



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

**State Narrative for
Iowa**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

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

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

See attachment for Assurances and Certifications.

An attachment is included in this section.

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; expires May 31, 2009.

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.

/2007/ There were approximately 200 hits to the Title V public input section of the Web page. Numerous emails were sent to Title V staff to provide comments on the 2007 application.

The MCH Advisory Council members were asked to assist in the establishment of the Title V priority needs and performance measures. The Council endorsed the state plan at their June 1, 2006 meeting. The members were also asked to provide 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. See the attachment for a list of members and by-laws.

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. /2007/

/2008/ There were over 100 hits to the Title V public input section of the IDPH Web site. There were several e-mails from local community partners providing input on the state priorities, performance measures, and activities within the performance measures.

The Council endorsed the state plan at their June 14, 2007 meeting. The members were also asked to provide 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. Local contract

MCH agencies were encouraged to provide input on the Title V priorities and performance measures. //2008/

//2009/ There were about 550 hits to the Title V public input section of the IDPH Web site. There were several emails from local community partners providing input on the state priorities, performance measures, and activities within the performance measures. This input was used to provide enhancement for the application.

The Council endorsed the state plan at their June 12, 2008 meeting. The members were also asked to provide 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. Local contract MCH agencies were encouraged to provide input on the Title V priorities and performance measures. //2009// An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

Title V Five Year Needs Assessment

Iowa continues to work on system development to improve the public health infrastructure for all Iowans. In the 2008 General Assembly the health care reform was a major priority. The intent of the legislation is to provide all children with hawk-i and Medicaid insurance coverage by January 2011 and to expand the hawk-i program up to 300 percent FPL if federal funding becomes available. It also extends coverage for children through age 25 who are on their parent's health insurance plan. It also establish a medical home initiative with an advisory board. The legislation will establish an electronic health information commission.

The Iowa Department of Public Health (IDPH) has been working on state and local public health redesign for the last four years. Iowa's public health system is fragmented and lacks formal integration. For years, public health programs in Iowa have operated in silos at the state and local levels, with little incentive for communication among the different disciplines. In addition, the system lacks benchmarks or standards at both the state and local levels. Furthermore, the public health workforce suffers from inadequate training and faces retention problems due to an aging population and workforce fatigue.

The redesigning public health is a partnership between the local and state level. Workgroups have been set up to serve as the steering committee. The Work Group decided that one of the first steps for Redesigning Public Health was to develop standards for local and state public health. The Work Group asked a broad group of stakeholders with expertise in public health to serve on committees to draft standards and criteria. The Iowa Public Health Standards provide a consistent and accountable approach to promoting and protecting the health of Iowans.

The following is a summary of the major points of progress in meeting Iowa's state and national priority needs.

Topics:

Early Childhood Priorities:

Early Childhood Iowa (ECI) has developed public and private partnership to develop and implement a comprehensive, integrated early care, health, and education system. One component of the system is working to improve the quality of programs. ECI has been working over the last two years to develop a family support credentialing process. The credentialing process includes standards, core competencies, and common outcomes.

Child and Adolescent Priorities:

IDPH and partners have been working on a state plan to address nutrition and physical activity to prevent obesity and other chronic diseases. Iowa's project, Fit for Life, received funding from the CDC to develop a plan and implementation. IDPH also received a Harkin Wellness grant and state appropriations to implement at the local level through local boards of health.

The Early Hearing Detection Initiative has been working with partners to implement statewide newborn screening and follow-up services. The EHDI project staff have been working to educate health care providers, parents, early childhood advocates about the importance of screening and follow-up.

Oral Health Priority:

The I-Smile program was created in response to legislation that mandates all Medicaid children 12 years and younger have a dental home. I-Smiles was created through a partnership with DHS and IDPH. Components of I-Smile include improving the dental support system for families, improving the dental Medicaid program, implementing recruitment and retention strategies for underserved areas, and integrating dental services into rural and critical access hospitals.

Maternal Health Priorities:

In partnership with the Iowa Chapter of the March of Dimes, IDPH has implemented a Iowa Pregnancy Risk Assessment Monitoring System pilot project for the last two years.

Children with Special Health Care Needs Priorities:

The SAMHSA System of Care project in northeast Iowa has completed its planning and, now, nearly 3/4ths of its first implementation year. This project is addressing our state priority need to improve access to pediatric specialty care - mental and behavioral health specialty care, in this case. A "wraparound" model of service delivery promotes the family-driven, youth-guided service philosophy. A prescribed evaluation plan will assure ability to determine the influence of the service delivery model on child and family outcomes.

The Iowa Medical Home Initiative (IMHI) and the Iowa/Nebraska Primary Care Association (IA/NEPCA) have partnered to investigate the potential contribution of the medical home model to selected health provider organizations considered to be part of Iowa's safety net - specifically rural health clinics, free medical clinics, MCH clinics, and local boards of health. IMHI staff provide technical assistance and resource sharing to interested safety net provider staff. The ultimate goal is to help meet the state legislative mandate that safety net providers "help families determine a medical home."

CHSC has expanded its Parent Consultant Network (PCN). There are now over 40 employed members of the PCN serving as peer-to-peer support and as care coordinators in several program areas. Programs in which PCN members serve include: 1) Medicaid Waiver programs; 2) Iowa's Part C early intervention program; 3) the SAMHSA System of Care project; 4) the Early Hearing Detection and Intervention project; and 5) the CHSC direct clinical service programs. Through these programs and projects, the PCN is allowing CHSC to progress toward meeting the priorities of greater family participation, greater family satisfaction, and improved organization of services.

Additional Comment:

Although, as documented above, Iowa's Title V MCH and CSHCN programs continue to strive towards meeting identified national and state priority needs, we proudly mention here that a recent Commonwealth Fund report (May, 2008) on states' "Child Health System Performance" ranked Iowa as first in the nation. General ranking factors included: access, quality, cost, equity, and potential to lead healthy lives.

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 demography, population changes, economic indicators and significant public initiatives. Additionally, major strategic planning efforts affecting development of program activities are identified.

Iowa's Land

Most of Iowa is composed of gentle 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 country. The deep black soil yields huge quantities of corn, soybeans, oats, hay, wheat, and barley, which help support its cattle and hogs 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 2.9 million people. According to census projections, Iowa will experience a modest three percent growth in population by 2015. The population will continue to shift from rural areas to urban areas. One-third of Iowa's 99 counties are expected to lose population. Ninety-four percent of the population is white; however, racial and cultural diversity is increasing. Residents of Hispanic origin are the fastest growing ethnic group. The Hispanic population increased from 1.2 percent in 1990 to 2.8 percent in 2000, and continued to increase to 4.0 percent in the 2007 estimate. Birth data indicate an increase in Hispanic population. In 2000, live births to Hispanic women made up 5.6 percent of all births, double the population proportion in the same year. This ratio is even higher in 2007 (8.2 percent vs. 4.0 percent). Approximately 234,366 children are five or younger and make up about 7.8 percent of the total population. Of the children between the ages of zero and five, 7.8 percent are children of Hispanic origin and an estimated 8.9 percent of children have a special health care need. Children ages 19 or younger had a higher rate of poverty (22.3%) than the general population (17.5%) in 2006.

Employment and Population Changes

Iowa's unemployment rate has steadily increased since 2000. The 2000 unemployment rate was 2.6 percent and it has increased to 4.8 percent in 2004. ***//2009/ The 2007 unemployment rate has decreased to 3.8 percent //2009//***

The most notable population change is the increase in Hispanic immigrants. Census estimates show that residents of Hispanic origin increased from 2.8 percent in 2000 to 3.5 percent in 2004. Iowa's overall population has increased by 1.4 percent from 2000 to 2005. ***//2009/ The most notable population change is the increase in Hispanic immigrants. Census estimates show that residents of Hispanic origin increased from 2.8 percent in 2000 to 4.0 percent in 2007. Iowa's overall population has increased by 2.0 percent from 2000 to 2007. //2009//***

Even with the influx of new citizens, Iowa's total population is projected to experience only modest growth between now and 2010. While the overall population remains stable, the minority populations are expected to grow in both absolute numbers and total population.

Poverty

The percentage of families in Iowa living at or below the federal poverty level has been fluctuating. In 2000, the rate was 10 percent and in 2002 the rate decreased to seven percent. The 2004 data showed an increase in the number of families living in poverty to 9.2 percent. This is approximately 68,000 families defined as poor by the federal poverty level. There were 12.8 percent of children 0-17 years old living at or below the federal poverty level in 2004. ***//2009/ The 2006 data showed an increase in the number of families living in poverty to 7.3 percent.***

This is approximately 58,000 families defined as poor by the federal poverty level. There were 13.7 percent of children 0-17 years old living at or below the federal poverty level in 2006. ///

Community Empowerment Areas

Iowa has been progressive in implementing partnerships between local and state government. In 1997, legislation provided for the establishment of "innovation zones." Several state agencies collaborated with local organizations within approved zones to reduce barriers to services as identified by communities. In 1998, legislation was passed which built upon the "innovation zones" concept to promote "empowerment" areas. The purposes of Community Empowerment legislation were to establish local community collaborations, create a partnership between communities and state government, and improve the well-being of children 0-5 years of age and their families. An additional goal was to empower communities to build a system of services to improve the effectiveness of local education, health, and human services programs. Community Empowerment areas have been designated to cover all 99 counties. This legislation directly influences community-based MCH services in Iowa.

Iowa was one of five states and one community to receive a Technical Assistance Grant to help strengthen and expand the state's and local partnership for providing quality care and education for young children in Iowa. The Technical Assistance Grant was from North Carolina Smart Start National Technical Assistance Center. The grant started in January of 2002 and will continued through January 2004. The grant was for technical assistance funding up to \$150,000 including: On-call coach, information and referral, site visits, mentoring program, conference calls, Smart Start Resource material, and Smart Start Speakers Bureau.

The following recommendations were designed to build upon and strengthen Community Empowerment's accomplishments and assist the initiative in moving to the next level of development:

1. Develop a comprehensive, compelling, and unifying vision for all of Iowa's young children.
2. Strengthen and build on the accountability for results at the state and local level.
3. Deepen and broaden the public will to support early childhood issues.
4. Strengthen the leadership to increase support for Community Empowerment and the greater vision for early childhood in Iowa.
5. Expand organizational capacity to meet the greater vision for young children.

Through the Smart Start Technical Assistance Grant a core early care, health, and education stakeholder group was formed. The purpose of the stakeholder group was to be an advisory group to the early care, health, and education system. The stakeholders include representatives from public and private entities throughout the state. The functions of the stakeholder group are to review, design, and participate in cross functional proposals, understand all parts of the system, create and update the plan, agree on common language for the system, develop a menu of best practices, encourage relationships across disciplines, and be a resource to the system.

The Bureau of Family Health in partnership with Community Empowerment developed an early childhood plan through the HRSA Early Childhood Comprehensive Systems grant. Key personnel from IDPH are the project director and coordinator. The State Empowerment Team has served as the coordinating body of the grant. The Early Childhood Iowa Stakeholders have served as the advisory body for the grant. Grant Initiatives have promoted the development of community-based comprehensive systems of services that assure coordinated, family centered, and culturally competent care for children.

The Early Childhood Iowa Stakeholder group developed Iowa Early Care, Health, and Education Strategic Plan. The stakeholder members are responsible for taking the goals, indicators, and strategies back to their constituents to get buy in. The IDPH applied for a three-year implementation grant in May 2005. /2007/ IDPH applied for the second year implementation continuation grant in June 2006. /2007/

The Early Childhood Iowa Stakeholder members developed six component workgroups to help move the system planning forward. The six component workgroups are: 1. Quality Services and Programs; 2. Public Engagement; 3. Resources and Funding; 4. Results Accountability; 5. Governance and Planning; and 6. Professional Development. More information on the Early Care, Health, and Education System building activities can be found at www.earlychildhoodiowa.org

/2007/ Community Empowerment launched a new parent Web site for families with young children. (www.parents.earlychildhoodiowa.org). The Web site will serve as a hub for the many online resources available to parents with young children.

This Web site provides information on the following categories: parenting, health and safety, child development, child care, preschool, healthy teeth, healthy eating and physical activity, community resources, 2-1-1 information and referral, learning to read and write, pregnancy, financial help, and help me now.

In addition to clicking on the categories, there is an A-Z search that will search for resources within the Web site. There is an evaluation component on the Web site to encourage general feedback and suggestions regarding the information available through the Web site. The Web site will be updated on an on-going basis to incorporate feedback. /2007/

/2008/ IDPH applied for the third year implementation continuation grant in June 2007. Iowa has developed a single, comprehensive plan for the Early Care, Health, and Education system. More information on the Early Childhood Iowa system building activities can be found at www.earlychildhoodiowa.org. /2008/

/2009/ IDPH applied for continuation funding to continue the work on the integration of a comprehensive early childhood system through MCHB. In the 2008 General Assembly, Early Childhood Iowa was formalized in legislative language. The language provides a formal structure for the Council and the State Agency Liaison Team. The language also names the Iowa Department of Public Health as the lead agency for Early Childhood Iowa. //2009//

Legislative Session for Early Childhood

The legislative session ended on Friday, May 20th, 2005. Early Childhood Education was a priority during this legislative session.

Preliminary results indicate an additional spending of over \$21.1 million for early childhood education. The preliminary numbers show additional spending of \$10.4 million for Community Empowerment and an additional \$10.75 million for child care. Below are a few of the highlights for the additional dollars:

Implement a quality rating system; Raise reimbursement rates for child care providers to the 2002 Market Rate Survey (effective September 1, 2005); Raise the child care subsidy eligibility for families from 140 percent to 145 percent of the Federal Poverty Level (effective September 1, 2005); and Raise the child care subsidy eligibility for families of children with special needs to 200 percent of the Federal Poverty Level.

Some of the specifics affecting Community Empowerment Areas include:

\$4.65 million of the State General Funds are targeted to support low income preschool tuition; and \$1 million will support professional development activities between the Iowa Empowerment Board, community colleges and the area education agencies.

/2007/ 2006 Legislative Session for Early Childhood

In May of 2006, Legislators appropriated \$19 million to the early care, health, and education

system. The following information highlights the increases in funding:

- \$5,000,000 to be used by Community Empowerment Area boards for family support services and parent education programs targeted to families expecting a child or with newborn and infant children through age three.
- \$5,500,000 to assist low-income parents with preschool tuition expenses. Funds are to be used for children ages four and five who are not attending kindergarten; they are also to be used to serve families to not more than 200 percent of the federal poverty level. In addition, if funding is available after addressing the needs of those who meet the basic income eligibility requirement, a Community Empowerment Area board may provide for eligibility for those with a family income in excess of the basic income eligibility requirement through use of a sliding scale or other co-payment provision.
- \$3,500,000 to be allocated for efforts to improve the quality of Early Care, Health, and Education programs. The IEB may reserve \$100,000 for the technical assistance in the Iowa Empowerment Office State Technical Assistance Team.
- \$1,000,000 to be utilized by the IEB to implement the recommendations of the Business Community Investment Advisory Council.
- \$1,200,000 for Professional Development activities for providers working in Early Care, Health, and Education.
- \$150,000 for Access to Baby and Child Dentistry (ABCD) for local MCH agencies to build infrastructure for oral health issues.
- \$325,000 for Healthy Mental Development Initiative for children 0 to 5 years and their families.
- \$2,000,000 for child care provider rate reimbursement, rate annualization, and increase to 2004 rate.
- \$325,000 for support to the Child Care Quality Rating System. /2007/

/2008/ Legislative Session for Early Childhood - The 2007 Legislative session was complete the end of April. The following information provides an overview of the program and services funded for the Early Care, Health, and Education system.

Quality Affordable Early Care and Education Services

- Timely Payments for Child Care Providers: establishes billing and payment standards for child care provided under the state child care assistance program administered by the Department of Human Services (DHS). Providers will be paid within 10 business days of submitting a correct invoice to DHS.
- Early Head Start Projects: implements early head start pilot projects addressing the comprehensive cognitive, social, emotional, and developmental needs of children from birth to age three, including prenatal support for qualified families. The investment of \$400,000 is the first time the legislature has appropriated state dollars to this federally funded program.
- Child Care Subsidy: provides \$16 million for the child care subsidy program. This should keep DHS from having to start a waiting list for child care assistance.

High Quality Preschool Programs

- Preschool Program for four year olds: creates a statewide voluntary preschool program for four-year-olds. Provides 15 million each year over the next five years.
- Shared Vision -- Preschool Project: provides a \$1.7 million dollar increase to Shared Visions state funded preschool program.

Child Health Care Coverage

- SCHIP --Iowa's hawk-i program: provides language around SCHIP: "if federal reauthorization of the state children's health insurance program provides sufficient federal allocations to the state and authorization to cover the following populations as an option under the state children's health insurance program, the department may expand coverage under the state children's health insurance program as follows: a. By eliminating the categorical exclusion of state employees from receiving state children's health insurance program benefits. b. By providing coverage for legal immigrant children and pregnant women not eligible under current federal guidelines. c. By covering children up to age twenty-one, or up to age twenty-three if the child is attending school."

Healthy Child Development

- 1st Five -- Healthy Mental Development: allocates \$525,000 to 1st Five to increase partnerships with community health providers to improve developmental screening for young children (0-5 years).
- Dental Screening: requires children to have a dental screening as a condition of enrollment in elementary or high school.
- Lead Screening: requires that children receive a blood lead test by age six or prior to enrollment in elementary school. A parent or guardian of a child under age two is strongly encouraged to have the child tested for elevated blood lead levels by age two.

Early Intervention

- Early ACCESS: expands the federal Individuals With Disabilities Education Improvement Act of 2004, as amended to January 1, 2007, birth through age three services due to increased numbers of children qualifying for those services. The allocation is \$1,721,400.
- Early Hearing Detection: Allocates \$238,500 that shall be used to provide audiological services and hearing aids for children.

Tobacco Tax

- Tobacco Tax: provides for an increase of \$1.00 on cigarettes and tobacco products, creating a health care task force and providing for a standing appropriation.

Income Tax Treatment of Families with Children

- Income Tax Credit: raises the state earned income tax credit from 6.5 percent to 7.0 percent and makes it refundable. This will benefit over 163,000 low-income working Iowa families. /2008/ /2009/ **Legislative Session for Early Childhood - The 2008 Legislative session was complete the end of April. The following information provides an overview of the program and services funded for the Early Care, Health, and Education system.**

Education Appropriations Bill

- **Provides \$15,000,000 for the Four-Year-Old Preschool Program through the Department of Education;**
- **Instructs Empowerment to study and report to the General Assembly on Family Friend and Neighbor Care;**
- **Reduces the percentage of carry forward dollars for Empowerment Areas from 30% to 20%; effective with FY 2009 ending balances;**
- **Instructs Empowerment to develop and implement a plan to strengthen fiscal accountability for CEA boards;**
- **Empowerment shall consider if support services to prevent the spread of infections diseases, prevent child injuries, develop health emergency protocols help with medication, and care for children with special health needs are being provided to child care facilities registered or licensed under chapter 237A; and**
- **Provides \$400,000 for Early Head Start**

Health and Human Services Appropriations Bill

- **Two percent increase for child care providers beginning October 1, 2008;**
- **Increase in funding for Income Maintenance Workers;**
- **Funding of \$18.4 million to avoid child care assistance waiting list;**
- **Requires child care homes and child development home to be located in a single-family residence;**
- **States if a child care record check is performed and the record indicates that the person has committed a transgression, the Department is required to perform an evaluation -- even if the record check is withdrawn by the individual. This will hopefully keep the individual from providing unregistered care, also; and**
- **Codifies Early Childhood Iowa (ECI).**

Child Care Studies

\$30,000 to DHS for a child care study through a workgroup. The State Child Care Advisory Council shall serve as this workgroup to address implementation issues associated with a change in child care regulation to mandatory registration or voluntary or mandatory licensure. They shall also address professional development, ensuring articulation between programs, meeting the needs of both children and their parents, and enhancing community engagement. They shall cooperate with other early childhood stakeholders and the private sector. The workgroup is also charged to explore other issues, such as:

- Using the Internet to provide information to providers;***
- Creating a database;***
- Educating the public on the advantages of using a registered child care provider;***
- Requiring a state and federal fingerprint criminal history check.***

\$50,000 for a study of ways to enhance access to health insurance by registered child development home providers. This study shall be conducted jointly with the collective bargaining organization representing registered providers. This organization shall provide matching funds.

Health and Human Services Appropriations Bill

- Funding for dental homes for children;***
- Funding for mental health system for children;***
- Funding for hawk-i and hawk-i expansion; and***
- Funding for a post-natal tissue and fluid banking network.***

Smoke-Free Air Act: Prohibits smoking in public places, places of employment, and some outdoor spaces.

Child & Family Economic Success: Earned Income Tax Credit and Volunteer or Free Income Tax Assistance Programs: Requires the Iowa Department of Human Services to ensure that education materials relating to the federal/state EITC and locations of free income tax assistance programs are provided to households receiving assistance or benefits under: hawk-I, FIP, Medicaid, Food Assistance, and any other appropriate program. This information shall be provided through mailings or the Internet.

The dental home mandate language was amended this year. Original legislation indicated dental screenings and preventive care as necessary services within the dental home. The new language includes diagnostic services, treatment services, and emergency services. Also, the deadline was extended to December 31, 2010. Oral Health Bureau staff continues working closely with the Department of Human Services in development of the I-Smile program in order to meet the mandate. The legislature appropriated additional funding to DHS for SFY2009 to assist Title V child health contractors in implementation of I-Smile activities.

Administrative rules were written regarding codification of the Oral Health Bureau and mandatory oral screenings prior to elementary and high school enrollment. The original legislation for school screenings was changed slightly during this legislative session, eliminating provisional enrollment. The administrative rules will be in effect July 1. //2009//

Public Health Redesign

/2007/Redesigning Public Health in Iowa is a partnership between local and state public health. Dozens of local and state public health professionals have been directly involved in shaping the future of Iowa's public health system. These individuals have served on committees to help guide the redesign initiative and to develop public health standards.

The Work Group for Redesigning Public Health in Iowa serves as the steering committee for the initiative. The Work Group sets the direction, develops goals, and oversees activities for the initiative. The Iowa Department of Public Health (IDPH) provides a facilitator/coordinator for the

Work Group.

The Work Group established two sets of Standards Committees to draft public health standards for the state of Iowa. The local standards committees developed standards and criteria in 2005-06 that pertain to local public health. The second set of committees added state criteria to the local standards in 2006-07. The resulting document is the draft of the Iowa Public Health Standards, April 2007.

Both sets of committees were structured around the components of the standards as follows:

1. Governance, Administration
2. Workforce
3. Communication and Information Technology
4. Community Assessment and Planning, Evaluation
5. Prevent Epidemics and the Spread of Disease
6. Protect Against Environmental Hazards
7. Prevent Injuries
8. Promote Healthy Behaviors
9. Prepare for, Respond to, and Recover from Public Health Emergencies /2007/

/2008/ The Work Group for Redesigning Public Health in Iowa released a draft of the Iowa Public Health Standards in April 2007. The new document combines the previous draft of local public health standards with state-level responsibilities. Committees comprised of local and state public health professionals and partners drafted the state criteria for the standards. After reviewing public comments, the Work Group anticipates releasing the next version of the Iowa Public Health Standards in Fall 2007.

IDPH is conducting a survey to assess local public health's capacity to meet the requirements of the local criteria of the standards. The results of the survey will be available by August 2007.

IDPH is planning to fund demonstration projects for local public health agencies to develop and implement strategies for complying with the standards.

Next steps for Redesigning Public Health include:

1. Conducting a survey to assess the capacity of IDPH to meet the state criteria of the standards.
2. Seeking additional resources and funding (federal, state, and private) to support the initiative.
3. Preparing a legislative package that includes desired code changes identified through developing the standards.
4. Monitoring national movement for accreditation.
5. Exploring an accreditation system for Iowa. /2008/

/2009/ In November 2007, the work group for Redesigning Public Health in Iowa held a strategic planning meeting to determine the next steps for Redesign. Five implementation committees were formed to oversee goal completion.

Those groups include:

- 1. A funding committee to look at the availability of funding currently for public health, the flexibility of funding, and forecasting future needs for funding.***
- 2. A metrics committee to address how local agencies will measure their compliance with the criterion.***
- 3. An increase knowledge committee that will form a communication plan and frame messages around the importance of public health and the need for implementation of the standards.***
- 4. An accreditation committee to design an Iowa accreditation process, and make sure that it aligns with the national accreditation process currently being designed by the Public Health Accreditation Board (PHAB).***
- 5. A code committee to assure that code and administrative code are inclusive of the Iowa Public Health Standards.***

Other highlights:

- The Iowa Public Health Standards were finalized in December 2007.***

- **Three counties received funding from IDPH to conduct demonstration projects piloting component areas of the standards.**
- **Iowa was named one of 16 "Lead States in Accreditation" and will receive funding from Robert Wood Johnson Foundation for involvement in the Multi-State Learning Collaborative through 2011.**
- **IDPH received \$25,000 from HHS to assist in the completion of a state assessment that looks at the ability of IDPH to meet the state criteria of the Iowa Public Health Standards. //2009//**

Newborn Hearing Screening Program

For the past several years, IDPH has taken a leadership role in establishing a quality system for Early Hearing Detection and Intervention (EHDI) in Iowa. In January 2004, Iowa implemented EHDI legislation that mandates every newborn be screened for hearing loss prior to hospital discharge and that the screening results be reported to IDPH within six days of the child's birth. The legislation also requires that the results of any rescreens and diagnostic assessments be reported to IDPH for any child under three years of age.

On April 1, 2005, the Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Health Resources and Service Administration (HRSA) awarded an Early Hearing Detection and Intervention grant to the state of Iowa. This grant was awarded to Child Health Specialty Clinics (CHSC).

The activities of this grant focus on reducing the number of infants who are "lost" in the system, therefore delaying the provision of early intervention services. The five goals identified in this grant are:

- All newborns will be screened appropriately prior to hospital discharge.
- All audiologic diagnoses will occur before children are three months of age.
- All eligible children will be enrolled in an early intervention program (Part C, Early ACCESS) before six months of age.
- All families with children 0-3 who are deaf or hard-of-hearing or are at risk for late-onset hearing loss will be linked to a medical home.
- All families with children 0-3 who are deaf or hard-of-hearing will receive family-to-family support.

IDPH recently entered into a three-year cooperative agreement with the Centers for Disease Control and Prevention. The activities of this agreement focus on developing and implementing a statewide EHDI surveillance system. The goals of the project are to:

- Complete the statewide implementation of the EHDI data system.
- Facilitate data integration linkages with related screening, tracking, and surveillance programs.
- Maximize the use of EHDI data for statewide and local decision making.
- Evaluate the Iowa EHDI system based on the performance indicators set forth in the National EHDI Goals and utilize the results to establish project sustainability.

Perinatal Guidelines

The 1998 Legislature directed IDPH to develop and maintain statewide perinatal guidelines. State guidelines were available previously; however, the new administrative rules were written with input from the public and the Perinatal Advisory Committee. These rules, effective March 17, 1999, allowed for voluntary participation by the hospitals. The guidelines provide the framework to be used in defining and evaluating the level of perinatal services being offered. It also outlines the steps and process for a hospital to be reviewed for a new designation. Facilities that provide hospital care for obstetrics and newborn infants are classified on the basis of functional capacities and organized within a regionalized system of perinatal care. This regionalized system of perinatal care helps ensure that each newborn infant is delivered and cared for in a facility appropriate for his or her health care needs and to facilitate the achievement of optimal outcomes. The functional capabilities of facilities that provide inpatient care for obstetrics are

classified from basic to comprehensive services.

/2007/ IDPH and the Perinatal Advisory Committee are in the process of updating the Perinatal Guidelines. The Committee is hoping to have the final guidelines by December 2006. /2007/

/2008/ IDPH and the Perinatal Advisory Committee are still in the process of updating the Perinatal Guidelines. The committee recommended adding a level of neonatal care, which delayed the release, and to amend the rules regarding the levels of perinatal care in the Iowa Administrative Code. This year there were also changes in legislation regarding HIV testing of pregnant women. The guidelines are being updated to including these changes. The 8th edition of the guidelines should be completed and released to the public by the fall of 2007. /2008/

/2008/ March of Dimes Funds Pregnancy Risk Assessment Monitoring System Pilot Project
The Iowa State Chapter of the March of Dimes awarded nearly \$10,000 to the Iowa Department of Public Health for its Iowa Pregnancy Risk Assessment Monitoring System pilot project (I-PRAMS)./2008/

Currently, the Department sponsors a survey of new moms before they leave the hospital to find out about their behaviors and experiences (e.g., nutrition, stress, weight, smoking, etc.) before and during pregnancy as well as their baby care plans once they return home (e.g. sleep position, breastfeeding, etc.). I-PRAMS will take this one step further through a follow-up phone survey with new moms four months after delivery. We will learn if moms were able to follow through with their plans and if not, why not. In addition, I-PRAMS will provide information about moms' well being after pregnancy and the families' access to newborn/well baby care. Survey participants will be randomly selected among all new moms in Iowa. /2008/ ***/2009/ Over 400 randomly selected new Iowa moms completed surveys in calendar year 2007. We expect to have preliminary data results based on calendar year responses by late July 2008. The calendar year 2008 I-PRAMS pilot project is progressing as planned. //2009//***

State Child Health Insurance Program

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 percent of the federal poverty level. Iowa also chose to establish a separate private insurance plan for children with a family income between 133 percent and 200 percent of the poverty level; this program is called hawk-i (Healthy and Well Kids in Iowa.)

In July 1999, the Family Health Bureau became a Robert Wood Johnson Foundation (RWJF) grantee for Iowa's Covering Kids project. The projects focused on three goals 1) design and conduct outreach programs in pilot communities to help identify and enroll children into Medicaid or hawk-i; 2) simplify the enrollment and renewal process and 3) coordinate existing coverage programs for low-income families. The Covering Kids grant ended in 2002. However, RWJF extended the grant entitled Covering Kids and Families (CKF) that builds on Covering Kids efforts. On July 1, 2005, Iowa's CKF began the fourth year of the project. Priorities for year four were to 1) engage school districts to accept a central role in assuring health care coverage for children; 2) develop suggested guidelines and materials to support the role of health care professionals in providing consumer education on health care coverage; 3) identify and analyze barriers to enrollment and renewal and make comprehensive policy and program recommendations for removing barriers; and 4) assure coordination of state level and community based enrollment efforts.

In addition to the CKF project, the Bureau of Family Health became the contractor with DHS for 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 coverage for all 99 counties at a local 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.

/2007/ The CKF project will end June 30, 2006, with a request to extend the project until September 30, 2006. CKF sustainability efforts will focus on building activities and strategies that support enrollment into SCHIP into the Title V and hawk-i outreach infrastructure. The process improvement collaborative team developed through CKF will continue to look at maximizing the efficiency and effectiveness of Medicaid and hawk-i eligibility systems through addressing barriers to enrollment and retention. Barriers to enrollment and retention will be identified through use of a study conducted by the University of Iowa Public Policy Center and through the expertise provided by the CKF pilot sites. Strategies to reduce barriers will be small scale tested for effectiveness and implemented statewide when proven effective. hawk-i outreach efforts will continue through each local Title V agency with coordinated leadership provided by IDPH through the Outreach Task Force. Training will be provided to outreach coordinators through the Outreach Task Force and two statewide conferences. The CKF state coalition will continue to look at funding sources for sustainability of identified key activities that work to reduce barriers to enrollment and increase public awareness of Medicaid and hawk-i. /2007/

/2008/Sustained funding for Covering Kids and Families in Iowa continued through support provided by the Wellmark Foundation. In addition, a special project titled Iowa Covering Kids and Families: Access through Health Literacy began in May 2006 and was completed in April 2007. The project seeks to reduce the number of uninsured Iowa children through improved health literacy. Principles of health literacy were applied to reduce enrollment barriers in health care coverage programs and increase health literacy awareness. Building on experience and resources developed through the seven-year CKF project, this initiative worked through a statewide coalition and a trained process improvement team to achieve project goals. Through a structured change process, the project addressed two main goals: 1) apply principles of health literacy to selected materials and develop additional resources for families and key stakeholders; 2) provide health literacy training for key stakeholders. To achieve these goals, the coalition restructured to combine workgroups and focused on outreach, simplification and coordination of health care coverage for Iowa children. In addition, the coalition continues to develop policy briefs to educate and inform key decision makers on health care coverage issues affecting Iowa children. Statewide outreach for hawk-i continued to take place through schools, faith based organizations, health care providers and special populations. Coordination of outreach took place through sustaining an Outreach Task Force which brings together hawk-i outreach coordinators across the state to discuss barriers to enrollment and retention of children in public coverage programs. /2008/

/2009/ The Healthcare Reform" legislation. The intent of this legislation is to provide all children with hawk-i and Medicaid insurance coverage by January 1, 2011 and to expand the hawk-i program up to 300 percent FPL if federal funding becomes available. If federal funding does not become available, state only money will be used to create a program that builds upon the current hawk-i program. It establishes an electronic health information commission, end of life care promotion, extends coverage for children through age 25 who are on their parent's health insurance plan, eases restrictions on preexisting conditions, establishes a medical home initiative, wellness, chronic care, transparency and direct care worker provisions. //2009//

Fit for Life

The IDPH has awarded CDC funding to address nutrition and physical activity to prevent obesity and other chronic diseases. The funding is intended to build the state's capacity to address the epidemic of overweight and obesity. Currently the focus is building partnerships to write a comprehensive state plan for nutrition and physical activity. The Iowans Fit for Life Partnership will assist with writing the six components of the state plan: educational settings, early childhood, older Iowans, business and agriculture, health care, and community. More information can be found at: <http://www.state.ia.us/iowansfitforlife/>

/2007/ The plan will be completed and the Iowans Fit for Life Partnership will begin implementing

individual objectives and strategies. The intervention will continue in the 12 communities. /2007/

/2008/ The lowans Fit for Life Partnership continues to implement objectives and strategies. The intervention continues in the 12 schools and communities. /2008/

/2009/ The Health Promotion and Wellness Unit of the Bureau of Nutrition and Health Promotion is inclusive of Fit for Life. An Iowa Healthy Communities Initiative Grant Program has been implemented using continuation funding for the Harkin Wellness Grants and state appropriations. This grant initiative integrates several programs across the department and will provide wellness grants to communities for measurable health improvements. These two year grants offer local boards of health working with local partnerships the opportunity to plan and implement local health programs to address community needs. Focus areas include nutrition, physical activity, tobacco use prevention, mental health, oral health, and prevention of chronic disease. The applications are due in July of 2008 and the grant period will run through July of 2010. //2009//

Building Healthy Communities in Iowa through Harkin Wellness Grants

On May 23, 2005, IDPH issued an RFP to local Iowa communities for 36 Building Healthy Communities in Iowa through Harkin Wellness Grants. Examples of eligible community organizations are counties, cities, schools, tribes, health departments, and philanthropic organizations. The goals of the grants are planning and promoting individual and community health and wellness, prevent the incidence of chronic disease, and sustain these efforts into the future.

The RFP explains that building healthy communities in Iowa will not happen by accident or through a single program, but through a comprehensive, community-based approach. Five components of a process to build healthy communities include:

1. strengthening the grassroots effort to address the communities' health and quality of life issues,
2. embracing a process that will determine a measure of where the community is (assessment) and where it should go (vision),
3. maintaining the commitment of key partners by engaging them in specific strategies that can move the community toward the vision,
4. promoting structural and systematic change that will result in health and quality of life improvements, and
5. maximizing limited resources and leveraging additional resources including possible redirection of resources to areas that help the community achieve the vision.

The project period is from September 21, 2005 to June 30, 2007. First year funding will be awards three levels consistent with the demographics of the community, demonstrated needs, and scope of the project. For the first year, the RFP offers twenty level I awards (valued at <\$75,000), twelve level II awards (valued at \$75,001-\$150,000), and four level III awards (valued at \$150,001-\$250,000). Applications for the Building Healthy Communities in Iowa through Harkin Wellness Grants are due to IDPH on July 15, 2005.

/2007/ The communities that were approved for Harkin Wellness Grants included local public health agencies (9 awards, cities (4), hospitals (4), worksites (4), Iowa State Extension Offices (3), and a series of other entities such as schools, foundations, YMCA organizations and a mental health center. Of these awardees twenty-six of the twenty-eight are doing some component of nutrition and physical activity programming. Ten of the 28 are doing tobacco abatement programs and seven of the 28 have a mental health component as part of their work plan. IDPH Building Healthy Communities staff continue to provide technical assistance to local projects.

A second grant period will begin in July 2007 for this two year award and future grants in this program will depend on the availability of new funding. /2007/

/2008/ Twenty-eight grant awards were made and over the 2005-2007 grant period the funded communities accomplished the program goals in a variety of ways.

George, Iowa used volunteer hours to build a trail completely surrounding their community and developed walking programs and support groups to improve health status. Aurora, Iowa developed a wellness center that has had constant use since it opened its doors. An Iowa school system created a playground that encourages physical play, minimizes injuries and in conjunction with changes in school policies that allow recess times for play has made a large impact in the health, and well being as well as the attitudes of the children. Another community created a nutrition education, tasting opportunities, and an after school activity program in two of its elementary schools. They partnered with their city YMCA and Parks and Recreation Department to engage the community in the health of their children. This partnership has spawned multiple other active children partnerships and is now being sustained within city budgets. A worksite wellness program developed in one project community created a valued series of health programs, screenings and even healthy cooking classes for employees. The employers have reported enough health benefit to request the project to continue the services in a fee-based arrangement. Success here shows up in health care costs as a result of healthier employees who are better able to self manage their own chronic illness or develop healthier lifestyles to prevent disease.

All 28 grant projects ended on May 29th. Several of the projects participated in the statewide Barn Raising Public Health Conference as exhibitors, poster presentations or as conference presenters. This was a valuable opportunity which allowed funding to implement community based health improvement concepts and ideas. /2008/

/2009/ The Office for Healthy Communities (OHC) works to foster healthy communities through education, consultation and resources to improve and strengthen community health. Healthy communities produce stronger economies, better education outcomes, safer environments and a healthier people. The Office for Healthy Communities provides technical assistance and support services to help communities improve their capacity to plan and implement health improvements. The Office offers support in five areas:

- Building capacity through technical assistance and skill development;***
- Facilitating collaboration through networks, coalitions, partnerships, collaboratives, learning and community initiatives;***
- Planning, organizational planning, strategic planning, program development and system analysis;***
- Coordination of services for efficiency, resources for improved impact and initiatives with grants;***

Over the past year the OHC has facilitated town hall meetings and developed the outcome report of the Iowa Wellness Commission, provide team support and developed the final report for the Governor's Task Force on Nurse Shortage; coordinated a series of grant writing workshops in regions of the state; developed a built communities workshop with other state departments and facilitated planning for multiple local public health departments. The Office acts as liaison to IDPH for the NE Iowa Kellogg project called Food and Fitness and the Built Communities projects of Economic Development as well as the AARP projects known as Livable Communities. //2009//

Children with Special Health Care Needs

Child Health Specialty Clinics (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. Including the Iowa City office, CHSC currently supports 13 regional centers throughout the state. 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 quality improvement. Additionally, the CHSC Director, Jeffrey Lobas, M.D., works collaboratively with the state MCH Director, Part C (of IDEA) Coordinator, and Medicaid Director to implement and develop programs to meet the health-related needs of all Iowa children. The collaboration is enhanced by Dr. Lobas's 0.2 FTE appointment as Medical Director for the Division for Health Promotion and Chronic Disease Prevention of IDPH. ***/2009/ Dr. Lobas resigned as CHSC's director in December, 2007. Brian Wilkes, MSW, is CHSC's new Chief Administrative Officer and co-director. A new CHSC Chief Medical Officer (CMO) and co-director has been recruited and is expected to join the program in late ffy'08. The new CMO is expected to be 0.4 FTE with CHSC and additional FTE commitments to the Bureau of Family Health and the University of Iowa Dept. of Pediatrics will be determined. //2009//***

Organizational capacity has varied over the previous five-year program cycle. The Title V MCH Block Grant reformulation, state de-appropriations, and then re-appropriations, have demanded annual "scenario planning" activities by program leadership. As a result, both hours of operation and array of service offerings have fluctuated. When services such as cardiology, gastroenterology; and community-based nutrition consultation for CYSHCN have been decreased or eliminated, CHSC works to assure that resulting service gaps are minimized. When new grants or contracts are obtained, consideration is given to the sustainability of new initiatives or services.

/2008/A newly identified gap filled by CHSC involves the administration and management of selected Title V MCH community-based child health centers. Although not a typical responsibility of the Title V CSHCN Program, this gap-filling activity may enhance local MCH/CYSHCN program partnerships. /2008/

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 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 2000 Iowa Child and Family Household Health Survey and the National Children with Special Health Care Needs Survey (2001). Both are random sample, population-based surveys that are scheduled to be repeated in the next year or two. Repeated survey administration will provide information about changes in family experiences over time. In keeping with current high-level interest in early childhood health and development, the next version of the Iowa Child and Family Household Health Survey, scheduled for 2005, will have a special focus on early childhood issues. */2007/ Data from the 2005 Iowa Child and Family Household Health Survey has been collected and is in the process of being summarized by the contracted agency, the University of Iowa Public Policy Center. Data review and interpretation by Title V CYSHCN and MCH staff will begin later this summer. /2007/*

*/2008/ The 2005 Iowa Child and Family Household Health Survey has now been completed and summarized. This provides new cross-sectional and some longitudinal data for program planning. /2008/ ***/2009/ The 2006 National CSHCN Survey data has been released. This data will now be used in conjunction with the 2005 Iowa Child and Family Household Health Survey data to further enrich understanding of Iowa family experiences caring for their CSHCN. //2009//****

The population-based surveys, in combination with the problem identification and prioritization activities, have 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 a 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. /2007/ One new method to more effectively address priorities for Iowa's CYSHCN involves CHSC's direct participation in the official budget request process used by the executive branch to guide its own budget priorities. /2007/ ***/2009/ Another important avenue for representing CSHCN-related public health priorities at the state level involves having CHSC staff on state boards. CHSC staff are now members of the State Board of Health, the State Empowerment Board (target population is 0-5 year olds), and the Governor's Medical Assistance Advisory Board (target population is Medicaid recipients). /2009//***

More and more, CHSC self-identifies as an organization 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 and spreading the medical home model to improve quality of care for CYSHCN. /2007/ CHSC is also seeking to more clearly define and document the important function of care coordination, as well as to standardize the competencies expected of any staff member providing care coordination services. /2007/ To assure success in system development, CHSC is incorporating program evaluation, health services research, economic analysis, and partnership building strategies -- all with an eye to positively influencing policymakers.

/2008/ Pertinent examples include: 1) participation in Iowa's Part C Early Childhood Outcomes measurement efforts; 2) membership on the evaluation planning team for a new SAMHSA-supported children's mental health system development effort; and 3) more deliberate quality improvement activities to assure minimum quality standards across all CHSC regionally-based Birth to Five Programs. /2008/ ***/2009/ With respect to quality improvement efforts, CHSC is currently in the midst of a continuing education activity to teach all program leaders and coordinators the fundamental application of rapid cycle change strategies to accomplish process improvement. /2009//***

B. Agency Capacity

State Title V Agency Capacity

In Iowa, Title V administration is the joint responsibility of the Bureau of Family Health (BFH) at the 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 zero to 21, 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.

Preventive and Primary Care for Pregnant Women, Mothers, and Infants Women's Health Team

The Women's Health Team provides direction, oversight, and monitoring for the 30 local maternal health and/or family planning contract agencies that provide services in Iowa. Systems development activities are coordinated with the IDPH Family Planning Program, the Family Planning Council of Iowa, hospitals, schools, local boards of health, providers of adolescent health programs, and statewide women's health initiatives. Technical support is provided to local maternal health and family planning agencies. Contracts are managed with the University of Iowa Hospitals and Clinics (UIHC), Departments of OB/GYN and Pediatrics. The MH Community Health Consultant coordinates activities with the Healthy Start Project managed by Visiting Nurse Services of Des Moines.

Local Maternal Health Agencies

The 24 local MH contract agencies provide services to all 99 counties in Iowa. The map of local MH contract agencies is located at http://www.idph.state.ia.us/hpcdp/common/pdf/mh_map.pdf. Local MH 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, postpartum visits, and presumptive eligibility for Title XIX. Outreach efforts include community-based strategies for hard to reach populations, with special emphasis on informing clients of available services. Modes of delivery of the medical components of prenatal care include clinic settings, purchase of services from private practitioners, and agreements with local hospitals. Performance standards have been developed to ensure the provision of quality maternal health service throughout the state. MH Agencies also complete a Quality Assurance Matrix evaluating the provision of enhanced services and conduct direct care chart audits on an annual basis.

Statewide Perinatal Care Program

The Statewide Perinatal Care Program provides training of health care professionals, development of care standards, consultation for regional and primary providers, and evaluation of quality of care through the state's 82 hospital facilities that provide obstetrical and newborn services. The team consists of a neonatologist, a perinatologist, a dietitian, an ob nurse, and a neonatal intensive care nurse. Through a contract with the University of Iowa Hospitals and Clinics, these services are provided to all hospitals that perform deliveries; more intensive services are directed toward Iowa's three tertiary care centers and 19 secondary care centers. Quarterly, the team also publishes two newsletters: "The Iowa Perinatal Letter" for health care providers and "The Progeny" for perinatal nurses. The publications are used for general prenatal education and to disseminate information.

Des Moines Infant Mortality Center Consortium

The mission of the Consortium is to improve birth outcomes and to reduce infant mortality by enhancing maternal child health interventions to vulnerable populations. One of the consortium goals is to enhance partnerships between state and local government, maternal and infant health care providers, and the private and public sector to provide integrated community-based care for pregnant women and their infants. The consortium includes physicians, nurses, social workers, community leaders, and legislators. The consortium is a collaboration between the IDPH, Visiting Nurse Services (VNS) of Polk County, and Healthy Start. The VNS of Polk County holds the Healthy Start Grant to Eliminate Disparities in Perinatal Health. Strategies include outreach and recruitment efforts directed toward identifying and engaging pregnant women in services in the first trimester, family development, home-based case management, health education, depression screening, and community support services. All vulnerable minority populations are included in the targeted population for the Polk County Healthy Start Program; however, a specific emphasis was placed on the African American and Hispanic/Latino populations due to infant mortality rates in the identified project area. The consortium continues to work with Polk County Healthy Start to continue to address the significant disparities in infant mortality.

Abstinence Education

IDPH applied for federal funding through Section 510 and Community Based Abstinence Education (CBAE), formerly SPRANS, of Title V of the Social Security Act. Section 510 will secure contractors through a competitive Request for Proposal (RFP) to provide abstinence education programming throughout the state. Programming may include curriculum-based programs, community involvement, mentoring, media campaigns, positive youth development, informational programs, parent involvement, and peer education. CBAE will fund three community-based agencies, selected through an RFP, to provide programming through curriculum-based instruction, community involvement, and mentoring components. Evaluation will be conducted.

/2007/ IDPH applied to the DHHS, for funding through Section 510. Through an RFP, IDPH

contracted with eight local agencies to provide abstinence education programming. IDPH will also submit a competitive CBAE application to the Administration for Children and Families. /2007/

/2008/ IDPH applied to the DHHS, Administration for Children and Families for funding through Section 510. Through a continuation RFA, IDPH contracted with eight community-based agencies to provide abstinence education programming. The University of Iowa conducts a program evaluation that assesses Iowa's progress towards achieving the abstinence education performance measures. /2008/

/2009/ IDPH continued its participation in the Section 510 Abstinence Education Program through June 30, 2008. IDPH continued to operate on federal extension funding, providing continuation funds to seven community-based agencies for abstinence education programming and the University of Iowa for program evaluation. In March 2008, Governor Culver announced IDPH would no longer be authorized to accept Title V, Section 510 funds effective June 30, 2008. As a result the Department did not renew current Section 510 contracts. //2009//

Preventive and Primary Care for Children Child Health Advocacy Team

Members of the Child Health Advocacy Team (CHAT) have extensive experience working with child and adolescent health issues. The team provides direction and oversight to 23 local child health contract agencies covering all 99 counties in Iowa. Program activities include cooperative efforts with the Oral Health Bureau, Bureau of Disease Prevention and Immunization, Bureau of Lead Poisoning Prevention, Bureau of Nutrition and Health Promotion, Center for Congenital and Inherited Disorders, Early ACCESS (IDEA, Part C), Early Hearing Detection and Intervention, Empowerment, Early Childhood Iowa, Early Periodic Screening, Diagnosis and Treatment (EPSDT), Adolescent Health, Family Planning, Healthy Child Care Iowa, Healthy Mental Development, Covering Kids and Families, hawk-i Outreach, Head Start, and the Asthma Control Program.

/2007/ CHAT advocated for a quality performance measure using lead screening as a proxy indicator. The team collaborates with the IDPH Bureau of Lead Poisoning Prevention to monitor state data; match STELLAR with relevant data sets to determine whether children have been tested; promote comprehensive screening services that include lead testing within medical homes; promote referrals for appropriate testing and follow-up services; and provide ta to MCH agencies regarding lead testing as a component of comprehensive child health services. /2007/

/2008/ CHAT focused on promoting timely immunizations for Iowa's children. The team collaborates with Medicaid and the IDPH Immunization Program to review state data; provide updated information on immunizations; provide consultation to MCH agencies regarding use of Immunization Registry Information System; promote enrollment in IRIS among private providers; promote referrals for immunizations through care coordination services; and provide information through the EPSDT newsletter on new vaccines and recommended practice. //2008/

/2009/ The Child Health team has two primary areas of focus. A core group of consultants that provide technical assistance to child health contract agencies meet every other month. This group addresses issues pertaining to contract management. The broader CHAT group meets on alternative months and continues to provide a forum for facilitating communication and collaboration across IDPH programs that impact children. //2009//

Local Child Health Agencies

Local CH contract agencies are charged with developing health programs that are responsive to the needs of the community. The MCH Performance Standards described previously are used to ensure the provision of quality CH services throughout the state. The CH agencies focus on infrastructure building, population-based services, and enabling services to assure that children have access to well child screening services. Other activities of contract agencies include

outreach for uninsured children, education and referrals to families about services, assuring medical homes, providing direct care services where access is limited, improving oral health access, promoting health and safety in child care settings, and coordinating with Early ACCESS.

//2007/ The FFY 2006 RFP resulted in contract awards to 24 local CH contract agencies serving Iowa's 99 counties. The map of local child health contract agencies for Iowa is located at <http://www.idph.state.ia.us/webmap/default.asp?map=epsdt> .

/2008/ The FFY 2007 RFA resulted in contract awards to 23 local CH contract agencies serving Iowa's 99 counties. Each contract agency continues to implement plans to address priority needs within their service area. Initiatives include a series of trainings for local agency staff in the role of service coordination for the Early ACCESS (Part C) program. /2008/

/2009/ The FFY 2008 RFA resulted in contract awards to 23 local CH contract agencies serving Iowa's 99 counties. Each contract agency continues to implement plans to address priority needs within their service area. Due to an Office of Inspector General Targeted Case Management Audit and changes in Iowa Medicaid rules for service documentation, special emphasis has been placed on quality assurance/ quality improvement pertaining to documentation and delivery of services. Each local agency is required to have a quality assurance plan that addresses internal review of service documentation. IDPH also conducts quality assurance review of documentation based upon a random sample of Medicaid paid claims. //2009//

Oral Health Program

The Oral Health Bureau (OHB) promotes access to dental care and preventive health behaviors to reduce the risk of oral disease. In addition to administering programs such as the school fluoride mouth rinse, school-based dental sealant, and dental care for persons with disabilities, the OHB staff offers consultation and assistance to MCH agencies in assuring good oral health for the women and children they serve. Local CH contract agencies receive funding to be used in three ways: to provide limited preventive and restorative dental care for their uninsured or underinsured clients through agreements with local dentists; for infrastructure-building activities; and to pay for costs associated with dental hygienist services. Local CH contract agencies also receive money for the Access to Baby and Child Dentistry (ABCD) program, to be used to improve oral health status and increase access to dental homes for Medicaid-enrolled children. MCH clients receive direct preventive care from dental hygienists in more than half of Iowa's 99 counties.

OHB staff also collaborates with several private and public organizations to improve access to oral health care. Partners include the University of Iowa College of Dentistry, Delta Dental Plan, the Iowa Dental Association, the Iowa Dental Hygienists' Association, the Head Start Association, DHS, the Iowa-Nebraska Primary Care Association, the Iowa Rural Development Council, the University of Northern Iowa, and the Iowa Prevention of Disabilities Policy Council.

/2007/ The OHB will continue to seek additional partnerships and funding to work toward improved oral health of at-risk Iowans. The OHB is also overseeing two community projects to improve access to children's oral healthcare. One project is developing a local coalition to attract dentists to its rural area; the other is training local healthcare providers on oral assessments and the importance of children's oral health. /2007/

/2008/ In FFY2008, the OHB continues to collaborate with the Department of Human Services (DHS). DHS supports the I-Smile project, implemented through CH agencies, with the goal of assuring dental homes for Medicaid-enrolled children. A new state mandate that children have a dental exam or screening prior to school enrollment will create opportunity for the OHB to work more closely with the Dept of Education./2008/

/2009/ Additional funding for I-Smile during FFY2009 has been requested, to be used for

increasing infrastructure at both state and local levels. Funds have also been requested to increase primary prevention (fluoride varnish, sealants) at the local level, particularly for children ages 6 and younger.

OHB staff will continue to work with local contractors, Early Childhood Iowa, DHS, and many other partners in order to create service systems to ensure access to oral health for families served. OHB will continue to collaborate with Delta Dental of Iowa and the IDPH Division of Environmental Health for a community water fluoridation grant project. The grant will provide both funding and technical support to communities seeking to start water fluoridation activities.

OHB will maintain its support of education opportunities for primary care providers. New avenues of oral health trainings will include web-based curriculum through the Iowa chapter of the AAP and office based lunch and learns through I-Smile Coordinators.

A contract between OHB and the University of Northern Iowa's Center on Health Disparities will assist in assuring culturally appropriate health promotion. The OHB program planner will use information gathered during FFY2008 to determine health promotion needs and investigate availability of products or design products as needed. //2009//

Healthy Child Care Iowa

Iowa has 79 child care nurse consultants (CCNC). Training is offered annually to registered nurses entering a consultant role with early care and education businesses. Five full-time regional CCNCs have communication and mentoring responsibilities for the part-time CCNCs in their region. Funding for CCNC positions comes from Child Care Developmental Funds, Empowerment funds, and Head Start/Early Head Start. Iowa's Title V grants to local MCH agencies require the local agency to support a registered nurse as 0.5 FTE child care nurse consultant. Agencies use a variety of strategies to fulfill this requirement. CCNC conduct on-site assessments and technical assistance, training, and respond to requests for information. An encounter-based activity logging system was field-tested. Quality improvement instruments were completed, field-tested, and readied for dissemination.

/2007/ Iowa offers CCNC services to child care businesses through local child health agencies. The CCNCs conduct on-site assessments of health and safety and offer technical assistance and training in response to findings. The CCNC record encounters with child care businesses using the CCNC encounter-based activity recording system. /2007/

/2008/ Iowa has 66 child care nurse consultants (CCNC) working a total of 25 FTEs. The number of CCNC has decreased, but the number of FTE has increased. CCNC involvement in the Iowa Quality Rating System (QRS) continues. The QRS nurse activities are a business partnership agreement; initial child care survey of 25 items; injury prevention checklist of 40 items; child record review - 18 items; and a health and safety assessment which reviews written policy and provider practices. Iowa offers two child care nurse consultant trainings per year, four optional continuing education sessions; and one required meeting./2008/

/2009/ Iowa has 70 child care nurse consultants (CCNC) filling 28 FTE positions. Initial training for CCNC is offered twice a year. The CCNC training contains a classroom didactic portion with field study. Child care business involvement in the Iowa Quality Rating System grows. Health and safety are included in the QRS assessments. Program fidelity remains a priority for CCNC. The major areas of concern are control and prevention of communicable disease and injury prevention. //2009//

Child Death Review Team

The Iowa Child Death Review Team (CDRT) reviews medical, investigative, and medical examiner records of all Iowa children from birth through 17 years of age who died during the

previous calendar year. CDRT recommendations to prevent future deaths are made annually to the Governor, legislature, state agencies, and the public.

/2008/ CDRT partners with Blank Children's Hospital in Des Moines to host a conference on child death. /2008/

Sudden Infant Death Syndrome 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. Grief counseling is provided within the county of death by public health nursing staff. 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.

Center for Congenital and Inherited Disorders

In 2004, state legislation was passed that renames the Birth Defects Institute and some of its programs. The Institute is now called the Center for Congenital and Inherited Disorders (CCID). Programming from the CCID includes: Iowa Registry for Congenital and Inherited Disorders Regional Genetic Counseling Services, Iowa Neonatal Metabolic Screening Program (INMSP), Maternal Serum Alpha-fetoprotein (MSAFP) screening program, and the Neuromuscular and Related Disorders program.

With the possible addition of cystic fibrosis carrier screening as part of the MSAFP, and cystic fibrosis screening as part of the INMSP, the genetics program staff has been working closely with the Pulmonology and Allergy Department staff at the University of Iowa.

The Center is also participating in the Heartland Regional Neonatal Screening and Genetics Collaborative that serves eight states in the Midwest. The Center is promoting the U.S. Surgeon General's Family Health History initiative through presentations and public service campaigns.

/2007/ The CCID now provides oversight for seven programs: the Iowa Registry for Congenital and Inherited Disorders, the Regional Genetic Consultation Service, the Iowa Neonatal Metabolic Screening Program (panel now includes cystic fibrosis), the Maternal Serum Alpha-feto-protein screening program, the Neuromuscular and Related Disorders program, the Iowa Stillbirth Surveillance Project and prevention activities, and the Family Health History Initiative. /2007/

/2008/ The CCID has established an "executive team" to review policies, procedures, standards, and needs of the newborn screening program. /2008/

/2009/ The CCID continues all of the above activities, and additionally is working to: address genetic discrimination through policy development; promote stillbirth awareness through national campaigns in collaboration with First Candle; provide information to consumer groups regarding obtaining and using a family health history; develop a newborn metabolic screening business process analysis document; and working through the executive team to consider the addition of Severe Combined Immune Deficiency (SCID) to the newborn screening panel. //2009//

Early Hearing Detection and Intervention

The state's Early Hearing Detection and Intervention (EHDI) efforts are directed by the IDPH and CHSC. IDPH has entered into a new three-year cooperative agreement with the Centers for Disease Control and Prevention to improve the state's capacity to collect and track hearing-related information for children zero to three. CHSC entered into a three-year EHDI grant with MCHB. The purpose of the MCHB project is to assure that all infants and toddlers who are identified as deaf or hard of hearing receive timely and appropriate follow-up services.

/2007/ IDPH and CHSC are collaborating to implement the electronic reporting system in birthing

hospitals and to improve access to appropriate follow-up hearing services. /2007/

/2008/ IDPH and CHSC implemented the electronic reporting system in all birthing hospitals throughout Iowa, as well as each Area Education Agency in Iowa. /2008/

/2009/ IDPH and CHSC are developing policies, procedures, and protocols for the EHDI system. The document will be distributed to birthing hospitals and audiologists throughout the state over the next year and a half as the focus turns to quality assurance with reporting and follow-up services for children who are deaf or hard-of-hearing. //2009//

Iowa Collaboration for Youth Development (ICYD)

The Collaboration is a partnership of state and local entities concerned about youth and youth policies. This interagency initiative is designed to better align state policies and programs and to encourage collaboration among multiple state and community agencies on youth-related issues. The goals of the initiative are to promote the use of positive youth development principles in state policies and programs and to facilitate the use of effective youth development practices in communities.

The Interagency Steering Committee for the ICYD has endorsed the concepts and principles put forth in the design for "Enhancing Iowa's Systems of Supports for Learning and Development". This document introduces a set of new concepts for systems of supports that students need if they are to achieve at high levels.

/2007/ The ICYD continues to play an active role in supporting the Department of Education in its learning supports initiative. /2007/

/2009/ The ICYD issued a Healthy Youth Data Brief in March of 2008. The report is the fourth in a series of data briefs covering the youth development framework indicators developed by the ICYD. //2009//

Improving Academic Achievement by Meeting Student Health Needs

The Iowa Interagency Health Promoting Communities and Schools team developed "Improving Academic Achievement by Meeting Student Health Needs". The purpose of the briefing was to gather scientific-based research supporting school health promotion to improve academic achievement. The briefing encourages and focuses discussions on building student and staff health into school improvement and accountability systems.

/2008/The IHPSC team reviewed the Community School Improvement and site visit process of the Dept of Education and did not find an integrated health component. Since significant health needs of children affect their achievement, the IHPSC team recommended that districts compile health information with achievement data to help determine areas of impact that can improve child performance. /2008/

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.

/2007/ A team representing the Depts of Education, Human Rights, and Health, and one community member attended Preventing Violence training. /2007/

/2008/ IDPH recently received notification of SAMHSA Garret Lee Smith grant funding for suicide

prevention.

STIPDA State Technical Assistance Team conducted an assessment on IDPH injury and prevention activities. /2008/

/2009/ Beginning July 2007, the IDPH was given \$1.2 million for a three-year suicide prevention project. The focus is on suicide prevention activities for 15 -- 24 year olds in Iowa. The Columbia Teen Screen will be used as the model. It will target youth in high schools for screening, follow-up and treatment.

Following receipt of the report from the STIPDA State Technical Assistance Team visit, the Executive Team approved IDPH to move ahead with the recommendation to complete a comprehensive injury report. The Bureau of Disability and Violence Prevention has taken the lead in this initiative, but is working with data analysts from the Bureau for Health Statistics, EMS, and DOT to do the report. //2009//

Culturally Competent Care for MCH Populations

The Office of Minority Health was renamed to the Office of Multicultural Health and remains under the Division of Health Promotion and Chronic Disease Prevention. The Office continues to increase the capacity to provide training to MCH agencies on cultural diversity/sensitivity and health disparities and educational awareness workshop presentations at local and statewide MCH related conferences and seminars.

The Office of Multicultural Health consultant serves as a resource person for IDPH programs, especially those programs with strategies, goals and objectives to address the needs of women, children and families of minority, immigrant and refugee populations. Resources include educational materials, outreach, and networking to access for services, community stakeholders and networks, curriculum training design and instruction.

Minority Health Advisory Board

The Minority Health Advisory Board is currently being examined for reactivation. Although it recently has not formally met due to restructuring of IDPH advisory boards, the Office of Multicultural Health consultant continues to communication and networking with representatives from the African American, Latino, Asian/Pacific Islander, Native American, refugee and immigrant populations.

Local Minority Health Coalitions

The Office of Multicultural Health entered into agreement with the Polk County Minority Health Coalition Infant Mortality Subcommittee and produced the Polk County Health Infant Mortality video specifically targeted to decrease the disproportionate rates of infant mortality in the African American community.

/2008/ In 2007 the Office of Multicultural Health received funds for infrastructure building. A five year strategic plan for FY 2007 -- FY2011 was completed. /2008/

/2009/ In 2008 the Office of Multicultural Health received grant funds for a one-day African American female youth summit. The summit targeted young ladies ages 14 -- 18 and addressed self-esteem building, positive life-style choices, and HIV/AIDS and STD awareness. The summit provided an essential mechanism towards efforts to decrease disparities through educating young African -- American women on the impact of risky lifestyles and choices and the impact on their health and their community. It is the intent of OMH that this summit approached be utilized by all diverse populations of females within this age group and replicated around the state. //2009//

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Child Health Specialty Clinics (CHSC) uses an organizational structure of 13 regional centers to

provide family-centered, community-based, coordinated services to Iowa children and youth with special health care needs (CYSHCN) and their families.

Direct Clinical Services

The Integrated Evaluation and Planning Clinic (IEPC) is CHSC's cornerstone direct clinical service. It is a multidisciplinary service located in all CHSC regional centers, except Iowa City and Des Moines. The IEPC primarily evaluates and makes recommendations for children with behavioral and emotional problems. As a major community-based resource for children with behavioral and emotional problems, IEPCs are an important platform for family access to intensive care coordination, as well as to child psychiatry consultation via telehealth communication modalities. IEPC staffing includes some or all of the following: an advanced registered nurse practitioner or nurse clinician, a contracted medical consultant, an Area Education Agency psychologist and/or speech and hearing professional, a contracted or DHS social worker, and a parent consultant. Most children seen in an IEPC have complex behavioral or emotional problems that are not successfully addressed by parents, educators, or primary care physicians. The IEPCs provide a cost-effective resource to evaluate and monitor treatment for these children within their local communities. /2007/ An IEPC program evaluation revealed that local discretion produced a non-standardized, irregular clinical service that sometimes failed to meet current practice standards. Therefore, CHSC is now standardizing the referral, staffing, diagnostic, therapeutic, and follow-up processes for the IEPC service across regional sites. /2007/

The Birth to Five Program is CHSC's direct clinical service contribution to Iowa's early childhood service system. Births to Five services are located in all CHSC regional centers. The Birth to Five Program provides developmental screening, assessment, and follow-up for young children who are at-risk for developmental delay. Recommendations and family support are provided, as is care coordination, if needed. Advanced registered nurse practitioners with extensive expertise in the care and management of young children with special health care needs are the providers. The Birth to Five Program collaborates closely with Iowa's Part C (of IDEA) Program and local primary care providers. Children served by the Birth to Five Program include children who are at risk for developmental delay in the areas of growth, motor skills, language, and social interaction; children subjected to abuse or neglect; and children affected by exposure to drugs during pregnancy or later at home. /2008/ The Birth to Five Program is undergoing an in-house evaluation to document clinical and care coordination processes of the program staff and to assess the progress and outcomes for young, 0-5 year old enrollees. /2008/ **/2009/ As of approximately mid-2008, all CHSC regional Birth to Five clinics added a new service - autism screening for young patients at risk for developmental delay. //2009//**

/2009/ Effective in sfy'08, the Iowa Department of Education contracted additional funds for CHSC to provide nutrition consultation services to young children enrolled in Iowa's Part C early intervention program. //2009//

Care Coordination Services

CHSC's Health and Disease Management (HDM) Unit, composed of both nurse professionals and parent consultants, is designed to help families evaluate a child's needs and obtain services. Since 1985, CHSC has had an agreement with the Iowa Department of Human Services (DHS) to assist with care coordination of CYSHCN eligible for the Medicaid Home and Community-Based Services III and Handicapped Waiver. Now, care coordination is provided for children enrolled in Medicaid's consolidated Waiver Program. The number of CYSHCN enrolled in Waiver Programs served by CHSC's HDM Unit depends on the amount of Medicaid funds available.

General care coordination is also available for CYSHCN and families enrolled in the direct care IEPCs or Birth to Five Program. For children with significant behavioral health problems, an especially intensive care coordination effort is being offered.

The Continuity of Care Program is a care coordination service to improve linkages and outcomes

for CYSHCN discharged from the Children's Hospital of Iowa (at the University of Iowa) to community-based services. /2008/ The Continuity of Care Program is now administered and financially supported by the University of Iowa Children's Hospital. CHSC continues to provide office space for the program's staff. /2008/

A major new care coordination initiative will facilitate linkages of all primary care practices in the state -- pediatric and family medicine -- to community-based care coordination resources, most of which will be affiliated with the Title V Program. This initiative is part of an MCHB-supported Integrated Community Systems (ICS) grant.

/2008/ A successful pilot has motivated Iowa's Part C Early Intervention Program to provide support to selected members of CHSC's Parent Consultant Network to function as service coordinators for medically complex children, 0-3, enrolled in Part C. /2008/ ***/2009/ Effective in sfy'08, the Iowa legislature appropriated additional funds for CHSC to expand its service coordination capacity for Part C enrollees with conditions of prematurity, early drug exposure, or medical complexity. //2009//***

Family Support Services

The CHSC Parent Consultant Network (PCN) is affiliated with the CHSC regional centers and utilizes parents of CYSHCN to serve as community-based consultants to other parents and families. Two family participation coordinators, both PCN 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, promote collaboration, and organize family advocacy efforts.

Families play a large role in system development activities. For example, there will be a faculty member of the 2005 statewide learning collaborative who will provide content and guidance to primary care providers seeking to improve the family-centeredness of their practices. /2007/ With reference to 2006 Chronic Care Improvement (Medical Home) Learning Collaborative, participating primary care practices are given a family perspective to motivate quality improvement efforts relevant to family interests and experiences. A CHSC PCN co-leader is now a permanent member of the ICS grant planning group. /2007/ ***/2009/ In sfy'08, a longstanding PCN member accepted an offer to serve on the statewide Governor's Medical Assistance Advisory Committee. //2009//***

Families of CYSHCN are able to use the IOWA COMPASS Toll-Free Hotline as a statewide information resource.

Infrastructure Building Services

In keeping with evolving public health roles and responsibilities, 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 Policy and Planning Unit 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. ***/2009/ A new leadership training effort will involve teaching CHSC staff the fundamentals of rapid cycle change techniques to build an orientation toward problem identification and continuous quality improvement. //2009//***

Examples of notable CHSC infrastructure building efforts include: evaluation of the IEPC clinic service; development of a new model to expand access to pediatric behavioral and mental health services; hypothesis generation and testing using Iowa Child and Family Household Health Survey data; implementation and evaluation of the Iowa Medical Home Initiative and Healthy & Ready to Work Project; and collaborative systems planning with stakeholders in the Early Childhood Comprehensive Systems Project and the Assuring Better Child Health and

Development Project. CHSC also partners in system development efforts of the Iowa Part C (of IDEA) Program, the Governor's children's mental health system redesign effort, /2007/ and the IDPH-sponsored Safety Net Provider Network. /2007/ ***/2009/ CHSC is partnering in IDPH-based efforts to improve early childhood developmental screening through the 1st Five Program and to create patient-centered medical homes, initially for children on Medicaid and, ultimately, for all Iowans. CHSC is also partnering with the Iowa-Nebraska Primary Care Association to provide invited technical assistance to safety net providers (e.g. free clinics, MCH agencies, local boards of health, and community health centers) who are interested in incorporating elements of the medical home model into their service structure. //2009//***

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 House File 737 of the 2000 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 Appendices. 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 organizational change. Mary Mincer Hansen, RN, PhD was appointed as director of IDPH in March 2003. There are five divisions within IDPH structure they are: the Division of Acute Disease Prevention and Emergency Response, the Division of Behavioral Health and Professional Licensure, the Division of Environmental Health, the Division of Health Promotion and Chronic Disease Prevention, and the Division of Tobacco Use Prevention and Control.

/2008/ In January 2007, Governor Chester Culver, became Iowa's new governor. There were also many new legislators that started the session with Culver and also a democratic led House of Representatives and Senate. Iowa has not experienced this type of change in several decades. Governor Culver appointed a new Department of Public Health Director, Thomas Newton, MPP, REHS, in May of 2006. Director Newton retained the existing IDPH organizational structure but added a new Bureau of Communication and Planning and a Deputy Director, Mary Jones. /2008/

Bureau of Family Health

Public health functions relating to the health of mothers, children, and families are centered in the Bureau of Family Health (BFH). Organizational structures within BFH include the Women's Health Team and the Child Health Advocacy Team. 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 (IDE), 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 Disease Prevention and Immunization, 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.

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. Abstinence Education programs funded by Title V Section 510 and Special Programs of Regional and National Significance (SPRANS) are coordinated within the Bureau of Family Health (BFH). A joint project coordinator is responsible for both abstinence education budgets and is assisted by two program planners. A project director housed in the BFH administers the State Systems Development Initiative (SSDI) funds awarded to Iowa. A nurse clinician functions as a liaison between the IDPH Bureaus of Family Health and Information Management and serves as the SSDI project director. SSDI staffers work closely with the Genetics statewide coordinator who administers the grant from the MCHB Genetics Services Branch that also focuses on data integration. A project director and coordinator in the BFH administers Iowa's Early Childhood Comprehensive System project. A project coordinator in the BFH directs the administration of Iowa's Community Integrated Service Systems (CISS) grant that supports health and safety in early care and education programs. A community health consultant in the BFH serves as the coordinator for the Assuring Better Child Healthy Development (ABCD II) grant from the Commonwealth Fund. As our State Medicaid Agency, DHS was the applicant and recipient of the grant. /2008/ IDPH did not receive funds for Abstinence Education programs. IDPH did receive the Perinatal Depression grant from MCHB in August of 2006. The Center for Cogenital and Inherited Disorders also received a Family Participation grant from HRSA. IDPH has also received funding from the March of Dimes to pilot the Iowa's PRAMS survey and evaluation component. /2008/

Iowa's Early Hearing Detection and Intervention Program is a collaborative effort. Child Health Specialty Clinics administers a HRSA MCH Improvement Projects Grant to improve the system of newborn hearing screening and follow-up in Iowa. In addition, IDPH is developing a surveillance and monitoring system through a cooperative agreement with the Centers for Disease Control and Prevention. In January 2004, a bill was passed by the legislature and signed by the governor that will mandate newborn hearing screening in Iowa. The bill requires that all newborns be screened for hearing loss prior to discharge from hospital and that the results be reported to IDPH. The program director, within the BFH, has been providing technical assistance to maternity hospitals to begin data input into the eSP data system.

Early ACCESS is Iowa's program funded by the Individuals with Disabilities Education Act (IDEA, Part C). Early ACCESS is an interagency collaboration between the Iowa Department of Education, the Iowa Department of Public Health, the Iowa Department of Human Services, and Child Health Specialty Clinics. The system is a partnership between families with young children, birth to age three, and providers from local public health, human service, education, and child health specialty agencies. The Iowa Department of Education is the lead agency, as appointed by the Governor of Iowa for the implementation and maintenance of the system.

The IDPH Bureau of Family Health, in collaboration with the Community Empowerment branch of the Iowa Department of Management, applied for a HRSA State Maternal and Child Health Early Childhood Comprehensive Systems Implementation Grant in May 2005. Iowa has developed an Early Care, Health, and Education Strategic Plan and will be using the three year implementation grant to help carry out strategies. A project director in the BFH directs the coordination of the Early Childhood Comprehensive System Grant (ECCS). The grant is coordinated through the IDPH and the State Empowerment Technical Assistance Team.

ABCD II - Assuring Better Child Healthy Development

In November 2003 the National Academy for State Health Policy (NASHP) approved the Iowa Department of Human Services' grant application for the Assuring Better Child Healthy Development (ABCD) initiative. Funded by the Commonwealth Foundation, this grant project is aimed at identifying and implementing policy and system changes to support the provision of preventive care by Medicaid providers to children 0 to 3. The NASHP funding of \$55,000 per year, is matched by Medicaid funding of the same amount. Iowa intends to move toward the development and infusion of healthy mental development services into our current EPSDT system. /2008/ Iowa received state funds in 2006 and 2007 General Assembly for 1st Five Healthy Mental Development. Building upon the lessons learned from the two ABCD II demonstration projects, the newly established 1st Five Healthy Mental Development Initiative seeks to develop statewide spread. Current plans include increased collaboration between 1st Five and CHSC's Iowa Medical Home Initiative (described below). /2008/ **/2009/ 1st Five continued to receive state funds from the 2008 General Assembly. There are currently four local projects and an RFP has been posted to add another locality. //2009//**

Responsibility for coordinating Iowa's program for CYSCHN 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.

Child Health Specialty Clinics

/2009/ With the resignation of CHSC's physician director in December, 2007, a new program leadership structure has been developed. Leadership will be shared by a full-time Chief Administrative Officer and a part-time (0.4 FTE) Chief Medical Officer. The new leadership should be in place by the end of ffy'08. //2009//

Responsibility for family-centered, community-based, coordinated care for children and youth with special health care needs (CYSHCN) is placed in the Child Health Specialty Clinics (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, parent consultants, and support staff. A map of the CHSC regional centers, in addition to other general program information, is located at www.uihealthcare.com/chsc.

CHSC has managed several funded grants and contracts under the general heading of the Iowa Medical Home Initiative (IMHI), which ultimately strives to meet the national goal of enrolling all CYSHCN in a medical home. A three-year MCHB grant to CHSC facilitated the establishment of medical homes for CYSHCN in self-selected pediatric and family physician practices. A companion three-year MCHB grant to the Iowa Academy of Family Physicians (IAFP) supported a more local effort to establish medical homes for young children through enhanced primary practice and public health partnerships. These grants were consolidated with the goal of boosting medical home momentum in both the pediatric and family practice provider communities. Another MCHB-funded grant, now ended, was given to 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. A contract between CHSC and Iowa's Part C Program has provided significant professional development funds to support the IMHI effort.

As these three grants near termination, a new MCHB Integrated Community Services (ICS) grant to build integrated systems for CYSHCN will extend federal support for system improvement. This will occur through linking primary care practices to Title V care coordination resources; offering learning collaboratives to stimulate practice-based quality improvement efforts with an

emphasis on chronic care improvement; and enhancing partnerships to increase early and continuous screening in primary care settings. /2007/ To date, approximately thirty primary care practices have participated in the Chronic Care Improvement Learning Collaborative. /2007/ Part C, through renewal of the professional development contract, is continuing to support this medical home-focused system improvement effort. /2008/ To meet the goal of increased collaboration with Iowa Department of Public Health's 1st Five Healthy Mental Development Initiative, the ICS grant is has begun to redirect its activity plan. The ICS grant will support a more locally intensive facilitation model with primary care practices, using early childhood developmental screening and referral as the seed for building wider medical home model practice-based quality improvements. /2008/ **/2009/ A request for a no-cost extension of the ICS grant was approved by MCHB and will extend the project termination date until April 30, 2009. A new ICS project partnership will occur with the Iowa-Nebraska Primary Care Association to assist them meet a new legislative mandate. The mandate is to study how Safety Net Providers can help safety net using families determine a medical home. CHSC will offer technical assistance to safety net providers as they decide how best to adapt the medical home model to their particular service structures. //2009//**

An attachment is included in this section.

D. Other MCH Capacity

MATERNAL AND CHILD HEALTH

The administrative office for Iowa's Title V program is located in the capitol complex in close proximity to the State Capitol, in Des Moines, Iowa. The IDPH employs the Bureau of Family Health Chief, a Division Medical Director, and 22 professional and four support staff who manage the functions of Iowa's Title V program. Dr. Jeff Lobas, Director of Child Health Specialty Clinics, serves as the Medical Director at 20 percent of his time. The department contracts with 24 local maternal health agencies and 23 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 3B Agency Capacity.

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 the IDPH Center for Health Statistics (CHS). A BIM staff member serves as liaison to the BFH and focuses on data integration efforts for the major MCH data systems in Iowa. A CHS senior statistician coordinates all analysis requirements for Title V programs.

The Bureau of Family Health and the Center for Health Statistics has established an agreement with CDC to have an MCH Epidemiologist assigned to Iowa. Dr. Debbie 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.

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 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 12 regional centers located in or near the state's population centers. Most Iowans are within a one-hour drive of a regional center. Of the total staff complement, 18 individuals are housed in the Iowa City office. The remaining 100 staff members are housed in or associated with the other 12 CHSC regional centers.

The capacity to perform core public health functions is shared among professional and support

staff. Policy and Planning Unit staff have education and experience in public health science and practice and take a lead role in coordinating core public health activities. Families of CYSHCN add program capacity through the Parent Consultant Network (PCN), a community-based network of part-time parent consultants affiliated with the regional centers. CHSC's family participation program is led by two experienced members of the PCN. They lead the PCN by advising on policy and program planning, recommending training, monitoring activity, and updating resource information. All parent consultants undergo a structured training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports.

External contracts and grants have increased CHSC's capacity to contribute to prescribed priorities. Contracts with the Iowa Department of Education Part C Program expand CHSC's participation in the areas of early intervention (especially system development and quality assurance) and medical home training (especially the early childhood screening component). /2008/ A new pending contract with the Part C Program will support additional service coordination performed by CHSC parent consultants; additional nutrition consultation services for young children with developmental delay; and direct assistance to eligible families with insurance co-pay liabilities. Specific details will be agreed to in the forthcoming contract. /2008/ A contract with the Iowa Department of Human Services commits CHSC to provide care coordination to "medically fragile " children enrolled in Medicaid Waiver Programs. A contract with Magellan Behavioral Care of Iowa supports CHSC's leadership in improving statewide access to pediatric mental and behavioral health services. **/2009/ The contract with Magellan Behavioral Care of Iowa has been terminated; however, the mental and behavioral health consultation service via telehealth technology has expanded and is now funded through third-party reimbursement. //2009//** Finally, an MCHB grant supports a systems integration effort that highlights medical home model spread, linkage of primary care providers with public health care coordinators, and partnerships to improve early childhood screening and referral practices. /2007/ A new one-year contract with the Iowa Department of Public Health supports the growth of telehealth technology by researching and reporting current telehealth efforts; developing and pilot testing a training module for providers new to telehealth technology; making recommendations to enhance the effectiveness of telehealth services; and suggesting a plan to further develop and sustain telehealth. /2007/

/2007/ A bid for technical writing assistance was offered by the Iowa Department of Human Services (DHS) and won by CHSC. The product will be revised and new proposal documents suitable for submission by DHS to the Substance Abuse and Mental Health Services Administration (SAMHSA) for funds to support a major children's mental health systems improvement effort. /2007/ /2008/ The proposal to SAMHSA was successful and CHSC is now 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 is intended to produce a sustainable model that can successfully spread to the entire state. /2008/

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.

Senior level management employees are M. Jane Borst, chief of the IDPH Bureau of Family Health and Dr. Jeffrey Lobas, director of Child Health Specialty Clinics. Their qualifications appear in brief biographies attached to this section. **/2009/ Dr. Lobas resigned in December 2007. A new CHSC program leadership structure has been developed. Leadership will be shared by a full-time Chief Administrative Officer and a part-time (0.4 FTE) Chief Medical Officer. The new leadership should be in place by the end of ffy'08. //2009//**

An attachment is included in this section.

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 WIC

The statewide WIC program is integrated with MCH services at the state and local levels. The Bureau of Nutrition and Health Promotion coordinates the nutrition components of MCH projects and provides staff assistance to both state and local MCH programs. Training, consultation, and educational programs are provided for all MCH programs. The Iowa Lactation Task Force, a statewide coalition, includes private sector and public health professionals who provide technical assistance to the WIC program, MCH, family planning, public health nursing/visiting nurse agencies, and private health care providers.

/2007/ The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) coordinates with MCH services at the local level to provide a comprehensive service delivery model for low-income families. WIC's short-term intervention program, coupled with the services provided by MCH, is designed to strengthen families by influencing lifetime nutrition and health behaviors in a targeted, high-risk population. WIC's combination of nutrition education, nutritious foods, breastfeeding support and referrals to MCH services provides a gateway to good health in more than 140 clinics administered by 20 local agencies. /2007/

Family Planning

IDPH provides family planning services in 45 of the 99 counties in Iowa through Title X funding. A program coordinator, housed in the IDPH Bureau of Family Health, manages services provided by eight contracted agencies. IDPH Family Planning Service Area (IDPHFPSA) includes four metropolitan counties and two urban counties. The balance of the IDPHFPSA contains rural counties. The Iowa counties not part of the IDPHFPSA are funded with Title X dollars through the Family Planning Council of Iowa.

/2007/ In January 2006, the Center for Medicare and Medicaid approved Iowa's request to waive section 1115 of the Medicaid rules in order to implement a demonstration program that expands the eligibility for Medicaid covered family planning services in Iowa. The program, called the Iowa Family Planning Network (IFPN), expands eligibility for Medicaid covered family planning services to all Medicaid covered post partum women for one year without eligibility redetermination. It also expands eligibility for the program to all Iowa women aged 12 through 44 years, whose income is up to 200 percent of poverty. Iowa women can take required documentation to family planning clinics and receive services immediately. IDPH anticipates that IFPN will provide expanded access to free family planning services and potentially decrease the number of unintended pregnancies in Iowa. /2007/

/2008/ In February 2006 Iowa implemented the Iowa Family Planning Network (IFPN). IFPN is Iowa's program developed to implement its waiver of section 1115 of the Medicaid rules. Title X family planning clinics have to enter client information onto a secure Medicaid web site for determining eligibility for the program at the family planning clinic site. From February 1 to December 31, 2006 approximately 25,000 females have been enrolled into IFPN. The IFPN program reimburses the Title X contract agencies for services that previously were not reimbursed or for which the family planning agencies received minimal reimbursement. Evaluation of IFPN began in January 2007. IDPH anticipates the IFPN evaluation will show a decrease the unintended pregnancies in Iowa and a savings of Iowa and federal Medicaid expenditures. IDPH /2008/

/2009/ The IDPH Family Planning Program works closely with Family Planning Council of Iowa, the other Title X grantee in Iowa to create efficiencies in carrying out required functions. Examples include participating in the joint Training and Education Advisory Committee and planning for the annual family planning conference. IDPH works closely

with Iowa Department of Human Services in carrying out the 1115 Medicaid Waiver program - IFPN. IDPH also participates with The Iowa Initiative to Reduce Unintended Pregnancies, a statewide project to reduce unintended pregnancies in Iowa in women 18-30 years. The Iowa Initiative is a multi-year effort that is working with the University of Northern Iowa (UNI). The Title X delegate agencies will be cooperating with the Iowa Initiative and UNI as appropriate. There may be opportunities to participate in research projects. //2009//

DHS Cooperative Agreement

IDPH, Division of Health Promotion and Chronic Disease Prevention maintains an ongoing cooperative agreement with the Department of Human Services. The agreement defines cooperative efforts toward an integrated system of high quality, comprehensive, cost-effective, adequately financed health services for mutual beneficiaries. The annual agreement is available upon request.

EPSDT Care for Kids

The IDPH provides services for the EPSDT Care for Kids program under an intergovernmental agreement with the Iowa Department of Human Services (DHS). Under this agreement, local child health contract agencies are approved as EPSDT screening centers. Each month, local EPSDT care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the about the child's Medicaid coverage and the importance of well-child care. Care coordinators also contact the family when the child is due for well-child care according to the EPSDT Periodicity Schedule. The statewide toll-free Healthy Families Line also links families with an EPSDT care coordinator for assistance with access to medical and dental care. Care coordinators partner with local physicians to ensure that children receive the comprehensive screening requirements of the program. BFH staff members routinely provide training and technical assistance to local EPSDT care coordinators. Topics include developing care coordination skills, determining the costs for informing and care coordination activities, and maintaining the electronic clinical record.

State agency coordination is necessary throughout the EPSDT Care for Kids program in order to assure that families receive appropriate services. Data system integration between the two state departments occurs every day in order to give local CH agencies access to current Medicaid eligibility information. To accomplish this level of integration the Iowa Title XIX database at DHS sends eligibility information to the Child and Adolescent Reporting System (CAREs) at IDPH every day at midnight. The next day local child health agencies can obtain Medicaid eligibility information for a child directly from CAREs. As services are provided to the child, clinical record documentation is entered in CAREs by the local agency staff.

The BFH coordinates with related IDPH programs in managing the EPSDT Care for Kids program. Ongoing and routine communication occurs with program staff involved in immunizations, lead poisoning prevention, early intervention services, oral health, behavioral health, and other programs related to the health of Iowa's children.

/2007/ In April 2006, EPSDT program training was provided for EPSDT staff of each local CH contract agency. Goals were to provide staff with a basic foundation for the program and to enhance effective implementation at the local level. Over the next year, initiatives to improve the immunization status of Medicaid enrolled children will be explored. /2007/

/2009/ Due to the release of the federal Targeted Case Management Interim Final Regulation, the BFH and Iowa Department of Human Services (Iowa Medicaid Enterprise) have been developing plans regarding the future delivery of informing and care coordination services under the EPSDT program. Both agencies recognize that the extensive case management requirements within the regulation are not appropriate for population-based preventive health services. As a result, the Iowa Medicaid Enterprise has proposed removing informing and care coordination from the Medicaid State Plan as

Targeted Case Management Services and classifying them as 'administrative services'. DHS would then contract with IDPH to reimburse informing and care coordination services to local contract agencies. Contract language has been drafted and submitted to the Centers for Medicare and Medicaid Services along with proposed Medicaid State Plan changes. Local contract agencies have been apprised of the proposed plans through meetings, conference calls, and the FFY 2009 Request for Application. //2009//

hawk-i (Health and Well Kids in Iowa)

In October 2002, the Department of Human Services (DHS) contracted with IDPH to provide grassroots outreach and enrollment for hawk-i. In November 2002, IDPH contracted with the 24 local child health agencies to perform hawk-i outreach and enrollment efforts. Collaboration between IDPH and DHS will continue 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. Efforts will be expanded to continue coordination of state level outreach efforts through an Outreach Task Force and further development of partnerships, such as working with community and migrant health centers, free clinics, school nurses, ministers and other community representatives.

/2007/ IDPH continued to contract with DHS to provide hawk-i outreach efforts through the 24 local child health agencies. The Outreach Task Force meetings take place twice a year at two statewide conferences and are being supplemented with regional meetings that encourage networking among coordinators. Training for new coordinators is offered before or after task force meetings. Coordinators are also required to attend certain breakouts at the two statewide conferences. The breakouts are intended to enhance training efforts. A new reporting system is also being used to report local efforts to DHS. /2007/

/2008/ IDPH renewed their contract with DHS to provide hawk-i outreach through the local child health agencies. The Outreach Task Force meetings continue to take place twice a year at two statewide conferences. The statewide outreach coordinator made site visits to local agencies to provide technical assistance and offer one-on-one training to new coordinators. Trainings on cultural competence were offered to coordinators through Web casts. Outreach continues to focus on the original four target areas: schools, health care providers, faith-based organizations, and special populations. An emphasis was also placed on collaborating with Community Health Centers. /2008/

/2009/ IDPH continued to contract with DHS to provide hawk-i outreach through the local child health agencies. Outreach to Community Health Centers has been taken to a new step and in Iowa's largest urban setting of Des Moines, a local coordinator spends part of her week in the clinics enrolling families. The coordinator is also working on a best practices toolkit working with CHCs that can be shared with other Title V agencies. A large emphasis is still being placed on conducting outreach to underserved populations in Iowa through various means such as local businesses that either employ or serve large numbers of underserved populations, service providers and local festivals. Outreach was also conducted on a statewide level at tax preparation sites for those qualifying for the earned income tax credit and Pay day loan/ check cashing facilities. //2009//

Preventable Diseases Program

The Disease Prevention and Immunization Bureau 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 Bureau of Family Health, the Disease Prevention and Immunization Bureau, and Department of Human Services 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, the IDPH recommends that all Iowa children under the age of six receive routine blood lead testing. Local contract agencies, local health departments, and private practitioners test children. Through continuing education programs, 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. This will be achieved through strengthening the capacity of Iowa's local boards of health that, through local health departments, public health agencies, programs and services, strive to create healthy people in Iowa communities.

The bureau promotes and supports development of public health infrastructure at the local and state level to assure that Iowa's public health system has the capacity to be responsive to current and emerging public health issues.

//2009/ The Bureau of Local Public Health Services staff have been providing training and technical assistance to local public health agencies on Iowa's public health standards. //2009//

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 IRCID works to develop mechanisms to enhance IDPH access and utilization of birth defects surveillance data. IDPH also works with the various early intervention programs including IDEA-Part C (Early ACCESS), Title V, IDPH Child Health Advocacy Team, and parent groups to ensure that IRCID data are made available for them to use for program planning. The CCID works closely with the Early Hearing Detection Initiative to coordinate screenings for all newborns in the state.

Matching newborn metabolic screening and birth certificate records is performed to identify unscreened newborns. Follow-up occurs with the birthing facility and/or physician's office to arrange for screening of missed newborns. The INMSP and IBDR collaborate with the Child Death Review Team to decrease unnecessary contact of families whose child has died. Newborn screening education to nursery managers, lab managers, and health care providers is provided through the quarterly Heel Stick News and the INMSP Healthcare Practitioner's Manual found on the Web site.

The IRCID will begin conducting surveillance on stillbirths starting in October 2005. Birthing facilities will receive education from the Statewide Perinatal Care Team on the use of a stillbirth evaluation tool. Providers will complete the information required in the tool, and submit it to the IRCID.

/2007/ The CCID has added two additional programs: the Iowa Stillbirth Surveillance Project (ISSP) with coordinating prevention activities and the Family Health History Initiative. The ISSP expands on the existing birth defects registry to include surveillance of fetal deaths in Iowa. This surveillance is conducted through a cooperative agreement with the CDC in Atlanta. Through education sessions and promotional materials, the Family Health History Initiative was introduced and disseminated. /2007/

/2008/ The CCID received a grant, Iowa's Family Participation Project, from HRSA for \$100,000 for three years. The grant will address:

- Attitudes and beliefs of parents are not consistently addressed by newborn screening programs.
- Family and provider participation in planning, implementation and evaluation of newborn screening programs is minimal.
- Newborn screening program information to parents and providers is not provided in a manner that meets their needs.

Through the 2007 General Assembly CCID will convene a task force on postnatal tissue and fluid banking. /2008/

/2009/ In 2007, South Dakota became the latest state to contract with the Iowa newborn screening program to conduct its statewide testing. Louisiana has resumed testing for its newborns, expanding its testing panel with the assistance of the Iowa program. //2009//

Unintentional Injury Prevention

The BFH collaborates with multiple partners to prevent unintentional injuries to children. Staff from the BFH provide leadership on the Iowa Safe Kids Coalition as well as the Greater Des Moines Safe Kids Coalition. Through the Healthy Child Care Iowa campaign, state agencies collaborate regarding health and safety in child care. Distance learning opportunities are offered quarterly to consultants who work with early care and education.

The BFH works closely with the Governor's Traffic Safety Bureau (GTSB) to identify strategies for information dissemination. Local MCH agencies are able to request free educational materials from the GTSB to share with clients, particularly regarding child passenger safety.

The BFH collaborates with the Division of Environmental Health's liaison to the U.S. Consumer Product Safety Commission. Child care nurse consultants visit child care and early education providers on-site using a Consumer Product Safety Commission-approved checklist to assess hazardous and recalled children's products.

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 CHSC. The system is a partnership between families with young children, birth to age three, and providers from local public health, human service, education, and child health specialty agencies. Partnerships also exist for families with other public or private service and resource providers. The Iowa Department of Education (DE) is the lead agency, as appointed by the Governor of Iowa for the implementation and maintenance of the system. A state level multidisciplinary council, the Iowa Council for Early ACCESS advises and assists the DE in the implementation of Early ACCESS.

/2007/ Signatory partners continue to collaborate with the DE to address the needs of children ages 0-3 with developmental delays or the risk of delay and their families. State staff is working to incorporate IDEA 2004 Law changes that impact Part C into Iowa practice. Early ACCESS is

concentrating efforts to standardize practice across service delivery areas. Service coordinator training around competencies has been developed. /2007/

/2009/ A State wide procedure manual has been drafted to facilitate the standardization process. Service coordinator training around competencies has been developed and work is being done to increase the constancy in the tools used to evaluate and monitor children's development. //2009//

Federally Qualified Health Centers

Iowa currently has eight designated Federally Qualified Health Centers (FQHC) in Council Bluffs, Davenport, Des Moines, Ottumwa, Sioux City, Waterloo, Burlington and Decatur County. Storm Lake and Fort Dodge received New Start Funds in December 2005 with operations to begin in April 2006. Two of the six designated centers have subcontracts with IDPH for local CH contract agencies. The remaining six FQHCs collaborate with the designated Title V agencies in their area.

Primary Care Association

The IDPH has a long-standing relationship with the Iowa/Nebraska Primary Care Association (IA/NEPCA). The Association provides technical and non-financial assistance to the community and migrant health centers of Iowa and Nebraska. These health centers offer comprehensive, physician-based "one-stop" primary care with a focus on prevention. The seven community health centers in Iowa are IA/NEPCA members. The Association works closely with the state departments of health in Iowa and Nebraska, along with the Federal Bureau of Primary Health Care, and participates in collaborative activities promoting quality health care services.

College of Public Health, The University of Iowa

The College of Public Health strives to be a comprehensive public health resource for the state of Iowa. There are six departmental units: Biostatistics, Community and Behavioral Health, Epidemiology, Health Management and Policy, Occupational and Environmental Health, and the Program in Public Health Genetics. Degree programs include the MPH, MS, MHA, and PhD. A Public Health Certificate Program was initiated in 2002.

Des Moines University

The Master of Public Health program at Des Moines University (DMU) began in 1999 and received full accreditation from the Council on Education for Public Health in 2002. The MPH program is offered at a number of sites around the state. A dual degree program offers students the opportunity to obtain both the MPH and MPA. A Graduate Certificate in Public Health is also offered. DMU is developing courses for web-based delivery to accommodate the needs of Iowa's rural public health work force.

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 professions and public health students - graduate and undergraduate - learn about community-based service delivery through participation in direct care specialty clinics, care coordination services, 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) IDPH, BFH - to provide public health services at the community level including Child Health, Child Dental Health, and hawk-i Outreach;

3) Iowa Department of Education, Division of Vocational Rehabilitation, Disability Determination Services Bureau - to define responsibilities related to applicants and recipients under age 16 of the Supplemental Security Income (SSI) Program and under age 22 who need specialized health services regardless of SSI eligibility; **/2009/ (This agreement is no longer in effect due to the Social Security Administration's need to review procedures for the purpose of assuring SSI client confidentiality. CHSC hopes to renew the agreement as soon as possible.) //2009//**

4) Area Education Agencies - to provide service coordination, 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;

5) IDHS - 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);

6) IDHS - to define responsibilities of the parties in assessment, planning, and care coordination activities for applicants and recipients of the consolidated Waiver Programs of Title XIX;

7) IDHS (through its contract with Magellan Health Services for the Iowa Plan for Behavioral Health Medicaid Community Reinvestment Funding) - to develop a statewide system to deliver comprehensive child psychiatric services to Iowa Plan Medicaid enrollees ages 0-21 with mental health needs living in rural or underserved areas and to improve the skills of community-based providers serving the target population. **/2009/ The CHSC component of the Magellan contract has been terminated, though CHSC's child psychiatric consultation services have expanded and are now supported by third-party reimbursement. //2009//**

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	48.4	48.4	48.4	42.7	42.9
Numerator	875	875	875	820	841
Denominator	180839	180755	180755	192055	195916
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

It is anticipated the apparent increase in 2007 data is likely related to improved reporting of secondary diagnosis. Data staff are investigating the apparent increase.

Notes - 2006

The 2006 data were obtained from the Iowa Hospital Association.

Notes - 2005

The 2005 data were obtained from the Iowa Hospital Association.

Narrative:

Iowa's Asthma Control Program continues to be guided by the Iowa Plan for Improving the Health of Iowans with Asthma, adopted in 2003. At its April 26, 2007 meeting, the Iowa Asthma Coalition adopted a Strategic Plan for Improving Asthma Treatment and Self-Management through Systems Level Interventions (2007-2010). The strategic plan contains input from the education, environment, and surveillance subcommittees of the statewide coalition. Each goal of the strategic plan is supported by specific action steps and measurement indicators.

The report for HSCI #01 appears on Form 17.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	99.9	99.9	94.6	95.5	89.1
Numerator	16495	17565	17636	18498	17258
Denominator	16508	17590	18639	19379	19378
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report. Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Notes - 2006

The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2005

The 2005 data were obtained from the Annual EPSDT Participation Report - CMS 4.16 Report.

Narrative:

Iowa's Medicaid services received a boost through a new legislative mandate to assure a dental home for Medicaid-enrolled children in Iowa. The I-Smile Program was developed to fulfill the legislative directive for oral health. The program emphasizes early intervention, prevention, and family-centered assistance. Primary strategies of the I-Smile Program were implemented in the

local contract agencies throughout Iowa and fully integrated with the local EPSDT programs.

The upgrade to the Child and Adolescent Reporting System (CAREs) was described in detail in the 2007 narrative for HSCI #2. During FFY2007, the business requirements for the CAREs upgrade were reopened to incorporate the data needs of the I-Smile Program. The revised business requirements were approved in December 2006. At the time of this application, the design document for the CAREs upgrade is being developed. The design document will translate the business requirements into the technical requirements needed to ensure that the CAREs upgrade meets the needs of the Bureaus of Family Health and Oral Health and their grantee agencies.

The report for HSCI #02 appears on Form 17.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	3	6	15	9	9
Denominator	3	6	15	9	9
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data were obtained from hawk-i 2007 data. The small number is due to financial eligibility at 185 percent poverty level. Most infants who qualify for public health insurance qualify for Medicaid.

Notes - 2006

The small number is due to financial eligibility at 185 percent poverty level. Most infants who qualify for public health insurance qualify for Medicaid.

Notes - 2005

The small number is due to financial eligibility at 185 percent poverty level. Most infants who qualify for public health insurance qualify for Medicaid.

Narrative:

Iowa's SCHIP program, called Healthy and Well Kids in Iowa (hawk-i) continues to be administered through the Iowa Department of Human Services (DHS). The Iowa Department of Public Health holds the DHS contract for statewide hawk-i outreach activities. Through this agreement IDPH contracts with outreach coordinators in the local child health agencies. These outreach coordinators focus their efforts on vulnerable populations, faith-based organizations, health care providers, and schools.

In a separate, but related, program IDPH serves as the fiscal agent and provides coordination of the Covering Kids and Families (CKF) statewide coalition. Although seven years of funding for the CKF project from the Robert Wood Johnson Foundation has ended, the project obtained

sustainability funding through the Wellmark Foundation.

There are three goals of the Covering Kids and Families statewide coalition.

Goal 1: Design and conduct best practices for outreach

Goal 2: Simplify the Medicaid and hawk-i enrollment process

Goal 3: Identify and analyze barriers to enrollment and retention and provide public policy education to support children's access to health care coverage

The CKF project applied the principles of health literacy in an attempt to reduce enrollment barriers to health care coverage. Through a special project, also funded by the Wellmark Foundation, the CKF is able to address the following goals.

Goal 1: Reduce barriers to enrollment and retention of children's health insurance through increased health literacy among consumers.

Goal 2: Increase awareness of health literacy among key stakeholders that work to enroll children in health care coverage.

The report for HSCI #03 appears on Form 17.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	75.4	76.2	75.2	82.8	74.0
Numerator	28757	29096	29336	32539	29602
Denominator	38139	38159	39014	39275	40000
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Iowa implemented a revised birth certificate during this reporting period. The questions about entry into prenatal care was changed. Data staff are investigating the accuracy of the reporting. Data were obtained from 2007 Vital Statistics data.

Notes - 2006

An error in our calculations of the previous years Kotelchuek index was identified. This was corrected for this year and future years.

Notes - 2005

The HSCI #4 data differs from the NPM #18 because HSCI #4 uses women ages 15-44 and NPM #18 uses women of all ages.

Narrative:

Direct health care, enabling, and population-based program activities are provided by 24 local maternal health grantee agencies serving all 99 counties in Iowa. Maternal health grantee agencies provide services to facilitate early entry into prenatal care. These services include

Medicaid presumptive eligibility determination, care coordination, case management including follow-up, and case-finding and outreach with a focus on high-risk women. The IDPH works with the Iowa Department of Human Services (DHS) to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

Local maternal health grantee agencies continue to use the Women's Health Information System (WHIS) to document assessment and services for the Title V maternal health population. WHIS provides information on the timing and number of prenatal visits as well as the newborn's gestational age. IDPH is opening up the WHIS data system for an upgrade to incorporate the updated Medicaid Risk Assessment from the Iowa Department of Human Services. The WHIS upgrade will also add service documentation features to comply with recently revised Medicaid documentation requirements.

The report for HSCI #04 appears on Form 17.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	59.7	61.7	63.6	64.9	43.6
Numerator	128260	141222	151992	159473	106857
Denominator	214993	228738	239068	245785	244853
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report. Due to a change in the data collection by CMS, Iowa rates have shown a decrease. We will be working to assure that the current data collection accurately reflects the services provided in Iowa with a focus on continued steady incremental improvement.

Notes - 2006

The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report. The numerator represents the number of Medicaid eligible individuals who received at least one initial or periodical screen. The denominator represents the number of individuals eligible for EPSDT.

Notes - 2005

Data were obtained from the 2005 CMS 4.16 Report. The numerator is the total Medicaid eligibles who receive a service at least one initial or periodical screen. The denominator is the total individuals eligible for EPSDT.

Narrative:

As previously noted in HSCI #2, Iowa's Medicaid services received a boost through a new legislative mandate to assure a dental home for Medicaid-enrolled children in Iowa. The I-Smile Program was developed to fulfill the legislative directive. The program emphasizes early intervention, prevention, and family-centered assistance. Primary strategies of the I-Smile

Program were implemented in the local contract agencies throughout Iowa and fully integrated with the local EPSDT programs.

The upgrade to the Child and Adolescent Reporting System (CAREs) was described in detail in the 2007 narrative for HSCI #2. During FFY2007, the business requirements for the CAREs upgrade were reopened to incorporate the data needs of the I-Smile Program. The revised business requirements were approved in December 2006. At the time of this application, the design document for the CAREs upgrade is being developed. The design document will translate the business requirements into the technical requirements needed to ensure that the CAREs upgrade meets the needs of the Bureaus of Family Health and Oral Health and their grantee agencies.

The report for HSCI #07A appears on Form 17.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	55.0	51.9	52.8	53.7	53.7
Numerator	22440	22678	24390	25768	25757
Denominator	40810	43717	46216	47985	47943
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2006

The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2005

The 2005 data were obtained from the Annual EPSDT Participation Report - CMS 4.16 Report.

Narrative:

The I-Smile Program was developed to fulfill a legislative directive to assure a dental home for Medicaid-enrolled children. The program emphasizes early intervention, prevention, and family-centered assistance. Primary strategies of the I-Smile Program were implemented in the Title V grantee agencies throughout Iowa and fully integrated with the local EPSDT programs. The IDPH dental director works with Community Health Center dental providers, emphasizing integrating their services within local public health and involvement in community-based health planning.

The IDPH Oral Health Bureau provides contracted funding to seven local child health agencies for the provision of school-based dental sealant programs during FFY08. The programs provide dental screenings and/or examinations and dental sealants to low-income, uninsured, and/or underinsured children in school-based settings. EPSDT care coordinators work with children identified with untreated decay or no source of regular dental care to assist them in accessing

follow-up care from local dentists.

The report on HSCI #07B appears on Form 17.

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

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	98.7	92.4	91.9	91.7	
Numerator	1203	1201	1175	1058	0
Denominator	1219	1300	1278	1154	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The Iowa Title V CSHCN Program is unable to supply data for HSCI #8 because of an SSA-initiated interruption in the sharing of data regarding children < 16 years old enrolled in the SSI Program. There are apparently confidentiality-related questions that have remained unresolved since early calendar year 2007. If and when sharing of SSI enrollment data with CHSC resumes, CHSC will, in turn, resume contacting families of SSI-enrolled children to offer assistance connecting children and families to needed rehabilitative services.

Notes - 2006

Our Iowa Title V definition of rehabilitative services includes mailing a detailed letter to each family of a child determined eligible for SSI. The letter reiterates the beneficiary's eligibility and encourages application for Medicaid, as well as describes additional Title V CYSHCN services that may be useful or of interest.

The Title V CYSHCN Program realizes that receiving a letter inviting SSI beneficiary families to request assistance from Title V is not precisely the same as providing "rehabilitative services." We do, however, believe that the letter does offer a potential connection between SSI beneficiary families and Title V services.

Notes - 2005

Our Iowa Title V definition of rehabilitative services includes mailing a detailed letter to each family of a child determined eligible for SSI. The letter reiterates the beneficiary's eligibility and encourages application for Medicaid, as well as describes additional Title V CYSHCN services that may be useful or of interest.

Narrative:

Child Health Specialty Clinics continues to distribute information letters to over 90% of families whose children are approved for SSI Program enrollment. The reason that 100% of families don't receive an information letter 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 offers a reminder for

families to apply for Medicaid services. Medicaid eligibility is automatic, but enrollment is not, so application is necessary. The CHSC letter also provides 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 FFY07, problems with interagency sharing of SSI Program enrollment data has prevented CHSC from distributing information letters to families. Negotiations between CHSC, the Disabilities Determination Services Bureau, and the Social Security Administration are in progress to review and reaffirm a memorandum of agreement to permit interagency sharing.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	8.2	5.8	6.7

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2006 was used to calculate the percent of Iowa infants born with LBW. The proportion of LBW infants born to Iowa mothers overall (2005 =7.1; 2006=6.7), those born to Medicaid recipients, (2005=8.7; 2006=8.2) and those born to non-Medicaid recipients (2005=6.3; 2006=5.8) decreased from CY 2004 to 2005. The IDPH will address this stable trend in LBW by using new data sources to provide a clearer understanding of appropriate intervention strategies.

IDPH developed a Pregnancy Risk Assessment Monitoring System (PRAMS) application in January 2006. Although the project was not selected for funding, the project development process identified several potential opportunities for enhancing data use. Program development activities associated with the application process clarified the role of PRAMS as a critical method for evaluating program effectiveness and guiding new program development. Currently, resources are not available to implement the plan in the absence of outside financial resources. However, with support from the March of Dimes, IDPH will conduct an Iowa-PRAMS pilot and survey 400 women in FFY07. Over 400 randomly selected new Iowa moms completed surveys in calendar year 2007. We expect to have preliminary data results based on calendar year responses by late July 2008. The calendar year 2008 I-PRAMS pilot project is progressing as planned.

The report for HSCI #05A appears on Form 15.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

<i>MCH populations in the State</i>					
Infant deaths per 1,000 live births	2006	matching data files	6.5	4.3	5.2

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2006 was used to calculate the Infant Mortality Rate (IMR) for Iowa infants. The overall IMR increased slightly (2005= 5.0; 2006=5.2). The IMR for non-Medicaid infants decreased from 2005= 4.6 to 2006=4.3.

The IMR for Medicaid infants decreased from 2005= 5.9 to 2006=4.3. The IDPH will monitor this finding closely to determine whether the decrease will be sustained.

The IDPH will use new data sources to enhance understanding of appropriate intervention strategies. The March of Dimes funded I-PRAMS pilot was described in the HSCI #05A narrative. Additionally, a Perinatal Periods of Risk (PPOR) initiative will begin in the fall of 2007. The PPOR project will assist Iowa's maternal health system to use evidence-based practices to identify gaps in community resources and define disparities.

The report for HSCI #05B appears on Form 18.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	78.9	92	86.4

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2006 was used to examine the proportion of women who initiated prenatal care (PNC) in the first trimester. The overall proportion of Iowa mothers who initiated PNC in their first trimester decreased slightly for CY 2005 and 2006 (2005= 87.6; 2006=86.4). Likewise the proportion of non-Medicaid mothers (2005= 91.6; 2006=92) remained about the same and Medicaid mothers (2005=79.6; 2006=78.9) who initiated PNC in the first trimester decreased slightly for CY 2005 and 2006.

Local maternal health contract agencies provide presumptive eligibility. Local agency activities involved in increasing the number of women who enter prenatal care in the first trimester include a public awareness campaign; outreach presentations to churches, schools, and community centers; flyers distribution to pregnant women; WIC and MCH staff providing follow-up contacts; and school nurses providing information on the MH programs encouraging education on early prenatal care. In FFY2009, several agencies plan to offer free pregnancy tests to improve early identification of adolescent pregnancies. This information is shared with local school nurses to help increase awareness and referrals for pregnancy testing and prenatal care.

The report for HSCI #05C appears on Form 18.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	77.5	87.2	83.1

Notes - 2009

Data were obtained from 2006 Vital Statistics.

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2006 was used to calculate the Kotelchuck index for Iowa mothers. Overall 82.8% of Iowa mothers received adequate PNC in CY 2005 compared to 83.1% in 2006. Eight-seven percent of non-Medicaid women received adequate prenatal care. The proportion of Medicaid mothers who received adequate prenatal care was 77.5 over ten percent lower than non-Medicaid mothers.

As discussed in the HSCI #4 narrative, local maternal health agencies use the Women's Health Information System (WHIS) to document assessment and services for the Title V maternal health population. WHIS provides information on the timing and number of prenatal visits as well as the newborn's gestational age. IDPH is opening up the WHIS data system for an upgrade to incorporate the updated Medicaid Risk Assessment from the Iowa Department of Human Services. The WHIS upgrade will also add service documentation features to comply with recently revised Medicaid documentation requirements.

The report for HSCI #05D appears on Form 18.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 <i>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	185
INDICATOR #06 <i>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	200

Narrative:

The 2005 Iowa Child and Family Household Health Survey was completed in late 2005 and early 2006. The resulting data indicated that the percentage of Iowa children without health insurance was three percent. In May 2008, enrollment for Medicaid was 170,190 and enrollment in the SCHIP program was 19,272. Although uninsured rates in Iowa continue to decline, according to the Iowa Department of Human Services 2006 estimates, approximately 64,000 children are uninsured and 43,000 of these children are eligible for Medicaid or SCHIP.

Iowa's three percent uninsured rate compares favorably to the national rate of nine percent. However, there are new barriers to enrollment in public health care coverage. The Deficit Reduction Act of 2005 (DRA) requires each enrollee in Medicaid, upon enrollment or renewal, to provide documentation of their citizenship and identity. This process was implemented on July 1, 2006 in Iowa. Additionally, SCHIP funding shortfalls and SCHIP reauthorization delays could impact children's enrollment into public health care coverage programs. Iowa is one of approximately sixteen states set to run out of funding by September 30, 2007. This means that unless funding is redistributed to the states, Iowa will stop enrolling children in the SCHIP program on that date.

The report for HSCI #06A appears on Form 18.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2007	200

Narrative:

An overall discussion of HSCI 06 can be found under HSCI 06A.

The report for HSCI #06B appears on Form 18.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	185
INDICATOR #06	YEAR	PERCENT OF

The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.		POVERTY LEVEL SCHIP
Pregnant Women	2007	200

Narrative:

An overall discussion of HSCI 06 can be found under HSCI 06A.

The report for HSCI #06C appears on Form 18.

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

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

Iowa continues to score lowest on the HSCI #09A indicator related to MCH and WIC data sharing. Although administrators of both programs have historically expressed the willingness to share appropriate data, the WIC program was not allowed to share data for non-WIC purposes according to federal guidelines. New rules were published by the US Department of Agriculture in the Federal Register on 9-27-2006 with an effective date of 11-27-2006. The applicable

Federal Register is located on the Web at <http://www.fns.usda.gov/wic/regspublished/miscrulepdf.pdf>. The new rules relax the federal guidelines on WIC data sharing, allowing state WIC agencies greater flexibility in sharing confidential applicant information with appropriate non-WIC agencies. In Iowa, a state plan will be written, policies will be developed, and approval will be obtained from the USDA regional office. Regional USDA approval will be sought in September prior to the implementation date for the new rules of 10-1-2007. After the federal requirements have been completed, the IDPH programs covering WIC and MCH will begin to develop memoranda of agreement to guide regular data integration activities.

Iowa's State Systems Development Initiative (SSDI) continues to devote its resources to ensuring that MCH program partners have access to policy and program relevant information. The implementation and analysis of the 2005 Iowa Child and Family Household Health Survey (HHS) is a priority SSDI initiative. The survey was a population-based statewide household telephone survey. The survey process began with a screening question to determine if the residence was home to a family with children. If so, the adult most knowledgeable about the health and health care of a randomly selected child under age 18 in the household was asked to complete the interview. The 180-question survey averaged 22 minutes to complete and surveyors obtained a 77% cooperation rate. Three reports containing analysis of the 2005 HHS have been posted to the Web at <http://ppc.uiowa.edu/health/ICHHS/iowachild2005/ichhs2005.htm>. The first report, published in December 2006, contained comprehensive statewide results. The second report, published in the spring of 2007, contained early childhood results. The third report, published in the spring of 2008 focused on nutrition and physical activity. This population-based survey has provided important program-relevant data for local and statewide MCH agencies. The continuing analyses will provide valuable information for the next Title V Five Year Needs Assessment.

IDPH obtained a grant from the March of Dimes to implement a PRAMS-like pilot project. The \$10,000 grant will allow a survey of several hundred new mothers four months after delivery to see if they are caring for their newborns as planned, as well as provide an understanding of the new mothers' post-partum behavior. It will also provide insights into possible relationships between lifestyles before birth and poor pregnancy outcomes, such as low birth-weight infants. The survey is called the Iowa Pregnancy Risk Assessment Monitoring System (I-PRAMS).

The report on HSCI #09A appears on Form 19.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No
Iowa Youth Survey - every three years	2	No
Iowa Youth Tobacco Survey - every two years	3	Yes

Notes - 2009

Narrative:

Just Eliminate Lies (JEL), a youth-led movement targeting tobacco use throughout Iowa, in collaboration with Des Moines advertising agency ZLRIGNITION, received five awards for Excellence in Public Health Communication at the 2006 conference for the National Public Health

Information Coalition.

The Iowa Youth Tobacco Survey (IYTS) is conducted every 2 years. It is a comprehensive survey of tobacco use, secondhand smoke exposure, access, cessation, tobacco-related attitudes, tobacco marketing and tobacco prevention exposure, and awareness of the JEL campaign among Iowa youth. The IDPH Division of Tobacco Use Prevention and Control conducts the IYTS to measure the effectiveness of youth tobacco-use prevention and cessation programs within Iowa. The IYTS results indicate that tobacco-use prevention efforts in Iowa have been successful. Youth tobacco use in Iowa declined by 7 percentage points between the 2002 survey and the 2004 survey. The rate is well below the national average.

In November 2006, Iowa's 2nd Annual Tobacco Control Conference, From Vision to Victory, brought together over 120 participants from communities across Iowa. The conference featured a series of skill-building presentations and workshops that showcased successful strategies advocates can implement locally. Key topics included information on reducing the use of tobacco through grassroots organization, smoke-free workplace campaigns, implementing tobacco-free campuses, utilizing media, mobilizing youth and working with populations at high risk for tobacco use. Keynote presenters included Vinnie DeMarco, J.D.,M.A., Johns Hopkins University, Bloomberg School of Public Health on Building Grassroots Support for a Tobacco Tax Increase, and Annie Tegen, Program Manager, Americans for Nonsmokers' Rights Foundation on Building Local Support for Smoke-Free Campaigns. The conference ended with youth members from JEL (Just Eliminate Lies) leading adult conference participants in tobacco education events in downtown Des Moines. The messages illustrated the importance of advocating for clean indoor air and protecting nonsmokers from exposure to secondhand smoke.

The report on HSCI #09B appears on Form 19.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The five year plan for 2006-2010 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.

B. State Priorities

DIRECT HEALTH CARE AND ENABLING SERVICES:

1. Need Statement: Assure access to pediatric specialty care for all children.

Analysis of the "2000 Iowa Child and Family Household Health Survey" provided information about the health status and related circumstances of families, both those with and without CYSHCN. Twenty-five percent of families with a CYSHCN had trouble getting specialty care when their child needed it. In contrast, but still notable, 11 percent of families without a CYSHCN had trouble accessing specialty care when needed. In the Title V needs assessment prioritization process, stakeholders ranked increased access to pediatric specialty care for all children as the #12 priority need.

2. Need Statement: Minimize developmental delay through early intervention services for children 0-3 years.

According to a report from the U.S. Department of Education, Office of Special Education Programs, Iowa's Early ACCESS system (Part C of IDEA) served 1.11 percent of Iowa's 0-1 year old children and 2.07 percent of Iowa's 0-3 year old children in 2004. Thus, Iowa met the OSEP recommendation that early intervention programs serve 1 percent of children 0-1 and 2 percent of children 0-3. In the Title V needs assessment prioritization process, increased access to early intervention services was ranked as the #3 priority need by stakeholders.

3. Need Statement: Assure developmental evaluations are provided to Medicaid enrolled children 0-3 years.

In Iowa, approximately 18,000 children ages 0-3 years need mental health services each year. This means that one in five young Iowans experience the signs and symptoms of mental disorders. According to a Commonwealth Report, "12 to 16 percent of children experience developmental problems, only one-third of those children - usually those with the most obvious conditions- are identified in pediatric practices prior to school entry." In the Title V needs assessment prioritization process, increased developmental evaluations for children 0-3 years was ranked as the #11 priority need by stakeholders.

According to data from the "2000 Iowa Child and Family Household Health Survey," thirty percent of families with CYSHCN and four percent of families without CYSHCN required behavioral or emotional care in the previous year. A review of the "Community Health Needs Assessment and Health Improvement Plan" indicates that 14 counties are addressing mental health issues. Examples of priority issues for these counties are: poor access to services and health professionals, limited number of rural psychiatrists for adults and children, and inadequate mental health screening.

4. Need Statement: Improve the quality of family support and parenting education programs and services.

Iowa currently does not have an integrated, comprehensive systemic approach to family support, home visitation, and parenting education. Most of Iowa's local home visiting programs and parenting education programs follow the model that meets the funding requirements. At the local level, Community Empowerment Areas are statutorily required to strive for spending 60 percent of their state funds on family support, home visiting, or parenting education. Community Empowerment Areas use a variety of national models and community-created models. Currently, Iowa supports the HOPES-HFA (Healthy Opportunities for Parenting to Experience Success -- Healthy Families America) model through IDPH. Twelve counties use this home visiting model. Additional counties use a HOPES-like model for their home visiting program. Counties use the HOPES-like model because of the cost and lengthy accreditation process required by "official" HOPES-HFA Program. There are also 64 Parents as Teachers (PAT) programs throughout the state. The locally designed models generally do not include an evaluation component or preventive health component, both of which are included in more widespread evidenced-based models. In the Title V needs assessment prioritization process, improve the quality of family support and parenting education programs and services was ranked as the #9 priority need by stakeholders.

In the Community Health Needs Assessment and Health Improvement Plan, three counties are addressing parenting and family support issues. These counties will focus on unifying and improving availability of parenting education classes in their communities.

POPULATION-BASED SERVICES:

5. Need Statement: Improve the quality of primary care for children in Iowa.

Iowa's screening plan for preventive health services for children is consistent with standards established by the American Academy of Pediatrics. The periodicity schedule for comprehensive health screening for all children ages 12 months to 6 years includes testing for blood lead levels. Quality improvement reviews of preventive care records for Medicaid eligible children suggest that lead screening is likely to be the last component of the comprehensive screen to be completed. For this segment of the child health population, it appears that there is a correlation between the completeness of the recommended preventive health screen and testing for lead poisoning. Based on this observation, Iowa selected blood lead testing as an indicator of the comprehensiveness of primary care provided to children. The percentage of children receiving a blood lead test is identified as a proxy measure for the quality of primary care provided for children.

In 2000, the Iowa Department of Public Health started to examine elevated blood lead rates for birth cohorts. A birth cohort represents children who were all born in a given time period. The percentage of children tested and the prevalence of lead poisoning were determined for children under the age of six years. Data analysis for the 1998 birth cohort was complete as of December 31, 2004. Of 37,262 children born in 1998, 57.1 percent received a blood lead test before the age of six years. Of children who were tested, 7.5 percent had blood lead levels greater than 10 micrograms per deciliter ($\mu\text{g}/\text{dL}$), which is the blood lead level used to define lead poisoning. This is more than three times the national average of 2.2 percent. The Medicaid population is of special concern because the prevalence of lead poisoning in Medicaid children is 2.5 times the prevalence of lead poisoning in non-Medicaid children. In the Title V needs assessment prioritization process, stakeholders ranked improve the quality of primary care for children in Iowa as the #5 priority need.

The Community Health Needs Assessment and Health Improvement Plan from local boards of health indicated that 17 counties are addressing lead screening and follow-up. Most of the

counties will focus on educating health care professionals and parents on the importance of lead screening for children under six years old.

6. Need Statement: Assure access to oral health care for children in Iowa.

Access to dental care for low-income families in Iowa is limited due to a number of barriers. These include: lack of financial resources to pay for care, lack of knowledge of the importance of good oral health, lack of dentists willing to see children under the age of three, shortage of dentists participating in the Medicaid program, shortage of dentists within the state, and issues of patient compliance.

In the "2000 Iowa Child and Family Household Health Survey," eight percent of responding families reported there was a time during the previous year that their child needed dental care, but could not obtain it. In the Title V needs assessment prioritization process, increased access to oral health services was ranked as the #6 priority need by stakeholders.

In the Community Health Needs Assessment and Health Improvement Plan, four communities are focusing on access to dental services for children, including Medicaid clients. Most of these communities will work with their local MCH agency to help with recruitment of dentists to treat all children at an earlier age.

7. Need Statement: Assure children enrolled in early care and education programs are in quality environments.

Iowa ranks in the top three states for percentage of children under age six whose parents are in the labor force. Seventy-seven percent of Iowa families with children 0-5 years old have both or the only parent working. The increase of working parents in the last decade has resulted in the need for child care arrangements for about 30,000 additional children. In the Title V needs assessment prioritization process, stakeholders ranked improve health and safety in child care and preschool as the #10 priority need.

According to the "2000 Iowa Child and Family Household Health Survey," almost half (46%) of Iowa children under age 10 receive child care from someone other than a parent. Four percent of parents of CYSHCN were very dissatisfied with their child care arrangements compared to only one percent of parents of other children. The parents of CYSHCN were more likely than parents of other children to report trouble finding child care when their child was sick (33% vs. 25%). About one-third of parents of CYSHCN had difficulty finding child care because of the child's special health care need.

The Midwest Research Consortium on Quality in Child Care documented the status of quality on Iowa's early care and education programs. A 2002 study found poorer quality infant and toddler care in both center-based and home-based care in Iowa compared to other Midwest states. The study concluded that at the time of the survey, Iowa had fewer statewide initiatives to support quality or professional development of the child care workforce than other Midwest states.

INFRASTRUCTURE BUILDING SERVICES:

8. Need Statement: All children and adolescents should be physically active for at least 30 minutes, limit screen time to no more than two hours, and eat five or more servings of fruits and vegetables each day.

According to the "2002 CDC Pediatric Nutrition Surveillance System," 30 percent of low-income children aged 2-5 years in Iowa are overweight or at risk of becoming overweight and 61 percent of Iowa adults are overweight or obese. In Iowa, the obesity rate in adults has increased by 70 percent from 1990 to 2002. In the needs assessment prioritization process, stakeholders ranked

improve physical fitness of children as the #4 priority need.

A review of submitted Community Health Needs Assessment and Health Improvement Plans revealed a collective top priority of related factors: overweight, nutrition, and physical activity. There are 63 counties focusing efforts around these issues.

9. Need Statement: Reduce the number of infant deaths due to prematurity. Infant mortality is a critical indicator of the health of a population, as it reflects the overall state of maternal health, as well as the quality and accessibility of primary health care available to pregnant women and infants. Advances in medical technology and access to care have produced declines in infant mortality rates across the country, including Iowa. In the Title V needs assessment prioritization process, reduce infant mortality was ranked as the #8 priority need by stakeholders.

Provisional data for calendar year 2004 points to a potential decrease in the rate of infant mortality per 1,000 births, from 5.7 in 2003 to 5.0 in 2004.

In the Community Health Needs Assessment and Health Improvement Plan, 15 counties are addressing prenatal care and birth outcomes.

10. Need Statement: Assure pregnant and parenting women are screened and referred to appropriate mental health services.

The IDPH Women's Health Information System contained records for 9,344 women in 2004. The top needs listed by the women were emotional and social needs (7.6%), language/cultural barriers (3.9%), and domestic violence assistance (3.1%).

A review of the Community Health Needs Assessment and Health Improvement Plan indicated that 14 counties are addressing mental health issues such as poor access to services and health professionals, limited number of rural psychiatrists for adults and children, and inadequate mental health screening.

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	2003	2004	2005	2006	2007
Annual Performance Objective	99.5	99.7	99.8	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	47	43	44	58	184
Denominator	47	43	44	58	184
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

FFY07 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

Notes - 2006

FFY06 data were obtained from the Center for Congenital and Inherited Disorders and the Iowa Neonatal Screening Program.

Notes - 2005

FFY05 data were obtained from the Neonatal Metabolic Screening Program.

a. Last Year's Accomplishments

The performance objective of 100 percent was met. Data provided to 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 SERVICES

The Center for Congenital and Inherited Disorders joined the Heartland Regional Newborn Screening and Genetics Collaborative in October 2004. Iowa participates with seven other states in this collaborative to develop standards of care, educational programs, and sharing of best practice models.

The CCID also participates in the Connections program for data integration through the Public Health Informatics Institute. This collaboration evaluates opportunities for data analyses, evaluation, and integration. The CCID works with the data/information management liaison from the Bureau of Family Health in this effort. The state genetics coordinator is participating on a Connections subcommittee developing a business case model for newborn screening programs.

The INMSP Healthcare Practitioner's Manual on the Center for Congenital and Inherited Disorders Web page was updated. The manual is a guide created to help the practitioner comply with Iowa rules and to better understand the Iowa Neonatal Metabolic Screening Program. The manual includes information on specimen collection, when to obtain a second sample, frequently asked questions, and additional helpful information. The Web page for the Center for Congenital and Inherited Disorders is <http://www.idph.state.ia.us/genetics>. Fact sheets for various inborn errors of metabolism have been posted to the CCID Web page.

An Executive Team consisting of the state genetics coordinator, the newborn screening program medical director, the screening laboratory director, and the newborn screening program administrative assistant was established. This team reviews fiscal status of the program, makes policy recommendations, reviews current disorders provided by the screening panel for efficacy, and reviews and makes recommendations to the advisory committee and the Iowa Department of Public Health regarding other disorders to add to the screening panel.

Iowa's 2007 82nd General Assembly approved legislation that appropriates \$300,000 to the Metabolic Formula and Medical Foods program to assist individuals with metabolic diseases in the purchase of metabolic formula and medical foods necessary for management of their disorder. The University of Iowa's Metabolic Formula and Medical Foods programs have initiated a work plan to distribute funds for the purchase of medical foods to every program participant.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to implement the notification system for child deaths				X

to decrease the unnecessary contact of families.				
2. Collaborate with the early hearing detection initiative.				X
3. Ensure the capacity for uniform short term follow up and monitor identified newborns through adulthood.	X	X	X	
4. Work with CDC to develop a system for the collection of data and the surveillance of all fetal deaths.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

POPULATION-BASED SERVICES

The Iowa Neonatal Metabolic Screening Program is a fee-for-service program that provides laboratory, follow-up, consultative, and educational services. Responsibility for the Neonatal Metabolic Screening testing is assigned to the University Hygienic Laboratory at the University of Iowa (U of I). The U of I Newborn Metabolic Screening program staff provides 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 oxidation disorders detectable by tandem mass spectrometry; hypothyroidism; galactosemia; hemoglobinopathies; congenital adrenal hyperplasia; biotinidase deficiency; and cystic fibrosis.

Newborn metabolic screening records are matched with birth certificate records to identify newborns that were not screened. To facilitate this process, a Web-based matching system is used. This system has been developed to identify unscreened newborns and infants. When an unscreened newborn is identified, the birthing facility and/or physician's office is contacted to determine the reason that the newborn was not screened. If a missed screening is identified, it is arranged for the newborn to be screened.

The INMSP has restructured its follow-up system to provide centralized short-term follow-up services that manage cases from presumptive positive test results through to confirmatory diagnosis and linkage with a medical home.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The CCID will continue to work with the Information Management Bureau of the IDPH to explore the feasibility of integrating data analysis, such as screening rates, between the neonatal metabolic screening program and the newborn hearing screening programs. The objective would be to assure every child receives comprehensive newborn screening. The implementation of the Electronic Birth Certificate (EBC) project in Iowa will provide information on the screening status for both programs. EBC implementation began in January 2007, and imports of birth certificate records to the child discovery database began in October 2007. The MCH program liaison to the Information Management Bureau continues to explore available data integration programs as resources allow.

The CCID received a federal grant from HRSA MCHB to increase participation of families in the planning, implementation, and evaluation of newborn screening services (including hearing screening). The CCID contracts with the University of Iowa College of Nursing and Department of Pediatrics to assist in convening work group meetings of populations that historically have not actively participated in the newborn screening programs. These populations include Sudanese immigrants; families associated with a state college of chiropractic medicine; adoptive parents; Amish families; Native American Indians; and families of children with a positive screening result,

a false positive screening result, and positive carrier screening result.
 The Iowa Family Participation Project, as this initiative is known, will also convene a meeting of providers, including pediatricians, obstetricians, nurse practitioners, hospital staff representatives, and nurse midwives.

The goal of all of these meetings is to ascertain the level of awareness and understanding of the newborn screening programs, gather suggestions as to how to develop and disseminate materials most appropriate for the population, and recruit members for an ongoing Information and Education committee to provide guidance for the provision of newborn screening programs.

The Iowa Neonatal Metabolic Screening Program coordinator will continue to promote and assess quality newborn screening testing of birthing providers, the follow-up programs and the testing laboratory. The coordinator provides annual and as needed reports to the state genetics coordinator at the CCID.

The state genetics coordinator will conduct a review of the newborn screening program to ascertain adherence to policies and procedures and assess efficiency.

The Congenital and Inherited Disorders Advisory Committee (CIDAC) has evaluated the progress of the State Plan for Genetic Services, and has made recommendations for additional, deletion, or amendment of activities.

The Iowa Neonatal Metabolic Screening Program will continue to work with the Child Death Review Team to develop a notification system for child deaths to decrease unnecessary contact.

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	2003	2004	2005	2006	2007
Annual Performance Objective	59.2	59.9	60.6	61.3	62
Annual Indicator	58.6	58.6	58.6	58.6	64.7
Numerator	225	225	225	225	
Denominator	384	384	384	384	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	65.1	68.4	71.8	75.4	79.2

Notes - 2007

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 - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National

CYSHCN Survey - approximately every 5 years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The FFY07 performance target objective of 62% was met. The indicator value for Iowa was 64.7% based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 5th highest among U.S. states and statistically significantly better than the national mean.

INFRASTRUCTURE BUILDING SERVICES:

In FFY07, a new CHSC Family Participation Program co-leader replaced a retiring co-leader. Family Participation Program leadership has become a standard participant in and contributor to all Title V CYSHCN Program strategic planning and high level decision-making. There are also now defined roles, expectations, and standards for performance of the parent consultant network at the regional center level.

CHSC Family Participation Program leadership continued to recruit parent consultant network colleagues to formulate and influence public policy relevant to service systems for CYSHCN.

Family involvement was a major strategy in a new SAMHSA-supported System of Care system development effort co-led by CHSC to improve services for children with severe emotional disorder.

Family participation in the Iowa Medical Home Initiative remained a goal, although many of the participating primary care practices became inactive due to major contractual obstacles and consequent revision of project activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Include family participation leaders in deliberations about programmatic implications of new survey data from the National CSHCN Survey and Iowa Child and Family Household Health Survey.				X
2. Maintain involvement in any rewrite and resubmission of Iowa's Family-to-Family Health Information Center grant proposal.				X
3. Review and update CHSC's bank of family stories instrumental in program marketing and advocacy efforts.				X
4. Adhere to "family-driven" and "youth-guided" principles as essential components of the SAMHSA-supported System of Care project.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, family participation in CHSC, Iowa's Title V Program for Children with Special Health Care Needs (CSHCN), expanded by 20 new hires for a total of over 40 parents of CSHCN working in five major program areas -- regional clinic programs; Medicaid Waivers and EPSDT; Part C service coordination; SAMHSA-supported system of care project; and the Early Hearing Detection and Intervention project.

Family participation by two CHSC parent consultants continues on the CHSC Leadership Council, the primary strategic planning team in the organization.

A CHSC community-based parent consultant serves on a Governor-appointed statewide Medicaid advisory committee.

The new CHSC co-led Community Circle of Care SAMHSA-supported System of Care project is adhering to "family-driven" and "youth-guided" principles.

Six CHSC parent consultants attended the Association of Maternal and Child Health Programs national conference to learn and participate in a variety of issue-oriented presentations and workshops.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, continue to support and expand, as possible, CHSC's family participation across all levels of the Maternal and Child Health pyramid.

Include family participation leaders in deliberations about programmatic implications of new survey data from the National CSHCN Survey and Iowa Child and Family Household Health Survey.

Maintain involvement in any rewrite and resubmission of Iowa's Family-to-Family Health Information Center grant proposal.

Review and update CHSC's bank of family stories instrumental in program marketing and advocacy efforts.

Engage families in new satisfaction-oriented survey and/or focus group data collection efforts as a major part of the upcoming Title V quinquennial needs assessment plan.

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	2003	2004	2005	2006	2007
Annual Performance Objective	58.2	59.4	60.6	61.8	63
Annual Indicator	57.1	57.1	57.1	57.1	57.4
Numerator	413	413	413	413	
Denominator	723	723	723	723	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	60.3	63.3	66.5	69.8	73.3

Notes - 2007

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.

Although, we did not meet the 2007 target, we are encouraged to set increasing target objectives based on the assumption that recent 2008 health care reform state legislation will have a strong positive influence on primary care providers to pursue a medical home model of care delivery.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CUSHCN Survey - approximately every 5 years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The FFY07 performance target objective of 63% was not met. The indicator value for Iowa was 57.4% based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 1st among U.S. states and statistically significantly better than the national mean.

INFRASTRUCTURE BUILDING SERVICES:

In FFY07, the IMHI project activities were reconceptualized based on major contract obstacles to implementing the original planned activities. Essentially, the statewide Learning Collaborative model for interested primary care practices was replaced by two new partnerships: 1) with the Iowa Dept of Public Health 1st Five project emphasizing improved early childhood developmental screening and referral practices by primary care providers; and 2) with the Iowa-Nebraska Primary Care Association to facilitate investigation of medical home model practices by Iowa's safety net providers (e.g. free clinics, MCH agencies, and local boards of health).

As part of the plan for project spread and sustainability - both financial and conceptual - the IMHI project work group reviewed potentially advantageous new partnerships.

The coordinator for the 1st Five project, Iowa's early childhood healthy mental development initiative, was added to the IMHI work group planning team.

Prevalence of medical home models of care was discussed as a potential common performance indicator among an array of related Iowa grantee HRSA-supported projects.

The IMHI evaluation team summarized and analyzed survey data collected from Learning Collaborative participants, as well as a comparison group of primary care practices not

participating in the Learning Collaborative.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Make CHSC expertise available for any state or regional effort to spread the medical home model in accordance with the legislative requirements of Iowa's new health care reform bill.				X
2. Produce a short report based on project evaluation comparisons of primary care provider medical home learning collaborative participants and non-participants.				X
3. Partner with the Iowa-Nebraska Primary Care Association to provide technical assistance to selected safety net providers involved in fulfilling a legislative mandate to help Iowa families "determine a medical home."				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, the CHSC-led Iowa Medical Home Initiative (IMHI) continues a collaboration with the Iowa Department of Public Health's 1st Five Program to provide developmental-oriented consultation to primary care practices, as well as any requested consultation on care coordination and the medical home model.

The IMHI has entered a new partnership with the Iowa-Nebraska Primary Care Association to provide technical assistance to selected safety net providers involved in fulfilling a legislative mandate to help Iowa families "determine a medical home."

CHSC staff are guiding a public health graduate student who is beginning to study, summarize, and make recommendations regarding the experience of selected safety net providers with pursuit of medical home model attributes.

The IMHI was a resource to the Iowa Affordable Health Care Commission medical home workgroup and formulated a set of medical home designation criteria with suggested training resources for use by the director of the Iowa Department of Public Health.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, CHSC will continue collaborations with the IDPH 1st Five Program and the Iowa-Nebraska Primary Care Association Safety Net Provider projects to fulfill any requested consultation on care coordination and the medical home model.

CHSC will make its expertise available and position itself as a potential partner for any new state or regional efforts to spread the medical home model in accordance with the legislative

requirements of Iowa's new health care reform bill.

Consideration will be given to publishing a short report based on project evaluation comparisons of primary care provider medical home learning collaborative participants and non-participants.

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	2003	2004	2005	2006	2007
Annual Performance Objective	63.9	63.3	67.7	71.1	74.7
Annual Indicator	64.5	64.5	64.5	64.5	68.6
Numerator	468	468	468	468	
Denominator	726	726	726	726	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	72	75.6	79.4	83.4	87.6

Notes - 2007

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.

Although we did not meet the 2007 target, we set increasing target objectives because of the consistently and broadly acknowledged high importance of this insurance-related outcome priority.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CYSHCN Survey - approximately every 5 years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The FFY07 performance target objective of 74.7% was not met. The indicator value for Iowa was 68.6% based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 4th highest among U.S. states and statistically significantly better than the national mean.

INFRASTRUCTURE BUILDING SERVICES:

In FFY07, planning occurred for CHSC to be involved in an Iowa Foundation for Medical Care study to analyze the cost and service utilization effects of care coordination services provided for high-cost Medicaid inpatients discharged to community-based care resources.

The Iowa Medical Home Initiative continued informal connections with third-party payers, especially Wellmark Blue Cross/Blue Shield, regarding innovative chronic illness management practices consistent with a high quality, cost-effective medical home standard of care for children with special health care needs.

CHSC provided input to a statewide policy advocacy organization seeking to maintain Iowa's Children's Health Insurance Program (CHIP) coverage and to enhance the quality of care provisions under state CHIP authorization language.

CHSC was represented on the work group, the advisory panel, and the executive board of the Assuring Better Child Health and Development (ABCD II) project, which, as one of its project goals, developed and submitted a list of Medicaid barriers impeding full participation of primary care practices in early childhood developmental screening activities.

CHSC was a planning partner in a statewide early childhood advocacy effort - the "Off to a Good Start Coalition" - that promotes the health-related goals of Iowa's Early Childhood Comprehensive Systems project, one of which is to assure adequate health and dental coverage.

DIRECT AND ENABLING SERVICES:

CHSC regional centers worked with families of CSHCN patients to apply for Medicaid or SCHIP and, if needed, assist them with the application process.

CHSC's Health & Disease Management unit provided guidance and information for families of CSHCN on Medicaid Waiver and EPSDT programs regarding health care financing.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide staffing to the Covering Kids and Families Coalition, whose mission is to assure coverage for all Iowa children and families.				X
2. Participate on and suggest activities for the Off to a Good Start Coalition which has as one major goal, the assurance that young children are adequately insured.				X
3. Provide guidance and information for families of CSHCN on Medicaid Waiver and EPSDT programs regarding health care financing.				X
4. Participate and review of the Iowa Child and Family Household Health Survey special report on insurance status of Iowa families.				X
5. Support a CHSC community-based parent consultant to serve on a Governor-appointed statewide Medicaid advisory committee.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, CHSC continues to provide staffing to the Covering Kids and Families Coalition, whose mission is to assure coverage for all Iowa children and families.

CHSC participates on and suggests activities for the "Off to a Good Start Coalition" which has as one major goal, the assurance that young children are adequately insured.

CHSC is a participant and reviewer of the Iowa Child and Family Household Health Survey special report on insurance status of Iowa families.

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 under and uninsured Iowans.

A CHSC community-based parent consultant serves on a Governor-appointed statewide Medicaid advisory committee.

DIRECT AND ENABLING SERVICES:

CHSC regional centers work with families of CSHCN patients to apply for Medicaid or SCHIP and, if needed, assist them with the application process.

CHSC's Health & Disease Management unit continues to provide guidance and information for families of CSHCN on Medicaid Waiver and EPSDT programs regarding health care financing.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, continue to provide staffing to the Covering Kids and Families Coalition, whose mission is to assure coverage for all Iowa children and families.

Participate, as requested, in any survey-based special reports (e.g. from the Iowa Child and Family Household Health Survey) on the insurance status of Iowa families.

Continue representation 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 under and uninsured Iowans.

Continue CHSC parent consultant participation on a Governor-appointed statewide Medicaid advisory committee.

Volunteer or agree to participate on any task force assembled by the Iowa Insurance Division to investigate improvement strategies in coverage for services to Iowa children with autism spectrum disorders.

DIRECT AND ENABLING SERVICES:

Continue to assist and enable families of CSHCN patients to apply for Medicaid or SCHIP.

Continue to utilize the Health & Disease Management unit to provide guidance and information for families of CSHCN on Medicaid Waiver and EPSDT programs regarding health care financing.

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	2003	2004	2005	2006	2007
Annual Performance Objective	79.4	81	82.6	84.3	86
Annual Indicator	77.8	77.8	77.8	77.8	92.9
Numerator	301	301	301	301	
Denominator	387	387	387	387	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	93.8	94.7	95.6	96.6	97.6

Notes - 2007

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.

Although our data source for this NPM (the National CSHCN Survey) is only repeated every five years, we felt responsible to revise and raise the annual target objectives by a modest percentage as motivation to remain involved in system development efforts designed to improve families' easy use of community-based service systems.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CSHCN Survey - approximately every 5 years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The FFY07 performance target objective of 86% was met. The indicator value for Iowa was 92.9% based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 2nd highest among U.S. states and statistically significantly better than the national mean.

INFRASTRUCTURE BUILDING SERVICES:

In FFY07, CHSC state and regional staff participated in a SAMHSA-supported System of Care system improvement effort to develop a new, coordinated, family-driven system of care for children with severe emotional disorders.

Based on participant evaluations for the Chronic Care Improvement Learning Collaborative, a theme for a subsequent medical home-related learning collaborative was chosen to be "care coordination."

A graduate student supported under Iowa's LEND grant furthered the work of CHSC to develop: 1) a standard definition of care coordination; 2) a reasonable method to document care coordination activities; and 3) a set of skills and competencies needed to offer an acceptable quality of care coordination service across several clinical settings.

The state coordinator for a new state-supported project called "1st Five" to assure early childhood healthy mental development began serving on the Iowa Medical Home Initiative project planning work group to help link Title V community-based care coordination resources with primary care practices.

DIRECT AND ENABLING SERVICES:

The CHSC Health and Disease Management Unit continued to provide care coordination to complex CYSHCN enrolled in Medicaid Waiver Programs under a contract with the Iowa Department of Human Services.

Telehealth consultations between CHSC regional staff and medical center-based child psychiatry staff for children with difficult behavioral problems was increasingly utilized.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist interested primary care practices to develop their care coordination awareness and capabilities.				X
2. Continue CHSC parent consultant network participation as formally trained "service coordinators" for CSHCN and families enrolled in Iowa's IDEA Part C Program.		X		
3. Collaborate with the Iowa Department of Public Health's 1st Five project to assure that families of young children at-risk for developmental delay are connected to needed community-based early intervention services.		X		X
4. Utilize the Guide By Your Side program to provide family support, emotional support, information, and mentoring to children enrolled in the Early Hearing Detection and Intervention program.		X		X
5. Increase involvement in developing statewide programs to improve the identification, early intervention, and care coordination for children with autism and autism spectrum disorders.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, CHSC nurse practitioners, under an MCHB-supported Integrated Community Services grant, assist interested primary care practices -- family medicine and pediatrics -- to develop their care coordination awareness and capabilities.

CHSC plays a major role in a SAMHSA-supported System of Care multiagency effort to improve access, delivery, and coordination of mental health services for children with severe emotional disorders.

Collaboration continues with the Iowa Department of Public Health's 1st Five project to assure that families of young children at-risk for developmental delay are connected to needed community-based early intervention services.

CHSC developed a Guide By Your Side program to provide family support, emotional support, information, and mentoring to children enrolled in the Early Hearing Detection and Intervention program.

DIRECT AND ENABLING SERVICES:

CHSC continues to increase its use of telehealth technology to improve families' access to services, especially for children with behavioral problems.

CHSC's Health & Disease Management unit continues to provide care coordination to CSHCN and families on Medicaid Waiver and EPSDT programs via contract with the Iowa Department of Human Services.

Additional members of CHSC's parent consultant network have been formally trained and function as "service coordinators" for CSHCN and families enrolled in Iowa's Part C Program (of IDEA)

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, CHSC will increase involvement in developing statewide programs to improve the identification, early intervention, and care coordination for children with autism and autism spectrum disorders.

Continue to fill a major role in the SAMHSA-supported System of Care multiagency effort to improve access, delivery, and coordination of mental health services for children with severe emotional disorders.

Continue collaboration with the Iowa Department of Public Health's 1st Five project to assure that families of young children at-risk for developmental delay are connected to needed community-based early intervention services.

DIRECT AND ENABLING SERVICES:

Continue to utilize the Health & Disease Management unit to provide care coordination to CSHCN and families on Medicaid Waiver and EPSDT programs via contract with the Iowa Department of Human Services.

Continue to provide - and expand if necessary - service coordination to selected young CSHCN enrolled in Iowa's Part C Program (of IDEA) and their families.

Continue participation in the Guide By Your Side program to provide family support, emotional support, information, and mentoring to children enrolled in the Early Hearing Detection and Intervention program.

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	2003	2004	2005	2006	2007
Annual Performance Objective			6.4	7	7.7
Annual Indicator	5.8	5.8	5.8	5.8	47.3
Numerator	310	310	310	310	
Denominator	5351	5351	5351	5351	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	49.7	52.2	54.8	57.5	60.4

Notes - 2007

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.

We are hoping that participation in a technical assistance experience will boost our Title V CSHCN Program's accomplishments for this national priority outcome.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Although we realize the indicator value only changes with new data obtained from the National CYSHCN Survey - approximately every 5 years - we have chosen to increase our annual target objective to reflect our intention to annually progress toward meeting this priority need.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The FFY07 performance target objective of 7.7% was met. The indicator value for Iowa was 47.3% based on data from the 2005-6 National Children with Special Health Care Needs Survey. This indicator ranks Iowa 11th highest among U.S. states and statistically significantly better than the national mean. The indicator value far exceeded the target because the 2005-6 survey items were changed significantly from the 2000-1 survey items.

INFRASTRUCTURE BUILDING SERVICES:

In FFY07, Healthy & Ready to Work project evaluation results remained available to Title V CYSHCN program planners and other interested stakeholders concerned with adolescent transition issues.

Iowa Medical Home Initiative nurse advisors remained available to primary care providers pursuing a medical home quality of care and who requested technical assistance to develop transition approaches and plans for their adolescent patients with special health care needs.

The CHSC co-led SAMHSA-supported System of Care project formed a youth advisory group to help guide planning and implementation of system improvement efforts for mental health services for young northeast Iowans, including services to assure effective transition to adult care and independent living.

DIRECT AND ENABLING SERVICES:

CHSC's Health and Disease Management (HDM) Unit helped families choose the best Medicaid Waiver for children dealing with transition issues. For example, the Mental Retardation Waiver is preferable for young adults because it includes supported community living services, while the Ill and Handicapped Waiver does not.

CHSC's HDM Unit linked adolescents with special health care needs on Medicaid Waivers to Vocational Rehabilitation services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide program-related consultation to MCH epidemiologists undertaking a study (using National CSHCN Survey data) to investigate associations between individual and household variables and family report of receipt of transition services.				X
2. Co-lead a SAMHSA-supported mental health systems of care project that can be instrumental in facilitating effective transition for youth to adult care and independent living.				X
3. Assist families to choose and enroll adolescents with special health care needs in Medicaid Waiver programs and, when relevant, address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, a CHSC task force identified adolescent transition as a specific medical home component in a document prepared for the director of the Iowa Department of Public Health for use in designating primary care practices as medical homes.

An adolescent specialist pediatrician affiliated with the Iowa Medical Home Initiative presented adolescent transition as part of a CHSC-led learning session specifically designed for Iowa safety net providers pursuing adoption of medical home model components.

CHSC co-leads a SAMHSA-supported mental health System of Care project, which, according to family-driven and youth-guided principles, stands to be instrumental in facilitating effective transition for youth to adult care and independent living.

CHSC staff provide program-related consultation to MCH epidemiologists undertaking a study (using National CSHCN Survey data) to investigate associations between individual and household variables and family report of successful or unsuccessful receipt of transition services.

DIRECT AND ENABLING SERVICES:

Assist families with eligible adolescents to enroll in Medicaid Waivers programs and, when relevant, to address transition issues, e.g. linking adolescents to Vocational Rehabilitation services.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, continue to assist the Iowa Department of Public Health to develop designation criteria, including adolescent transition services, for primary care practices establishing themselves as medical homes.

Continue to co-lead a SAMHSA-supported mental health System of Care project to, in part, facilitate effective transition for youth to adult care and independent living.

Continue to provide program-related consultation to MCH epidemiologists undertaking a study (using National CSHCN Survey data) to investigate associations between individual and household variables and family report of successful or unsuccessful receipt of transition services.

DIRECT AND ENABLING SERVICES:

Continue to use the Health & Disease Management Unit to assist families choose and enroll adolescents with special health care needs in Medicaid Waiver programs and, when relevant, address transition issues, e.g. linking adolescents to Vocational Rehabilitation 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	2003	2004	2005	2006	2007
Annual Performance Objective	91	91	94	95	95
Annual Indicator	91.4	93.6	94.3	94.6	88.4
Numerator	6222	5968	5757	5469	5116
Denominator	6805	6374	6105	5781	5786

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
	2008	2009	2010	2011	2012
Annual Performance Objective	90	92	94	96	96

Notes - 2007

Data were obtained taken from the 2008 Public Sector Immunization Assessment report.

Notes - 2006

Data were obtained taken from the 2007 Public Sector Immunization Assessment report.

Notes - 2005

Immunization data are collected from January 2005 to December 2005 from public sector data.

a. Last Year's Accomplishments

The FFY07 performance measure of 95 percent was not met. Data from January through December 2007 indicate that 88 percent of the children assessed in public sector clinics were appropriately immunized by age two.

The decrease in the percentage of children fully immunized between last year (94.6) and this year (88) can be attributed to a change in assessment protocol. In addition to counting the number of doses, assessments also reviewed the intervals between doses to assure that minimum age and intervals had not been violated. If a minimum interval had been violated, the dose was not valid and the child was not counted as up-to-date. Doses of vaccine that are spaced too closely together and violate the minimum interval spacing are not valid and require re-vaccination at the proper interval for the child to be fully protected. The Iowa Immunization Program follows CDC assessment guidelines and ACIP recommendations on the minimum interval spacing as published on the Recommended Immunization Schedule for Persons Aged 0-6 Years and the Catch-Up Immunization Schedule.

INFRASTRUCTURE BUILDING SERVICES

Collaborative efforts continued between the Iowa Department of Public Health (IDPH) Bureau of Family Health, the IDPH Bureau of Disease Prevention and Immunization, and the Iowa Department of Human Services to improve immunization monitoring in Iowa.

POPULATION-BASED SERVICES

There were 84 new providers enrolled in the Immunization Registry Information System (IRIS) in 2007. As a result 567 immunization clinics throughout Iowa were utilizing IRIS to record immunizations given in local public health agencies, community health centers, private provider clinics and hospitals. As of December 31, 2007 there were 213,369 children at least four months of age and under six years of age that had records in IRIS, representing 83% of the state population of this age cohort.

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				X

providers.				
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 SERVICES

Funding is provided to local public health agencies and community health centers for immunization services. Some agencies are conducting satellite clinics and collaborating with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to provide immunizations. All health care providers are encouraged to use the Immunization Registry Information System (IRIS). Currently, there are 346 private provider clinics, 82 Federally Qualified Health Centers/Rural Health Centers, and 43 local MCH contract agencies enrolled in IRIS. Local child health contract agencies continue to monitor immunization status and offer counseling to families receiving EPSDT care coordination services. This includes Title XIX/Medicaid clients not served by an HMO.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The number of private providers using IRIS will continue to increase. Local child health contract agencies will continue to monitor immunization status and offer counseling to all families served.

Two local contract agencies have action plans related to childhood immunizations for the coming year. Activities to ensure the immunization schedule is followed at the local level include entering immunization information in IRIS, sending reminder cards and making phone calls to families, education of maternal health clients, English and Spanish bulletins at campsites, presentations at local doctor's offices and organizations about immunization services, immediate follow-up to immigrant families, and public awareness about the importance of immunizations.

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	2003	2004	2005	2006	2007
Annual Performance Objective	16	15	14.7	14.7	16
Annual Indicator	14.9	14.8	16.1	16.7	15.6
Numerator	912	895	963	999	973
Denominator	61361	60369	59906	59906	62364
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
	2008	2009	2010	2011	2012
Annual Performance Objective	15	15	14	14	14

Notes - 2007

Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006

Data were obtained from 2006 Vital Statistics data.

Notes - 2005

Data were obtained from 2005 Vital Statistics data.

a. Last Year's Accomplishments

The FFY07 performance objective of 16 per 1,000 was met. Iowa's 2007 Vital Statistics provisional data indicates the birthrate for teenagers aged 15-17 years old was 15.6 per 1,000.

INFRASTRUCTURE BUILDING SERVICES

In FFY07, Iowa continued abstinence education through Section 510. Section 510 funding was available to existing grantees through a non-competitive Request for Application. Following approval of applications, the Iowa Department of Public Health (IDPH) continued contracts with eight community-based agencies, in addition to the University of Iowa School of Social Work for evaluation services. The eight community-based agencies implemented abstinence education programs for adolescents ages 12 to 18 through curriculum-based instruction as well as community involvement, mentoring, peer education, parent workshops and media initiatives. Additionally, due to new federal guidelines, Iowa began planning efforts to expand its services to reach 19 to 29 year-olds.

The Iowa Abstinence Education Program continued its involvement in the Abstinence Till Marriage (ATM) Coalition, comprised of over 25 state abstinence education leaders from across the nation. The goal of the ATM Coalition is to identify one or more projects that can be promoted on a national level with participation of state coalitions and other interested abstinence organizations. The coalition held monthly conference calls to discuss: current state projects, national projects, state coalitions, state advisories, federal reauthorization, and state funding. The coalition served as a forum for sharing best practices, updating state leaders on national efforts in the abstinence until marriage campaign, and gaining support from fellow advocates.

Iowa continued research on science-based practices in pregnancy prevention. Science-based practices include techniques, characteristics, activities, and programs for which there is evidence of effectiveness. "Science-based" refers not only to the type of program but also to the process for developing a program.

In 2006, the Iowa Department of Human Services (DHS) received approval from the Centers for Medicare and Medicaid to implement a program, the Iowa Family Planning Network (IFPN), which waives section 1115 of the Medicaid rules. IFPN was implemented on February 1, 2006. The program extends Medicaid coverage for only family planning services to women who had Medicaid covered pregnancies and deliveries and to all women in Iowa 13 to 44 years whose income is below 200 percent of federal poverty. Information for eligibility determination for this program is obtained at family planning clinics as well as DHS offices. The notice of determination of eligibility for the program and clinical services can be obtained at the family planning clinic the day a woman applies for the program. Almost all of the women determined eligible for the program have applied at family planning clinics. The IDPH Bureau of Vital Records collaborated with DHS to establish a Web site for those obtaining information for Medicaid eligibility to obtain Iowa birth certificate information for proof of citizenship.

ENABLING SERVICES

IDPH contracted with eight Title X Family Planning (FP) programs to conduct outreach and educational programs in 45 of Iowa's 99 counties. Developmentally appropriate educational programs stressed the value of abstinence, encouraged communication with parents, emphasized responsible decision making, avoidance of coercive sexual activity, and information on pregnancy and STD/HIV. A focus of FP programming was to provide clinical services to adolescents (under 20 years of age). One of the goals for the FP program was to maintain the number of adolescents served at 5,277 (CY 2004) clients. The CY06 and CY07 program data indicate a decrease in the number served. The decrease is likely a result of clinics closing due to financial reasons and changing the Title X provider for Polk County in October 2006.

Number of adolescents (under 20 years) served by IDPH Title X Clinics for calendar year 2004 was 5,277; 2005 5,030; 2006 4,892; and 2007 4,821.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide family planning services and education to adolescents.	X	X	X	
2. Increase the number of adolescent males that are served by family planning.	X		X	
3. Continue to provide support to local abstinence education programs.				X
4. Collaborate with other state family planning agencies and the Iowa Family Planning Network to support outreach and education.		X	X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Following the expiration of the Section 510 Abstinence Education Program on June 30, 2007, U.S. Congress passed a three-month extension of the program. Although an agreement on reauthorization was not reached, the three-month extension allowed for continuation of the program and the ability to access remaining FFY07 funds. IDPH contract amendments to terminate contracts with eight community-based agencies were rescinded and contracts remained in effect through September 30, 2007.

Two additional federal program extensions followed, allowing Iowa to continue its participation in Section 510 Abstinence Education through June 30, 2008. Continuation funding was made available to seven existing grantees for abstinence education programming, in addition to the University of Iowa School of Social Work for evaluation services. (One grantee ended their contract with IDPH effective July 30, 2007) The Section 510 Abstinence Education project continues to implement programs for adolescents and adults ages 12 through 29, with a focus on 12 to 18 year olds. Programming includes curriculum-based instruction, community involvement, mentoring, peer education and media initiatives.

Family planning agencies continue to work hard to apply Medicaid eligibility requirements. It is

anticipated that this program will increase the number of adolescents seeking and accessing family planning services in Iowa. This could decrease the number of births to teens in Iowa.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

Iowa's Governor Chester Culver announced on February 29, 2008 that Iowa will reject any future federal funding for the Abstinence Education Program in its current form. Iowa's program will continue to operate on extension funding through June 30, 2008 at which time program services will cease. Any remaining funds will be returned to the Administration for Children and Families, DHHS. If federal reauthorization or extension beyond June 30, 2008 occurs, Iowa will re-evaluate the Section 510 program. If restrictions have been relaxed regarding the A-H guidelines, Iowa will determine if it will apply for future funding.

ENABLING SERVICES

IDPH will contract with eight community-based family planning agencies to serve 45 of the state's 99 counties. Family planning efforts will focus on outreach and educational programs towards teenagers. The educational programs will stress the value of abstinence, encourage adolescents to talk with their parents about sexuality issues, emphasize responsible decision-making skills, avoidance of coercive sexual activity, and provide information related to pregnancy and STD/HIV prevention, including all contraceptive methods. IDPH will also continue to collaborate with the other state-level Title X Family Planning grantee and the Iowa Family Planning Network to support outreach activities and continuing education opportunities for staff members.

DIRECT HEALTH CARE SERVICES

IDPH utilizes an integrated approach to community-based maternal and child health and Title X family planning services. IDPH Title X contract agencies continue to provide developmentally appropriate services to adolescents, including provision of direct care clinical services to sexually active adolescents. Family planning contract agencies have designed specific activities to reach adolescents by partnering with schools, holding extra clinics at convenient times for adolescents, and including adolescents on their advisory committees.

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	2003	2004	2005	2006	2007
Annual Performance Objective	42	43	44	46	45
Annual Indicator	40.0	43.4	45.5	44.0	44.5
Numerator	12513	14577	15500	15198	15446
Denominator	31283	33588	34064	34540	34709
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
	2008	2009	2010	2011	2012

Annual Performance Objective	47	49	50	50	50
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Notes - 2007

The OHB previously conducted an annual sealant survey to determine this rate for the past eight years. Based upon the results of the data collected, a careful evaluation of the statistical significance or cost effectiveness to continue the annual survey was done. A decision of repeating the survey every third year was made. The data consultant for Iowa's Title V application will continue to use the forecast formula to estimate the sealant rate every other year.

Notes - 2006

The OHB previously conducted an annual sealant survey to determine this rate for the past eight years. Based upon the results of the data collected, a careful evaluation of the statistical significance or cost effectiveness to continue the annual survey was done. A decision of repeating the survey every other year was made. The data consultant for Iowa's Title V application will continue to use the forecast formula to estimate the sealant rate every other year.

Notes - 2005

Data were obtained from the IDPH Sealant Survey.

a. Last Year's Accomplishments

Using the indicator arrived at through the forecasting methodology the FFY07 performance objective of 45 percent was met. The dental sealant rate of 44.5 percent for 3rd grades was based on the forecast of the last four years of data. The OHB had conducted annual sealant surveys to determine this rate for the past eight years. Based upon the results of the data collected, a careful evaluation of the statistical significance or cost effectiveness to continue the annual survey was done. A decision of repeating the survey every other year was made. The data consultant for Iowa's Title V application will continue to use the forecast formula to estimate the sealant rate every two years.

INFRASTRUCTURE BUILDING SERVICES

The Oral Health Bureau requested a Medicaid policy change regarding coverage of dental sealants. In response, the Department of Human Services proposed an amendment to their rules to include coverage of sealants on all posterior primary and permanent teeth. The amended rules were adopted and implemented on February 1, 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Train primary care providers on the importance of sealants and fluoride varnish.			X	X
2. Provide training to community health center oral health staff.	X		X	
3. Continue to promote I-Smiles project and the state and local level.				X
4. Partner with local schools district on the implementation of the mandatory dental screen prior to school entry.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Wellness and health care initiatives in the state have continued discussion about the need for changes to federal legislation for the State Children's Health Insurance Program (SCHIP) in order to allow families to enroll for dental coverage only. School-based dental sealant data from FY2007 identified 26 percent of children with no payment source for dental care. This is consistent with data from previous years. OHB will continue to advocate for increasing the number of children with dental insurance, in order to assure families' access to preventive services, such as sealant application.

OHB is assessing oral health knowledge of Iowa families, with the assistance of a Targeted Oral Health Service Systems (TOHSS) grant. The assessment will be the basis for an oral health promotion campaign to be implemented in future TOHSS funding years. The campaign will include emphasis on the need for regular preventive dental care, particularly for children.

POPULATION-BASED SERVICES, ENABLING SERVICES, AND DIRECT HEALTH CARE SERVICES

Seven local child health agencies will receive funding to continue their school-based sealant programs through FFY2010. During FFY2007, 5,245 children were screened and 19,643 sealants were placed. Seventy percent of the children receiving sealants were on the free/reduced lunch program. The OHB is aware of the possibility of additional school-based sealant programs beginning as a part of some local I-Smile projects.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

Beginning school year 2008-2009, Iowa children will be required to have proof of an oral screening prior to elementary and high school enrollment. As this is initiated, OHB foresees new avenues to promote sealants through its increased collaboration with schools. OHB staff will work with the state's two school nurse associations to provide oral health information to nurses at their annual meetings.

Enhancements to the Child and Adolescent Recording System (CAREs) will allow OHB to compile data regarding the number of children with a sealed tooth. The data will assist OHB to determine promotion needs and families' ability to access preventive services.

POPULATION-BASED SERVICES, ENABLING SERVICES, AND DIRECT HEALTH CARE SERVICES

During the second year of TOHSS funding, OHB will begin to develop oral health promotion materials to inform Iowans of the need for early, regular dental care. As the marketing campaign progresses, it is anticipated that the health literacy level of families will improve, including the understanding of preventive services such as sealants.

Seven school-based sealant programs will continue, applying sealants to children in grades two through six, through September 2010. OHB will also encourage I-Smile coordinators to promote benefits of sealants and to consider organizing local school-based programs if identified as a gap-filling need.

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	2003	2004	2005	2006	2007
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Annual Performance Objective	3.4	3.4	5	4.1	2
Annual Indicator	4.5	6.7	4.4	2.1	4.6
Numerator	26	38	24	12	25
Denominator	572000	569387	547627	581387	543571
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
	2008	2009	2010	2011	2012
Annual Performance Objective	4.5	4	3	2	2

Notes - 2007

Data were obtained from 2006 Vital Statistics provisional data.

Notes - 2006

Data were obtained from 2006 Vital Statistics data.

Notes - 2005

Data were obtained from 2005 Vital Statistics data.

a. Last Year's Accomplishments

The FFY07 performance objective rate of 2 per 100,000 was not met. Iowa Vital Statistics provisional data indicate the rate of death to children age 14 years and younger caused by motor vehicle crashes was 4.6 per 100,000.

INFRASTRUCTURE BUILDING SERVICES

The Bureau of EMS-EMSC and Injury Prevention Programs worked with the Iowa Safe Kids Coalition 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. During FFY07, certified technicians at statewide events checked a total of 5,457 child passenger safety seats. There were several events across the state that did not enter data into the state's CPS Web site. A total of 1540 new seats were distributed to families.

Child passenger safety advocates are working to provide outreach to physicians, health care agencies, and child care providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education to health care providers on car seat safety.				X
2. Provide child passenger safety check-ups across Iowa.	X		X	
3. Educate early care providers on the importance of car seat safety through child care nurse consultants.				X
4. Continue to be actively involved with the Iowa Safe Kids Coalition.				X
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities

POPULATION BASED SERVICES

The 'Join the Click' and Commander Alex educational campaigns were designed to increase awareness of appropriate use of seat belts and the need for occupant protection among the "tweeners" population. The multimedia campaign includes billboards, television, radio, and printed public service announcements.

The University of Iowa Injury Prevention Research Center conducted the 2007 Iowa Child Passenger Restraint Survey. At 36 locations statewide, 3,010 children under the age of 11 years were observed in motor vehicles. The numbers indicate Iowans understand the importance of securing infants in child safety seats with 99.2 percent of children age one or younger appear to be properly restrained. It is also clear that as the child's age increases he or she is less likely to be restrained in the motor vehicle. Ninety-five percent of toddlers and 82 percent of youth were restrained. Overall, 89.3 percent of all children observed were restrained. The overall 2007 survey results were an increase of two percent over the previous year. Another important improvement is the increase in the percentage of toddlers that are being restrained using a booster seat along with a seatbelt.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

Physician outreach regarding child passenger safety will continue. Materials are provided to physician offices at no cost. Physicians have an opportunity to educate families with young children about appropriate child passenger safety systems. Continued work within child care settings and schools will assist in assuring that a broad based population receives education on appropriate occupant protection

POPULATION BASED SERVICES

The Bureau of Family Health, Bureau of EMS-EMSC, and Injury Prevention programs along with the Iowa Safe Kids Coalition will collaborate to provide outreach to Iowa childcare providers and families. One strategy includes offering online ordering of materials via the Healthy Child Care Iowa Web site (<http://www.idph.state.ia.us/hcci/products.asp>).

Training will continue for certified child passenger safety technicians. During FY09 six CPS certification trainings are scheduled around the state and one annual CPS Technician Workshop.

One local contract agency has made decreasing child mortality related to motor vehicle accidents a priority. The activities toward reaching this goal include distribution of car seat safety materials in English and Spanish, certified car safety seat inspectors provide education and demonstrations at community events, WIC and VFC immunization clinics, and utilization of free car seat safety seat inspection cards.

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	2003	2004	2005	2006	2007
--	-------------	-------------	-------------	-------------	-------------

Annual Performance Objective				28	35
Annual Indicator			27.5	34.7	44.9
Numerator			10496	103	193
Denominator			38133	297	430
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
	2008	2009	2010	2011	2012
Annual Performance Objective	46	48	50	52	54

Notes - 2007

Data obtained from the CDC National Immunization Survey. The data is breastfeeding rates at six months of age for children born in 2004. In 2007, CDC changed how they analyzed the breastfeeding data from when the data was analyzed to when the baby was born.

Notes - 2006

Data were collected from the National Immunization Survey. Last year was the first year of collecting data on mothers who breastfeed their infants at six months. Iowa has decided to switch data sources from the Pediatric Nutrition Surveillance Survey data set to the National Immunization Survey.

Notes - 2005

Data were obtained from the Pediatric Nutrition Surveillance Survey.

a. Last Year's Accomplishments

The performance measure for FFY07 was 35 percent of babies to be breastfed at 6 months of age was met. We are unable to say if this measure was met due to a change in CDC's time frame of analysis. Data collected on the National Immunization Survey showed that 44.9 percent of infants were being breastfed at six months and born in 2004. Two years ago was the first year of collecting data on mothers who breastfeed their infants at six months. Iowa has decided to switch data sources from the Pediatric Nutrition Surveillance Survey data set to the National Immunization Survey. Last year we had data from CDC through 2006. This data showed breastfeeding rates by the year the data was analyzed. The middle of 2007 CDC changed and started having the data reported as the year the baby was born. The most current data to date from CDC due to the change is 2004.

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 Fit for Life Early Childhood workgroup to implement family friendly policy recommendations on breastfeeding.		X		X
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

ENABLING SERVICES

IDPH co-sponsors the annual breastfeeding conference with Iowa Health Systems. IDPH provides leadership for the Iowa Lactation Task Force (statewide breastfeeding coalition). The IDPH also provides technical assistance to local WIC agencies on breastfeeding.

INFRASTRUCTURE BUILDING SERVICES

The IDPH Bureau of Nutrition and Health Promotion requires local contract agencies to expend a minimum of 20 percent of the total allocated Nutrition Program for Women, Infants, and Children (WIC) funds on nutrition education, including a minimum of three percent of the WIC funds to be spent on breastfeeding promotion and support.

The Bureau of Nutrition and Health Promotion has received a USDA-Peer Counseling grant since 2004. The purpose of the grant was to start a peer-counseling program in Iowa. Two pilot projects were started in local WIC agencies. Evaluation of the pilot projects continue on a yearly basis. Local agencies that include WIC received informational training on breastfeeding peer counseling.

DIRECT HEALTH CARE SERVICES

All of the WIC agencies implemented action plans targeting community-based breastfeeding promotion and support. The following list represents activities of local WIC contract agencies:

- Collaborate with OB physicians to increase breastfeeding rates.
- Provide breastfeeding education and support to communities.
- Train staff and health care professionals with a basic breastfeeding training.
- Visit area businesses to discuss breastfeeding

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The Bureau of Nutrition and Health Promotion staff will provide technical assistance on breastfeeding to the local contract agencies. Local maternal health contract agencies will continue to develop and implement community-based strategies for breastfeeding. An RFP for agencies that want to start a WIC breastfeeding peer counselor program will be available the summer of 2008 with the selected agencies beginning their contact period on October 1, 2008.

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	2003	2004	2005	2006	2007
Annual Performance Objective	88	97	99	98	99.8
Annual Indicator	93.2	98.9	95.7	97.4	98.2
Numerator	16682	15716	35757	37970	39684
Denominator	17899	15892	37360	38996	40414
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
	2008	2009	2010	2011	2012
Annual Performance Objective	99	99.5	99.6	99.7	100

Notes - 2007

The 2007 data were obtained from the eSP newborn hearing screening data. 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.

Notes - 2006

The 2006 data were obtained from the eSP newborn hearing screening data. IDPH is in the process of implementing the eSP data system statewide. 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.

Notes - 2005

Data represents final 2004 data from eSP data system for the number of newborns screened before hospital discharge.

a. Last Year's Accomplishments

The FFY07 performance objective of 99.8 percent was not met. The newborn hearing screening rate was 98 percent.

EHDI made great strides this past year with statewide implementation of a newborn hearing screening data base, eSP (eSCREENER Plus). 79 birthing hospitals in Iowa were trained to report newborn hearing screens using this system, as well as all educational audiologists (app. 60) to report re-screens and diagnostic assessments for children under three. All paper reporting forms previously used from 2004 to 2007 were entered into the data system.

The EHDI program started making referrals for children who were missed or did not pass their newborn hearing screen and did not receive a follow-up screen in May 2007. The follow-up program continues to expand in the area of additional quality assurance checks to ensure unnecessary follow-up and hopes to increase the number of family support referrals in the next year.

By May 2007 all birthing hospitals and Area Education Agencies staff responsible for newborn hearing screening and/or assessment were trained and reporting the results electronically using eSP. One private practice office was also trained and uses eSP to report the results for all hearing screens and assessments for children under age of three through eSP. Only two hospitals submit their results by paper because they average less than 50 births per year. Other audiologists and health care professionals providing newborn hearing screens, rescreens, and/or diagnostic assessment report their results to IDPH by paper, as well. Because of the large increase in electronic reporting, IDPH was able to gather accurate baseline data for newborn hearing screening outcomes and started initial analysis of that data.

Various components of program evaluation took place. Parents were surveyed in the fall of 2006 to determine what information was shared at the hospital regarding newborn hearing screening, results, and follow-up. The EHDI program conveyed that information to hospitals and other health care professionals involved with the EHDI program. The EHDI program also used the parent feedback, in addition to national recommendations, to revise their newborn hearing screening brochure to make it easier to read and include a place for the newborn screen results and follow-up.

IDPH implemented various quality assurance measures within the IDPH system including hospitals and facility reporting to ensure records were complete and/or accurately reflected the outcome for each child. In addition, a letter was mailed to all licensed audiologists in the state of Iowa to ensure they were aware of the reporting requirement and had the forms to report on all children under the age of three. Since that time, follow-up screen reporting and assessments has increased and private practice audiologists are getting signed up for training to report their results using eSP.

Child Health Specialty Clinics (CHSC) EHDI staff members continued the activities of the Universal Newborn Hearing Screening and Intervention (UNHSI) grant awarded to CHSC by MCHB, U.S. Department of Health and Human Services, Health Resources and Service Administration (HRSA).

The activities of this grant focuses on reducing the number of infants who are "lost" in the system, therefore, delaying the provision of early intervention services. The goals are:

- All newborns will be screened appropriately prior to hospital discharge.
- All audiologic diagnoses will occur before children are three months of age.
- All eligible children will be enrolled in Early ACCESS before six months of age.
- All families with children zero to three who are deaf or hard-of-hearing or are at risk for late-onset hearing loss will be linked to a medical home.
- All families with children 0-3 years who are deaf or hard-of-hearing will receive family-to-family support.

The IDPH entered into a three-year cooperative agreement with the Centers for Disease Control and Prevention in July 2005. The goals of the project are to:

- Complete the statewide implementation of the EHDI data system.
- Facilitate data integration linkages with related screening, tracking, and surveillance programs.
- Maximize the use of EHDI data for statewide and local decision-making.
- Evaluate the EHDI system based on the performance indicators set forth in the National EHDI Goals and utilize the results to establish project sustainability.

The two programs work together to assure collaboration.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to hospital and Area Education Agencies.				X
2. Continue to monitor eSP data.				X
3. Use pediatric audiologist to provide technical assistance to facilities providing newborn screening.			X	
4. Provide training to early childhood professionals on childhood hearing loss.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

IDPH continues to convene the Iowa Early Hearing Detection Intervention Advisory Committee on a quarterly basis. Over the last year, the committee developed a draft sustainability plan to guide

the EHDI program goals and objectives.

POPULATION BASED SERVICES

There are now 81 birthing hospitals in Iowa; down from 82; all of which provide universal newborn hearing screening services as required by law.

The EHDI program participates in outreach and public education opportunities regarding the program, the needs of children and families whose child has been identified with hearing loss, follow-up and family support. The program does this through their quarterly newsletter (Iowa EHDI News), conferences, and other program/association publications.

ENABLING SERVICES

In April 2007, the EHDI program began a family support program for children and families of children identified as deaf or hard of hearing: Iowa Guide by Your Side. The program has adult mentors and parent guides to assist children and families in their journey.

Pediatric audiologists continue to provide technical assistance to newborn hearing screening programs in hospitals and the AEAs throughout Iowa. They provide training and serve as a resource to troubleshoot an increase in refer or miss rates and hearing screening equipment.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

EHDI staff will focus on educating birth centers and midwives about the importance of screening and follow-up for children who do not pass the initial screen, and for those children who have risk factors for late-onset hearing loss.

EHDI will implement follow-up procedures for children born at home, but not reported to IDPH. This will include a match between vital records reports and eSP and mailing follow-up letters to the medical home and family regarding the importance of screening and where to obtain those services.

Data sharing mechanisms will be implemented between EHDI and Early ACCESS to ensure children diagnosed with hearing loss are enrolled in early intervention services before six months of age. To ease data sharing between the two programs, EA service coordinators will be asked to obtain consent to release information at first contact so the information can be shared with the EHDI program.

EHDI will continue program evaluation including the various aspects of the program including hearing screening, follow-up, referral, early intervention, family support, and data reporting. Evaluation results will be shared with the EHDI Advisory Committee and new goals and objectives written to continue moving EHDI towards a sustainable comprehensive screening and follow-up program.

ENABLING SERVICES

Emphasis will be placed on implementing quality universal hearing screening programs in all birthing hospitals. IDPH and CHSC will continue to work with the Center for Disabilities and Development (CDD) audiologists to provide training to hospital and AEA staff across the state. Emphasis will be placed on "refer" and "miss" rates, as well as follow-up. Site visits will be scheduled with all hospitals to review their programs and offer technical assistance to ensure programs are family centered and procedures are in place to increase communication with the medical home and reduce the number of families "lost to follow-up."

The CHSC UNHSI program will evaluate family support services provided through the Guide by

Your Side program and make changes, as needed.

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	2003	2004	2005	2006	2007
Annual Performance Objective	4	3	5	2	2.7
Annual Indicator	8.6	6.0	2.8	2.8	2.8
Numerator	60028	41000	20640	19124	19919
Denominator	698000	683000	737212	683000	711403
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
	2008	2009	2010	2011	2012
Annual Performance Objective	2.6	2.5	2.5	2.5	2.5

Notes - 2007

The numerator was obtained from the 2005 Child and Family Household Health Survey data. The denominator was obtained from the 2006 Census data for children <18 years.

Notes - 2006

The numerator was obtained from the 2005 Child and Family Household Health Survey data. The denominator was obtained from the 2005 Census data for children <18 years.

Notes - 2005

The numerator was obtained from the 2005 Child and Family Household Health Survey data. The denominator was obtained from the 2000 Census data.

a. Last Year's Accomplishments

The FFY07 performance objective of two percent was not met. The 2005 Iowa Child and Family Household Health Survey data indicates 2.8 percent of children were uninsured in Iowa.

The Iowa Department of Human Services continued to contract with the Iowa Department of Public Health (IDPH) for hawk-i outreach. After completing its final year of a Robert Wood Johnson Foundation grant in FFY 2006, the Iowa Covering Kids and Families (CKF) project sustained its efforts through funding from the Wellmark Foundation. The CKF project was awarded a one-year health literacy grant and continued to focus on increasing access to health care for low-income uninsured children. Outreach coordinators in the local child health agencies focused their efforts on vulnerable populations, faith-based organizations, health care providers, and schools.

Highlights of FFY07 CKF and hawk-i outreach efforts include:

INFRASTRUCTURE BUILDING SERVICES

- Conducted regional meetings of the hawk-i Outreach Task Force.
- Translated two Medicaid outreach brochures into Spanish: How to Apply brochure, which explains to families how they can apply for Medicaid and where to find a Medicaid application in

their local area; and Using Your Medicaid brochure, which summarizes the Medicaid program and assists families in navigating through the system.

- Distributed culturally competent outreach materials focusing on immigrant eligibility.
- Developed and disseminated Issue Brief #11 on the Deficit Reduction Act and Issue Brief #12 on SCHIP Reauthorization. These issue briefs, along with past issue briefs, can be found at: www.idph.state.ia.us/coveringkids/marketing_guide.asp.
- Developed and disseminated the CKF 2007 Winter Report. This report can be found at: www.idph.state.ia.us/coveringkids/marketing_guide.asp.
- Developed and disseminated the June 2007 CKF Electronic Newsletter. This newsletter can be found at: www.idph.state.ia.us/coveringkids/marketing_guide.asp.
- Created a Marketing Guide which lists all of the outreach materials created by CKF over the years. This guide can be accessed at the following link: www.idph.state.ia.us/coveringkids/marketing_guide.asp.
- Monitored enrollment numbers monthly to assess the success of outreach efforts.

POPULATION BASED SERVICES

The CKF and outreach staff continued to provide outreach materials at numerous statewide conferences representing various target audiences such as: Dental Association, Farm Bureau, education/ school based, medical providers, economic development, and diversity conferences. Other activities include:

- Assisted in coordinating a Back-to-School Campaign, press conference and a corresponding health fair.
- Collaborated on Cover the Uninsured Week 2007 activities.
- Outreach staff attended daily at Iowa's annual State Fair, talking to families and disseminating materials.

ENABLING SERVICES

Local coordinators worked directly with families to navigate the enrollment process. This entailed assistance in filling out the application and advocating for the family during the eligibility process.

IDPH will continue to oversee hawk-i Outreach under a contract with the Iowa Department of Human Services. Selected CKF activities are being sustained through hawk-i Outreach and child health initiatives, and IDPH continues as the fiscal agent for the Covering Kids and Families State Coalition through a grant funded by the Caring Foundation. hawk-i Outreach activities focus on collaboration with free clinics and special populations. Training has been provided for outreach coordinators to become better equipped to provide outreach to special populations.

Covering Kids and Families' priorities are focused on public policy development and advancing health care coverage for low-income, uninsured families on a national scale. Iowa's CKF project has joined the National CKF Network and staff will be attending the inaugural meeting in Washington D.C. to determine the Network's operating structure and establish the platform for its work over the next several years.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhance outreach to special populations.				X
2. Continue to oversee the hawk-i outreach contract with local child health agencies.				X
3. Promote the public awareness campaign on hawk-i.				X
4. Provide technical assistance to local child health agencies.				X
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

In the 2008 General Assembly, legislators passed the Health Care Reform bill. The intent of this legislation is to provide all children with hawk-i and Medicaid insurance coverage by January 1, 2011 and to expands the hawk-i program up to 300 percent FPL if federal funding becomes available. It establishes an electronic health information commission, end of life care promotion, extends coverage for children through age 25 who are on their parent's health insurance plan, eases restrictions on preexisting conditions, establishes a medical home initiative, wellness, chronic care, transparency and direct care worker provisions.

Additionally, Iowa CKF was one of eight states selected to be part of the Southern Institute on Children and Families' Retention Initiative: Achieving Stability in Medicaid and the State Children's Health Insurance Program (SCHIP) Coverage. The focus of the initiative is on improving the retention of eligible children and adults in Medicaid and SCHIP by encouraging Medicaid and SCHIP programs to adopt changes in policies & procedures designed to improve retention rates. CKF, as part of the Process Improvement Collaborative team, is participating in the Initiative's activities and beginning efforts to improve Iowa's retention rates.

IDPH continues to closely monitor the effects of the Medicaid citizenship requirement and to make recommendations to DHS as appropriate.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

CKF will participate in the National Covering Kids and Families Network. CKF staff will be involved in the Advocacy and Policy and Communications subcommittees. Subcommittee work will include developing and implementing the Network's policy agenda and priorities and advancing the internal and external communication needs of the Network. Priorities for FFY 2008 are SCHIP reauthorization and coverage expansion, CMS directives and rule changes, and simplification efforts.

Efforts of the National Network and the Retention Initiative will align and allow for cross communication and technical assistance. The Network will advocate requiring HHS to establish a streamlined and simplified enrollment system to be applied by all states, incorporating best practices and lessons learned from Medicaid and SCHIP. In Iowa, Medicaid and SCHIP administrators will work to align polices of multiple programs (Medicaid, SCHIP, TANF, FIP, FA) allowing for simplified and streamlined application processes.

Additional efforts of the Retention Initiative will include testing strategies for increasing the number of renewal forms returned, advocating rule changes to allow for data matching income verification and acceptance of an electronic signature on online applications and renewals.

CKF will build its statewide coalition, increasing advocate and legislative membership. The coalition will construct policy recommendations for presentation to the legislature through issue briefs. The CKF project coordinator will continue to advocate for federal reauthorization of SCHIP beyond the March 31, 2009 extension.

POPULATION BASED SERVICES

Outreach will continue across Iowa to educate families about Iowa's health insurance options. There may be an increased demand for outreach due to many proposals being discussed at

Iowa's statehouse to increase the number of Iowa's children that qualify for the hawk-i program. Outreach coordinators will continue to focus on the four established issue areas. Coordinators will be used as the vehicle to disseminate materials created by the Covering Kids and Families program.

ENABLING SERVICES

Outreach coordinators will continue to help families navigate the Medicaid and hawk-i process and will continue to assist families with the requirements of the Deficit Reduction Act. Coordinators will bring barriers they learn about through assisting families to the Department of Human Services via the use of occurrence reports. The state outreach coordinator and local coordinators will place a large emphasis on working with Community Health Centers (CHCs) to screen clients, coming in their doors for treatment, for insurance coverage. The majorities of CHCs' clients are uninsured and are a target population for outreach efforts.

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	2003	2004	2005	2006	2007
Annual Performance Objective				13	30
Annual Indicator			14.0	32.5	32.5
Numerator			9205	9802	9802
Denominator			65753	30161	30161
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
	2008	2009	2010	2011	2012
Annual Performance Objective	30	30	25	23	20

Notes - 2007

PedNSS data for 2007 will not be available until later this year. Numerators are calculated from the number of children tested x percent with BMI >85th percentile as reported in CDC PedNSS Reports.

Notes - 2006

Data were obtained from WIC clinic clients.

Notes - 2005

Data were obtained from WIC clinics where children were weighed and measured at WIC clinics.

a. Last Year's Accomplishments

The FFY07 performance objective of 30 percent was not met. The 2006 data for PedNSS reports 32.5 percent of children ages two to five years have a BMI at or above the 85 percentile. PedNSS data for 2007 is not available until fall 2008.

INFRASTRUCTURE BUILDING SERVICES

WIC Program:

Participation in WIC increased during 2007, serving over 36,000 children. A USDA report found improved diet quality and a reduced risk for overweight for children participating in WIC. The Iowa

WIC Program is working to positively impacting the diets of child WIC participants.

The WIC Program has an ongoing priority to improve nutrition assessment through USDA's Value Enhanced Nutrition Assessment (VENA) initiative. ICN trainings were held in 2007. Regional interactive trainings will be held in the spring of 2008. Consumer skills modules are being developed in conjunction with a group of local agency dietitians. The emphasis was on planning, purchasing, and preparing healthy meals under the time and cost constraints that WIC participants face.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer regional interactive VENA trainings				X
2. Implement the strategies in the Healthy Kids Act				X
3. Promote fruit and vegetable consumption using the Pick a Better Snack social marketing materials in 2008.				X
4. Promote breastfeeding-friendly worksites in the state				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Iowans Fit for Life

The Iowans Fit for Life partnership, which is organized under a Cooperative Agreement with the Centers for Disease Control and Prevention, began an intervention in six communities to promote healthy lifestyles. Children were weighed, measured, and participated in food recall activities at the six schools.

The Early Childhood workgroup of the Iowans Fit for Life partnership conducted a pilot Family Support Training for family support staff in November, 2007. Over 100 staff attended. The training was very well received. Additional trainings were held in four regions of the state in March 2008. The regional trainings were broadened and encouraged all early care, health, and education providers to participate.

Legislative Session:

The Healthy Kids Act directs the Iowa Department of Education (DE) to establish nutritional standards for food and beverages sold by schools and require DOE, in collaboration with IDPH, to establish an advisory panel to review research on pediatric nutrition. The panel may submit recommendations for stronger nutritional content in school foods to the State Board of Education. The act also requires every physically able child in kindergarten through grade 5 to participate in a minimum of 30 minutes of physical activity per day and students grades 6 through 12 are required to participate in a minimum of 120 minutes of physical activity per week. The bill also requires students to take CPR.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

WIC

Regional interactive VENA trainings will continue to be offered in the fall of 2008 and spring of

2009.

Consumer skills modules are being developed in conjunction with a group of local agency dietitians that will emphasize planning, purchasing and preparing healthy meals under the time and cost constraints that WIC participants face.

Iowans Fit for Life

The Fit for Life program and other programs with IDPH will be working on implementing the strategies in the Healthy Kids Act. The advisory panel will begin work in the fall of 2008.

A subgroup is working to promote breastfeeding-friendly worksites in the state.

BASICS

The BASICS Program will continue to work with schools, child care and youth programs to promote fruit and vegetable consumption using the Pick a Better Snack social marketing materials in 2008.

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	2003	2004	2005	2006	2007
Annual Performance Objective				17	18
Annual Indicator			17.9	18.0	14.9
Numerator			3265	3284	6075
Denominator			18241	18247	40788
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
	2008	2009	2010	2011	2012
Annual Performance Objective	14	13	12	11	10

Notes - 2007

Data was obtained from 2007 Vital Statistics provisional data.

Notes - 2006

Data were obtained from the Iowa Barriers to Prenatal Care Survey.

Notes - 2005

Iowa is not able to collect data for the percent of women who smoke in the last three months of pregnancy. Iowa's revised birth certificate which is scheduled for use beginning in calendar year 2007, will ask new mothers about smoking behavior per trimester and if she quit smoking at any point in pregnancy.

a. Last Year's Accomplishments

The FFY07 performance objective of 18 percent was met. The 2007 Vital Statistics provisional data indicate 14.9 percent of women smoked during the last three months of pregnancy. Iowa's revised birth certificate, which began implementation January of 2007, asked new mothers about

smoking behavior per trimester and if she had quit smoking at any point in pregnancy.

Iowa applied for and received funding from Association of Maternal Child Health Programs (AMCHP) and the Centers for Disease Control and Prevention (CDC) - a mini grant to expand the successful pilot tobacco intervention model based on 3 A's :

Ask every client about tobacco use

Advise every tobacco user to quit

Refer -- We are suggesting the Iowa Quitline: 1-800-QUIT-NOW

Regional trainings were held for staff from local maternal and child health agencies and family planning agencies.

INFRASTRUCTURE BUILDING SERVICES

Starting January 1, 2007 Medicaid began payment for Nicotine Replacement Therapy (NRT) -- patch and gum, and generic prescriptions, through referrals to the Iowa Quitline.

Iowa Medicaid approved a new billing code for tobacco cessation counseling for dental hygienists to provide tobacco cessation counseling to prevent oral health disease.

In the 2007 General Assembly, efforts were successful in passing legislation to increase the tobacco tax.

A study was completed of births to Medicaid women by matching Medicaid claim file and birth certificate data from calendar year 2005. The data showed that mothers on Medicaid were more likely to smoke during pregnancy than mothers not on Medicaid (30% vs. 9.3%). IDPH staff has met with Medicaid leadership to plan continued activities to assist Medicaid women in tobacco cessation efforts during pregnancy and following delivery.

Iowa's PRAMS pilot will allow improved data collection from Iowa women regarding tobacco usage.

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		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. Meet monthly with ACOG, Planned Parenthood, AMCHP and tobacco bureau staff				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Staff continues to meet monthly with a collaborative team that began with the Action Learning Lab. The partnership contains members from ACOG, Planned Parenthood, AMCHP and tobacco

bureau staff. The team is committed to continue to reduce tobacco cessation in women of childbearing age.

ENABLING SERVICES

Training will continue to be offered on the tobacco intervention model to local maternal and child health agencies and family planning agencies.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

Staff will expand tobacco cessation training for dental hygienists and local I-Smiles coordinators. The training will also be offered to WIC staff at the annual statewide conference.

The IDPH maternal health consultant and the CDC epidemiologist assignee are planning follow-up meetings with Medicaid leadership to discuss strategies to decrease the number of Medicaid women smoking during pregnancy. Staff will continue to explore methods to work collaboratively to improve tobacco cessation efforts in Medicaid pregnant women.

Iowa PRAMS pilot will continue and allow a second year of improved data collection from Iowa women on tobacco usage.

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	2003	2004	2005	2006	2007
Annual Performance Objective	13.7	11	10	10	10
Annual Indicator	8.9	10.4	11.0	10.6	10.1
Numerator	19	22	23	23	22
Denominator	214000	211983	209303	217268	217502
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
	2008	2009	2010	2011	2012
Annual Performance Objective	9.8	9.8	9.6	9.5	9.4

Notes - 2007

Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006

Data were obtained from 2006 Vital Statistics data.

Notes - 2005

Data were obtained from Vital Statistics 2005 Data.

a. Last Year's Accomplishments

The FFY07 objective of 10 was met. Iowa's provisional data indicate that the suicide rate for youths aged 15-19 was 10 per 100,000.

INFRASTRUCTURE BUILDING SERVICES

The Child Death Review Team examined records of children whose cause of death was listed as a suicide. Deaths due to suicide or medical conditions may be prevented through timely and appropriate interventions to combat depression, bullying, and disease. Hanging was the most frequent means of ending a life. The Centers for Disease Control and Prevention has reported that youth suicides using firearms has decreased nationally over the last few years, while hangings have increased.

Identified risk factors for suicide and attempted suicide for young people include: mood disorders, substance abuse, certain personality disorders, low socioeconomic status, childhood maltreatment, parental separation or divorce, inappropriate access to firearms, and interpersonal conflicts or loss.

Adolescents often experience stress, confusion, and depression from situations occurring in their families, schools, and communities. Such feelings can overwhelm young people and lead them to consider suicide as a "solution."

The Child Death Review Team recommended that schools 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote participation in evidence-based mental health and suicide screening and assessment programs				X
2. Promote "Youth Suicide Prevention through Mental Health Screening" grants				X
3. Target youth in high schools for screening, follow-up and treatment				X
4. Develop a symposium for continued training and collaboration among grantees				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services

Beginning July 2007, IDPH was given \$1.2 million for a three-year project called the Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention, or State/Tribal Youth Suicide Prevention Grants. IDPH's RFP announcement was called "Youth Suicide Prevention through Mental Health Screening." The focus is on suicide prevention activities for 15 -- 24 year olds in Iowa. The Columbia Teen Screen will be used as the model. It will target youth in high schools for screening, follow-up and treatment. This project will also provide support for survivor groups and promote awareness in Iowa.

An RFP for expansion of Columbia Teen Screen activities in Iowa schools was released in March,

2008. One goal of the RFP is to promote participation in evidence-based mental health and suicide screening and assessment programs for Iowa youth.

POPULATION-BASED SERVICES

IDPH and the Suicide Prevention Steering Committee (SPSC) utilized the Surgeon General's Call to Action to Prevent Suicide and the National Strategy for Suicide Prevention, which highlight the need to increase awareness of suicide as a public health issue and calls for a public health approach focused on suicide prevention.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

Years two and three goals, objectives, and activities of the State/Tribal Youth Suicide Prevention Grant will be focused on continuation of the projects implemented in year one and will include a symposium for continued training and collaboration in year two.

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	2003	2004	2005	2006	2007
Annual Performance Objective	70	80	96	96	96
Annual Indicator	87.6	95.3	94.7	94.0	94.2
Numerator	352	427	463	453	468
Denominator	402	448	489	482	497
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
	2008	2009	2010	2011	2012
Annual Performance Objective	97	97	97	97	97

Notes - 2007

Data were obtained from 2007 Vital Statistics provisional data.

Notes - 2006

Data were obtained from 2006 Vital Statistics data.

Notes - 2005

Data were obtained from 2005 Vital Statistics data.

a. Last Year's Accomplishments

The 2007 performance objective of 96 percent was not met. Of the total birth of very low birth weight babies, 94.2 percent were delivered at facilities for high-risk deliveries and neonates. Of the 468 very low birth weight infants delivered in 2006, 68 percent were delivered at Level III, 26 percent were delivered at Level II Regional, or Level II facilities, and five percent of very low birth

weight infants were born in a Level I. This clearly shows that Iowa's system of regionalized perinatal health care is indeed stratified and highly effective. The number of recognized Level III perinatal centers remained at three, while Level II Regional facilities were seven, and Level II facilities were 11.

INFRASTRUCTURE BUILDING SERVICES

The Perinatal Guidelines committee, in response to AAP subcommittee recommendations and in response to our regional infrastructure, added a level of care to our regionalize system of perinatal care. The new level is Level II Regional Neonatal Centers. This was added to accurately reflect the level of care the Regional II centers with neonatologists can provide. The Iowa Code and the Statewide Perinatal Guidelines were updated to reflect this change. Birthing centers that wish to change their level status will need to apply to the Perinatal Guidelines committee and show that they meet the criteria to change levels. To date there are no Level II Regional Neonatal Centers.

The Statewide Perinatal Care Team, along with support from IDPH, developed a Web page on IDPH's Web site. All current and archived issues of the Perinatal Guidelines are posted there. The new 8th Edition of the Guidelines for Perinatal Care is also available on this Web page.

IDPH continues our contract with the Iowa Statewide Perinatal Care Program. Activities included: continuation of regular meetings of the Perinatal Guidelines Advisory Committee; consultation to all Level II, Level II Regional, and Level III hospital nurseries and obstetric departments on at least a bi-annual basis; administrative consultation to hospital and health-related groups; coordination with the High-Risk Infant Follow-up Program; on-site review of birthing center medical records, assessment of educational needs of staff and physicians, and presentation of educational programs at least every three years for Level I hospitals and at least annually for the Level II and higher birthing centers. The team completes an assessment of the effectiveness of Iowa's regionalized system of perinatal care through the review of preterm birth rates and location of preterm deliveries and on-site record reviews of the quality of care provided.

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	
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 SERVICES

Birthing centers that wish to change their level status will need to apply to the Perinatal Guidelines committee and show that they meet the criteria to change levels. It is anticipated that four of the seven Level II Regional Perinatal Centers will apply for a level change.

ENABLING SERVICES

The addition of Level II Regional Neonatal Centers to our statewide system of regional care will

provide increased access to a higher level of care for the very low birth weight infants in Iowa. This is important in rural areas with long travel times to the Level III Perinatal Centers.

POPULATION-BASED SERVICES

During FFY07, publication of the Iowa Perinatal Newsletter continued on a quarterly basis. The 33rd Annual Iowa Conference on Perinatal Medicine was held April 3 and 4, 2006 with about 200 attendees. The focus was perinatal substance abuse and the effects on the infant and family. There was information provided to attendees on the regional levels of perinatal care and need for appropriate referrals. There was also an education session on SIDS prevention. The 34th Annual meeting is planned for April 9 and 10, 2008. The focus will be perinatal depression and it's effects on infants and young children.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

IDPH, the Statewide Perinatal Care Program and the Department of Human Services medical director plan to meet on a quarterly basis to discuss quality improvement strategies for premature and low birth weight babies on Medicaid.

ENABLING SERVICES

The Statewide Perinatal Care Team will continue its current activities with Iowa birthing hospitals. They will also explore Web-based training, or posting MS PowerPoint presentations to their Web site to increase their education efforts.

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	2003	2004	2005	2006	2007
Annual Performance Objective	88	88.5	88.6	88.7	87
Annual Indicator	88.6	88.7	87.2	86.4	77.7
Numerator	33809	34021	34244	35047	31740
Denominator	38139	38369	39255	40564	40835
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
	2008	2009	2010	2011	2012
Annual Performance Objective	80	84	86	88	89

Notes - 2007

Iowa implemented a revised birth certificate during this reporting period. The questions about entry into prenatal care was changed. Data staff are investigating the accuracy of the reporting. Data were obtained from 2007 Vital Statistics data.

Notes - 2006

Data were obtained from 2006 Vital Statistics data.

Notes - 2005

Data were obtained from Vital Statistics 2005 Data.

a. Last Year's Accomplishments

The performance objective of 88.6 percent was not met. Data from 2007 Vital Statistics provisional data show the percent of women entering prenatal care in the first trimester was 77.8 percent. While the reason for the lack of forward progress to this objective is not known, recent experience in working with immigrant populations suggests that the decrease in the percent of women entering prenatal care in the first trimester may be related to the state's significant increase in Hispanic and other immigrant populations. While local MCH contract agencies are working to adjust to the increase in services to minority populations, this area of concern represents an on-going challenge and opportunity for improvement.

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. Target vulnerable populations				X
5. Advocate for improved access for undocumented (immigrant) women				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Local maternal health contract agencies identify strategies for coordinating with other community programs. Fourteen of the local contract agencies have implemented an action plan targeting prenatal care for women in their community. Many are conducting surveys of women who entered prenatal care late to determine what barriers the women had, if any.

POPULATION-BASED SERVICES, ENABLING SERVICES, AND DIRECT HEALTH CARE SERVICES

Direct health care, enabling, and population-based program activities are provided by 24 local maternal and child health (MCH) agencies serving all 99 counties. MCH agencies provide services to facilitate early entry into prenatal care including Medicaid presumptive eligibility determination, care coordination, case management including follow-up, and case-finding and outreach with a focus on high-risk women. IDPH also works with the Iowa Department of Human Services to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

In FFY08, data from vital records and the Women's Health Information System and the surveys of women who did not receive early care will be used to determine the population in need of specific efforts. IDPH staff members will continue to promote communication and collaboration between local maternal health contract agencies, other local agencies, and local providers for maternal referral. Integration of maternal health services with Special Supplemental Nutrition Program for WIC, child health programs, family planning services, and DHS programs will also continue. IDPH staff members will support and monitor local contract agencies' vulnerable population action plans, and will advocate for improved access to early prenatal care for undocumented (immigrant) women. All local contract agencies are required to submit an action plan for early prenatal care targeting vulnerable populations in their communities. The number of agencies who offer free pregnancy tests at their agency had doubled; this should help to improve early identification of adolescent pregnancies. This information is shared with local school nurses.

ENABLING SERVICES

Local maternal health contract agencies will continue to provide presumptive eligibility to pregnant women and comprehensive, community-based, culturally competent, family-centered care. Fourteen local contract agencies have made a commitment to increasing the women who have early entry into prenatal care. The activities proposed to increase the women who enter prenatal care in the first trimester include a public awareness campaign; outreach presentations to churches, schools, and community centers; flyers distribution to pregnant women; WIC and MCH staff will provide follow-up contacts; and school nurses will provide information on maternal health programs, encouraging education on early prenatal care.

D. State Performance Measures

State Performance Measure 1: *Percent of children served by family support programs, whose primary delivery method is a home visit, that are served through evidence-based programs.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12	55
Annual Indicator			19.0	42.0	42.0
Numerator			11	12502	12502
Denominator			58	29756	29756
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	60	65	68	70	70

Notes - 2007

Data were obtained from an environmental scan conducted in February of 2007 with family support programs whose primary delivery method is a home visit. The performance measure data set was change to show the most recent data on family support. The environmental scan will be updated every two years.

Notes - 2006

Data were obtained from an environmental scan conducted with family support programs whose primary delivery method is a home visit. The performance measure data set was change to show the most recent data on family support.

Notes - 2005

Data were obtained from the Community Empowerment Family Support Survey.

a. Last Year's Accomplishments

The FFY07 performance objective of 55 percent was not met. An environmental scan of family support programs funded by Iowa's Early Care, Health, and Education system indicated that 42 percent were evidence-based programs. The data were collected in the spring of 2007. The environmental scan was the first attempt to collect data on evidence-based practice family support programs funded through the Community Empowerment Area family support system.

INFRASTRUCTURE BUILDING SERVICES

Through the Early Childhood Comprehensive Systems Project the Early Childhood Iowa Stakeholders group and the Quality Services and Programs (QSP) component group have focused on parenting education and family support. QSP brought together family support and parent education leaders from the state and local level and developed a Family Support Leadership group. The Family Support Leadership group serves in an advisory capacity to the Quality Services and Programs component group on issues related to family support and continues to meet three to four times a year. The QSP component group continues to promote the Evidence-based Assessment Workbook: Developing Quality Assurance and Evidence-based Practices for Your Family Support Program for local family support and parenting education programs to assess the quality of their program. The tool can be found on the Web site: www.earlychildhoodiowa.org.

In the 2006 General Assembly, Community Empowerment received funding to hire a state Family Support Coordinator through the Office of Empowerment. The Family Support Coordinator provides technical assistance and training to family support programs within the Early Care, Health, and Education system. Janet Gartin was hired in January 2007 as the Family Support Coordinator.

Over the last year workgroups were formed from the Family Support Leadership Group. The workgroups include: Standards and Core Competencies, Outcomes, and Peer Review and Credentialing Process. The workgroups include members outside the network of the Family Support Leadership group to bring in more partners.

During the 2007 General Assembly, an early care best practice committee was formed. The committee made the decision to focus on family support best practice. Final recommendations were released in January of 2008 and can be found at the following link:

<http://www.legis.state.ia.us/Isadocs/IntReport/2008/IPJCP001.PDF>. The focus of the recommendations continues to be on working to improve the quality of family support programs through continuing the Peer Review and Credentialing Process. Early Childhood Iowa also shared the structure of the Early Care, Health, and Education system to the interim committee.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide technical assistance and promote evidence-based family support programs.				X
2. Through Early Childhood Iowa, continue to convene the Family Support Leadership group.				X
3. Promote Iowa's Family Support Credentialing process.				X
4. Provide technical assistance on the family support standards.				X
5. Finalize the family support core competencies.				X
6.				
7.				
8.				

9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Standards and Core Competencies group: The group conducted research to determine standards and core competencies that other states are using. The group used the Council on Accreditation standards and adapted them for Iowa's standards. The workgroup will be reviewing the standards annually to make sure they meet the needs of family support programs.

Peer Review and Credentialing Process group: In the fall of 2007, three Family Support Peer Reviews pilots were conducted with local family support programs. The workgroup took the comments from the peer reviewers and the programs and improved the format and structure of the Peer Reviews. The Peer Review and Credentialing Process was rolled out in January of 2008. Currently there are nine programs in the Peer Review and Credentialing Process.

Through the Peer Review and Credentialing Process peer reviewers were selected and trained and a Family Support Technical Assistance Team was selected and trained to begin work with the local family support programs going through the process.

Outcome group: The group has been working on developing a core set of indicators for all family support and parent education programs to collect. The tools to collect outcomes are: Life Skills Progress tool and the Protective Factors Survey from the National Resource Center Abuse Prevention Community Based Child Abuse Prevention programs. Training on the tools will be provided across Iowa.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The Family Support Leadership workgroups will continue to meet and work on strategies within their workgroups. The Peer Review and Credentialing Process will continue to provide technical assistance to local family support programs going through the credentialing process. Training will be offered to increase the network of technical assistance team members. The Family Support Coordinator will continue to work with local providers to improve the quality of family support programs.

A toolkit will be developed in the fall of 2008 for family support programs and will be based around tools for each standard.

The family support needs assessment was conducted last year revealed training needs and supervision support were the top needs for local programs. The Office of Empowerment posted an RFB for Family Support Supervision training. The University of Iowa was awarded the contract. The Office of Empowerment, the University of Iowa, and the Family Support Leadership group will be working over the next six months to develop curriculum for supervisory training. The trainings will be available in the winter of 2008.

State Performance Measure 2: *Percent of early care and education businesses who have received a training or service from a child care nurse consultant.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1224	1750

Annual Indicator			1182	1717	29.7
Numerator					2280
Denominator					7688
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	35	38	40	45	50

Notes - 2007

Data were obtained from the Healthy Child Care Iowa encounter data and the National Child Care Information and Technical Assistance Center.

Notes - 2006

Data were obtained from the Healthy Child Care Iowa Child Care Nurse Consultant log.

Notes - 2005

Data were obtained from the Healthy Child Care Iowa Child Care Nurse Consultant log.

a. Last Year's Accomplishments

The performance measure was changed from number of encounters to the percentage of early care and education businesses who child care nurse consultant provided a service to in 2007. The FFY07 performance objective was 29.7 percent of all early care and education businesses received a services from a child care nurse consultant.

Iowa did not achieve the projected number of child care businesses to receive a CCNC service. The Iowa Quality Rating System activities demanded considerable contact time with CCNC. QRS contacts with CCNC were as follows:

- 1133 new child care businesses that entered into partnership agreements
- 1045 child care businesses completed preliminary health and safety survey
- 805 businesses were involved with injury prevention assessment including assessments of playgrounds
- 303 businesses were involved in review of enrolled children health record audits for receipt of timely preventive health care
- 166 businesses were involved in a health and safety assessment of their facility

INFRASTRUCTURE BUILDING SERVICES

Iowa has 58 local CCNCs affiliated with local child health centers. The local CCNCs work part-time as there are only 28.54 FTE. There are four (4 FTE) regional CCNCs affiliated with child care resource and referral agencies. Iowa continues to support distance training opportunities for child care businesses pertaining to Universal Precautions. A total of six UP/ECP trainings were conducted with over 1,600 attendees. Six Mandatory Child Abuse Reporter distance learning sessions were provided with over 1,000 attendees. Three distance learning sessions were conducted for professionals that consult with child care businesses. Topics included transportation in Iowa child care (85 attendees), emergency/disaster preparedness (49 attendees) and playground safety-supervision (77 attendees). The Healthy Families Line services has a talkline for information and referral for child care businesses.

The HCCI Web site was expanded to include health and safety (Standard 5 Health) resources for child care businesses enrolled in the NAEYC program accreditation.

POPULATION-BASED SERVICES

There was an increase in the number of CCNC encounters with child care businesses. In 2006 there were 15,888 encounters and in 2007 there were 21,951 encounters. All types of child care businesses are eligible to receive CCNC services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to serve on the Quality Rating System oversight team.				X
2. Provide technical assistance training to child care nurse consultants.				X
3. Continue to advocate for sustained child care nurse consultant funding.				X
4. Continue the operations of the HCCI talkline and Web site.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Activities include:

- Two training sessions are scheduled for child care nurse consultation using the NTI curriculum.
- Six Universal Precautions and Exposure Control Plan (UP/ECP) distance learning sessions are scheduled. HCCI is applying for National Administrator Credential (NAC) continuing education approval. The training evaluation is moving to measure outcome of practice as a result of training.
- Six Mandatory Child Abuse Reporter Training (MART) distance learning sessions are scheduled.
- Three professional development distance learning sessions are scheduled addressing: pesticide use in child care, new federal guidelines for the Child and Adult Care Food Program, and a session about infant and toddler play-spaces.
- CCNC encounter data collection method options are being explored to include online data reporting.

POPULATION-BASED SERVICES

HCCI will expand the Web site to include health and safety resource materials for Iowa child care directors enrolled in the National Administrator Credential training.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

Bureau of Family Health and Department of Human Services childcare staff will continue to explore options to alter infrastructure of network of regional CCNC. Staff will continue to offer professional development opportunities for child care business personnel for UP/ECP and MART with six sessions for each topic planned throughout the year via distance learning. CCNC will also have professional development opportunities around three main topics: updated federal fire code for child care, American's with Disabilities Act, and the topic medication: policy, administration, documentation. BFH staff will offer two CCNC training using the NTI curriculum. Local CCNC will continue to implement the encounter data.

POPULATION-BASED SERVICES

- Restructure professional development for consultants to include child care directors or owners.
- Collaborate with IDPH social marketing team and the National Program for Playground Safety to include playground safety topic for broadcast on the Iowa Public Television network.

State Performance Measure 3: *Percent of Medicaid enrolled children zero to five years who receive developmental evaluations.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				7	10
Annual Indicator			8.2	8.7	8.0
Numerator			7004	7624	7179
Denominator			85386	87979	89419
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	12	15	20	25	30

Notes - 2007

The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2006

The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2005

Data were obtained from the 2005 CMS 4.16 Report.

a. Last Year's Accomplishments

The FFY07 performance objective of 10 percent was not met. Data from Department of Human Services shows that eight percent of Medicaid enrolled children ages zero to five received a developmental evaluation.

INFRASTRUCTURE BUILDING SERVICES

Building upon the lessons learned from the two ABCD II demonstration projects, the 1st Five: Healthy Mental Development Initiative continues to develop a statewide spread providing consistent screening/surveillance and linking children and families to community-based intervention services. Three Title V Maternal and Child Health sites began implementing the 1st Five program, engaging 27 medical practices in providing comprehensive developmental surveillance, including social/emotional surveillance, impacting approximately 22,000 children age birth to five. Project objectives include promoting the spread of the standards and practices developed through ABCD II within pediatric and family medical practices, and facilitating referrals of children and their families to recommended community-based services and support. The charge of the Healthy Mental Development Initiative projects is to:

- Build the capacity of local primary care providers to provide healthy mental development screening, referral and follow-up;
- Establish a formal referral and follow up system between public and private providers who provide healthy mental development services to children and families;
- Convene a local coalition of stakeholders to develop an effective, coherent healthy mental development system in the service area; and
- Identify and respond to concerns of maternal depression and recommended interventions through trainings and outreach to local service providers, including primary care providers.

The demonstration projects worked with the IDPH Healthy Mental Development coordinator to coordinate training efforts with other statewide initiatives; design and implement community-based training and outreach materials; and collect data regarding children and families related to healthy mental development.

To promote program development, Child Health Program Coordinators and EPSDT Coordinators participated in specialized training activities and telephone or written surveys related to maternal depression and child developmental screening. As a component of maternal health and child health program development for FFY 2008, agencies were encouraged to advance the following objectives.

- To support the spread of recommended screening standards within pediatric and family practice medical practices
- To facilitate referrals and follow-up for children and families identified in need of services and support for healthy mental development
- To promote knowledge of children's healthy mental development including identifying and responding to family stress and maternal depression, and making recommended interventions
- To integrate children's healthy mental development principles into their work with families.
- To collect data regarding children and families related to healthy mental development based on guidance from the IDPH.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to local 1st Five projects.				X
2. Develop a public awareness campaign on the importance of developmental screening and surveillance.				X
3. Collect and evaluate data on screenings, referrals, and follow-up from pilot projects.				X
4. Continue to work with Early Childhood Iowa, Iowa Medical Home initiative, and Iowa's perinatal depression project.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

In addition to the three implementation sites, IDPH will continue to implement strategies designed to improve services that support healthy mental development with a focus on children age birth to five. IDPH is doing this by adding an additional implementation site that includes two counties and three planning grants that include five counties. These additions are projected to engage an additional 38 medical practices that will impact approximately 20,000 more children age birth to five.

To compliment the program's statewide spread, 1st Five is currently developing a Web page that will serve as a resource for Iowa health care professionals, legislators, and Iowa parents regarding healthy mental development and the role of 1st Five. The page will also link users with several other early childhood Web sites including the EPSDT Web page, the Iowa Department of Public Health Web site, and the Early ACCESS Web page. Information regarding the site and its features will be distributed upon site completion.

c. Plan for the Coming Year

IDPH will continue to spread 1st Five strategies with additional implementation sites and community planning grants. IDPH will continue to collaborate with other statewide initiatives to coordinate training for medical practices and Title V agencies.

Additionally, best practices from the 1st Five Healthy Mental Development Initiative will continue to be shared with Title V Child Health Agencies on ways to integrate children's developmental principles.

State Performance Measure 4: *Percent of children who needed care from a specialist who received the care without problem.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				87	88
Annual Indicator		83.7	83.7	85.1	85.1
Numerator		101929	101929	113046	113046
Denominator		121842	121842	132839	132839
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	89	90	91	92	93

Notes - 2007

Although our data source for this SPM (the Iowa Child and Family Household Health Survey) 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 families' ease of access to specialty care.

Notes - 2006

The 2006 annual indicator value was calculated from data collected in the "2005 Iowa Child & Family Household Health Survey" - a random sample phone survey supplemented with some convenience sampling.

Notes - 2005

The 2005 annual indicator value has not yet been calculated from data collected in the "2005 Iowa Child & Family Household Health Survey"; therefore, the 2004 indicator value is used here. We expect the updated calculation to be available before the end of ffy06.

a. Last Year's Accomplishments

The FFY07 performance objective of 88.0 percent was not met based on results of the population-based 2005 Iowa Child & Family Household Health Survey. The indicator value derived from the survey was 85 percent.

INFRASTRUCTURE BUILDING SERVICES:

In FFY07, the Iowa Medical Home Initiative nurse advisors continued to provide information and resources to primary care practices working to assure needed specialty services for children and youth with special health care needs.

A 2nd annual statewide conference promoting the Early Childhood Comprehensive Systems goals for early childhood health care services is promoting new policies to assure access to needed specialty health and dental services for young children.

Under SAMHSA support, CHSC and the Iowa Department of Human Services collaborated with

other community agencies to develop a System of Care to improve access to and quality of mental health services for children and youth with severe emotional disorder.

DIRECT AND ENABLING SERVICES:

The CHSC telehealth behavioral consultation program continued to provide telehealth and telepsychiatry consultations to children from geographically remote regions of Iowa who are without access to specialty care.

A new board-certified developmental pediatrician was added to CHSC's array of telehealth consultant specialty service providers.

CHSC's Early Hearing Detection and Intervention project used family support staff to assist families adapt to and understand the special needs and services newly associated with their child's hearing loss.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use CHSC's Health & Disease Management unit to provide assistance accessing needed community-based and medical center-based specialty services for children enrolled in Medicaid Waiver and EPSDT programs.		X		
2. Collaborate with the Iowa Department of Public Health's 1st Five project to assure referrals to needed specialty services for young children who are developmentally at-risk or delayed.		X		X
3. Increase use of telehealth technology and consultation services to broaden remote access to medical center-based pediatric medical and behavioral health services.	X			
4. Partner with the Iowa-Nebraska Primary Care Association to benefit selected Iowa safety net providers through medical home-related technical assistance, including suggestions for helping patients access needed specialty care.				X
5. Lead an MCHB-supported Early Hearing Detection and Intervention project to, in part, improve access to specialty hearing services for children identified with or at risk for hearing problems.				X
6. Co-lead a SAMHSA-supported System of Care project to improve access to and quality of mental health specialty services for children and youth with severe emotional disorder.	X	X		X
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, co-lead a SAMHSA-supported System of Care project to improve access to and quality of mental health specialty services for children and youth with severe emotional disorder.

Partner with the Iowa-Nebraska Primary Care Association to benefit selected Iowa safety net

providers through medical home-related technical assistance, including suggestions for helping patients access needed specialty care.

Collaborate with the Iowa Department of Public Health's 1st Five project to assure referrals to needed specialty services for young children who are developmentally at-risk or delayed.

Lead an MCHB-supported Early Hearing Detection and Intervention project to, in part, improve access to specialty hearing services for children identified with or at risk for hearing problems.

DIRECT AND ENABLING SERVICES:

Provide facilities support to the University of Iowa's Continuity of Care Program to assure and coordinate access to specialty care and other community-based services for seriously ill children and their families.

Use CHSC's Health & Disease Management unit to provide assistance accessing needed community-based and medical center-based specialty services for children enrolled in Medicaid Waiver and EPSDT programs.

Increase use of telehealth technology and consultation services to broaden remote access to medical center-based pediatric medical and behavioral health services.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, continue to co-lead a SAMHSA-supported System of Care project to improve access to and quality of mental health specialty services for children and youth with severe emotional disorder.

Continue to partner with the Iowa-Nebraska Primary Care Association to benefit selected Iowa safety net providers through medical home-related technical assistance, including suggestions for helping patients access needed specialty care.

Continue collaboration with the Iowa Department of Public Health's 1st Five project to assure referrals to needed specialty services for young children who are developmentally at-risk or delayed.

Continue to lead an MCHB-supported Early Hearing Detection and Intervention project to, in part, improve access to specialty hearing services for children identified with or at risk for hearing problems.

CHSC will co-plan and participate in any statewide conference to promote the goals of Iowa's Early Childhood Comprehensive Systems, some of which relate to assuring that young children have access to specialty care services guaranteed by medical and dental homes.

Review any recently released "access to specialty services" data elements from the National CSHCN Survey and the Iowa Child and Family Household Health Survey for use in upcoming CHSC's in-house and system-wide needs assessment and strategic planning efforts.

DIRECT AND ENABLING SERVICES:

Continue to provide facilities support to the University of Iowa's Continuity of Care Program to assure and coordinate access to specialty care and other community-based services for seriously ill children and their families.

Continue to use CHSC's Health & Disease Management unit to provide assistance accessing needed community-based and medical center-based specialty services for children enrolled in Medicaid Waiver and EPSDT programs.

Continue to use telehealth technology to access consultation services to broaden remote access to medical center-based pediatric medical and behavioral health services.

State Performance Measure 5: *Percent of children 0-3 years served by Early ACCESS (IDEA, Part C).*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2.4	2.8
Annual Indicator		2.1	2.3	2.7	2.7
Numerator		2331	2581	2932	3185
Denominator		110276	110650	108593	116411
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	2.9	3	3.1	3.2	3.3

Notes - 2007

Data were obtained from the IDEA, Part C - Early ACCESS Information Management Systems data.

Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

Notes - 2006

Data were obtained from the IDEA, Part C - Early ACCESS Information Management Systems data.

Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

Notes - 2005

Data were obtained from the IDEA, Part C - Early ACCESS Information Management Systems data.

Although Iowa currently meets the OSEP recommendations for percentage of the 0-3 populations enrolled in Part C, there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

a. Last Year's Accomplishments

The FFY07 performance objective of 2.8 percent was not met. The FFY07 indicator value was 2.7 percent according to data from the Early ACCESS (IDEA, Part C) database. Although Iowa currently meets the OSEP recommendations for percentage of the zero to three populations enrolled in Part C (2.0%), there is debate regarding possible upward revision of the enrollment rate target. In anticipation of this, we have, therefore, set progressively higher annual performance target objectives.

INFRASTRUCTURE BUILDING SERVICES:

In FFY07, CHSC and the Iowa Department of Public Health (IDPH) continued collaboration with Iowa's Part C Program to improve access and services to children who have or are at-risk for developmental delay.

IDPH identified specific populations of children to provide Part C services. Target populations were identified based on the scope of practice of child health service providers.

Strategic plans were formulated to expand Part C-related MCH services to children who did not pass their newborn hearing screen and children who have been diagnosed with a genetic or metabolic conditions that put them at risk for developmental delay.

DIRECT AND ENABLING SERVICES:

Procedures were implemented in MCH contract agencies to provide Part C service coordination for the initial target population of lead poisoned children. They also provided Part C developmental evaluation and assessment.

Within IDPH, MCH and Environmental Health partnered to offer expanded comprehensive services to lead poisoned, Part C eligible children. Lead Program case managers then worked with the child's county MCH agency to make referrals for Part C developmental evaluation and assessment.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide IDEA Part C service coordination at all CHSC regional centers for children who are medically complex; drug-exposed; or born prematurely.		X		
2. Provide nutrition consultation services statewide for children enrolled in IDEA Part C.	X			
3. Partner with IDEA Part C and IDPH 1st Five to improve the performance of primary care providers regarding early childhood developmental screening and referral for early intervention.				X
4. Expand the Regional Autism Services Program to screen all CHSC clinic patients 18-36 mos. for autism and assure regional autism teams train local staff to appropriately identify children with autism spectrum disorders.				X
5. Continue the Early Hearing Detection Intervention (EHDI) project to improve the system of early identification and referral for children with hearing problems.				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES:

In FFY08, CHSC and local MCH contract agencies continued to refer to Part C. Improvements and consistency in assessment and evaluation techniques were made.

Part C continues to contract with CHSC's Iowa Medical Home Initiative to improve the performance of primary care physicians regarding early identification and referrals and promotes developmental screening and early intervention services by primary care practices.

The Regional Autism Services Program (RASP), based at CHSC and funded by the Department of Education, assures that regional autism teams train local staff to appropriately identify children with autism spectrum disorders.

DIRECT AND ENABLING SERVICES:

CHSC provides Part C service coordination at 11 regional centers to three target populations of children: medically complex; drug-exposed; and premature birth.

CHSC provides Part C nutrition services statewide by connecting to three registered dietitians using polycom technology.

The RASP expanded screening for autism to include all toddlers entering CHSC between the ages of 18 and 36 months.

In addition to the CHSC Early Hearing Detection Intervention (EHDI) project sponsored by MCHB, the IDPH Bureau of Family Health and the CDC have an agreement to improve Iowa's EHDI surveillance system to appropriately identify children.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES:

In FFY09, IDPH and CHSC will continue partnering with the interagency Part C System to assure that young children are identified and appropriately served according to designated procedures and standards.

New CHSC and MCH contract agency service coordinators will be trained in the delivery of the DAYC Evaluation tool.

CHSC participates as a stakeholder in Iowa's Early Childhood Comprehensive Systems effort (Early Childhood Iowa) via participation on the Results Accountability and Quality Services and Programs subcommittees.

IDPH staff will assist with the definition and development of an electronic Individualized Family Services Plan (IFSP) that will increase efficiency and data collection capabilities, as well as allow data to be shared between partners.

CHSC will monitor and evaluate the effectiveness of autism screening of all children age 0-3 seen in CHSC clinics and will continue providing staff development to Part C staff and early care providers regarding strategies to treat food refusal in children with autism spectrum disorders.

The MCHB-sponsored Early Hearing Detection and Intervention (EHDI) grant will begin activities scheduled for year one of the new three year grant. Audiologists and EHDI program staff will provide intensive technical assistance to hospitals with high miss and referral rates.

IDPH staff will help to build capacity for statewide data collection by using an agreed upon assessment tool (DAY-C) to assess all Part C children with venous lead levels of 20ug/dL or greater.

DIRECT AND ENABLING SERVICES:

EHDI project efforts will focus on increasing the percentage of children getting the follow-up hearing services they need and educating families and professionals about the importance of screening and diagnosis.

Under the EHDI grant, family support organizations will be connected to each other and the Guide By Your Side family support program will be continued.

CHSC nutritionists will be available to assist Part C staff to: 1) administer a nutrition and feeding questionnaire to identify nutrition risks in 0-3 year olds; and 2) use referral guidelines to access nutrition services for children at risk.

State Performance Measure 6: *Percent of Iowa counties that have at least one participating targeted community in the CDC nutrition and physical activity obesity prevention project.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				15	18
Annual Indicator			12.1	18.2	12.1
Numerator			12	18	12
Denominator			99	99	99
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	24	36	40	45	48

Notes - 2007

Data were obtained from the IDPH - Fit for Life Project.

Notes - 2006

Data were obtained from the IDPH - Fit for Life Project.

Notes - 2005

Data were obtained from the IDPH - Fit for Life Project.

a. Last Year's Accomplishments

The FFY07 performance objective of eighteen percent of Iowa counties participated in targeted community projects was not met. Data from the lowans Fit for Life project indicate 12 percent of all counties are participating in targeted community projects. The decrease from 18 percent to 12 percent in 2007 was a result of decreased state funding in 2007.

Last year, school and community resources were accessed to find baseline data. Third, fourth, and fifth graders' Body Mass Index (BMI) was assessed; along with fourth and fifth graders completing two fruit and vegetable preferences and consumption questionnaires, one physical activity questionnaire, one physical activity attitudes questionnaire; plus fourth and fifth grade parents completed a parent survey. Fourth and fifth graders also wore pedometers for two

weekdays and two weekend days to assess physical activity. Community forums were held to determine community strengths, barriers and possible community intervention strategies. A report of the intervention was written from the data collected in FFY06.

INFRASTRUCTURE BUILDING SERVICES

The Iowa Department of Public Health received funding from the Centers for Disease Control and Prevention (CDC) to conduct a multi-year pilot intervention. Designed to reduce obesity and other chronic conditions in Iowans through increased physical activity and improved nutrition, the goal of the project is to develop model communities that can be replicated across the state.

Communities were selected for the pilot intervention and were randomly assigned into an evaluation design cell. The four cells include: IDPH school and community intervention and the USDA fruit and vegetable snack program, IDPH school and community intervention only, USDA fruit and vegetable snack program only, and no formal intervention.

In the past year, school and community resources were accessed. Assessments were expanded to include third, fourth and fifth graders' Body Mass Index (BMI); along with fourth and fifth graders completing two fruit and vegetable preferences and consumption questionnaires, one physical activity questionnaire, one physical activity attitudes questionnaire; as well as fourth and fifth grade parents completed a parent survey. Fourth and fifth graders also wore pedometers for two weekdays and two weekend days to assess physical activity. This is an expansion of initial efforts, when only third and fourth graders were assessed.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support Fit for Life stakeholder group and workgroups.				X
2. Provide technical assistance to local targeted communities working on nutrition and physical activity.			X	X
3. Continue to conduct assessments with third, fourth, and fifth graders on physical fitness.	X		X	
4. Implement the recommendations of the Healthy Children's Task Force.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through the pilot interventions community coalitions were in place and expanded access to fruits, vegetables and physical activity opportunities in their communities. The curriculum that was established in FFY06 continued to be used in schools, and teachers from five of the intervention schools revised the cross-disciplinary curriculum.

Data were collected (BMI, physical activity surveys, nutrition surveys, and parental surveys) and analyzed. An initial report of the intervention was written from the data collected in FFY06.

Teacher feedback was collected to look at how the intervention may need to be modified for future years.

The intervention has continued for the 2007-2008 school year. The funding was provided through the Iowa Legislature, and Senate File 2124. The interventions were similar to the Iowans Fit for Life intervention, but received minimal technical assistance, materials, and intense evaluation.

POPULATION-BASED SERVICES

A cross-disciplinary curriculum was established for use in the intervention schools. The curriculum focuses on fruits, vegetables and physical activity and provides opportunities for both fruit and vegetable tasting and physical activity. The Pick a Better Snack and ACT social marketing campaign was also implemented in the schools.

Physical education teachers were trained on using FITNESSGRAM and ACTIVITYGRAM. School food service personnel were trained on Fruits and Vegetables Galore.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The data collection process will be repeated using the same methods referenced above, using third, fourth and fifth graders for the assessment. Community coalition and the physical activity interventions will continue. The school intervention including the cross-disciplinary curriculum will continue as well. Schools will continue using FITNESSGRAM and ACTIVITYGRAM and school food service personnel will use Fruits and Vegetables Galore. The intervention communities will switch intervention design cells, to provide program opportunities to schools and communities that did not receive any programming activities during the first two years of the pilot intervention (i.e., 2005-07). In addition, program sustainability will be monitored in the original programming groups.

Eleven local MCH contract agencies have identified action plans to reduce occurrence of childhood obesity. The activities in the action plans include staff collaboration to determine methods of addressing childhood weight, providing healthy eating/physical activity materials in English and Spanish, and working with local school districts to address healthy eating and physical activity.

State Performance Measure 7: Percent of Medicaid enrolled children ages 9-35 months receiving a blood lead test.

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				60	68
Annual Indicator			57.5	67.2	61.4
Numerator			11768	12251	13281
Denominator			20474	18242	21620
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	68	69	70	70	70

Notes - 2007

Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

Notes - 2006

Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

Notes - 2005

Data were obtained from the STELLAR and Medicaid data match conducted by the IDPH Bureau of Lead Poisoning Prevention.

a. Last Year's Accomplishments**INFRASTRUCTURE BUILDING SERVICES**

The FFY07 performance objective of 68 percent of Medicaid enrolled children received a lead test was not met. There were 61 percent of Medicaid children that received a blood lead test.

The IDPH Bureau of Family Health (BFH) worked closely with the IDPH Bureau of Lead Poisoning Prevention to monitor statewide data for children receiving blood lead tests. The Bureau of Lead Poisoning Prevention conducted a data match with Medicaid enrolled children who are in STELLAR (Systemic Tracking of Elevated Lead Levels and Remediation). Data reflecting the percent of children ages 9-35 months receiving a blood lead test was shared with each Title V child health contract agency. The data included testing percentages for both Medicaid and non-Medicaid children for each agency's service area. The indicator for SPM #7 was included as a key data element on the FFY 2007 Year End Report for Title V child health contract agencies. This established a baseline measure at the local level for future monitoring.

The EPSDT program training was offered to all local Title V child health contract agency staff upon request and also monthly from July -- November 2007. This training emphasized blood lead testing as an important component of comprehensive health screening for all Iowa's children according to the Iowa Recommendations for Scheduling Care for Kids Screenings.

During FFY 2007 vendors began marketing the Lead Care II, a CLIA waived blood lead analyzer which allows the local child health contract agencies to perform blood lead analysis for capillary draws. IDPH provided guidance on reporting requirements for test results. The Iowa Medicaid Enterprise provides reimbursement for blood lead draws and blood lead analysis for Medicaid enrolled children.

Information on childhood lead poisoning was included in the BFH Update, an electronic newsletter for local Title V contractors. Articles addressed qualifications of licensed dietitians to perform finger stick blood draws, proposed rule making to ban children's metal jewelry containing more than 0.06 percent lead, and updated Childhood Lead Poisoning Prevention Program service regions.

State level policy establishes eligibility for the Early ACCESS program (IDEA, Part C) based upon a child's blood lead level. Any child who has venous blood lead levels equal to or greater than 20 µg/dL is eligible for Early ACCESS services. Local CH agencies began providing service coordination for children who meet this criterion. Regional trainings were provided for CH agencies to address the effects of childhood lead poisoning and the importance of early testing and monitoring and referral for children with elevated blood lead levels. Trainings were provided for CH agencies about the IDEA law and state Early ACCESS policies and procedures. Title V CH agencies also received guidance on building local capacity for implementation in terms of staff qualifications, services to be provided, and billing procedures.

POPULATION-BASED SERVICES

Contractors provided access to blood lead testing by coordinating care through a child's medical home or providing the gap-filling service through the Title V child health contract agency. Many child health contractors arrange for blood lead testing in conjunction with other programs such as WIC, immunizations, preschool, child care, and Head Start and Early Head Start.

Five local CH contract agencies identified increasing blood lead testing rates as a priority for action plans. Activities for FFY 2007 include data collection and analysis, public education programs, enhanced outreach and care coordination, and working with local practitioners to promote blood lead testing in a medical home.

The 2007 Iowa General Assembly passed legislation requiring evidence of a blood lead test upon a child's enrollment into school by the age of six. A bill modifying language within the law has been proposed by the 2008 Iowa General Assembly. The IDPH and the Iowa Department of Education are working together to plan for implementation of these lead testing requirements. This legislation has focused media attention on the issue. Press conferences and articles in a variety of newspapers across the state featured the legislation and the importance of blood lead testing. IDPH continues emphasis on early blood lead testing according to EPSDT guidelines (ages 12 and 24 months and if high risk, also at 18 mo, 3, 4, and 5 years).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the state level data for blood lead levels.				X
2. Work with local school districts to implement the required lead screening prior to school entry.			X	X
3. Provide technical assistance to local MCH, WIC, and Public Health agencies.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

The IDPH Bureau of Family Health continues to work closely with the IDPH Bureau of Lead Poisoning Prevention to monitor statewide data for children receiving blood lead tests. Relevant data for the 2004 birth cohort has been provided to local Title V CH contract agencies. Although in 2007 the percent of children ages 9-35 months enrolled in Medicaid receiving a blood lead test declined, increases were noted in both the number of children enrolled in Medicaid in this age range and the number of children tested since 2006. Current data demonstrate that for July -- September 2007, there has been a 27.1 percent increase in the total number of children tested under six years of age. Contract agencies will continue to monitor and report the performance indicator for the percent of Medicaid enrolled children ages 9-35 months receiving a blood lead test in their service area.

POPULATION-BASED SERVICES

The IDPH Bureau of Lead Poisoning Prevention's public service announcements and county-specific brochures promoting blood lead testing are shared with local Childhood Lead Poisoning Prevention Programs and county public health agencies. CH contractors began providing service coordination under Early ACCESS (IDEA Part C) for children who have venous blood lead levels equal to or greater than 20 µg/dL. During the first six months of implementation, 52 referrals for service coordination were made to child health agencies.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

The IDPH Bureau of Family Health will continue to work closely with the IDPH Bureau of Lead Poisoning Prevention to monitor statewide data for children receiving blood lead tests. Title V contract agencies will continue to monitor and report the performance indicator for the percent of Medicaid enrolled children ages 9-35 months receiving a blood lead test for their service area.

The Centers for Disease Control and Prevention (CDC) is working on development of a Web-based data system for tracking blood lead test results. Implementation of a Web-based system would improve the quality of the data transmitted to IDPH and would also improve the timeliness of data receipt and reporting. Upon implementation, training and access to the system will be provided to local child health contractors.

It is anticipated that a growing number of providers will invest in the Lead Care II, allowing for immediate results of the analysis of capillary blood lead draws and thereby encouraging providers to conduct blood lead tests for all children.

The IDPH and the Iowa Department of Education will continue to work together to implement the mandatory lead testing requirements enacted by the 2008 Iowa General Assembly for children entering school by the age of six. It is anticipated that the legislation will include parameters for data matching and the provision of care coordination services for children who have not had a blood test. An interim legislative committee will examine funding for testing, case management, and remediation of lead sources. Opportunities for additional training and education regarding the mandatory lead testing legislation will be explored for the Bureau of Family Health's Fall Seminar and the University of Iowa's Annual School Nurse Conference.

POPULATION-BASED SERVICES

Title V child health contractors will continue to promote blood lead testing and appropriate follow-up services within their service area.

The IDPH Bureau of Family Health will promote the use of media resources among CH contract agencies to encourage childhood blood lead testing. The Bureau of Lead Poisoning Prevention's public service announcements and county-specific brochures will be shared with Title V child health contractors.

State Performance Measure 8: *Percent of Medicaid enrolled children ages 1-5 years who receive dental services.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				38	38
Annual Indicator			37.0	38.4	42.1
Numerator			27646	29413	32808
Denominator			74672	76637	77889
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	40	40	45	45	47

Notes - 2007

The 2007 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2006

The 2006 data were obtained from the CMS 4.16 Annual EPSDT Participation Report.

Notes - 2005

Data were obtained from the CMS 4.16 Report.

a. Last Year's Accomplishments

The FFY07 performance objective of 38 percent of Medicaid enrolled children ages 1-5 years received a dental service was met. The 2007 CMS report shows 42.1 percent of children 1- 5 years who are enrolled in Medicaid received a dental service.

INFRASTRUCTURE BUILDING SERVICES

In FFY2007, OHB submitted a request to Department of Human Services to recognize oral screenings as part of the dental EPSDT periodicity schedule. The revised periodicity schedule also includes a minimum of one exam by a dentist each year. The impetus for the request was the I-Smile initiative, which uses risk assessment and trained health care providers to screen children, thus allowing a broader network for fulfilling periodicity guidelines. DHS requested that OHB seek endorsement for the periodicity schedule changes from the Iowa chapter of the American Association of Pediatric Dentistry. The public health dental director approached AAPD, however has not yet received their endorsement.

Due to the continuing dental access issues, DHS approved several new dental service codes for use by maternal and child health agencies. New services include nutritional counseling and tobacco counseling specific to the prevention of oral disease. OHB worked with DHS to create protocols, including the ability of non-dental health care professionals to provide billable services.

POPULATION-BASED SERVICES AND ENABLING SERVICES

Carryover funding through the State Oral Health Collaborative Systems grant was used to create and print I-Smile Screening Guides for Health Care Professionals. A marketing intern worked with OHB to create the guides, which provide basic information on how to conduct an oral screening and apply fluoride varnish for children ages 0-3, in addition to some basic oral health education information that can be shared with parents.

A Targeted Oral Health Service Systems grant from HRSA is being used to promote I-Smile and the importance of early, regular care for children beginning at age one, as well as to create an oral health surveillance system for early childhood. During this initial year, OHB is conducting assessments to determine health promotion needs of Iowa families. This includes assistance from Iowa's Center on Health Disparities to assess needs of our ethnic, minority, immigrant, and refugee populations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the I- Smiles project at the state and local level.				X
2. Provide technical assistance to local I-Smiles coordinators on infrastructure building activities.				X
3. Continue to promote a public awareness campaign on the importance of dental homes.				X
4. Implement physicians trainings on oral health and early childhood in partnership with the Iowa Chapter of the American Academy of Pediatrics.			X	X
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

Each local Title V child health agency now has a dental hygienist serving as an I-Smile coordinator. The agencies are implementing action plans which were written to focus on the strategies of partnerships and planning, local board of health linkage, and screenings and risk assessments. OHB staff sponsors quarterly coordinator meetings to assist in I-Smile system development. Meetings this year have included presentations on public health core functions, health literacy, and cultural competency. The meetings also allow coordinators to share best practice examples with one another.

In response to Medicaid policy changes, OHB staff created presentations for I-Smile coordinators to train non-dental professional staff. The presentations include information on the importance of oral health, how to provide oral screenings, how to apply fluoride varnish, and oral health education topics.

A physician training pilot project funded through the State Oral Health Collaborative Systems grant is being replicated throughout the state. I-Smile coordinators are partnering with physicians and other non-dental health care providers, providing trainings on oral screenings, and fluoride varnish applications for children age three and younger. The coordinators are distributing the I-Smile Screening Guides through these trainings. In addition, the Iowa chapter of the American Academy of Pediatrics has offered video conference trainings.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

I-Smile is being incorporated into the FFY2009 MCH grant application process. Agencies will submit specific action plans and budgets focusing on the I-Smile strategies of partnerships and planning, local board of health linkage, child health agency staff training, agency oral health protocols, care coordination, education for health care professionals, oral screening and risk assessment, and preventive gap-filling oral health services. In addition to semi-annual site visits, OHB staff will continue to sponsor quarterly meetings for the I-Smile coordinators to ensure a strong program foundation. Year-end reports from FFY2008 will assist OHB with technical assistance and further program development.

The Targeted Oral Health Service Systems grant will assist OHB to develop oral health promotion campaign in order to assure a dental home for children beginning at age 1.

The OHB anticipates several new sources of oral health data which will enhance its ability to implement programs. An oral health surveillance system for children under age five will begin during FFY2009. OHB will work through I-Smile Coordinators to conduct open mouth assessments of children to determine baseline oral health status. Target populations include children in child care, Head Start, and WIC. In addition, OHB will collect oral health status information through the new school screening requirement and enhancements to the Child and Adolescent Reporting System (CAReS).

POPULATION-BASED SERVICES AND ENABLING SERVICES

Health promotion material created through the TOHSS grant will be shared with local Title V agencies. I-Smile coordinators will serve as local promotion and outreach providers, in an effort to reach all Iowans. A Web site will also be developed, to include oral health information for the public as well as a secure area for I-Smile coordinators to share ideas, protocols, and resources.

Due to the limited number of dentists willing to see children younger than age three or those

uninsured, underinsured, or Medicaid-enrolled, most local child health agencies will provide oral screenings and preventive services such as fluoride varnish application. Child health agencies will also be involved in providing gap-filling oral screenings to assist families in meeting the new school screening requirement. Involvement may include providing the screenings or training health care providers to do screenings.

State Performance Measure 9: Rate (per 1,000 births) of infant deaths due to prematurity.

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				3.2	3.1
Annual Indicator			3.2	3.0	3.0
Numerator			127	121	120
Denominator			39255	40564	40488
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	3.1	3	2.8	2.8	2.7

Notes - 2007

Data were obtained from provisional 2007 Vital Statistics provisional data.

Notes - 2006

Data were obtained from provisional 2006 Vital Statistics data.

Notes - 2005

Data were obtained from 2005 Vital Statistics provisional data.

a. Last Year's Accomplishments

The FFY07 performance objective of 3.1 per 1,000 (births) for prematurity deaths was met. The 2007 Vital Statistics provisional data shows a prematurity rate of 3.0 per 1,000 births.

INFRASTRUCTURE BUILDING SERVICES

IDPH worked with Planned Parenthood sites in Iowa to expand tobacco cessation efforts to all of Planned Parenthood of Greater Iowa locations. Training based on Ask, Advise and Refer was provided at the following Title V Maternal and Child Health Agencies: Webster County Public Health, Matura Action Corporation, Community Health Services of Marion County, American Home Finding, Visiting Nurse Services of Dubuque, Visiting Nurse Services in Des Moines, Taylor County Public Health, and at North Iowa Community Action. Staff from the local tobacco coalition were included in the training to provide ongoing support and patient education materials about tobacco cessation to the agencies.

The Bureau of Family Health and the Oral Health Bureau will continue to work with local maternal health contract agencies to emphasis oral health screening and prevention services for pregnant women. The Oral Health Bureau has begun an I-Smile project. Each MCH agency now has a 0.5 FTE dental hygienist on staff. MCH agencies will include pregnant women in their target groups to provide oral health exams and fluoride varnishes.

IDPH staff participated in a conference call from the Centers for Medicaid and Medicare (CMS) and State Operations on Neonatal Outcome Improvement. Medicaid in Iowa has expressed an interest to collaborate with IDPH on a national effort by the CMS to reduce premature deliveries. The CMS has identified nine evidence-based strategies to decrease preterm births and/or improve outcomes for those infants who are delivered prematurely. IDPH will explore a collaborative relationship with Medicaid on this project.

POPULATION-BASED SERVICES

New legislation passed to increase the tobacco tax in Iowa by \$1.00 per pack of cigarettes.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to participate in the Prevention of Prematurity Summit for health care providers.				X
2. Host a physician based training on maternal depression and the effect to infants.				X
3. Continue to provide trainings to local MCH agencies on smoking cessation.			X	X
4. Continue to promote the partnership with the Division of Tobacco, Planned Parenthood and ACOG.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Maternal/child health Title V Agencies continue to provide education and support to all maternal health clients on reducing risk factors for preterm birth (including encouraging tobacco cessation, stress reduction, importance of medical home, early entry prenatal care and the importance of prenatal care).

Tobacco cessation training and training in motivational counseling will be held on May 2, 2008 conducted by staff from the Mayo Clinic The I- Smile dental hygienists are included in this training.

Medicaid approved a new billing code for dental hygienists working with maternal health clients to be able to bill for tobacco cessation counseling as it relates to oral health. This has resulted in an increase in the counseling provided to pregnant women.

Medicaid is covering the cost of some Nicotine replacement therapy for clients, including pregnant women with approval from their physician or midwife.

Quitline Iowa provides free telephone counseling for smokers who want to quit.

The CMS and State Operations on Neonatal Outcome Improvement project provided no funding to the pilot projects, so Iowa Medicaid has decided to put a hold on this project.

In collaboration with the University of Iowa Carver School of Medicine and the March of Dimes, IDPH held a Summit on Prevention of Prematurity on November 14, 2007 for both parents of preterm newborns and health care professionals.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

MCH staff will continue to provide training for local MCH and family planning agencies to ask every mother about tobacco use, advise them to quit and refer women to Quitline Iowa.

- Provide training at grantee meetings to MCH and Title V agency staff on Fax referral to Quitline Iowa and methods to assist Medicaid clients with reimbursement for Nicotine replacement therapy.
- Work with DHS to explore collaborative efforts to reduce smoking among pregnant Medicaid women.

POPULATION-BASED SERVICES

New legislation passed in the 2008 General Assembly in Iowa requires bars and restaurants to ban smoking in Iowa. This should decrease effects of second hand smoke, especially for pregnant women who work in bars or restaurants.

State Performance Measure 10: *Number of professionals trained on the use of appropriate maternal depression screening tools and the available referral resources.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				600	200
Annual Indicator					
Numerator			150	150	1440
Denominator			1	1	1
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	1500	1500	1600	1700	1700

Notes - 2007

Data were obtained from Maternal Depression trainings that were conducted in 2007.

Notes - 2006

Data were obtained from Maternal Depression trainings that were conducted in 2006.

Notes - 2005

Data were obtained from Maternal Depression Training Trainings that were conducted in 2005.

a. Last Year's Accomplishments

The FFY07 performance objective of 200 professionals trained on the use of appropriate depression screening tools was met. There were 1440 professionals trained in 2007.

During 2007, state and local professionals conducted approximately 50 trainings related to perinatal depression and screening. Through state funding, a Train the Trainer workshop (TTT) was offered. The TTT works to increase the number of certified trainers in the state of Iowa. The trainers can teach others in their community how to screen women for depression with a focus on pregnant and postpartum women. An additional training, the Support and Training to Enhance Primary Care for Postpartum Depression (STEP-PPD) was offered for the first time. This Web-based training provides information and resources to help physician and advance practice nursing providers to better understand the symptoms of perinatal depression. Its goal is to provide education, resources, and support to primary care providers for improved management of perinatal depression in the primary care settings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to promote the Maternal Depression train the trainer in partnership with the University of Iowa Center for Depression and Clinical Research.				X
2. Provide support for local maternal depression trainings.			X	X
3. Continue to work on the Perinatal Depression Project.				X
4. Collaborate with Early Childhood Iowa, 1st Five, and Iowa Medical Home Initiative.				X
5. Through the Center of Depression and Clinical Research, provide a newsletter on maternal depression.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

INFRASTRUCTURE BUILDING SERVICES

Currently, the TTT is in its third round of training of certified trainers. This will add over 15 more trainers to the growing cadre of 31 so far. The STEP-PPD training is currently being evaluated for its effectiveness and is also being developed for online availability to health care providers. Training are being offered at the local level to early care, health, and education providers.

c. Plan for the Coming Year

INFRASTRUCTURE BUILDING SERVICES

For the coming year of FFY2009, more funding for the TTT will be sought. In addition, the TTT is expected to be modified to fit the needs of early care and education providers. The STEP-PPD training, once evaluation is complete, will be made available online to providers free of charge.

E. Health Status Indicators

The nine Health Status Indicators (HSI) provide critical information about the capacity of Iowa's MCH health status for the Title V populations served. Iowa made progress on the HSI in recent years, as indicated on forms 20. There are several reasons for the improvements seen in the HSI measures.

State agency coordination activities, such as those described in the previous section of this application, had a positive impact on the capacity of IDPH to progress on specific initiatives. For example, the maternal health program, local maternal health agencies and local maternity providers have worked together to increase access to maternity services throughout the state. Ongoing partnerships between IDPH and other state departments also had a positive impact.

/2007/ Data collection for the 2005 Iowa Child and Family Household Health Survey was completed and analysis has begun. Additional details can be found in the Overview: Data Capacity section of this application. The Data Integration Steering Committee and MCH Data

Integration Team continue to build the capacity of the mid-level managers and database managers. Both groups demonstrate high levels of engagement by participants and provide routine learning opportunities for the entire data workforce. The 2005 Iowa Child and Family Household Health Survey will provide us with population data to determine the health status of children, pregnant women, and families. //2007/

//2008/ Analysis for the 2005 Iowa Child and Family Household Health Survey has been completed. A Statewide report, Early Childhood report, and Health Insurance report has been published and disseminated. Staff is still working on completing analysis and a report for physical activity and nutrition. Additional details can be found in the Overview: Data Capacity section of this application. The Data Integration Steering Committee and MCH Data Integration Team continue to build the capacity of the mid-level managers and database managers. Both groups demonstrate high levels of engagement by participants and provide routine learning opportunities for the entire data workforce. The 2005 Iowa Child and Family Household Health Survey will provide us with population data to determine the health status of children, pregnant women, and families. //2008/

//2009/ The Iowa MCH Data Capacity Project is on schedule to attain the FFY2007-2011 SSDI goals listed above. Activities related to the goals have been completed according to the SSDI timeline. The Title V agency has access to analysis of high-risk subpopulations from the 2005 Iowa Child and Family Household Health Survey (goal one). The Iowa MCH Data Capacity Assessment was completed to ascertain the utility of the data systems for statewide and local decision-making (goal two). The Data Integration Steering Committee and MCH Data Integration Team have considered using existing data sets for a new purpose related to policy development and program planning (goal three). Additional details can be found in the Overview: Data Capacity section of this application.

In February 2007 a report of the early childhood results of the 2005 Iowa Child and Family Household Health Survey was published. The purpose of the report was to provide information about Iowa's children ages 0-5 (i.e., prekindergarten). Analysis revealed that young children in Iowa appear to be more likely to be in child care than children nationally. Almost two-thirds of children under five in Iowa were in child care for some time in the week prior to the interviews. In December 2007 a report of the health insurance coverage of children from the 2005 Iowa Child and Family Household Health Survey was published. Results for uninsured children were compared to those for publicly (Medicaid and hawk-i) and privately insured children.

Results of the Iowa MCH Data Capacity Assessment were described in a workshop at the 2008 AMCHP Annual Conference on March 3, 2008. The workshop was presented by Debra Kane, PhD, RN (CDC epidemiologist assigned to Iowa), Lucia Dhooge, RN, BSN, MBA (Iowa's SSDI director), and Breana Lipscomb, BS (GSIP Intern). Participants received a description of Iowa's assessment results and a step-by-step guide to completing a data capacity assessment in their own states and territories. //2009//

F. Other Program Activities

Other (MCH) Capacity

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 Community Empowerment 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. ***//2009/ Contracts and memorandums of agreement are found in the attachment for this section, IV-F. //2009//***

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.

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 the ILEND (Iowa Leadership Education in Neurodevelopmental Disorders) program. The CHSC Director is the co-director of the ILEND grant.
4. CHSC, when requested, works with the Iowa Departments of Human Services and Public Health to assure quality care for CYSHCN enrolled in Medicaid and SCHIP Programs.
5. Staff participate in planning and field-testing new approaches to delivering physical and behavioral health care services and consultation to community-based sites using telemedicine techniques. /2007/ A one-year grant from the Iowa Department of Public Health to CHSC focuses on telehealth and requires a review of technology use; assessment of telehealth training needs; pilot testing of training modules; and submission of a summary report with recommendations. /2007/
6. Staff lead and participate in constructing and implementing the long-range statewide public health blueprint, "Healthy Iowans 2010", which is modeled after "Healthy People 2010".
7. CHSC is represented on the College of Public Health "Community Health Partners Advisory Committee" that seeks to provide training and field experiences to new public health professionals.
8. Staff direct a SPRANS grant project to integrate systems for CYSHCN with emphasis on the medical home, care coordination for primary care practices, and early childhood screening.
9. Staff lead an MCHB-supported project to improve the statewide system of early hearing detection and intervention for newborns and infants.
10. Staff participate in an MCHB-supported Department of Public Health effort to establish a comprehensive early childhood system.
11. 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.
12. Staff participate in several IDEA Part C program planning and quality assurance activities. /2007/ Staff also function as "service coordinators" for selected children enrolled in Part C who have complex medical problems. /2007/
13. Staff serve on a Governor appointed multidisciplinary collaborative work group to develop a statewide system of mental health services for children.
14. Staff serve in an advisory capacity to the Department of Public Health data integration initiative.
15. /2007/ Staff serve in an advisory capacity for the new Iowa Department of Public Health's

initiative to improve the "provider safety net" (community health centers, rural health clinics, and free medical clinics) for medically underserved Iowans. /2007/

16. /2008/ 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. CHSC leads the clinical operations portion of a new multi-partner SAMHSA-supported system development effort for children with severe emotional disorder (SED). /2008/

18. ***/2009/ Staff partner with the Iowa Department of Public Health and the Univ of Iowa Public Policy Center to prepare, interpret, and disseminate the quintennial Iowa Child and Family Household Health Survey. //2009//***

An attachment is included in this section.

G. Technical Assistance

The Bureau of Family Health is requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2006 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis of the early childhood section. This technical assistance will help the Early Care, Health, and Education System with population based data for four of the system indicators in Iowa's Early Childhood Iowa Strategic Plan.

The Bureau of Family Health and Child Health Specialty Clinics are also requesting technical assistance to pay the honorarium for a plenary speaker at the 2006 Public Health Conference. The plenary session will focus on capacity building within the public health system. The annual Public Health Conference will be held March 28-29, 2006 in Ames, Iowa.

/2007/ The Bureau of Family Health is requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2005 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis of the child health section. This technical assistance will help provide data for the Maternal and Child Health Title V Block Grant application.

The Bureau of Family Health and Child Health Specialty Clinics are also requesting technical assistance to pay the honorarium for a plenary speaker at the 2007 Public Health Conference. The plenary session will focus on capacity building within the public health system. The annual Public Health Conference will be held in April 4-5, 2007 in Ames, Iowa.

BFH is also requesting technical assistance from a national consultant, Kay Johnson, to provide expertise for child health policy and system change that will focus on the private medical community. IDPH will bring together partners from Early Childhood Iowa, Iowa Medical Home Initiative, Child Health Specialty Clinics, Healthy Mental Development Initiative, Early ACCESS, Community Empowerment, local maternal and child health agencies, and the Iowa Chapters of the American Academy of Pediatrics and Family Practice Academy. /2007/

/2008/ The Bureau of Family Health is requesting technical assistance to support an expert consultant from Syracuse, New York on cost reporting for maternal and child health services. The technical assistance will focus on how local MCH agencies need to develop skills in determining the cost of direct care and enabling services. This will promote provision of cost effective services and support funding requests and third party reimbursement.

BFH is also requesting expert consultation to medical and health care staff to advance the development of systems of care that support developmental screening and includes social emotional development and a medical home for all children.

The Bureau of Family Health and Child Health Specialty Clinics are also requesting technical assistance to pay the honorarium for a speaker at a statewide conference for local based MCH providers. The plenary session will focus on capacity building within the public health system. /2008/

/2009/ The Bureau of Family Health (BFH) and Child Health Specialty Clinics (CHSC) are requesting expert consultation to medical and health care staff to advance the development of systems of care that support developmental screening and includes social emotional development and a medical home for all children.

BFH and CHSC are also requesting technical assistance to pay the honorarium for a speaker at a statewide conference for local based MCH providers. The plenary session will focus on the diffusion of innovation theory.

BFH and CHSC are also requesting technical assistance to support an expert consultant from the University of Iowa Public Policy Center on the 2005 Iowa Child and Family Household Health Survey. The technical assistance will support staff time in completing additional multivariate analysis for the 2010 MCH needs assessment.

The BFH is also requesting technical assistance to support follow-up cost reporting for maternal and child health services. The technical assistance will also focus on cost reporting for child care nurse consultants.

The BFH is also requesting technical assistance to conduct an evaluation of the professional development system for health and safety consultation services. IDPH would like to contract with Dr. Jonathan Kotch from the National Training Institute for Child Care Health Consultation.

CHSC is requesting technical assistance to strategize inclusion of the adolescent transition national Title V CSHCN outcome as a more intensively addressed priority in CHSC's program implementation plans. For several years, competing priorities have resulted in underemphasis on the transition-related outcome. Technical assistance would ideally come from another state Title V CSHCN Program that has successfully addressed the transition planning and services outcome priority. //2009//

V. Budget Narrative

A. Expenditures

See Forms, 3, 4, and 5

Form 3, State MCH Funding Profile, shows a federal allocation expenditure of \$7,371,735. With the exception of infant health category, budget and expenditures varied by less than eight percent. The infant health expenditures varied from budget by 37 percent. This is due to changes in the contract for services for neonatology consultation, which was decreased from \$55,000 to \$15,500. In addition, the proportion of infants served by local Child Health agencies were less than expected. In both instances, this additional amount was expended in the child health category. Contracts with CHSC for MCH Block Grant funds are written for two-year contract periods. Consequently, federal funds not expended in year one of this contract do not meet the DPH Fiscal Bureau's definition of unobligated funds. Therefore, they are not included in the reported unobligated balance.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2004 in the amount of \$15,782,119. Of this amount, \$8,488,083 was funded by federal Title V. The state match is reported at \$5,225,941. This exceeds both the state match requirement and the maintenance of effort requirement. Federal Title V funds expended for infant and child health primary and preventive care was \$3,235,323 or 38 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at \$2,984,475 or 35 percent of the federal block grant funds expended for the year. Administration expenditures of \$391,678 represent four percent of the federal Title V amount.

Expenditures for FFY04 exceed Block Grant budgeted amounts. This can be attributed to a decrease in state funds appropriated by the General Assembly. Other variances are explained by efforts to maximize the use of other funding sources and recognize Title V as the payor of last resort. In the attachment, Figure 1 depicts the distribution of federal Title V expenditures by types of individuals served.

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 a continual gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, 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.

/2007/See Forms, 3, 4, and 5

Form 3, State MCH Funding Profile, shows a federal allocation expenditure of \$6,669,050. With the exception of infant health category, budget and expenditures varied by less than eight percent. The maternal health expenditures varied from budget by 26 percent. This is due to increases in the number of pregnant women served.

An unobligated amount of \$1,116,348 was used from the FFY 04 allocation.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2005 in the amount of \$13,883,988. Of this amount, \$6,669,050 was funded by federal Title V. The state match is reported at \$5,086,166. This exceeds both the state match requirement of \$5,001,788 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 \$2,580,283 or 39 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special

health care needs is reported at \$2,205,909 or 33 percent of the federal block grant funds expended for the year. Administration expenditures of \$493,796 represent seven percent of the federal Title V amount.

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 a continual gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, 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.

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, 2004 -- June 30, 2005. There are no findings in the 2005 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office. /2007/

/2008/See Forms, 3, 4, and 5

Form 3, State MCH Funding Profile, shows \$6,774,579 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 05 award. Due to a decrease in the state's award for FFY 06, carry forward funds were necessary to maintain community-based programs at current levels for maternal health, child health and children with special needs. Administration expenditures were 13 percent under budget due to staff vacancies.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2006 in the amount of \$14,224,632. Of this amount, \$6,774,579 was funded by federal Title V. The state match is reported at \$5,360,295. This exceeds both the state match requirement of \$5,080,934 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 \$2,524,401 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 \$2,314,898 or 34 percent of the federal block grant funds expended for the year. Administration expenditures of \$429,603 represent seven percent of the federal Title V amount.

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 a progressive, gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, 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, 2005 to June 30, 2006. There are no findings in the 2006 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office. /2008/

/2009/See Forms, 3, 4, and 5

Form 3, State MCH Funding Profile, shows \$7,599,309 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 06 award. Due to a decrease in the state's award for FFY 07, carry forward funds were necessary to maintain community-based programs at current levels for maternal health, child health and children with special needs. Administration expenditures were 7 percent under budget due to staff vacancies.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2007 in the amount of \$16,809,478. Of this amount, \$7,599,309 was funded by federal Title V. The state match is reported at \$5,699,923. This exceeds both the state match requirement of \$5,080,934 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 \$2,625,990 or 35 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at \$3,054,066 or 40 percent of the federal block grant funds expended for the year. Administration expenditures of \$429,011 represent five percent of the federal Title V amount.

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. For CHSC they have experienced a significant increase in Title V expenditures for direct care and exceeded budgeted numbers. Additionally CHSC received state appropriations for High Risk, Hemophilia, and Cancer that were not known at the time the budget was developed. Additionally, 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, 2006 to June 30, 2007. There are no findings in the 2007 audit. The report is submitted to the federal clearinghouse by the state Auditor's Office. //2009// An attachment is included in this section.

B. Budget

The FFY06 Title V appropriation is projected to be \$6,737,839 and a unobligated amount of \$830,778 for a total of \$7,568,617. As itemized in the attachment, this expected allocation is budgeted as follows: \$1,704,248 (23%) for maternal health services; \$249,609 (3%) for infant health services; \$2,664,646 (35%) for child health services; \$2,420,591 (32%) for services to children with special health care needs; and \$529,523 (7%) for program administration. These budgeted amounts include unobligated amounts that will be expended in FFY06. 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 FFY06 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

Completion of Budget Forms

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is \$5,164,902. Iowa continues to exceed the state maintenance of effort of \$5,035,775, required since 1989.

Iowa strives to maintain an unobligated balance of approximately \$650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. Additionally, unobligated funds may be used on an as-needed basis to prevent an interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be \$14,755,495. This figure, as well as the following breakout by level of services, includes a projected unobligated balance of \$830,778 from FFY05. In the 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.

Direct Services.

The federal-state partnership expenditures for continuation of direct care services are estimated at \$3,971,482. This represents approximately 27 percent of the partnership budget. The amount includes 16 percent of the funding for local child health agencies and three percent of local maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of \$1,615,013 or approximately 32 percent of the CYSHCN budget. 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.

Enabling Services.

The federal-state partnership expenditures for continuation of enabling services are estimated at \$4,145,766 representing 28 percent of the partnership budget. This category includes 26 percent of the funding for local child health agencies. It also includes 100% of child health local funds and 56 percent of the funding for local maternal health. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Population Based Services.

The federal-state partnership expenditures for continuation of population-based services are estimated at \$1,731,221, which represents 12 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 22 percent of the funding for local child health agencies and 10 percent of local maternal health funds. IDPH projects expenditure of \$1,412,639 (plus the related administrative costs of \$95,314), and CHSC projects a budget of \$223,267 or approximately four percent of the CSHCN budget.

Infrastructure Building Services.

Estimated expenditures for continuing development of core public health functions and system development are \$4,907,026 or 33 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal health, child health, and EPSDT. This category includes 36 percent of the funding for local child health agencies and 31 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities and child health systems development consultation. CHSC's budget for infrastructure building services is estimated at \$844,399 (17 percent of the CSHCN budget).

/2007/ The FFY07 Title V appropriation is projected to be \$6,760,133 based on the 05 award. As itemized in the attachment, this expected allocation is budgeted as follows: \$1,409,395 (21%) for maternal health services; \$289,940 (4%) for infant health services; \$2,175,652 (32%) for child

health services; \$2,333,591 (35%) for services to children with special health care needs; and \$551,554 (8%) 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 FFY06 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 \$5,370,734. Iowa continues to exceed the state maintenance of effort of \$5,035,775, established in 1989.

Iowa strives to maintain an unobligated balance of approximately \$650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. Additionally, unobligated funds may be used on an as-needed basis to prevent an interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be \$15,874,543. 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.

Direct Services.

The federal-state partnership expenditures for continuation of direct care services are estimated at \$4,231,828. This represents approximately 27 percent of the partnership budget. The amount includes 19 percent of the funding for local child health agencies and three percent of local maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of \$1,772,557 or approximately 35 percent of the CYSHCN budget. 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.

Enabling Services.

The federal-state partnership expenditures for continuation of enabling services are estimated at \$4,062,622 representing 26 percent of the partnership budget. This category includes 26 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Population Based Services.

The federal-state partnership expenditures for continuation of population-based services are estimated at \$1,835,042, which represents 12 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 22 percent of the funding for local child health agencies and 11 percent of local maternal health funds. IDPH projects expenditure of \$1,562,247 and CHSC projects a budget of \$217,639 or approximately four percent of the CYSHCN budget.

Infrastructure Building Services.

Estimated budget for continuing development of core public health functions and system development are \$5,745,051 or 36 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal health, child health, and EPSDT. This category includes 34 percent of the funding for local child health agencies and 34 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities and child health systems development consultation. CHSC's budget for infrastructure building services is estimated at \$821,892 (16 percent of the CYSHCN budget).

/2007/

/2008/ The FFY08 Title V appropriation is projected to be \$6,579,555 based on the FFY06 award. As itemized in the attachment, this expected allocation is budgeted as follows: \$1,376,928 (21%) for maternal health services; \$295,468 (4%) for infant health services; \$2,111,412 (32%) for child health services; \$2,190,992 (33%) for services to children with special health care needs; and \$604,755 (9%) 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 FFY08 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is \$6,030,199. Iowa continues to exceed the state maintenance of effort of \$5,035,775, established in 1989.

Iowa strives to maintain a carry forward balance of approximately \$650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. Additionally, these funds may be used to minimize the impact of fluctuations in the award amount that might otherwise threaten continuity of operations. Additionally, this approach to budgeting prevents interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be \$17,767,760. 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.

Direct Services.

The federal-state partnership expenditures for continuation of direct care services are estimated at \$4,824,423. This represents approximately 27 percent of the partnership budget. The amount includes 19 percent of the funding for local child health agencies and three percent of local maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of \$1,964,486 or approximately 29 percent of the CYSHCN budget. 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.

Enabling Services.

The federal-state partnership expenditures for continuation of enabling services are estimated at \$45,487,762 representing 31 percent of the partnership budget. This category includes 26 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Population Based Services.

The federal-state partnership expenditures for continuation of population-based services are estimated at \$1,274,544, which represents 7 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 21 percent of the funding for local child health agencies and 11 percent of local maternal health funds. IDPH projects expenditure of \$976,779 and CHSC projects a budget of \$237,290 or approximately three percent of the CYSHCN budget.

Infrastructure Building Services.

Estimated budget for continuing development of core public health functions and system development are \$6,131,031 or 35 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 34 percent of the funding for local child health agencies and 34 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities. CHSC's budget for infrastructure building services is estimated at \$861,159 (13 percent of the CYSHCN budget).

Other federal funds directed toward MCH include:

State Systems Development Initiative;

Early Childhood Comprehensive Systems Grant;

Perinatal Depression Grant -- Services for Maternal and Infant Mental Health;

Medical Home Initiative for Children with Special Health Care Needs;

Title X Family Planning;

Early ACCESS (IDEA, Part C);

Center for Congenital and Inherited Disorders Family Participation Project; and

Early Hearing Detection and Intervention (CDC and HRSA). /2008/

Budget

/2009/ The FFY09 Title V appropriation is projected to be \$6,512,104 based on the FFY06 award. As itemized in the attachment, this expected allocation is budgeted as follows: \$1,342,229 (21%) for maternal health services; \$291,024 (5%) for infant health services; \$2,061,446 (32%) for child health services; \$2,190,992 (34%) for services to children with special health care needs; and \$626,413 (10%) 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 FFY09 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 \$5,293,246. Iowa continues to exceed the state maintenance of effort of \$5,035,775, established in 1989 and exceeds the required match of \$4,884,078.

Iowa strives to maintain a carry forward balance of approximately \$650,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in federal funding. For FFY09, Iowa will use \$260,463 to sustain current efforts.

The total budget for the federal-state partnership is projected to be \$18,292,156. 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.

Direct Services.

The federal-state partnership expenditures for continuation of direct care services are estimated at \$5,144,406. This represents approximately 28 percent of the partnership budget. The amount includes 17 percent of the funding for local child health agencies and one percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of \$2,636,301 or approximately 42 percent of the CYSHCN budget. 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.

Enabling Services.

The federal-state partnership expenditures for continuation of enabling services are estimated at \$4,495,951 representing 25 percent of the partnership budget. This category

includes 33 percent of the funding for local child health agencies. Healthy Families toll free information and referral line and the TEEN Line are included in this category. CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Population Based Services.

The federal-state partnership expenditures for continuation of population-based services are estimated at \$2,329,140, which represents 13 percent of the total partnership budget. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 17 percent of the funding for local child health agencies and 15 percent of local maternal health funds. IDPH projects expenditure of \$2,029,209 and CHSC projects a budget of \$237,291 or approximately two percent of the CYSHCN budget.

Infrastructure Building Services.

Estimated budget for continuing development of core public health functions and system development are \$6,322,659 or 35 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 33 percent of the funding for local child health agencies and 28 percent of local maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities. CHSC's budget for infrastructure building services is estimated at \$839,160 (5 percent of the CYSHCN budget).

Other federal funds directed toward MCH include:

***State Systems Development Initiative;
Early Childhood Comprehensive Systems Grant;
Title X Family Planning;
Early ACCESS (IDEA, Part C);
Iowa Medical Home Initiative;
SAMHSA Integrated Behavioral Health;
Center for Congenital and Inherited Disorders Family Participation Project;
Targeted Oral Health System Project; and
Early Hearing Detection and Intervention (CDC and HRSA). //2009//***

An attachment is included in this section.

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.