filling preventive services were provided to MH clients as needed. I-Smile™ Coordinators trained local MH nurses to provide screenings, fluoride applications, and oral health education.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Incorporate I-Smile™ strategies to MH programming				X
2. Oral health promotion, including PSAs on Iowa Public Television			X	
3. Review results of first year of oral health questions on the Barriers to Prenatal Care survey.				X
4. Provide care coordination and gap filling preventive services	X	X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building:
OHC staff continues to consider ways to use I-Smile™ strategies and best-practice principles within MH programming. I-Smile™ Coordinators are encouraged to provide assistance to local MH programs as a way to improve birth outcomes and the oral health of new moms. In October 2011, OHC staff completed two days of strategic planning. As a result, OHC is pursuing ways to expand oral health programs and advance oral health through policy development -- which should positively impact the MH population. Results from the first year that oral health questions were included on the Barriers to Prenatal Care Survey will be compiled and reviewed to assist in determining future program activities.

Population-based:
OHC staff encourages health promotion efforts by local MH agencies to further educate the public and MH clients about the importance of good oral health. Health promotion through the I-Smile™ program includes targeted messages to mothers, informing them of the ability to transmit decay-causing bacteria to their children.

Enabling:
In addition to site visits, OHC staff monitor care coordination services provided by MH agency staff through WHIS data and quality assurance audits. This ensures at-risk pregnant women receive the help needed to access necessary dental services.

Direct Care:
OHC staff assists local MH agencies in determining the need for direct preventive dental services for MH clients. All clients are referred to dentists to receive regular care.

c. Plan for the Coming Year

Infrastructure-building:
As part of the I-Smile™ strategic plan, OHC staff will review activities in other state MH programs to determine best practices that could be replicated in Iowa. OHC staff will also look for additional ways to integrate MH issues within current I-Smile™ strategies. For quality assurance, OHC staff will participate in direct service chart audits for MH contractors who provide direct oral health services to clients, and review and revise the chart audit tool as needed. Medicaid paid claims, WHIS, and Barriers to Prenatal Care Survey data will be reviewed to assist in determining program direction.

Population-based:
Local I-Smile™ coordinators and the OHC will incorporate messaging about oral health and pregnancy within health promotion efforts. Target populations for promotion will include obstetricians and gynecologists, dentists, family practice practitioners, and women of child-bearing age.

Direct Service:
Nearly all MH contractors plan to offer direct dental services to clients, including screenings, fluoride varnish applications, and counseling.

Twelve local MH agencies have 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.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				43.7	46
Annual Indicator				45.8	46.7
Numerator				48307	50848
Denominator				105429	108923
Data Source				CMS 4.16	CMS 4.16
Is the Data Provisional or Final?				Final	Final
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	46.9	47	48	49	50

Notes - 2011
FFY2011 data were obtained from the 2011 CMS 416 report.

Notes - 2010
FFY10 data were obtained from the 2010 CMS 4.16 report.

The 2010 data was reported differently than in the past, specifically breaking out services provided by dentists and services provided by other providers. The new category used is “any dental or oral health service”.

a. Last Year's Accomplishments
The FFY11 performance objective of 46 percent was met. Data from the 2011 Medicaid CMS 4.16 Report indicate that 46.7 percent of Medicaid enrolled children ages 0-5 years received a dental service.

Infrastructure Building:
OHC staff outlined an OHC surveillance system, identifying existing data and possible gaps, to direct future program planning. OHC used state data for policy briefs and reports about I-Smile™, illustrating the oral health needs and improvements for children. OHC staff developed the template for I-Smile™ Coordinators to use for local needs assessments. A dental public health curriculum was completed through a public-private partnership with Des Moines University. During FFY2011, OHC staff held three face-to-face and one web-based meeting for I-Smile™ Coordinators.

Local I-Smile™ activities included leading community oral health coalitions, training health care

providers about children's oral health, and organizing advocacy efforts for community water fluoridation.

Population-based:
In addition to supporting radio and television spots promoting I-Smile™ and early dental care, the OHC supported a "Dentist by 1" campaign through Delta Dental of Iowa, targeting families, dentists, physicians, and hospitals. Other health promotion activities included use of PSAs on Iowa Public Television and radio spots during National Children's Dental Health Month.

Enabling:
OHC staff emphasized the importance of I-Smile™ Coordinators working with hawk-i outreach coordinators to ensure eligible children are enrolled in Medicaid or hawk-i. OHC and BFH staff clarified care coordination guidelines to assist MCH agencies in providing quality care coordination for dental services and to document and bill appropriately.

Direct Care:
Title V agency staff provided gap-filling preventive services for very young children at WIC clinics, childcare settings, preschools, and Head Start centers. While most services are provided by dental hygienists using public health supervision, some are provided by registered nurses, trained by I-Smile™ Coordinators. Last year, 104 uninsured children age 5 and younger received dental care from dentists using Title V funds.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Completion of local I-Smile™ Needs Assessments.				X
2. I-Smile™ coordinator professional development				X
3. Pursue reimbursement to physicians for oral screenings.				X
4. Oral health promotion.			X	X
5. Provide care coordination and gap filling direct care.	X	X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Infrastructure Building:
I-Smile™ Coordinators submitted local oral health needs assessments to OHC in February. OHC staff provides technical assistance to contract agencies on how to use the assessments to guide program planning. Meetings continue between OHC, IME, and IA- AAP to pursue Medicaid reimbursement to medical practitioners for oral screenings. OHC staff spent two days facilitating I-Smile™ strategic planning.

Local activities include leading community oral health coalitions, training health care providers, and organizing water fluoridation advocacy efforts. I-Smile™ Coordinators are completing a dental public health curriculum developed last year by OHC and Des Moines University, focused on public health systems, policy development, surveillance, and health promotion.

Population-based:
OHC statewide promotion activities include sponsorship of Iowa Public Television children's programming and distribution of materials recognizing National Children's Dental Health Month.

Enabling:
OHC staff assists local CH agencies with care coordination protocols to ensure families receive the help they need to access dental care.

Direct Services:
Title V contract agencies are required to work with local WIC projects, at a minimum, to ensure gap-filling preventive services are provided to children age two and younger. Services may also be provided to older children, with particular emphasis on birth through age 5.

c. Plan for the Coming Year
Infrastructure Building
The I-Smile™ project will serve as the basis for most of the activities for this measure. To maintain quality and consistency, OHC staff will provide at least three trainings for I-Smile™ Coordinators. Requirements for CH contract agencies include developing partnerships with businesses, business organizations, civic organizations, and/or faith-based organizations to build local infrastructure. The dental director and OHC staff will continue their work with IME regarding reimbursement to physicians for oral screenings of children up to the age of 3. OHC staff will also continue working on an Early Childhood Iowa work group to determine core health services for early childhood professionals.

Population-based:
The OHC will promote oral health, particularly early and regular care, through its website, development and distribution of materials, and possibly through social media outlets such as Facebook. We will look for grant opportunities to support these activities. Title V contract agencies will be required to conduct oral health promotion as part of I-Smile™.

Enabling:
I-Smile™ Coordinators will maintain and build local referral networks to ensure families are able to access services. Families will receive dental care coordination, with a focus on the first visit by the first birthday. 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.

Direct Services:
Title V contract agencies will be required to ensure that children are receiving gap-filling preventive services at WIC. Additional gap-filling services may also be provided in other public health settings.

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	**2007**	**2008**	**2009**	**2010**	**2011**
Annual Performance Objective				12.2	6.3
Annual Indicator				12.4	11.2
Numerator				733	676
Denominator				589813	603673
Data Source				Iowa Hospital Association inpatient data	Iowa Hospital Association inpatient data

Is the Data Provisional or Final?				Final	Provisional
	2012	**2013**	**2014**	**2015**	**2016**
Annual Performance Objective	11	10.9	10.8	10.7	10.6

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.

Notes - 2010
FFY10 data were obtained from hospital inpatient data from the Iowa Hospital Association.

a. Last Year's Accomplishments
The FFY11 performance objective of 6.3 percent was not met. Provisional data from the Iowa Hospital Association indicate that the rate of hospitalizations due to unintentional injuries among children ages 0-14 years was10.7. In the FFY10 report, the FFY11 indicator was re-set based upon provisional data. Final data was not available until the close of the calendar year which showed a higher rate than that reported in FFY10. Data will continue to be monitored to track any changes in trends once final data is available for this measure.

Infrastructure Building:
BFH worked with the IDPH Bureau of Disability and Violence Prevention to conduct annual surveillance of statewide injury trends. A survey of Title V MCH contract agencies was conducted to identify local injury prevention initiatives. BFH encouraged collaboration at the local level on community initiatives related to injury prevention for Iowa children.

BFH staff participated in the statewide injury prevention advisory council and collaborated with the IDPH Healthy Homes initiative. BFH staff also contributed to Iowa's CDC Core Violence and Injury Prevention Program application.

Information was disseminated to MCH agencies and school districts during the 2011 National Public Health Week addressing the importance of injury and violence prevention through the theme "Safety is No Accident: Live Injury-free." BFH promoted the 10th Annual Iowa Child and Youth Injury Prevention Conference held at Blank Hospital in Des Moines. Staff also shared information on the "Love Our Kids" grant - Child Injury Prevention Project designed to provide funding to federally-appointed rural areas to develop and implement injury prevention and education initiatives for Iowa children.

BFH continued to promote health and safety assessments in childcare settings. Staff worked with the Children's Safety Network in strategic planning for injury prevention in child care. Educational sessions pertaining to health and safety were provided for childcare consultants and providers by local Child Care Nurse Consultants.

BFH staff provided leadership on preventing shaken baby syndrome (SBS) through participation in 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, has worked collaboratively to plan and implement a statewide program to prevent SBS. The Period of PURPLE Crying was selected as the educational program, and is the only SBS prevention program to have undergone randomized, clinical trials to measure its effectiveness. Using a child development education approach, the Period of PURPLE Crying program 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 provide education to parents prior to discharge from the hospital. Parents are sent home with a DVD and booklet to help them understand the serious nature of SBS, as well as techniques to prevent it.

Iowa was selected as one of thirteen states to participate in the Children's Safety Network's (CSN) National Rural Injury Prevention Community of Practice. Throughout the year, a series of educational presentations featured farm injury, rural drowning, suicides, family violence, ATV injuries, and poisonings. Participants shared and gained expertise on rural injury prevention interventions, data resources, and current research.

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. Continue to implement components of Rural Injury Prevention Community of Practice plan				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building:
BFH continues to work with the IDPH Bureau of Disability and Violence Prevention to conduct an annual surveillance of statewide injury trends. Best practice information on childhood injury prevention is distributed to Title V contractors and school districts addressing safety hazards in childcare settings and prevention of child and youth agricultural injuries. BFH promotes the Annual Iowa Child and Youth Injury Prevention Conference.

Iowa was recognized as a "Purple State" for statewide efforts to prevent SBS. An evaluation of the Period of PURPLE Crying curriculum in Iowa birthing hospitals has been completed. A DVD for childcare workers was developed to demonstrate how they can reinforce education on the Period of PURPLE Crying.

BFH promotes health and safety assessments in childcare settings. Educational sessions address immunizations, SBS, safe sleep, and playground safety. Recommendations have been made to Iowa DHS to make mandatory the reporting of child death and medically attended injuries in childcare settings within 24 hours. Recommended interim strategies include voluntary web-based reporting or active surveillance of incident reports in child care facilities. A pilot study was recommended.

Iowa's Rural Injury Prevention Community of Practice project features promoting ATV safety through dissemination of educational programs and resources, collecting data, monitoring legislation, and presentations at farm shows and health fairs.

c. Plan for the Coming Year

Infrastructure Building:
BFH will continue to work with the IDPH Bureau of Disability and Violence Prevention to conduct an annual surveillance of statewide injury trends. Results of the injury prevention survey of local Title V MCH contract agencies will be used to share best practices and encourage collaboration at the local level. BFH will continue to be involved in the IDPH Healthy Homes initiative.

BFH 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.

BFH will continue to promote health and safety assessments in childcare settings. Educational sessions pertaining to health and safety will be provided for consultants and providers of childcare.

BFH staff will continue to promote reinforcement of messages families receive in the hospital about preventing SBS. Dissemination of the Period of PURPLE Crying program to new mothers both prenatally and postnatally will continue through parenting/birth classes, family physicians/pediatricians, social workers, licensed childcare providers, and home visitors in order to help parents retain information about the characteristics of normal infant crying, the dangers of shaking an infant, and techniques to soothe and cope with infant crying.
Staff will continue to implement components of Iowa's plan for injury prevention developed through the CSN National Rural Injury Prevention Community of Practice.

Two local MCH agencies have action plans that address unintentional injuries by utilizing resources provided by Safe Kids USA. Agencies' activities include distributing materials at community events, presenting information at medical clinics and conferences, car seat safety checks, and utilzing a child care nurse consultant to providine health and safety consultation to local child care providers.

E. Health Status Indicators

#01 A, #01B; #02A,#02B (LBW, VLBW)

IDPH is tracking low birth weight (LBW) infant outcomes using Medicaid paid claims that are linked to the birth certificate. Medicaid status was based on a paid claim for any one of the delivery related DRGs (370 -- 375). The analysis is limited to Medicaid reimbursed deliveries (n=15,582). Infant LBW was examined according to maternal demographics (race, ethnicity, age, educational level and urbanicity). Infant LBW was also examined by prenatal care initiation, receipt of preventive dental care and maternal smoking in the third trimester of pregnancy. Chi-squared analysis and logistic regression was used to explore the factors associated with infant LBW among women with Medicaid reimbursed deliveries in Iowa.

The results showed that overall 7.2% (n=1,115) of women with a Medicaid reimbursed delivery gave birth to LBW infants. When examined according to race and ethnicity, the percent of non-Hispanic Black women and non-Hispanic women of other races who delivered a LBW infant was significantly greater than that of non-Hispanic white women. The percentages of women aged 19 years and younger, as well as women who were 30 years of age or older, who delivered a LBW infant were significantly greater than women between the ages of 20 -- 29. The percent of women who were not enrolled in the Special Supplemental Nutrition Program for Women, Infants and Children (commonly known as WIC) during pregnancy and who delivered a LBW infant was significantly greater than among those who were enrolled in WIC. The percent of Iowa women who delivered a LBW infant did not differ significantly by maternal education, urbanicity, prenatal care initiation, or receipt of preventive dental care during pregnancy. The full report is available at the following link:

http://www.idph.state.ia.us/hpcdp/common/pdf/family_health/2010_low_birth_rate.pdf

Action steps based on this analysis, key factors associated with infant LBW among Medicaid recipients in Iowa were maternal race/ethnicity, age, marital status, recipient of WIC and smoking in the third trimester. All agencies are focusing on low income women, especially minority women. Action plans are in place to address these health disparities. The IDPH completed training on tobacco cessation programs with grantee agency staff members at the MCH Fall Seminar in 2010, and are tracking and encouraging dental hygienist and trained nurses in our maternal health program to counsel women about tobacco cessation to prevent oral health disease. Pregnant women are assessed on admission to the maternal health program for tobacco use and, if the women are willing, are referred to the Quitline Iowa. It was surprising to note that 25% of the women with Medicaid reimbursed births reported that they had not received WIC benefits during their pregnancy. In 2013, BFH staff will strive to increase referrals to Quitline Iowa and expand efforts to encourage enrollment in WIC.

#03C and #04B (Unintended Injury/death by Motor vehicle)

Motor vehicle crashes remain the leading cause of injury and death to Iowa teens. Blank Children's Hospital is partnering with numerous organizations committed to working on related policy issues during the 2011 and 2012 legislative sessions.

The principles of a Graduated Driver Licensing (GDL) program are to maximize experience, minimize risks and implement policies for all novice drivers. Several key stakeholder groups recently came together to assess the most influential changes that can be made to Iowa's current GDL program in order to accomplish it's primary goals. Based on current research, the stakeholders determined that the following revisions would have the most impact: 1) Increase the length of driving on an instruction permit from 6 to 12 months; 2) Implement a passenger limitation for drivers on a school permit --of no more than one passenger under the age of 21, excluding family members; 3) For the intermediate license phase (1 year), the following restrictions would be applied:
• Institute a passenger limitation of no more than one passenger under the age of 21, excluding family members. This is a change from the current law that only limits the number of passengers to the number of seat belts.
• Expand nighttime driving restrictions to between 10:00 p.m. and 5:00 a.m. The current law restricts driving between the hours of12:30 a.m. and 5:00 a.m. Waivers would be available to drive to and from work and school activities.

In Iowa, all cell phone usage is illegal for learner permit and intermediate license holders. All drivers, regardless of age, are banned from texting.

Title V programs are increasing partnerships with the Iowa Chapter of the American Academy of Pediatrics. IA-AAP obtained a $25,000 award from the Teen Safe Driving Grant Program sponsored by the Allstate Foundation to educate policymakers and the public about teen driving safety and the importance of stronger graduated driver licensing laws.

#05A, #05B (Chlamydia)
The increase in Chlamydia rates in Iowa mirrors the increases noted nationally; the reasons behind the increase are unclear. The increase may reflect the expansion of Chlamydia screening activities, use of increasingly sensitive diagnostic tests and an increased emphasis on case reporting from providers and laboratories. The increase is especially notable among the 18-26 year old age group.

In addition, while young people seem to be delaying the initiation of sexual activity and are using

effective contraceptives, the use of condoms is less consistent. According to Child Trends, one out of two teen males is not using condoms consistently in his most recent sexual relationship. The 2011 Iowa Youth Risk Behavior Survey indicates that, of students who indicated they had sexual intercourse during the past three months, only 61.4% used a condom during their last sexual intercourse. Older teen males and those in longer sexual relationships are less likely to use condoms at their most recent sexual experience over time, perhaps because of a greater likelihood that a partner would be using a more effective method of pregnancy prevention. Indeed, analyses of the survey data found that a partner's use of contraception was linked with lower condom use.

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 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 are involved with planning and operation of Community Empowerment Areas.

2. Staff contribute to course development and teaching for the University of Iowa College of Public Health MCH focus track students and other graduate students.

3. Staff participate 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 participate 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 participate 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 lead 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 participate in an MCHB-supported Department of Public Health effort to establish a comprehensive early childhood system.

10. Staff participate 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 participate 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 serve in an advisory capacity to the Department of Public Health data integration initiative.

13. Staff serve 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 serve 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 a member of the Executive Board, American Academy of Pediatrics, IA Chapter and Co-Chair, American Academy of Pediatrics Planning Committee, Native American Child Health and Canadian Pediatric Society, International Meeting on Indigenous Child Health, March 2011

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. Staff partner with the Iowa Department of Public Health and the Univ of Iowa Public Policy Center to prepare, interpret, and disseminate the Iowa Child and Family Household Health Survey, next due in 2010.

18. The CHSC Regional Autism Services 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 parent consultants assist parents of children with ASD in learning Applied Behavior Analysis (ABA) techniques via a National Institute of Mental Health grant to the Centers for Disabilities and Development at the University of Iowa.

19. To promote family involvement at all levels of the MCH pyramid, CHSC community-based parent consultants serve on multiple state level advisory groups: Medicaid's Medical Assistance Advisory Committee, Iowa Collaborative Safety Net Provider Network, Early ACCESS (Part C IDEA) 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, the University of Iowa Hospitals and Clinics' Family Advisory Committee, the Maternal and Child Health Advisory Council, and local and county governance boards to guide Community Circle of Care (CCC).

An attachment is included in this section. IVF - Other Program Activities

G. Technical Assistance

Iowa is requesting technical assistance support to build capacity of local Maternal and Child Health agencies on implementation of the Title V Index and the use for quality improvement of maternal and child health practices. Through this technical assistance consultant, Iowa would also look for input on developing meaningful measures to monitor program quality and show return on investment of public health programs.

Iowa has integrated the ACE survey questions into the BRFSS survey and will be getting preliminary data in the fall 2012. 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 conducts the Iowa Child and Family Household Health Survey to provide population based data for child and family health outcomes and serve as the foundation for the MCH needs assessment data source. Additional technical assistance may be requested to conduct multivariate analysis on key indicators related to maternal and child health and social determinants of health.

Iowa is requesting technical assistance to formulate activities for local Title V MCH agencies and CHSC to develop relationships with Accountable Care Organizations within their communities. Technical assistance could be given through another state that has had success in working with ACO structures.

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 Georgetown National Center on Cultural Competency to develop Iowa's capacity to assure Title V services all ethnic minority groups and is working on system level strategies to address cultural competency.

CHSC is requesting data to work with the National Improvement Partnership Network (NIPN) to develop outcomes for care coordination in working with children and youth with special health care needs to illustrate benefits of care coordination not only to the family but to the health care system.

CHSC has implemented a successful Family to Family Navigator infrastructure and is requesting technical assistance to develop person-centered support plans for person with disabilities through the training of family to family navigators.

Iowa is requesting TA to continue to assure the Family to Family Iowa coalition remains strong and brings other family type coalitions together to form around a common message for families with children and youth with disabilities.

CHSC is requesting technical assistance from the National Center for Transitions for Youth in Florida to address transition infrastructure components that are key to successful transitions for adolescents with special health care needs.

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 2011		FY 2012		FY 2013	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	6528937	5337821	6159375		6442068	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	5399077	5368373	5531822		5350187	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	4537311	3872649	3947332		3852092	
6. Program Income *(Line6, Form 2)*	300000	352820	475000		350000	
7. Subtotal	16765325	14931663	16113529		15994347	
8. Other Federal Funds *(Line10, Form 2)*	6797535	6312571	8066628		13566821	
9. Total *(Line11, Form 2)*	23562860	21244234	24180157		29561168	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	1688581	1543373	1583901		1641918	
b. Infants < 1 year old	303163	277390	280137		301710	
c. Children 1 to 22 years old	9403585	8290250	8876848		9056884	
d. Children with	4763458	4238562	4766105		4387297	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	606538	582088	606538		606538	
g. SUBTOTAL	16765325	14931663	16113529		15994347	
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	0		0		150000	
d. Abstinence Education	0		860686		860594	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	180042		175000		190000	
j. Education	157317		156400		156400	
k. Home Visiting	0		0		7740642	
k. Other						
Autism	210516		0		154326	
CCHT-Intgr. Comm.	0		0		86489	
CDC Stillbirth	0		270000		270000	
CHIPRA	0		0		324766	
Early ACCESS-CHSC	1021670		0		211376	
EPSDT - HCBS IS	0		0		547076	
Family Planning	1345021		1301484		1333033	
Newborn Hearing-HRSA	0		300000		270000	
PRAMS	0		0		190046	
Prjct LAUNCH/Connect	0		957281		982073	
CCC- SAMHSA	2090231		2299435		0	
ECCS -HRSA	132000		140000		0	
Family Participation	0		130000		0	
Family to Family	95700		95700		0	
Home Visiting	0		1140642		0	
Newborn Scrn Surv	115100		140000		0	
Newborn Scrn-CHSC	299938		0		0	
Project Connect - DV	200000		0		0	
Project LAUNCH	850000		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		**FY 2012**		**FY 2013**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health	4332382	3812188	3989929		4691978	

Care Services						
II. Enabling Services	3930801	2961261	3252930		2963776	
III. Population-Based Services	1970058	1550061	1715982		1476974	
IV. Infrastructure Building Services	6532084	6608153	7154688		6861619	
V. Federal-State Title V Block Grant Partnership Total	16765325	14931663	16113529		15994347	

A. Expenditures

Form 3, State MCH Funding Profile, shows $5,337,821 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 10 award. Due to a decrease in the state's award for FFY11, carry forward funds were necessary to maintain community-based programs at current levels for maternal health and child health.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY11 in the amount of $14,931,663. Of this amount, $5,337,821 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 $5,368,373. This exceeds both the state match requirement of $4,858,819 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 $2,009,243 or 37 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at $1,619,179 or 30 percent of the federal block grant funds expended for the year. Administration expenditures of $555,353 represent 10 percent of the federal Title V amount.

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, 2010 to June 30, 2011. The Iowa Department of Public Health had four findings in the 2011 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 FFY13 Title V appropriation is projected to be $6,442,068, based on a status quo budget from the final FFY12 award. As itemized in the budget attachment, this expected allocation is budgeted as follows: $1,337,836 (20.8%) for maternal health services; $301,710 (4.7%) for infant health services; $2,036,838 (31.6%) for child health services; $2,159,146 (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 $5,055,274. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989 and exceeds the required match of $4,831,551.

The total budget for the federal-state partnership is projected to be $16,162,093. 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 $6,861,619 or 42.5 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 35 percent of the funding for local child health agencies and 29 percent of local maternal health funds. In addition, it will include contract services with the University of Iowa, Departments of Pediatrics, Perinatal Review Team, and IDPH 1st Five Initiative. . CHSC's budget for infrastructure building services is estimated at $1,404,519 (32 percent of the CYSHCN budget).

Population Based Services.
The federal-state partnership expenditures for continuation of population-based services are estimated at $1,476,975, which represents approximately 9.1 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 11 percent of the funding for local child health agencies and 6 percent of local maternal health funds. IDPH projects expenditure of $1,416,322. CHSC does not project expenditures in this category.

Enabling Services.
The federal-state partnership expenditures for continuation of enabling services are estimated at $2,963,776 representing 18.3 percent of the partnership budget. This category includes 40 percent of the funding for local child health agencies and 34 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. 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 $4,859,724. This represents approximately 30.1 percent of the partnership budget. The amount includes 14 percent of the funding for local child health agencies and 31 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 HOPES-Health Families Iowa home visiting. CHSC projects a direct care budget of $1,876,998 or approximately 42.8 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)
SAMHSA Integrated Behavioral Health
Iowa Stillbirth Surveillance Project (CDC)
Iowa Newborn Screening Surveillance Project (CDC)
Iowa Family Participation Project (HRSA/MCHB)
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)
Project Connect (Futures Without Violence)
CHSC grants

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.