



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

**State Narrative for
Iowa**

**Application for 2014
Annual Report for 2012**



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I. General Requirements

A. Letter of Transmittal

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

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

B. Face Sheet

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

C. Assurances and Certifications

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

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

D. Table of Contents

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

E. Public Input

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

//2014/During FFY12, the Iowa MCH Advisory Council provided input into the proposed goals and activities through focused conversations at the March 2013 meeting and also during the public comment period. The Council endorsed the proposed application in June 2013 through a virtual meeting and follow-up survey. A list of current MCH Advisory Council members is included in the attachment.

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

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

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

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

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

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

No update.

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

1st Five Healthy Development:

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

MCH Infrastructure:

Over the last two years, Iowa's Title V MCH program has been evaluating the state and local infrastructure. In November 2013, six regions were formed and assigned a consultant that acts as a single point of contact within the BFH.

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

Early Childhood Comprehensive Systems (ECCS) Grant:

As part of the competitive ECCS application, IDPH conducted a review and analysis using the Title V needs assessment (NA), the MIECHV NA and other resources to choose strategy #2, "Coordination of the expansion of developmental screening activities in early care and education settings statewide by connecting pediatric and other child health leaders with child care health consultants to link training and referrals among medical homes, early intervention services, child care programs and families."

Priority needs related to the ECCS grant are as follows:

- Problem Statements-Lack of adoption of quality improvement methods within MCH; Lack of coordinated system of care for nutrition services for CSHCN and lack of a coordinated system of healthcare provider training regarding early screening and early identification of autism; Racial disparities exist in MCH outcomes

In the past five years Iowa made substantial progress in establishing an early childhood system responsive to the needs of families. In addition, program development in the areas of medical home, developmental screening, preventive oral health services, and mental health screening and treatment services added significantly to addressing previously noted unmet needs.

Although no longer specifically addressed during the 2011-2015 Title V project period, the following need statements from the 2005 MCH Title V NA helped build the infrastructure to

address Iowa's capacity to increase developmental screening and continue to be a priority of Iowa's MCH program:

- Need Statements--Minimize developmental delay through early intervention services for children 0-3 years; Improve the quality of family support and parenting education programs and services ; Assure children enrolled in early care and education programs are in quality environments; Assure developmental evaluations are provided to Medicaid enrolled children 0-3 years

Family Planning:

As part of the Family Planning competitive grant, IDPH used the Title V NA, adolescent health NA and several other sources to build the framework for the Family Planning NA. One of the priorities for FP and Title V continues to be unintended pregnancy. In the FP NA data there are several interesting trends:

1. Family income: There is a substantial indirect relationship between unintended pregnancies and income; intendedness of pregnancies increased directly with income. About 67% of pregnancies were unintended when a family's income was less than \$10,000. Similarly, families with an income of less than \$30,000 were far more likely to experience an unintended pregnancy than families with an income of \$30,000 or more (55.9% vs. 21.2%).
2. Mother's age: For mothers under age 20, 78.1% report that their pregnancy was unintended. This compares to 29.4% of those 20 and older who reported an unintended pregnancy.
3. Race: Just over half of pregnancies experienced by African American women were unintended, compared to Hispanic women who reported 43.8% of pregnancies being unintended and 31.2% for White women.
4. Birth control use: For race, the percentages of women who did not use birth control ranged from 63.2% (White) to 71.9% (African American). Age did not play a significant role in whether or not birth control was used; 66.2% of women under 20 did not use birth control compared to 63.9% of women 20 and older.

Another overarching goal for IDPH's FP Program and Title V MH Program is to incorporate the life course health perspective model and reproductive life planning into all activities.

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

Iowa Child and Family Iowa Household Health Survey:

The Iowa Child and Family Iowa Household Health Survey (IHHS) is a comprehensive, statewide effort to evaluate the health status, access to health care and social environment of children of children and families in Iowa. Three IHHS have been conducted; 2000, 2005, and 2010 and serves as a foundation for Iowa's Title V five year NA and other program related NAs.

During FFY13, two reports were finalized and released:

1. Weight, Eating Habits, and Physical Activity -- Findings from the report include:
 - The gap between parent perceptions and the objective information on the proportion of overweight children creates a challenging situation because if parents do not perceive there is a problem, it will be more difficult to address the causes that can be influenced in the home.
 - Iowa's children appear to be active, although screen time may be a barrier for many children and these factors vary by age; older children are reported to be less active than younger children.
 - Children are eating some fruits and vegetables, and many drink no soda on an average day. Breakfast is consumed by most children. However, older children are less likely to meet guidelines for healthy eating.
 - The level of food insecurity among households with low-income children was significant. Although national data shows that one in four children receive some form of food assistance
2. Health Insurance -- Findings from the report include:
 - Iowa has one of the lowest rates of uninsured children in the United States, with only 3% of children uninsured. Uninsured children had lower health status ratings, were less likely to have a

medical home-like environment, and were more likely to seek care in the ER.

- Hispanic/Latino children were most likely to be uninsured, with the gap widening over the last 10 years.
- The role of public insurance programs was also evident in these data. More than one-quarter of very young children (ages 4 and under) were covered through either the Medicaid or the hawk-i programs; and the satisfaction ratings with their coverage were higher for public insurance than private insurance.
- There is still a significant difference between the rates of medical and dental insurance coverage, though the gap has declined some over the years. The increase in dental coverage could be attributed to the increased number of children covered by public insurance.

Early Childhood Needs Assessment (ECNA):

ECI, with funding through the Early Childhood Advisory Council (ECAC) grant, is conducting a comprehensive early childhood NA. Title V staff serve on the core advisory group for the needs assessment. The ECNA is divided into 4 deliverables: 1) Document overall population trends, identify and define populations of young children with high needs and identify and define "at risk communities"; 2) document the current supply, capacity, and quality of early childhood services; 3) provide a gap analysis based on 1 and 2; 4) complete a final report.

Currently, the contractor has shared the findings from deliverable 1 and is in process of completing deliverables 2 and 3:

- Relative to U.S., Iowa has seen modest growth
- Iowa is less diverse than the U.S., but growing more diverse at a faster rate
- Iowa has high rate of workforce participation among parents of young children and a growing proportion of single parents.
- There is a cluster of characteristics that constitute "need" among children and families (less-educated parents, poverty/low-income status, language/culture barriers, identifiable child needs (physical, developmental, behavioral, environmental))
- Young children with high needs are not evenly distributed within Iowa, but there is no place where there's no opportunity to improve outcomes.

MCH Advisory Strategic Plan:

Iowa's MCH Advisory Council participated in a strategic planning process to create a renewed structure and new energy to address issues that affect children and families in Iowa. Their work will serve as plans for 2013-2014, as well as the foundation for work in future years. The Council identified four categories of work that would assist them in supporting MCH services and programs. The four categories were as follows:

1. 4Rs: Recruit, Retain, Re-Energize and Re-Orient --expand the MCH Advisory Council membership to add expertise, with a focus on family perspectives, improve communication.
2. Develop Awareness --target outreach using a specific and varied public awareness campaign and promote MCH programs across the state.
3. Build Relationships and Advocate for Families -- Establish priorities and build synergies to advance goals and advocate.
4. Research Based Recommendations -- identify best practices, educating stakeholders about national trends and emerging issues and exploring equity of services.

III. State Overview

A. Overview

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

Iowa's Land

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

Changes in Demography

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

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

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

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

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

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

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

Employment and Population

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

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

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

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

Poverty

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

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

FOCUSED STRATEGIC PLANS:

Early Childhood Iowa

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

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

Current economic conditions pushed recent legislative sessions to more thoroughly and intentionally look at efficiencies and accountability in state government. Community Empowerment often became a focal point in conversations during legislative discussions regarding the efficiencies and effectiveness of Community Empowerment, both at a state and local level. In June 2009, the Department of Management's Office of Empowerment hosted a LEAN event to give leaders in early childhood the opportunity to reflect and build on what works in Iowa, while developing new models and strategies based on the latest early childhood research.

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

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

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

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

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

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

Project LAUNCH

Fragmented systems, inadequate resources, lack of understanding and lack of accountability contribute to Iowa's failures to meet the mental health needs of Iowa's youngest citizens and their families. Iowa's Project LAUNCH seeks to develop the necessary infrastructure and system integration to assure that Iowa children are thriving in safe, supportive environments and entering school ready to learn and able to succeed. Iowa's Project LAUNCH targets children ages zero to eight and their families in a seven- zip code area of inner city Des Moines with a focus on low-income and minority populations who are traditionally underserved. The purpose of Iowa LAUNCH is to develop a sustainable, systemic community-approach to promoting social, emotional and behavioral health for young children and their families. Overall project goals are to: 1) Build state and local infrastructure to increase the capacity and integration of the children's mental health system into a comprehensive early childhood system of care to promote positive development for Polk County children ages zero to eight and their families; 2) Deliver family-centered, fully integrated evidenced-based services for children living in a targeted community at-risk for poor social-emotional outcomes, and 3) Promote sustainability and statewide spread of best practices for system development. A state and local Project LAUNCH Strategic Plan was finalized in May 2010.

/2012/Project LAUNCH is in year two of a five year project with full implementation of the five direct service components. 1) Family Support - Nurse Family Partnership; 2) Parent Education - Positive Behavior and Intervention Support Case Management; 3) Developmental Screening - Ages and Stages and Ages and Stages - Social and Emotional; 4) Integration of Behavioral Health into Primary Care- 1st Five and Birth to Five Medical Home; and 5) Mental Health

Consultation - School Mental Health Consultants. The State LAUNCH Council developed five workgroups: Health and Wellness, Family Support, Early Childhood Mental Health Consultation and Policy and Advocacy. A LAUNCH Interagency Coordinating Committee was developed to bring together Division Directors of early childhood programs and business leaders to implement recommendations from the state council through policy and program changes. The workgroups and Interagency Committee addressed activities from the Project LAUNCH Strategic Plan. Project LAUNCH is also involved in the state redesign of mental health in Iowa. There is a workgroup addressing the children's mental health system on which members of the Project LAUNCH council will serve.//2012//

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

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

Project Connect

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

/2012/ In December of 2010, Iowa's first training on intimate partner violence and reproductive coercion (IPV/RC) was provided. Those in attendance were from maternal health, family planning and other sexual health disciplines. Comments from the training participants show the impact that these trainings made just one month later: "Just a simple question can start a conversation about healthy relationships." "I didn't know a lot of things about my client until I asked." "I was comfortable asking because I had resources to share and knew who I could call if the client needed more help than I could give." Iowa has provided training to over 250 public health professionals.

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

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

community resources to help the family; and referral to family planning and child health agencies after delivery to support the family's ongoing health care needs.

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

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

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

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

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

Modernization of Public Health in Iowa

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

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

address gaps in its ability to meet the standards and to improve work that already meets the standards.

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

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

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

Local MCH Agencies

Local maternal health and child health programs promote the development of community-based systems of preventive health care for pregnant women, children ages 0 through 21 and their families. Goals of the MCH programs are to:

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

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

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

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

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

The program is designed to: 1) Strengthen and improve the programs and activities carried out under Title V and other community service providers; 2) Improve coordination of services for at-

risk communities; and 3) Identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

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

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

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

1. Expand Healthy Families America and home-based Early Head Start programming in targeted at-risk communities.
2. Develop and implement a statewide centralized intake system for family support programming including Iowa's Part C program that also includes transition and transfer services within and outside of the state.
3. Develop a required state certification system for all family support practitioners.
4. Explore innovative practices used in the medical field to bring specialized services to rural areas for applicability to the family support field, such as tele-health services. Specialized services include domestic violence, mental health and substance abuse counseling in addition to consultation services to home visitors from these professionals.
5. Complete an in-depth workforce study and create an action plan to address workforce issues such as recruitment of a more ethnically diverse workforce and specialized tracks to increase worker competency in fields such as substance abuse, mental health and domestic violence.
6. Utilize the work of the marketing industry (the "q" rating or score) to complete a study of the personal attributes that families look for in-home visitors that cause them to stay engaged in the program. Create screening tools that will enable employing organizations to hire staff with personal attributes that will assist families in relating to the worker and will decrease drop-out rates.
7. Use social media to create a virtual home visitor program that will broaden the reach of home visiting services to include extended family members and other families not enrolled in a home visiting program.

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

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

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

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

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

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

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

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

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

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

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

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

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

being addressed at the local level.

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

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

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

SIGNIFICANT PUBLIC INITIATIVES:

Newborn Hearing Screening Program

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

Iowa's EHDI program goals include the following:

1. Develop and sustain a comprehensive coordinated system of care for Early Hearing Detection and intervention in Iowa.
2. Provide technical assistance to birthing hospitals, area education agencies and private practice audiologists relative to the hearing screening program and their responsibility under the law.
3. Implement a statewide Web-based surveillance system to assure all Iowa newborns are screened for hearing loss and receive follow-up services as needed.
4. Facilitate data integration linkages with related screening, tracking and surveillance programs to minimize infants "lost to follow-up."
5. Meet the National EHDI Goal of 1-3-6.
 - a. All infants are screened for hearing loss before 1 month of age, preferably before hospital discharge.
 - b. All infants who do not pass the screening will have a diagnostic audiologic evaluation before 3 months of age.
 - c. All infants identified with a hearing loss receive appropriate early intervention services before 6 months of age.

6. Review data to identify children with potential for hearing loss to ensure those children receive appropriate, timely early intervention services.
7. Collaborate with Early ACCESS (IDEA, Part C) to strengthen early intervention services for children who are deaf or hard-of-hearing.
8. Ensure families with children zero to three who are deaf, hard-of-hearing, or at risk of late-onset hearing loss will be linked to a medical home and receive family-to-family support.
9. Implement program evaluation that incorporates both process and outcome objectives which drives system development and program improvement.

Barriers to Prenatal Care

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

I-PRAMS

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

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

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

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

collection procedures and instruments are standardized to allow comparisons between states.

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

/2014/Iowa PRAMS began collecting data in February 2013 starting with mothers of babies who were born in November 2012. As of June 2013, 711 were contacted to complete the PRAMS survey. Of the 711 contacted, 262 exceeded the 90 day participation period and 52% completed the survey either by mail or phone interview. Of the remaining participants, 449 are still within the 90 day participation.

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

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

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

Iowa Child and Family Household Health Survey (IHHS)

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

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

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

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

/2013/The statewide report of the 2010 IHHS was published in April 2012. Dissemination of the report is underway utilizing multiple venues to reach the widest audience of state and local

program partners. A series of webinars will be offered to present information on the 2010 IHHS statewide report and sample methodology.

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

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

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

State Child Health Insurance Program

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

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

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

Emerging from prior health reform legislation, effective July 1, 2009, eligibility for hawk-i was expanded to 300% FPL and Medicaid for pregnant women and infants less than one year of age to 300% FPL. As part of SF 389, also effective July 1, 2009, children in lawful permanent resident status may receive Medicaid or hawk-i coverage if they are otherwise eligible, regardless of their date of entry into the United States; thus eliminating the past five-year bar placed on this population. Effective March 1, 2010 hawk-i implemented the nation's first dental only program

based on the CHIPRA legislation that allows states this option. The hawk-i Board unanimously approved a three tiered premium structure and assured that medically necessary orthodontia was provided under the dental only program.

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

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

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

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

Health Reform

As a result of the national and state level attention to health care, Iowa enacted a Health Care Reform bill (HF 2539) during the 2008 Iowa General Assembly. A Medical Home System Advisory Council was established from this legislation. The Council's charge is to advise and assist IDPH in implementing a medical home system for Iowa. HF 2539 provides a blueprint for the future of Iowa's medical home system that defines medical home, outlines needs for the statewide structure and focuses on the joint principles of a patient centered medical home. The Health Care Reform bill also identifies phases for the medical home beginning with children enrolled in Medicaid. The proposed outcomes are to reduce disparities in health care access, delivery and health care outcomes; improve the quality and lower the costs of health care; and provide a tangible method to document if each Iowan has access to health care. For children, goals and performance measures will include childhood immunization rates, well-child care utilization rates, care management for children with chronic illnesses, emergency room utilization and oral health service utilization. The medical home system for children will coordinate and integrate with existing newborn and child health programs and entities including local MCH agencies, Community Empowerment and ECI.

/2012/The Medical Home System Advisory Council (MHSAC) developed an Initial Progress Report in 2009 with four high-level recommendations that continue to be top priority and can be found on their website: <http://www.idph.state.ia.us/MedicalHome/>. Four workgroups on

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

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

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

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

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

/2014/The PCCM and MH Advisory Councils combined into one Council. The staff who coordinate the Council have an expanded role and are now the Office of Health Care Transformation (OHCT), which is a key point-of-contact for ACA related initiatives at IDPH including Health Benefit Exchange, Accountable Care Organizations, Medical Home, chronic care management initiatives and care coordination. The goals of the OHCT are

convening stakeholders, building relationships/partnerships, streamlining efforts, and offering technical assistance to organizations including Local Public Health Agencies and MCH grantees to prepare for ACA implementation.//2014//

Fit for Life

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

Significant lowans Fit for Life resources include:

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

/2014/lowans Fit for Life will conclude June 29, 2013 as the funding comes to a close. IDPH has received notice that the department received funding for the new heart disease, diabetes, nutrition and physical activity, and school health grant from the CDC. Many of the services will continue through the new grant program; however, some will not.//2014//

/2013/Community Transformation Grants

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

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

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

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

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

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

Children with Special Health Care Needs

CHSC is Iowa's Title V Program for Children and Youth with Special Health Care Needs (CYSHCN). The CHSC administrative office is located at the University of Iowa in Iowa City. In addition to the Iowa City office, CHSC currently supports 13 regional centers throughout the state, four of which are primarily dedicated to building an improved family-driven, youth-guided system of care for children's mental health services under a cooperative agreement with the Substance Abuse and Mental Health Services Administration (SAMHSA). Regional centers provide and manage a number of services for CYSHCN, including direct care clinics, care coordination, family support and infrastructure building services, including core public health functions (assessment, policy development and assurance), training, program evaluation and continuous quality improvement. The CHSC Director, Debra Waldron, MD, MPH works collaboratively with the state MCH Director and Part C (of IDEA) Coordinator to implement and develop programs to meet the health-related needs of all Iowa children. The collaboration is enhanced by Dr. Waldron's 0.2 FTE appointment as Medical Director for IDPH's Division for Health Promotion and Chronic Disease Prevention. /2012/It is also enhanced by CHSC's participation in the newly formed Partnership to Improve Child Health in Iowa (PI-CHI). PI-CHI seeks to improve the health of all Iowa children, including those with special needs.//2012// **/2014/Dr. Waldron was appointed the Director for the University of Iowa's newly created Division of Child and Community Health. In this capacity she oversees the Center for Child Health Improvement and Innovation as well as CHSC.//2014//** Dr. Waldron is a board certified pediatrician with extensive public health experience in system development and quality improvement.

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

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

surveys will be available late summer/fall 2011.//2012//

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

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

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

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

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

B. Agency Capacity

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

development and assurance are promoted.

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

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

1. Infrastructure and Performance Management
2. Reproductive, Maternal, & Women's Health
3. Early Childhood
4. Child and Adolescent Health//2013//

Women's Health

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

Local Maternal Health (MH)

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

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

Statewide Perinatal Care Program

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

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

Abstinence Education

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

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

Personal Responsibility Education Program (PREP)

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

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

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

Preventing Shaken Baby Syndrome (SBS)

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

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

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

Medical Home/EPSTDT Work Team

For the child health (CH) program, the work team includes a focus on both the Medical Home Project and the EPSTDT program. The Medical Home Project features a Medical Home System Advisory Council to make recommendations to IDPH on the plan for implementing a statewide, patient-centered medical home system. The initial phase will focus on providing a patient-

centered medical home for children who are eligible for Medicaid. Included in a later phase is a focus on providing a patient-centered medical home to children covered by the hawk-i program.

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

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

Local CH Agencies

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

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

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

/2013/BFH and OH staff provide extensive technical assistance to local agencies, including working with those impacted by budget reductions to help prioritize focus areas.//2013// ***/2014/CH agencies continue focus on establishing medical and dental homes. Iowa's FFY 2012 EPSTD participation rate was 81% for children ages 0-20 (CMS 416 Report). Over 55% received a dental or oral health service.//2014//***

Oral Health Program

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

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

support systems for families through work with dental providers, medical providers and community organizations. In addition to building local oral health infrastructure, the coordinators and other CH agency staff provide oral health promotion and education, care coordination and preventive dental services to ensure optimal oral health for children.

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

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

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

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

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

Healthy Child Care Iowa (HCCI)

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

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

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

those require onsite visits with the CCNC.//2013// ***/2014/ Iowa currently has 41 CCNCs working a total of 26 FTE positions.//2014//***

Child Death Review Team

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

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

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

Center for Congenital and Inherited Disorders

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

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

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

/2013/To comply with recommendations from the Secretary for the U.S. DHHS, CCID is planning for the implementation of newborn screening for Severe Combined immunodeficiency (SCID) and Critical Congenital Heart Disease (CCHD). The IDPH partnered with the State Hygienic

Laboratory and the UI Department of Pediatrics to develop screening protocols for each condition. CCID convened 2 expert work groups of health care providers, subspecialty care providers, parents of affected children and ancillary personnel to guide the planning and implementation of screening for these 2 additional conditions.//2013//

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

Early Hearing Detection and Intervention (EHDI) Program

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

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

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

/2014/Iowa's EHDI program was recognized by CDC EHDI for the quality and quantity of individualized data submitted as a part of the CDC iEHDI project.//2014//

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

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

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

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

the Governor and General Assembly that will improve the lives and futures of Iowa youth.

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

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

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

Improving Academic Achievement by Meeting Student Health Needs

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

Prevention of Youth Violence

Iowa's primary focus is to strengthen prevention of self-directed and interpersonal child and adolescent violence. These include such behaviors as suicide, child maltreatment, school violence, community violence and bullying. Comprehensive and sustained support of youth is necessary to improve youth outcomes and reduce suicide and interpersonal violence. The overarching theme of the violence prevention effort will be youth development. Youth development goes beyond problem reduction and applies to prevention, remediation and treatment, participation and involvement and academic and workforce preparation.

Culturally Competent Care for MCH Populations

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

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

/2013/The OMMH provides a lending library of "Unnatural Causes" educational videos and discussion guides to address health equity within MCH agencies. The DHHS Office of Minority Health National Partnership for Action Plan to Reduce Racial and Ethnic Health Disparities initiative was implemented by disseminating 8,400 postcards explaining the initiative, toolkits and

website information to all MCH agencies for distribution to staff and community partners. OMMH continues to provide cultural diversity education/awareness training and workshops as requested.//2013//

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

Children and Youth with Special Health Care Needs (CYSHCN)

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

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

Direct Clinical Services

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

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

CS currently performs essential surveillance functions regarding development, social-emotional skills, and nutrition. /2012/All CS screen for autism spectrum disorder using the Modified Checklist for Autism in Toddlers (M-CHAT). In 2010, CHSC's Regional Autism Services Program (RASP) reported a doubling of the number of autism spectrum disorder screenings of children 18-36 months seen in CHSC clinical settings. ARNP's, staff nurses and targeted Family Navigators are also trained in the evidence-based screening tools Ages and Stages Questionnaire (ASQ) and ASQ-Social Emotional (SE), and the Developmental Assessment of Young Children (DAYC). Registered Dietitians and other CS staff also implement the PEACH tool, a screening tool to detect feeding and nutrition needs of infants and toddlers. CHSC partners

with Early ACCESS to promote statewide use of the tool. Work is also underway to use Family Navigators to conduct hearing re-screens in selected areas of the state for children who missed the birth screen. The Oelwein and Fort Dodge regional centers provide follow-up hearing screening for infants who did not receive the screening at birth or need a re-screen for other reasons.

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

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

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

Care Coordination Services

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

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

/2012/Care coordination to connect subspecialty services is also available. ARNPs, staff nurses, social workers, and registered nurses also serve on the team of care coordinators to best meet families' needs as they evolve. Quality improvement techniques assure care coordination standards, staff training, and appropriate data tracking, including family impact data.//2012// /2013/Web-based training for care coordinators was introduced for new CHSC staff.//2013//

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

unduplicated patients served through external coordination.//2013//

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

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

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

Family Support

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

Through F2F IA, families are matched with other families who can best provide peer support and teach skills to help them become their child's primary navigator and advocate.

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

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

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

in 2012.//2013//

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

Infrastructure Building Services

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

Active projects of CHSC's infrastructure building efforts include:

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

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

/2012/CHSC is increasing attention to cultural diversity and cultural competence in several major program areas. CHSC will hire a bilingual Family Navigator to assist with translation and outreach to the Latino population, and a new Hispanic Early ACCESS service coordinator was hired in N.W. Iowa to serve eligible young Hispanic children and their families. CHSC will review the ARRA-funded white paper on social determinants of health to guide issues of cultural diversity and encourage policies promoting healthy outcomes for all of Iowa's early childhood target population. The cultural broker for the SAMHSA system of care mental health project will continue

to focus on inclusion for lowans living in rural poverty. The F2F IA project will identify and address cultural and linguistic competence technical assistance needs for its family information-sharing and mentoring initiatives. In addition, State Performance Measure #2 contains quality measures in each of the four systems of care components that address cultural competence, and the Public Health Division has assigned staff to renew the efforts to continually assure cultural competence in all program services and organizational structure. CHSC will also employ a paid consultant, the Director for Health Literacy from Iowa Health Systems, to advise on health literacy issues affecting all cultures.//2012// /2013/Staff serve on the state Health Literacy Committee and presented at the April state conference on health literacy. Program materials are systematically reviewed for adherence to health literacy standards by program staff.//2013//

/2014/SAMHSA 6-year funding for Community Circle of Care (CCC) ended. CHSC obtained \$1.5 million state appropriation to sustain elements of CCC. CHSC advocates for system of care for children's mental health and disability and integrated health homes. CHSC collaborates on American Board of Pediatrics Maintenance of Certification quality improvement projects. EMDI educates Audiologists, ENTs, Pediatricians, Family Practice Physicians and FQHCs on responsibilities of newborn hearing stakeholders. CHSC piloted "What to Do When Your Child Is Heavy" for potential incorporation into CS. CHSC secured state funding to improve system of care for children with ASD.//2014//

C. Organizational Structure

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

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

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

Bureau of Family Health

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

At the individual level, care coordination may involve providing information about available services, assisting clients in making health care appointments, coordinating access to needed support services, coordinating access to health care services and following up to ensure that services were accessed.

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

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

The BFH is represented on the Division of Health Promotion and Chronic Disease Prevention's Integration Team. The vision of this team is innovative integration through enhanced collaboration and use of our team's diverse skills and broad resources. The mission is to bring together a team to leverage opportunities, improve efficiencies and promote collaboration among all programs within the Division.//2012//

Child Health Specialty Clinics

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

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

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

New ARRA-supported contracts between CHSC and Iowa's Early ACCESS (Part C, IDEA) program have expanded CHSC's role in improving and influencing early childhood programs. Some examples are: increased service coordination for infants and toddlers enrolled in Part C; systems-building efforts such as quality improvement for infants born prematurely; evaluating the

effects of environmental toxin exposure on early child development; promoting early childhood literacy; studying early childhood risk factors associated with selected "upstream" social determinants of health, exploring the use of telemedicine to deliver in-home nutrition services to infants and toddlers ages 0-3, and assuring critical health reviews are conducted on infants and toddlers served by Part C early intervention.

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

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

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

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

D. Other MCH Capacity

Maternal and Child Health

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

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

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

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

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

The Bureau of Family Health established an agreement with CDC to have an MCH Epidemiologist assigned to Iowa. Dr. Debra Kane will assist the Department by providing consultation, technical assistance, surveillance and analysis of epidemiological information for Iowa's MCH population. Initial activities have focused on needs assessment and data integration and data linkages.

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

Children and Youth with Special Health Care Needs

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

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

The capacity to perform core public health functions is shared among professional and support staff. Public Health Division Unit staff have education and experience in public health science and practice and science of improvement methodology, and take a lead role in coordinating core public health activities. Families of CYSHCN add program capacity through the Family Navigator Network (FNN), a community-based network of part-time Family Navigators (FN) affiliated with the regional centers. CHSC's family participation program is led by three experienced members of the FNN. They lead the FNN by advising on policy and program planning, recommending training, monitoring activity, and updating resource information. All FN undergo a structured basic

training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports. In addition they are also trained to perform specific tasks related to their unique roles, e.g. autism, Early ACCESS (IDEA, Part C), Ill and Handicapped Waiver, Community Circle of Care, etc). /2013/One 0.5 FTE position was added in 2012 to oversee all quality improvement efforts within CHSC. CHSC currently has a roster of between 35-40 paid FN on staff, each working between 10-20 hours per week. The list of current FN is included in the attachment. The Iowa AMCHP Family Delegate led the F2F IA Health Information Center grant for the past 3 years. Administration for the F2F HICH grant will be transitioned to a nonprofit family-driven agency beginning June 1st, 2012.//2013// **/2014/The F2F HIC was transferred to ASK Resource Center, a family-driven nonprofit agency. The Iowa Family Delegate is participating in aspects of the Block Grant review this year, including participating in the on-site federal review. An additional FN position was created to provide support to children during the time period between positive screen for Autism Spectrum Disorder and time of appointment at diagnostic facility. An MPH graduate was hired to assist CHSC in data analysis and program evaluation. The newly established University of Iowa Center for Child Health Improvement and Innovation will provide staff that will interface with local Title V to serve well child as well as CYSHCN populations.//2014//**

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

Contracts with the Iowa Department of Human Services commit CHSC to provide care coordination to "medically fragile" children enrolled in Medicaid Waiver Programs and to develop a system of FN for the state. /2013/The DHS contract to develop the system of FN will be ending September 2012. Sustainability discussions are underway with key family advocacy leaders.//2013// **/2014/CHSC contracted with Magellan for a pilot to employ FNs to work with families whose children have diagnosed mental health conditions.//2014//**

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

Health Home project funded by Magellan which includes revenue-generating activities.//2014//

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

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

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

E. State Agency Coordination

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

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

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

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

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

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

Family Planning

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

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

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

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

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

IDPH and Iowa DHS Agreements

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

DHS Cooperative Agreement

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

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

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

Local CH care coordinators contact families of children who are newly enrolled in Medicaid. The families are informed about the services available under the EPSDT program and the importance of regular well-child and dental exams. Care coordination services link children with needed

medical, dental, and mental health services. DHS downloads information on Medicaid enrolled children into CARES, which is then available to local CH contract agencies.

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

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

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

DHS Agreement for Administrative Services

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

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

DHS Medicaid Outreach Agreement

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

DHS Medicaid and Vital Records Linked Data Agreement

In 1989, Iowa legislation directed DHS to evaluate the Medicaid program's effectiveness in serving low-income pregnant women. To examine the pregnancy and birth outcomes of women receiving Medicaid benefits, Medicaid claims data and birth certificate data are needed. An annual inter-departmental agreement is executed by DHS to provide Medicaid claims data to the IDPH. IDPH staff link Medicaid claims data to birth certificate data. The results are used to examine access to prenatal care and preventive dental care for pregnant Medicaid women, as well as to compare birth outcomes of those on Medicaid to non-Medicaid members.

hawk-i (Healthy and Well Kids in Iowa)

For the past eight years, DHS has contracted with IDPH to provide grassroots outreach and enrollment for hawk-i. IDPH continues to contract with 22 local CH agencies to conduct grassroots hawk-i outreach and focus on children's enrollment. The successful collaboration between IDPH and DHS continues to guide successful outreach to uninsured families in Iowa.

Outreach efforts focus on four areas: schools, health care providers, faith-based organizations and special populations. Additional efforts have included businesses, workforce development, chambers of commerce, insurance agents, tax preparation sites, and many other areas. /2012/ DHS has contracted with IDPH for the past nine years to provide grassroots outreach and enrollment for hawk-i.//2012//

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

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

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

Preventable Diseases Program

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

Childhood Lead Poisoning Prevention Program

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

Bureau of Local Public Health Services

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

Iowa Center for Congenital and Inherited Disorders

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

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

In 2009, Iowa contracted with the North Dakota newborn screening program coordinator to implement a "regional" newborn screening coordinator position. This person is responsible for the coordination of both states' education, communication, and quality assurance efforts regarding the newborn metabolic screening programs. Iowa also secured another CDC funded grant to expand the existing birth defects registry to include confirmed newborn screening cases. The Early Hearing Detection and Intervention (EHDI) program is included in this project, and work is underway to build a data dictionary necessary for EHDI reporting, based upon the completed work that established the variables and data dictionary for the metabolic screening reporting.

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

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

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

Unintentional Injury Prevention

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

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

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

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

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

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

Early ACCESS

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

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

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

Federally Qualified Health Centers (FQHCs)

/2013/Iowa currently has 13 FQHCs:

1. Community Health Care in Davenport
2. Community Health Center of Fort Dodge, Inc.
3. Community Health Centers of Southeastern Iowa in West Burlington
4. Community Health Centers of Southern Iowa in Leon
5. Council Bluffs Community Health Center
6. Crescent Community Health Center in Dubuque
7. Linn Community Care in Cedar Rapids
8. Peoples Community Health Clinic in Clarksville
9. Primary Health Care, Inc. in Des Moines and Marshalltown
10. Proteus Employment Opportunities in Des Moines
11. River Hills Community Health Center in Ottumwa
12. Siouxland Community Health Center in Sioux City
13. United Community Health Center Inc. in Storm Lake//2013//

Primary Care Association

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

Child Health Specialty Clinics (CHSC)

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

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

1) IDPH, BFH -to promote development of a cooperative and collaborative relationship at state and local levels through cross-referrals, sharing of staff, coordinating staff training, and interfacing data systems;

2) The Iowa Chapter of the American Academy of Pediatrics to provide staff to perform duties required of a state affiliate of Help Me Grow and to develop collaborative partnerships with the Iowa Chapter of American Academy of Pediatrics public health programs serving CYSHCN.

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

4) IDPH to provide community-based clinical consultation and care planning recommendations for children and youth with any combination of special needs. Provide core public health functions of assessment, policy development and assurance as applicable to system development and quality improvement for children and youth with special health care needs./2013/CH teams consisting of ARNPs, RNs and Family Navigators (parents or primary caregivers of CYSHCN) team with primary care providers within the community and specialists located throughout the state, for most efficient use of resources. New initiatives are occurring with Blank Children's Hospital (Adolescent Clinic and Pediatric Clinic), the University of Iowa Hospitals and Clinics Adolescent Health Clinic and Federally Qualified Health Centers to assure care coordination, family support, and access to telehealth. Potential to co-locate selected CHSC regional offices at Title V grantee agencies is also being explored./2013// **/2014/Sioux City CHSC center co-located with local public health./2014//**

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

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

7) Iowa Department of Human Services (DHS) -to define responsibilities of the parties in assessment, planning, and care coordination activities for children with special health care needs who are recipients of the EPSDT Program of Title XIX (Iowa Medical Assistance Program, and applicants and recipients of the consolidated Waiver Programs of Title XIX. **/2014/CHSC will create or identify existing transitions tools to assist providers, care coordinators, youth, and families served by the EPSDT program./2014//**

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

9) DHS --Funding through SAMHSA, Northeast Iowa Children's Mental Health Initiative. Develop and provide family-centered and community-based services for children with Severe Emotional Disturbances in a 10 county area./2013/SAMHSA funds will expire September 30, 2012./2013// /2013/Iowa's Statewide Systems of Care workgroup provides technical assistance, training, and support to providers regarding Systems of Care and wraparound services. Participants include

representatives of mental health and health care providers, decategorization and county funded programs, and Systems of Care programs, with an interest in learning about Systems of Care, networking with other providers of children's mental health services, or integrating Systems of Care practice and principles into their program.//2013// **/2014/DHS administers new Iowa Autism Support Fund with linkages to Title V.//2014//**

10) Iowa Department of Education (DE) --Through ARRA funds, provide specific deliverables that will benefit infants and toddlers ages 0-3 years, e.g. white paper re social determinants of health; white paper on exposure to environmental toxins; nutrition services delivered in natural environments; quality improvement for Iowa's system of care for premature infants; promotion of early literacy through Reach Out and Read; training for professional working with children with autism spectrum disorder; service coordination for children in foster care. Activities will be completed by September 30, 2011.//2013/All projects were completed according to specifications by September 30, 2011, at which time ARRA funds were no longer available.//2013//

11) DE -to delineate roles and responsibilities and provide technical assistance in the implementation of Early ACCESS (IDEA, Part C) including coordination and non duplication of services. To provide Early ACCESS service coordination and nutrition services for infants and toddlers who are born prematurely, drug-exposed, or medically fragile that contribute to a coordinated, statewide system of family-centered early intervention services.

12) DE to provide consultative technical assistance and staff development in the area of Autism disorders to state and local agencies serving children and youth with Autism. **/2014/New state contract secured for ASD.**

The UI Hospitals and Clinics -- Leadership from CHSC also directs the UI Department of Pediatrics' new Center for Child Health Improvement and Innovation that promotes health system integration. Initial project spreads Pediatric Integrated Health Homes throughout Iowa.//2014//

F. Health Systems Capacity Indicators

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 04 - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	74.4	81.9	82.9	86.2	86.3
Numerator	29431	32390	31924	32431	32971
Denominator	39573	39570	38502	37644	38225
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 - 2012

Due to missing data, the denominator does not include all live births. All ages included - n=34 women younger age15 and n=31 women older than 44.

Notes - 2011

Over the past year, IDPH has been working closely with the developers of the IDPH data warehouse to reach a consensus about how to best capture the variables that comprise the Kotelchuck index. In doing this, IDPH improved the ability to impute data and handle missing data. This has revised the estimated Kotelchuck index upward.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

It appears that for years 2007, 2008, and 2009, the proportion of women who initiated PNC in the first trimester was reported rather than the Kotelchuck Index. We have corrected this for 2010.

Narrative:

Direct health care, enabling, and population-based activities are provided by 21 local maternal health (MH) agencies, serving all 99 counties in Iowa. Local MH agencies provide services to facilitate early entry into prenatal care. These services include presumptive eligibility determinations, care coordination, case management including follow-up, and outreach with a focus on high risk women. IDPH works with the Iowa Department of Human Services (DHS) to plan and implement Medicaid coverage for local transportation and interpretation services for pregnant women with transportation or language barriers.

Local MH agencies continue to use the Women's Health Information System (WHIS) to document assessment and services for the Title V MH population. WHIS provides information on the timing and number of prenatal visits, as well as the newborn's gestational age. IDPH is upgrading the WHIS application to incorporate the Medicaid Risk Assessment from DHS. The WHIS upgrade will also add service documentation features to comply with recently revised Medicaid documentation requirements.

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

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1150	7000	6797	6970	7126
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 - 2012

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

Notes - 2011

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

Notes - 2010

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

Narrative:

Iowa's Title V definition of rehabilitative services includes a detailed discussion with each family of a child determined eligible for SSI. The discussion is offered to eligible families who are served by CHSC's Ill and Handicapped Waiver Program (IHWP). Annually IHWP serves between 1,700-1,800 children and youth less than 16 years of age. The discussions reiterate the beneficiary's eligibility and encourages application for Medicaid, as well as describe additional Title V CYSHCN services that may be useful or of interest. The CYSHCN Program realizes that SSI eligibility discussions with families to request assistance from Title V are not precisely the same as providing "rehabilitative services;" however, that discussion does offer a connection between SSI beneficiary families and Title V services. Discussions occur with approximately 90% of families served by IHWP under age 16 years who are approved for SSI. Discussions do not occur with 100% of families is because a relatively small percentage of SSI-approved children reside in foster homes or other out-of-home placements and are in regular contact with DHS, the logical and more effective resource regarding rehabilitative services. For the large majority of SSI-approved children, CHSC reminds families to apply for Medicaid. Medicaid eligibility is automatic, but enrollment is not, so application is necessary. CHSC staff also provide other information regarding access to direct health care services, care coordination, and financing. Families are encouraged to contact the CHSC regional office nearest them if they feel CHSC might be of assistance. This would then begin a more formal service relationship between the SSI-approved child, their family, and the CYSHCN Program.

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

The name of the IHWP changed to the Health and Disability Waiver Program (HDWP). Twenty-one DHS SSI Field offices continue to display materials as requested by CHSC. CHSC continues to send supplies to the Field offices quarterly. In FY 2012, CHSC served 1602 children under age 16 years who were either on or applying for the HDWP. DHS personnel indicated there were 1,731 children under age 16 with SSI income in FY 2012. In 2013, CHSC also revised the process for changing a Medicaid member from a Managed Health Care (MHC) Program to a non-MHC Program. The goal was to streamline the change process and improve standardization. CHSC provides care coordination for families who are approved to change from a Medicaid MHC Program to a non-MHC Program.

Health Systems Capacity Indicator 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	2012	matching data files	7	6.3	6.6

(< 2,500 grams)					
-----------------	--	--	--	--	--

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2013 was used to calculate the percent of Iowa infants born with low birth weight (LBW). The proportion of LBW infants born to Iowa mothers overall was 6.6% overall. The proportion of infants born with LBW has changed little during CY2007 through 2012; specifically, the year by year differences were not statistically significant. Likewise, although the proportion of infants born with LBW has fluctuated among women by year and by Medicaid status, the differences by year were not statistically significant. However, it is important to note that although Medicaid recipients access prenatal care later than non-Medicaid recipients and were less likely to receive adequate PNC, the proportion of differences in LBW by Medicaid status was not statistically significant. In other words, it was essentially equal.

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 MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2012	matching data files	5.3	4	4.5

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2013 was used to calculate the Infant Mortality Rate (IMR) for Iowa infants. The overall IMR remains steady compared to last year. There were 174 infant deaths reported in the linked infant-birth/infant death file. This compares to 170 deaths reported in CY2011, 142 deaths reported in CY2010, and 152 deaths reported in CY2009. The increase in the IMR from 2011 to 2012 is not statistically significant overall or by Medicaid status. Likewise, the IMR comparing Medicaid reimbursed births to non-Medicaid births is not statistically significant.

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	2012	matching data files	76.7	89	84

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2012 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 remained constant when comparing CY2011 to CY2012. There continues to be a gap between first trimester initiation of PNC among Medicaid reimbursed deliveries and non-Medicaid reimbursed deliveries.

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 public awareness campaigns; outreach presentations to churches, schools and other community centers; flyers distributed to pregnant women; WIC and MCH staff providing follow-up contacts; and school nurses providing information on the MH program to encourage early entry into prenatal care.

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])	2012	matching data files	81.2	89.7	86.3

Narrative:

The Medicaid claims file/birth certificate linked file for calendar year (CY) 2012 was used to calculate the Kotelchuck index for Iowa mothers. Overall, 86.3% of Iowa mothers received adequate or adequate plus PNC in CY 2012, compared to 86.2 in CY2011. Eighty-nine percent (89.74%) of non-Medicaid women received adequate or adequate plus PNC. The proportion of Medicaid mothers who received adequate or adequate plus PNC was 81.3%, approximately eight percent lower than that of non-Medicaid mothers.

As discussed in the HSCI #4 narrative, local MH agencies use the Women's Health Information System (WHIS) to document assessments 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. Software upgrades are expected to support incorporation of the updated Medicaid Risk Assessment from the Iowa Department of Human Services.

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)
ANNUAL DATA LINKAGES	3	No

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

Notes - 2014

Narrative:

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

A needs assessment was conducted to understand current data usage and future data needs. It also functioned to create project buy-in with front-line staff and provide them with a feedback channel for data issues. Focus groups, interviews and on-line surveys were used to gather information among local agency staff and directors, and state program administrators. The top priorities identified were 1) interoperability, 2) data element changes, 3) workflow/use improvement, 4) reports and query enhancement, and 5) future flexibility. In general, staff are excited about a new data system, and see the opportunity to improve data usage and program quality through an integrated data system.

A Request for Information (RFI) was issued in Spring of 2013 to gather information about qualified vendors who can provide IDPH with a new integrated data system. Nine responses

were received. Seven proposed solutions to both phases, and two proposed solutions to phase 2 only. Proposed solutions included both Commercial-Off-The-Shelf (COTS) products and custom builds. All responding vendors were invited to provide a demonstration of their products. The data integration team reviewed all responses to help determine system options, project budget, and to further define our data needs. The RFI responses, in addition to the needs assessment results, will be used to create business requirements and a Request for Proposal (RFP).

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

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

B. State Priorities

Problem Statements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Children need healthy teeth to eat food to nourish their bodies, speak properly, and build confidence. Cavities can develop as soon as teeth erupt (at around 6 months old) and can limit children's ability to eat and thrive, as well as their ability to concentrate and learn. Cavities can be prevented, but not enough children receive early preventive care. Children's oral health is addressed through the I-Smile™ dental home initiative. Fifty-five percent of Medicaid-enrolled children ages 1-5 do not receive dental services. In 2008, 99.6 percent of Medicaid-enrolled children did not receive an exam from a dentist prior to the age of one. The ADA recommends children have a dental exam by their first birthday. Forty-nine percent Iowa's general dentists always refer children younger than 3 to pediatric practices --there are 39 private-practice pediatric dentists in the state. Twenty-two percent of Iowa third graders have untreated decay, an increase from 13 percent in 2006.6

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

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

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

C. National Performance Measures

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	73	95	53	176	56

Denominator	73	95	53	176	56
Data Source	CCID and INMSP	CCID and INMSP	CCID and INMSP	CCID and INMSP	CCID and INMSP
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	100

Notes - 2012

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

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 100 percent was met. Data provided by the Center for Congenital and Inherited Disorders and the Iowa Neonatal Metabolic Screening program indicate that 100 percent of all eligible Iowa newborns that screened positive received short-term follow-up through to confirmatory diagnosis, and long-term follow-up for clinical case management and treatment.

Infrastructure Building Services:

The Center for Congenital and Inherited Disorders (CCID) is collaborating with staff of the Iowa Health Information Network (IHIN), Iowa's health information exchange, to include newborn screening reporting in the IHIN.

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

The SGC has made presentations to the Bureau of Family Health and Division leadership about the life course model, and began work to integrate division programming using the life course health development framework.

Enabling Services:

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

Population-based and Direct Health Care Services:

The CCID is continuing planning for the implementation of newborn screening for severe combined immunodeficiency (SCID) and critical congenital heart disease (CCHD). A SCID advisory committee is guiding the planning and implementation efforts, and the SHL is securing equipment and beginning staff training for SCID testing. The CCHD advisory committee for newborn screening was convened, and has developed screening protocols and algorithms. The CCHD advisory committee is working with other states to develop educational materials, and the University of Iowa's Department of Pediatrics, Division of Pediatric Cardiology is providing medical expertise.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Infrastructure Building Services:

The SGC met with the Iowa Department of Public Health (IDPH) wellness and disease prevention programs to link genetics and family health history throughout the life course with wellness and disease prevention efforts. A division-wide assessment survey was conducted to ascertain division staff awareness of the life course model and solicit information about other frameworks/health delivery models programs use. The SGC is cross-walking aspects of the life course model with other program models, such as CDC chronic disease prevention four domains to explore common activities to promote program integration.

The SGC is working with chronic disease programming to address genetic programming as it relates to the state cancer plan, the state Healthy Iowans cancer prevention and heart health goals, and other chronic disease programming. The SGC will work with an intern to develop a strategic plan based on genomic services provided across the lifespan.

The short-term follow up program is working with the state newborn screening laboratory to update and enhance the newborn screening data system. An RFI was posted seeking information from vendors about a new comprehensive newborn screening data system.

Population-based and Direct Health Care Services:
 Implementation of newborn screening for SCID will begin in FFY2013. The SGC continues to work with birthing hospitals to enable CCHD screening, which was added to the newborn screening panel Iowa legislature.

c. Plan for the Coming Year

Infrastructure Building Services:

Work will continue on the strategic plan for the provision and coordination of genetic/genomic programming across the life span. Key informant interviews will be conducted and stakeholders from chronic disease prevention, preconception health & family planning, health promotion, cancer prevention, and environmental health will be involved.

The Bureau of Family Health will develop a request for bids for a new newborn screening data system that will include data collection and reporting for all newborn screening programs, laboratory/machine testing result import capability, and follow up/case management documentation.

Population-based and Direct Health Care Services:

Newborn screening for CCHD will be monitored, as more hospitals screen newborns based on the 2013 legislation. Newborn screening for SCID will begin, and will be monitored for quality assurance, follow up and referrals to subspecialty care.

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

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

Total Births by Occurrence:	38423					
Reporting Year:	2012					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	38416	100.0	5	3	3	100.0
Congenital Hypothyroidism (Classical)	38416	100.0	28	23	23	100.0
Galactosemia (Classical)	38416	100.0	1	0	0	
Sickle Cell Disease	38416	100.0	12	4	4	100.0
Biotinidase Deficiency	38416	100.0	0	2	2	100.0
Cystic Fibrosis	38416	100.0	0	11	11	100.0

21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	38416	100.0	0	0	0	
Fatty Oxidation Disorders	38416	100.0	0	13	13	100.0
Maternal Prenatal Screening						
First Trimester Only	327		0	35	0	0.0
Quad Screen	5982		0	2290	0	0.0
Integrated Screen	2495		0	79	0	0.0
NTD only	686		0	108	0	0.0

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	65.1	66.4	67.7	69.1	76
Annual Indicator	64.7	64.7	64.7	75.8	75.8
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	78	80	82	84	85

Notes - 2012

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

are NOT comparable to earlier versions of the survey.

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

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 76 percent was not met. The indicator value for Iowa was 75.8 percent was based on data from the 2009-10 National Children with Special Health Care Needs Survey. The Iowa indicator of 75.8 percent is statistically better than the national mean of 70.3, though there is significant room for improvement.

Infrastructure Building Services:

One family navigator served as Iowa's AMCHP Family Delegate and attended the annual AMCHP meeting in Washington, DC. The Family Delegate was enrolled in the Family Scholars program.

CHSC employed between 35-40 family navigators who participated in activities from all levels of the MCH pyramid and served on local, state, and national committees.

Community Circle of Care family navigators created and maintained parent support groups. Other CHSC family navigators received training in conducting parent support groups for families of children and youth with serious emotional disturbances.

CHSC implemented Community Child Health Teams in two pilot sites (University of Iowa Children's Hospital and Blank Children's Hospital) through a HRSA System of Care/Evidence Based Models grant integrating family-to-family support within medical homes. Quality improvement efforts were conducted to provide data for spread to additional sites.

CHSC assured standard skill sets and competencies of family navigators and worked with technical assistants from the Iowa Family Support Credential process to explore potential to achieve home visiting family support credentialing.

CHSC collected family impact data from families served by family navigators for continuous

quality improvement. CHSC Quality Improvement Committee explored ways to increase family input for additional CHSC services.

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

CHSC conducted the third annual statewide Family to Family Iowa (F2F IA) Conference on April 22-23, 2012.

CHSC was awarded a Learn the Signs Act Early grant that created or adapted information materials related to Autism Spectrum Disorder. The materials were translated into the five most prevalent non-English languages in Iowa (Spanish, Arabic, Vietnamese, Laotian and Bosnian).

Enabling and Direct Care Services:

CHSC family navigators were paid staff and received ongoing training. Through special grant funding, CHSC trained 15 additional family navigators from F2F IA.

CHSC served on the Iowa Health Literacy Board and ensured CHSC materials that met health literacy and cultural needs of families.

Caregivers of children with hearing loss participated in the EHDl Systems of Care's Medical Home project Implementation Team.

CHSC staff interacted with family advocacy stakeholder groups from F2F IA to transition the HRSA Health Information Center grant to a nonprofit agency.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC will continue to participate in Family to Family Iowa, a network of family advocacy groups throughout the state that advises the state's HRSA-funded health information center.				X
2. CHSC will assure family representatives contribute to policy discussions regarding the importance of family-to-family support in a reformed child health care system.				X
3. CHSC will explore the use of social media to connect families of CYSHCN to one another and to current resources and services in a manner that best matches the preferences of the family.				X
4. Family Navigators will receive ongoing training to fulfill specific care coordination and family support functions within CHSC's system of care for CYSHCN.				X
5. CHSC will continue to maintain a roster of Family Navigators working in several program areas that can be best matched to the unique needs of families served.		X		
6. Family Navigators will receive ongoing training regarding advocacy, cultural competence and health literacy and will assist in developing new program materials.				X
7. CHSC will collect family impact data to evaluate effectiveness of Family Navigation services and to assure continuous quality improvement.				X
8. Family leaders will assist with planning for new orientation and training resources as training needs are identified.				X

9. CHSC will implement Community Child Health Teams in two remaining pilot sites through a HRSA System of Care/Evidence Based Models grant demonstrating important role of family support within medical homes and prepare for statewide replication.				X
10.				

b. Current Activities

Infrastructure Building Services:

CHSC is collaborating with other F2F IA partners to develop a working definition of family-to-family support to differentiate "family-to-family" peer support from "family support" as offered by home visiting programs.

A CHSC family navigator continues to serve as Iowa's AMCHP Family Delegate, is a family mentor, and assists with the MCH Block Grant application review.

CHSC community-based family navigators serve on community and state advisory groups.

CHSC is analyzing family impact data for continuous quality improvement of the family navigator Network.

CHSC serves on social media committees to learn how to maximize use of social media with families.

CHSC is implementing Community Child Health Teams in two FQHCs.

Enabling and Direct Health Care Services:

CHSC employs family navigators working in several program areas.

CHSC staff serves on the Iowa Health Literacy Board and ensure CHSC materials meet health literacy and cultural needs.

Caregivers of children with hearing loss participate in the EHDI Medical Home Implementation Team.

CHSC family navigator works with the UIHC Autism Center to connect families to local resources.

Family navigators collaborate with UIHC to build health homes for behavioral health. Expansion to additional regions will offer intense direct peer to peer support to families with children with SED.

Data Collection and Performance Assessment Committee is exploring ways to gather family input for all services offered.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC will expand role of Iowa's AMCHP Family Delegate to advise and assist with other Iowa MCH programs as needed. Family Delegate will continue to serve on team that develops and monitors the MCH Block Grant application, including attending the on-site Block Grant review in Kansas City. CHSC's AMCHP family mentor and CHSC's former AMCHP family scholars will collaborate with family leaders from other states to share best practices.

CHSC family navigators will continue to serve on the University of Iowa Hospitals and Clinics (UIHC) Family Advisory Council and other local, state and national committees.

Magellan Family Peer Support Navigation for families of children and youth with severe emotional concerns will continue to spread across the state to assist families to enroll in and be aware of community-based resources.

CHSC will continue to partner with the UIHC Autism Center to connect families with resources and supports.

CHSC will pursue opportunities to embed family centered principles in trainings for future health care practitioners (such as Leadership Education in Neurodevelopmental Disabilities) and within clinical teams (integrating family navigators within clinical care teams).

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

CHSC will use the definitions for family-to-family support and family navigation that were developed in the prior year, during discussions about the value of peer to peer support within a reformed health care system. The definition will provide clarity by differentiating "family-to-family" peer support from "family support" offered by home visiting programs.

CHSC will continue to serve on social media committees (e.g. AMCHP, the Iowa Department of Public Health, and the University of Iowa) to learn how to maximize use of social media with families. Data collected in FY 2012 regarding family satisfaction with social media will be analyzed to determine family preferences for communication methods.

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

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

Family navigators will collaborate with UIHC Pediatrics to build integrated health homes for behavioral health and will spread the model to additional regional centers to offer intense direct peer to peer support to families with children with SED diagnoses. Reimbursement will occur through Magellan.

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	2008	2009	2010	2011	2012
Annual Performance Objective	60.3	61.5	62.7	64	47
Annual Indicator	57.4	57.4	57.4	47	47
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	49	50	52	54	55

Notes - 2012

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

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

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 47 percent was met. The indicator value for Iowa was 47 percent was based on data from the 2009-10 National Children with Special Health Care Needs

Survey. The Iowa indicator of 47 percent is statistically better than the national mean of 43.0, though there is significant room for improvement.

Infrastructure Building Services:

CHSC developed relationships with two Iowa Federally Qualified Health Centers to integrate family-to-family support in a community child health team.

The SAMHSA supported System of Care (SOC) for youth with serious emotional disorder (SED) continued to link youth to a local medical home, coordinated care and support services.

Iowa became an affiliate of Help Me Grow, and began to identify ways to improve the collaboration between medical homes, home visiting, and other early care and education programs to promote early identification and follow-up for children ages 0-5 years.

CHSC's Early Hearing Detection and Intervention (EHDI) program was approved for a quality improvement project by the American Board of Pediatrics (ABP), Maintenance of Certification (MOC) to ensure follow-up for children at risk for delayed-onset or progressive hearing loss.

CHSC continued to participate in the National Improvement Partnership Network (NIPN).

CHSC EHDI partnered with the Iowa Chapter of the American Academy of Pediatrics (IA-AAP) on a Chapter Education and Training grant to improve the EHDI System of Care.

CHSC EHDI followed up with families whose children did not pass newborn hearing screening to ensure they received diagnostic audiology, enrollment in Early Intervention and Guide By You Side (GBYS) Family Support.

CHSC EHDI contacted over 3000 families and Primary Care Providers (PCPs) of children who passed their newborn hearing screening but have risk factors for late-onset or progressive hearing loss.

CHSC EHDI participated in a National Center for Hearing Assessment and Management (NCHAM) Learning Community with six other states to share strategies and address challenges for providing diagnostic and audiologic tele-audiology.

CHSC EHDI participated in development of the Early Hearing Detection and Intervention (EHDI) PALS (Pediatric Audiology Links to Services), a web-based system to help parents, hospital personnel, and physicians find appropriate pediatric audiology facilities that will meet an individual child's needs.

CHSC EHDI completed work on a DVD called Loss & Found featuring parents of babies that did not pass hearing screening at birth talking about importance of early detection and intervention.

CHSC EHDI was selected by the National Center for Cultural Competence (NCCC) and the National Center for Hearing Assessment and Management (NCHAM) to participate in a Community of Learners (COL) to advance and sustain cultural and linguistic competence in EHDI programs.

CHSC EHDI was a participating sponsor for the Iowa Symposium on Hearing Loss: Impact on Children and their Families.

CHSC began to analyze data from the 2010 Iowa Household Health Survey and 2010 National CYSHCN surveys regarding medical homes.

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

Enabling and Direct Health Care Services:

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

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

A CHSC workgroup piloted activities to assure children suspected of child abuse received appropriate evaluations and services. CHSC also piloted a portable health information summary for children in foster care.

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC maintains a 0.6 FTE Pediatric Clinical Consultant position to facilitate and oversee CHSC Clinical Services and develop standards for all aspects of CHSC's clinical care.				X
2. CHSC is implementing a vision statement to assure a system of care for CYSHCN. The systems contains two key components of a medical home: care coordination and family-to-family support. Quality improvement occurs re implementation.				X
3. CHSC maintains a care coordination workgroup to develop, implement and evaluate standardized procedures for the delivery of care coordination to CYSHCN within medical homes.				X
4. CHSC continues to participate in Early Childhood Iowa, a state level interagency systems and policy development group whose mission is to improve the system of early care, health and education of young children.				X
5. CHSC is initiating a Maintenance of Certification project with the American Board of Pediatrics to assure children at risk for late onset hearing loss receive appropriate follow-up care within medical homes and neighborhoods.				X
6. CHSC is implementing an "Innovative Evidence Based Models for Improving System Services for CYSHCN" grant from HRSA, focusing on community child health teams within medical homes.				X
7. CHSC staff member with expertise in data collection and evaluation will analyze results from 2010 ICHHS reports that revealed disparities for children with components of medical home, affecting CYSHCN and children with low incomes.				X
8. CHSC will continue to facilitate collaborative efforts for Help Me Grow and 1st Five, with emphasis in coordinated intake processes that partner with home visiting, primary care, and other early care and education groups.				X
9. CHSC will convene an expert panel for the Iowa Autism Fund to develop guidelines for the system of care for children with				

ASD.				
10.				

b. Current Activities

Infrastructure Building Services:

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

CHSC is reviewing learning opportunities from the MCH Navigator to educate staff regarding concepts of social determinants of health, medical home and other public health topics.

The SAMHSA supported SOC for youth with SED obtained state funding and will continue to connect youth to their local medical home with care coordination and support services.

CHSC is training 13 health care providers in southeast Iowa (family practice and pediatricians) to recognize signs of child abuse and how to respond.

Iowa will work with Help Me Grow affiliates to develop coordinated intake for referrals from medical homes and other early care and education providers.

Enabling and Direct Health Care Services:

CHSC provides care coordination and family-to-family support in partnership with PCPs and neighborhood health providers.

CHSC will continue to participate on Children's Mental Health Redesign and other health reform committees.

CHSC is exploring expansion of telehealth consults to PCPs on new topics to increase PCP ability to serve children with chronic conditions.

CHSC care coordinators, family navigators, and registered dietitians are partnering with PCPs to direct families to resources for children who are overweight or obese.

c. Plan for the Coming Year

CHSC care coordination team will document care coordination procedures for potential publishing.

Iowa Medicaid initiated its Health Home project through a State Plan Amendment on July 1, 2012, which will increase the number of children and adults with certain chronic conditions that will be enrolled in health homes. CHSC will monitor this measure to see if it shows that more individuals are receiving care in a medical home.

CHSC will present to Pediatric Grand Rounds regarding integrated health homes for children with SED.

CHSC EHDl will continue to work on a quality improvement project by the American Board of Pediatrics, Maintenance of Certification to ensure follow-up for children at risk for delayed-onset or progressive hearing loss.

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

CHSC EHDl will complete its participation in the National Center for Cultural Competence and the National Center for Hearing Assessment and Management Community of Learners to advance and sustain cultural and linguistic competence in EHDl programs.

CHSC will implement the final site for its HRSA-funded grant to implement community child health teams in final Federally Qualified Health Centers and conduct a statewide learning conference to share results of the three-year project.

CHSC will continue to facilitate collaborative efforts for Help Me Grow, with emphasis in coordinated intake processes that partner with home visiting, primary care, 1st Five, and other early care and education groups.

CHSC will convene an expert panel for the Iowa Autism Fund to develop guidelines for the system of care for children with ASD.

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

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

CHSC staff member with expertise in data collection and evaluation will analyze results from 2010 Iowa Child and Household Health Survey reports related to medical homes.

CHSC EHDl will continue to follow-up with families whose children did not pass newborn hearing screening or who are at-risk for late onset hearing loss.

CHSC will partner with the IA-AAP to develop a webinar to medical homes on the importance of early childhood brain development.

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	2008	2009	2010	2011	2012
Annual Performance Objective	72	73.4	74.9	76.4	66.6
Annual Indicator	68.6	68.6	68.6	64.6	64.6
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore					

a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	68.6	70.6	72.6	74.6	76.6

Notes - 2012

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

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

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

Notes - 2011

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

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

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 66.6 percent was not met. The indicator value for Iowa was 64.6 percent was based on data from the 2009-10 National Children with Special Health Care Needs Survey. The Iowa indicator of 64.6 percent is better than the national mean of 60.6, though there is significant room for improvement.

Infrastructure Building Services:

CHSC began to analyze data from the Iowa 2010 Iowa Child and Family Household Health Survey and NSCYSHCN 2009-10 related to financing issues.

The CHSC care coordination team designed methods to gather data that can be presented to

Medicaid or other payers to advocate for payment for care coordination and family-to-family support activities.

CHSC staff participated with other state and national child health advocacy groups to educate policymakers regarding the need for accessible, adequate, and affordable health insurance for all children and families, including those with special health care needs.

CHSC maintained a collection of family stories to educate policymakers on the special and unique needs of CYSHCN related to health, mental health, and related services to assure adequate health and development.

CHSC was represented on the Iowa Primary Care Association (IPCA) to assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

A family navigator participated on a Governor-appointed statewide Medicaid Advisory Committee.

CHSC staff participated in state and national learning events regarding the impact of the Affordable Care Act (ACA).

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

Enabling and Direct Health Care Services:

CHSC assisted and enabled families of CYSHCN to apply for Medicaid or SCHIP.

CHSC provides guidance and information for families of children enrolled in Medicaid Waiver and EPSDT programs regarding health care financing.

CHSC family navigators worked with children with autism spectrum disorder to collect data for a NIH-research grant that demonstrates the benefits of Applied Behavioral Analysis (ABA). CHSC participated in Phase II of the research that delivered the services inside the family's home. Data will be used to advocate for inclusion of ABA in health plans.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC participates on the Iowa-Nebraska Primary Care Association Leadership and Advisory Committees to help assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.				X
2. CHSC work group is collecting data that will be used with Iowa Medicaid/other payers to show the benefits of care coordination and family-to-family support to CYSHCN, advocate for public/private insurance policies that reimburse for these services.				X
3. CHSC regional centers work with families of children with special health care needs to apply for Medicaid or SCHIP and, if needed, assist them with the application process.		X		
4. Family Navigators work with University of Iowa researchers and families of children with autism spectrum disorder to collection data that demonstrate the benefits of Applied Behavioral Analysis.	X			
5. The Family to Family Iowa network of Family Navigators				X

includes the topic of resources for public/private insurance in its training modules for all Navigators.				
6. CHSC conducts quality improvement measures to assure billing codes continue to be maximized for all services delivered.				X
7. CHSC participates in learning events and ongoing discussions regarding the impact of the Affordable Care Act on benefits to CYSHCN.				X
8. CHSC staff are available to offer expertise related to CYSHCN during implementation of the Affordable Care Act and emphasize the importance of maintaining the public health infrastructure.				X
9.				
10.				

b. Current Activities

Infrastructure Building Services:

CHSC staff and families are reviewing proposals for essential health benefits packages in health care reform as requested by policymakers.

The CHSC care coordination team is continuing to gather data that can be presented to Medicaid and other funders to advocate for payment for care coordination and family support activities.

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

CHSC continues to participate on the IPCA to assure that Iowa's safety net providers enhance access to health care services for underinsured and uninsured Iowans.

A CHSC family navigator is continuing to participate on a Governor-appointed Medicaid Advisory Committee.

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

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

Enabling and Direct Health Care Services:

CHSC is continuing to assist and enable families of CYSHCN to apply for Medicaid or SCHIP, and to be aware of new options under the ACA.

CHSC will provide guidance and information for families of children enrolled in the Health and Disability Waiver and will care coordinate for those enrolled in EPSDT.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC staff will continue to participate in learning events and advocacy efforts regarding the impact of the ACA on CYSHCN.

CHSC will actively outreach to all Iowa non-profit hospitals, Maternal and Child Health grantees, and county boards of public health to ensure awareness of CHSC expertise in serving CYSHCN in a reformed health care system.

CHSC leadership will continue to provide expertise related to Iowa's Essential Health Benefits

package to meet the needs of CYSCHN.

CHSC family navigators will continue to participate in research projects, as invited, that demonstrate the benefits of ABA for children with Autism Spectrum Disorder to obtain data that will educate payers for potential policy changes regarding reimbursement for ABA.

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

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

Enabling Services:

CHSC family navigators and other staff will assist in educating and informing families of changes in health benefits options due to implementation of the ACA.

CHSC will standardize processes for Iowa Medicaid members to change from a Managed Health Care Program to a non-Managed Health Care Program and provide care coordination as requested.

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	2008	2009	2010	2011	2012
Annual Performance Objective	93.8	94.7	95.6	96.6	70
Annual Indicator	92.9	92.9	92.9	68	68
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	72	74	76	78	80

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted every 5 years by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared

to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

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

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

Notes - 2011

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

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

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

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

The FFY12 performance objective of 70 percent was not met. The indicator value for Iowa was 68 percent was based on data from the 2009-10 National Children with Special Health Care Needs Survey. The Iowa indicator of 68 percent is higher than the national mean of 65.1, though there is room for significant improvement.

Infrastructure Building Services:

CHSC staff used health literacy and cultural competence assessments to review program elements. CHSC educated policymakers regarding needs of families.

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

CHSC conducted pilot projects with child abuse agencies to utilize CHSC ARNPs for selected elements of evaluation for children suspected of being abused.

CHSC maintained Family to Family Health Information Center (Family to Family Iowa, F2F IA) website with family resources. A CHSC Latino liaison advised CHSC prior to his June 2012 resignation.

CHSC leadership participated on statewide committee to redesign Iowa's mental health system.

CHSC explored use of social media to link families to services through a pilot project with Heartland Regional Genetics and Newborn Screening Collaborative.

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

CHSC provided gap filling services in local communities.

CHSC participated in an Emergency Preparedness project (PrepKids) to assure families have knowledge to attain services during emergencies. CHSC used AMCHP's Learn the Signs Act Early funding to increase awareness of autism resources.

A CHSC workgroup defined family-to-family support and family navigation during discussions about the value-added of peer-to-peer support within a reformed health care system. The definition will provide clarity by differentiating "family-to-family" peer support from "family support" offered by home visiting programs.

CHSC maintained web-based resources via F2F IA and IA-AAP so families and providers could find them easily.

Enabling and Direct Health Care Services:

CHSC provided family support, care coordination, and telemedicine and is conducting critical health reviews for children served by Early ACCESS (IDEA, Part C) so families/providers understand the implications of health condition for early intervention activities.

CHSC continued a program focusing on behavioral health engaged military families in northeast Iowa by sponsoring family support and awareness events, and a conference.

CHSC provided telemedicine services for children with Serious Emotional Disturbances, nutrition consultation, and Auditory Brainstem Response (ABR) evaluations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC is participating in The National Improvement Partnership Network to improve partnerships between pediatricians and subspecialty providers.				X
2. CHSC is continuing to partner with child abuse agencies for pilot projects that utilize CHSC ARNPs for some elements of evaluations for child abuse.				X
3. CHSC is providing otoacoustic emission screening of newborns at two CHSC regional centers to ensure access and offers ABR telehealth evaluation at one site.	X			
4. CHSC is developing relationships with organizations representing underserved populations for program planning and recruitment.				X
5. CHSC is assuring all written materials are at a 7th grade level or below and available in other languages, as needed.				X
6. CHSC's Health and Disease Management Unit provides care		X		

coordination to children with complex health needs enrolled in Medicaid Waiver and EPSDT. CHSC Family Navigators will function as service coordinators for young children in Iowa's Early ACCESS.				
7. CHSC provides telemedicine services for children with Serious Emotional Disturbances, nutrition consultation, and ABRs. Services to children who are overweight or obese will be piloted.	X			
8. CHSC RN's mentor and train local agencies to conduct critical health reviews for children served by Part C, IDEA so families/providers understand implications of health condition for early intervention activities.				X
9. Collaborate with UIHC pediatric psychologists to evaluate the effectiveness and efficiency of conducting behavioral assessment and treatment for autism via telehealth to reach underserved and rural areas.				X
10.				

b. Current Activities

Infrastructure Building Services:

CHSC is continuing pilot projects with local agencies to use CHSC ARNPs for some parts of child abuse evaluations.

CHSC is providing otoacoustic emission screening of newborns at two CHSC regional centers and offers ABR telehealth evaluation at one site.

CHSC is working with the Help Me Grow state affiliate and is partnering to develop coordinated intake procedures.

CHSC is continuing PrepKids Emergency Preparedness program to assure families of CYSHCN have knowledge to prepare for emergencies.

CHSC is developing relationships with organizations representing minority groups for program planning.

CHSC is continuing to review written materials to assure they are at a 7th grade level or below and available in other languages.

CHSC will maintain CYC-I to provide consultative and services for primary care providers of patients with mental health needs.

Through F2F IA, CHSC is training a Spanish-speaking family navigator.

CHSC is training registered nurses at local agencies to conduct critical health reviews for children served by Early ACCESS, so families/providers know health implications for early intervention activities.

Enabling and Direct Health Care Services:

CHSC is providing telemedicine services for children with SED, nutrition consultation, ABRs, and is piloting services for children who are overweight/obese.

CHSC is partnering with Center for Disabilities and Development to provide family navigation for families of children with autism.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC will collaborate with other community agencies to identify potential bilingual family navigators.

CHSC will continue to partner with Center for Disabilities and Development to provide family navigation to families of children with autism. Also partner with University of Iowa Children's Hospital and Blank Children's Hospital to provide family navigation for families of children with other chronic conditions.

CHSC will educate stakeholders and the public about CHSC's role in assuring a system of care for CYSHCN and in public health.

CHSC will maintain the CYC-I, to provide consultative and supportive services for primary care providers caring for children and youth with mental and behavioral health needs.

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

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

CHSC will continue to collaborate with community agencies to sponsor family support and awareness events on behavioral health topics in northeast Iowa.

CHSC care coordinators will share emergency preparedness materials with families to assure they have knowledge to attain the services they need in emergencies.

CHSC will continue to mentor and train registered nurses at local community agencies to provide Early ACCESS health assessments.

CHSC's Health and Disease Management Unit will continue to provide care coordination to children enrolled in Medicaid Waiver and EPSDT. CHSC family navigators will function as service coordinators for young children in Early ACCESS.

CHSC will continue assessing all written documents to assure they are at 7th grade level or below, reviewing every three years and revising as needed.

CHSC leadership staff will continue to participate in statewide committee redesigning the children's mental health and developmental disabilities system.

CHSC will analyze the Iowa Household Health Survey for health disparities and examine ways to address the issues.

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	2008	2009	2010	2011	2012
Annual Performance	49.7	50.7	51.7	52.7	45

Objective					
Annual Indicator	47.3	47.3	47.3	45	45
Numerator					
Denominator					
Data Source	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN	NSCSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	47	49	51	53	55

Notes - 2012

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

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

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

Notes - 2011

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

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 45 percent was met. The indicator value for Iowa was 45 percent was based on data from the 2009-10 National Children with Special Health Care Needs Survey. The Iowa indicator of 45 percent is statistically better than the national mean of 40, though there is significant room for improvement.

Infrastructure Building Services:

CHSC's Medical Director leads efforts to assure standards of care for CHSC Clinical Services, including transition to adult care. CHSC formed a workgroup of University of Iowa staff and health care stakeholders to discuss transition needs of youth.

CHSC standardized care coordination for CHSC and Family 360/F2F IA. Family navigators addressed youths' needs using Life Course Health Development Theory (LCDT). Youth advised F2F IA Governance Council and Iowa Autism Council. F2F IA provided web-based transition resources.

CHSC co-led a SAMHSA-supported mental health System of Care project to aid transition to adulthood, provide care coordination and build support services. CHSC assisted with a support group for foster and adoptive youth helping to connect them and share personal stories.

CHSC worked with Partnership to Improve Child health in Iowa (PI-CHI) to explore quality improvement projects on transition for CYSHCN. PI-CHI leaders interfaced with the Community Child Health Team (CCHT) HRSA-funded grant, which focuses on youth 12-21 years with SED.

Enabling and Direct Health Care Services:

CHSC's Health and Disease Management (HDM) Unit assisted families with eligible adolescents (>12) to enroll in Medicaid Waiver programs and address transition issues. CHSC developed an age-based discussion guide, which family navigators use when contacting families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CHSC's Health and Disease Management Unit helped families with eligible youth enroll in Medicaid Waiver programs and address transition issues using an age-based guide.		X		
2. CHSC's Pediatric Clinical Consultant leads efforts to assure standards of care for CHSC Clinical Services, including transition to adult care and use of Life Course Health Development Theory.				X
3. CHSC partners with F2F IA to provide web-based transition resources.				X
4. CHSC received state funding to continue a SAMHSA-funded program providing care coordination and support to youth with mental health needs. Assisted with a support group for foster and adoptive youth.				X

5. CHSC is facilitating a workgroup to align efforts of University and health stakeholders, as well as develop a transition program for CYSHCN, starting by age 14.				X
6. CHSC will collaborate with partnering agencies to train health care providers, youth, and families on transition issues.				X
7. Create Medicaid-compatible written policies and tools to guide transition planning.				X
8. CHSC receives technical assistance from Association of Maternal and Child Health Programs to implement evidence based transition practices.				X
9. CHSC staff member will complete graduate-level certificate on integrating education and health care transition.				X
10. Community Child Health Team HRSA-funded grant providing care coordination and family support for youth with behavioral health needs during transition.		X		

b. Current Activities

Infrastructure Building Services:

CHSC's Medical Director is leading efforts to assure standards of care for CHSC Clinical Services, including transition to adult care and use of LCDT.

CHSC is partnering with F2F IA to provide web-based transition resources.

CHSC continues to provides care coordination and support youth with mental health needs, through a state appropriation. CHSC assists with a support for foster and adoptive youth.

CHSC is exploring QI projects with PI-CHI related to the CCHT HRSA funded grant that focuses on youth 12-21 years with SED.

CHSC is facilitating a workgroup to align efforts of state stakeholders on transition; developing a transition program for CYSHCN >14 years of age.

CHSC is standardizing care coordination and providing training on transition to youth, families, and health care providers.

CHSC received technical assistance from AMCHP and Children's Medical Services to implement evidence based transition practices and hosted a one-day transition conference for stakeholders.

CHSC is creating Medicaid-compatible written policies and tools to guide transition planning.

CHSC employee completed a graduate-level certificate on integrating education and health care transition.

CHSC hosted a live broadcast of Chronic Illness and Disability Conference for health care providers.

Direct and Enabling Services:

CHSC's HDM Unit is helping families with eligible youth enroll in Medicaid Waiver programs and address transition issues using an age-based guide.

c. Plan for the Coming Year

Infrastructure Building Services:

CHSC's Medical Director will continue to lead efforts to assure standards of care for CHSC Clinical Services, including transition to adult care and use of Life Course Health Development

Theory.

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

CHSC will implement tools developed with youth, families, and providers and draft recommendations to EPSDT policymakers regarding the transition program and previously developed tools. CHSC will revise these materials as needed.

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

CHSC will seek technical assistance on determining measurable outcomes of successful transition to adult health care to assess program effectiveness. Potential examples: number of emergency room visits, family stress and no-show rate, medication adherence, youth engagement, cost savings, quality of life.

CHSC will integrate transition tools developed into the electronic medical record to facilitate sharing between facilities.

CHSC will continue to work with PI-CHI to explore quality improvement projects on transition for CYSHCN.

CHSC will continue to facilitate a workgroup aligning state organizations' efforts regarding transition to adulthood, including health care.

Enabling and Direct Health Care Services:

CHSC's Health and Disease Management Unit will continue to help families with eligible youth enroll in Medicaid Waiver programs and address transition issues using an age-based guide.

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	2008	2009	2010	2011	2012
Annual Performance Objective	90	74	73	74	65
Annual Indicator	72.8	72.8	73.9	63.9	71.0
Numerator	3930	3930	15890	17511	19439
Denominator	5395	5395	21501	27402	27379
Data Source	PSIA report	PSIA report	Immunization Annual Report	Immunization Annual Report	Immunization Annual Report
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and					

therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	72	73	74	77	80

Notes - 2012

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

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 65 percent was met. The indicator value for Iowa was 71 percent was based on data from the 2012 Iowa Immunization Program Annual Report.

Infrastructure Building Services:

The Bureau of Immunization and TB Disseminated the Billing Tool Kit at four comprehensive billing training programs. There were 149 representatives of LPHAs in attendance. Seventy-seven of Iowa's 99 counties were represented at the meetings. This project included the development of a plan for a billing system with the intent of saving program revenue, enabled programs to reach additional populations, provided vaccines that are not currently offered and to take on new immunization initiatives to immunize special under-vaccinated populations and those with reduced access to vaccination services.

In 2012, the Immunization Program developed and published an Annual Report which included a report for childcare/school audits, county immunization rates for 2-year olds and adolescents, and a summary of the different components of the Immunization Program.

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recruit new private providers to use the IRIS data system.				X
2. Provide immunization training and in-services for VFC providers.				X
3. Provide technical assistance to local MCH, WIC, and other public health agencies.				X
4. Collaborate with the Department of Education on data exchanges to assure complete immunizations.				X
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

IRIS staff is working to increase the number of private providers using IRIS through a variety of outreach mechanisms. The new version of IRIS was rolled out the first week of June 2012. The new IRIS system includes an Immunization Billing Program. The upgrade also interfaces with the vital statistics database and includes the ability to link with electronic medical records.

Enabling Services:

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

c. Plan for the Coming Year

Infrastructure Building Services:

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

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

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

Enabling and Direct Health Care Services:

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	15	16	15.2	16	11.2
Annual Indicator	16.8	15.7	13.3	11.9	10.8
Numerator	1025	945	804	707	635
Denominator	61192	60016	60327	59558	59006
Data Source	Vital Statistics				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events					

over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	10.2	10	9.8	9.6	9.4

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

a. Last Year's Accomplishments

The FFY12 performance objective of 11.2 was met. 2012 Vital Statistics data indicates that the rate of birth (per 1,000) for teenagers aged 15 through 17 years was 10.7.

Infrastructure Building Services:

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

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

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

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

Enabling and Direct Health Care Services:

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

- 1) Investigating and disseminating best practices for working with adolescents
- 2) Expanding the use of electronic media
- 3) Expanding the role of youth on the state FP committees
- 4) Informing Dept. of Education on Title X services for use in their HIV/STI and pregnancy

prevention curricula

5) Developing partnerships between Title X agencies and foster care, intimate partner violence, and substance abuse resources

6) Collaborating with other agencies for increased funding for adolescent pregnancy prevention efforts.

Title X clinics have initiated efforts to ensure that all clients, including adolescents and males, are counseled about establishing a reproductive life plan (RLP) to set goals about having children. The concept of RLPs has also been expanded to WIC and maternal health clients.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assuring ongoing high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.	X	X	X	
2. Expanding access to a broad range of acceptable and effective family planning methods and related preventive health services.	X	X	X	
3. Assuring compliance with State laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape, or incest.			X	X
4. Emphasizing the importance of counseling family planning clients on establishing a reproductive life plan.	X	X	X	X
5. Encouraging participation of families, parents, and/or legal guardians in the decision of minors to seek family planning services; and providing counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.		X	X	X
6. Addressing the comprehensive family planning and other health needs of individuals, families, and communities through outreach to hard-to-reach and vulnerable populations, and partnering with other community-based health and social service programs.	X	X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

PREP contractors will carry out Year 2 implementation and evaluation will be conducted. IDPH will provide ongoing training and technical assistance to local PREP contractors And outreach will be carried out so as to gather resources to complement the program and create sustainability.

IDPH will provide training and technical assistance to community agencies implementing POWER Through Choices and the TOP program through the AEGP.

The PREP and AEGP program coordinators have developed an adolescent health website (www.IAMincontrol.org) specifically for teens.

Enabling and Direct Health Care Care:

IDPH has implemented its objectives for Year 4 of the five-year Title X plan, including expanding

services to minorities, adolescents, and males.

Continuing outreach efforts to adolescents and males using best practices, social media, and strengthening relationships with local and state partners.

Title X clinics have initiated efforts to ensure all clients, including adolescents and males, are counseled about the importance of establishing a RLP to set personal goals about having (or not having) children. RLP education has been expanded to WIC and MH clinic clients.

Five MCH contract agencies have action plans to address teenage pregnancy. Activities include building or participating in local pregnancy prevention coalitions and partnering with schools to present pregnancy prevention education.

c. Plan for the Coming Year

Infrastructure Building Services:

IDPH will continue to provide training and technical assistance to PREP and AEGP contractors, focusing on outreach activities and sustainability of the program. PREP and AEGP contractors will continue to recruit youth to participate in the program in a variety of settings.

Outreach plans to adolescents and males include: 1) continuing to investigate and disseminate best practices for working with adolescents; 2) expanding the use of social media to reach youth; 3) expanding the role of youth on the state family planning Information and Education committees; 4) continuing work with the Iowa DE staff informing them of Title X services for use in their HIV/STI prevention and pregnancy prevention curricula; 5) developing more formalized partnerships between Title X agencies and foster care, intimate partner violence, and substance abuse community resources; and 6) collaborating with other state agencies for increased funding for adolescent pregnancy prevention efforts in Iowa.

Four MCH contract agencies have action plans to address teenage pregnancy. Activities include utilizing a teen parent panel to educate high school students, distributing information, including the IDPH TEEN Line brochures, in both English and Spanish to middle and high schools, and collaborating with middle and high school staff, faith-based organizations, teen groups, and medical providers to educate individuals on teenage pregnancy.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	47	50	50	50	47
Annual Indicator	49.2	48.5	49.7	45.6	45.6
Numerator	17336	16962	17381	16111	16111
Denominator	35235	34972	34950	35332	35332
Data Source	third grade survey				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	47	50	51	52	53

Notes - 2012

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

The FFY12 performance objective of 47 percent was not met. The indicator value for Iowa was 45.6 percent was based on data from the 2012 Third Grade Oral Health Survey. Because schools that currently have an IDPH funded school-based sealant program were excluded from the survey, the state average may actually be higher than the survey results indicated.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 47 percent was not met. The indicator value for Iowa was 45.6 percent was based on data from the 2012 Third Grade Oral Health Survey. Because schools that currently have an IDPH funded school-based sealant program were excluded from the survey, the state average may actually be higher than the survey results indicated.

Infrastructure Building Services:

The Oral Health center (OHC) continued discussions with Delta Dental, looking at ways to expand school-based dental sealant programs. However, a staffing change within OHC has left the sealant coordinator position unfilled, thus limiting progress on these efforts. OHC coordinated an open mouth survey of third graders through each local I-Smile™ project. A sample of 33 schools was selected. In addition to measuring the prevalence of sealants, other data collected includes presence of decay, presence of restored teeth, and payment source for dental care. The report is available on the IDPH website. As a quality assurance measure, OHC developed a retention check completion and reporting process for each of the IDPH-funded school-based sealant programs. All but one met the criteria of at least 80% or greater retention rate; that contractor received technical assistance from OHC and is completing an additional retention check during FFY2013. OHC staff and local I-Smile™ Coordinators (ISC) continued their involvement in advocacy for community water fluoridation (CWF). OHC staff participated in a summit sponsored by Iowa Public Health Association and Delta Dental of Iowa with a focus on Iowa's CWF issues and needs.

Population-based Services:

School-based sealant programs (SBSP) completed the second of a three-year project period. Improvements were made to the I-Smile™ website (www.ismiledentalhome.iowa.gov) that include slide shows promoting dental sealants and fluoride varnish. The changes made to the site are intended to increase website traffic and improve users' understanding of the importance of good oral health for children. An I-Smile™ Facebook page was launched in May, promoting children's oral health and prevention.

Enabling Services:

Several ISC have become Qualified Entities, enabling them to determine presumptive eligibility for maternal and child health clients, which improves access to care for at-risk children.

Direct Health Care Services:

Gap-filling preventive services are provided in schools with a large proportion of students from low-income families, as well as for very young children at WIC, Head Start/Early Head Start programs, and preschools.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Further develop public-private partnerships to increase preventive services for children.				X
2. Promote I-Smile™ and dental disease prevention.			X	
3. Administer local school-based sealant projects to provide preventive sealants to at-risk children.	X		X	X
4. Continue advocacy for community water fluoridation.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

ISC and OHC staff offer education regarding CWF issues in order to maintain Iowa's current CWF systems. As a result of the CWF summit held in July, Dr. Russell is on a CWF task force with several other state partners. Based on the results of the 2012 survey of third graders and the Pew Foundation's report card, IDPH is issuing a RFP for a new SBSP project period. In addition to the IDPH-funded SBSP, I-Smile coordinators for contract agencies who administer SBSP through other funds receive TA. OHC helped educate the Iowa Dental Board on the need to include child care as a setting for public health supervision of dental hygienists; a measure which was then passed.

Population-based Services:

OHC oversees the third year of SBSP contracts. Prevention messages are shared with the public via Twitter and the I-Smile dental home Facebook page. The state requirement of dental screenings of kindergarten and ninth grade students also provide a means to encourage prevention.

Enabling Services:

Contract agencies now use texting and email as billable forms of care coordination, improving I-Smile staff's ability to reach families who rely mostly on mobile communication.

Direct Health Care Services:

All I-Smile projects must ensure that children age 0- 2 receive preventive services at WIC. Services for older children are also encouraged, based on local needs assessments, and most often provided in schools, preschools, and Head Start/Early Head Start centers.

c. Plan for the Coming Year

Infrastructure Building Services:

OHC will maintain current activities, including working with Delta Dental of Iowa on ways to

expand SBSP; participating in a task force supporting education efforts on the benefits of community water fluoridation; and providing guidance for state SBSP. Additional OHC preventive program planning for the state will be conducted based on available funding -- which may include new competitive federal oral health grant funds being sought during FFY2013.

Population-based Services:

FFY2014 will be the first year of a new project period for SBSP. OHC anticipates making level funding available as was used for FFY2013 contracts. OHC will also continue to support local contractors with health promotion guidance that promotes preventing dental disease, as well as continue providing messages through social media.

Enabling Services:

OHC staff will work with Bureau of Family Health staff to respond to changing needs for provision of care coordination services, including consideration of client-specific letters to health providers as billable care coordination.

Direct Health Care Services:

Gap-filling preventive services will continue through local contractors and ensuring services for ages 0-2 at WIC will still be a requirement.

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	2008	2009	2010	2011	2012
Annual Performance Objective	4.5	3	3	2.3	2.1
Annual Indicator	2.9	3.1	2.5	2.3	2.5
Numerator	17	18	15	14	15
Denominator	586749	589813	603673	601833	601376
Data Source	Vital Statistics				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	2.3	2.1	1.9	1.7	1.7

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics provisional data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

a. Last Year's Accomplishments

The FFY12 performance objective of 2.1 percent was not met. The indicator value for Iowa was 2.4 was based on data from 2012 provisional Vital Statistics data.

Infrastructure Building Services:

IDPH Bureau of EMS and the Safe Kids Coalition:

- Conducted four National Highway Traffic Safety Administration Child Passenger Safety Seat technician certification trainings in Iowa
- Provided a yearly update on new trends and technology for currently certified child safety seat technicians. Maintaining the currently recognized Fitting Station locations as well as the state's child passenger safety seat website.
- Continued partnership and stakeholder work on graduated driver license and distracted driving projects.

IDPH's Katrina Altenhofen was named the 2012 National Child Safety Seat Instructor of the Year by Department of Transportation's Secretary Ray LaHood.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct outreach activities, including "Spot the Tot" training.			X	
2. Provide demonstration and education of proper car seat and booster seat installation.		X	X	
3. Participate in planning of the Iowa's annual injury prevention conference.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The Bureau of EMS-Emergency Medical Services for Children (EMSC) Program works with Safe Kids Iowa and other nonprofit injury prevention organizations to support statewide child passenger safety check-ups at community events, as well as regularly scheduled child passenger safety inspection stations. Child passenger safety advocates work to provide outreach to physicians, health care agencies, and child care providers.

Population-based Services:

The BFH and EMS bureau are collaborating to provide outreach to childcare providers and families. The Bureau of EMS's EMSC program provides resources and information regarding recalls of child safety seats and bicycle safety, as well as other injury areas identified in the Iowa Burden of Injury Report.

The IDPH Bureau of EMS-EMSC program is longer the grant recipient for the National Highway Traffic Safety Administrative funds from the state's Governor's Traffic Safety Bureau. Instead those funds will be expended on the Safe Kids Iowa program. Despite the lack of funding to support an Injury Prevention/Child Passenger Safety Coordinator the EMSC program manager continues to be actively involved in the state's injury prevention projects and initiatives, including the occupant protection projects, Love Our Kids program administration, Injury Prevention

subcommittee of the state' trauma system, and the planning committee member for the state's injury prevention yearly conference.

c. Plan for the Coming Year

Infrastructure Building Services:

Although the IDPH Bureau of EMS-EMSC program is longer be the grant recipient for the National Highway Traffic Safety Administrative funds, the EMSC program manager will continue to be actively involved in the state's injury prevention projects and initiatives, including the occupant protection projects, Love Our Kids program administration, Injury Prevention subcommittee of the state' trauma system, and the planning committee member for the state's injury prevention yearly conference. Instead those funds will be expended on the Safe Kids Iowa program.

Two local CH agencies have specific action plans related to this measure. Agencies will utilize Safe Kids USA information and posting at immunization clinics, WIC clinics, schools, faith based organizations, libraries, physicians' offices, etc. One agency is seeking local funding to purchase car seats and will provide free car seat safety checks at various locations.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	46	20	19	16.5	17.5
Annual Indicator	20.0	18.1	16.4	17.3	17.7
Numerator	2927	2692	2410	2412	3101
Denominator	14633	14871	14692	13913	17513
Data Source	Pediatric NSS	Pediatric NSS	Pediatric NSS	Pediatric NSS	IWIN Breastfeeding Duration Report
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	18	18.5	19	20	21

Notes - 2012

FFY12 data obtained from the IWIN Breastfeeding Duration Report. Analysis of PedNSS data for the WIC Program was discontinued after the year 2011. As a replacement, this measure will now

utilize the breastfeeding duration report in the State database (IWIN). The results are compiled on an annual basis.

Notes - 2011

Data from 2011 PedNSS Data.

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 17.5 was met. Iowa WIC data indicates that 17.71 percent of mothers breastfed their infants at six months of age in 2012. The PedNSS CDC data collection for WIC was discontinued at the end of 2011. From this time forward, the breastfeeding duration report will be utilized for this measure.

Infrastructure Building Services:

In FFY2012, the Bureau of Nutrition and Health Promotion (BNHP) co-sponsored the 23rd Annual Breastfeeding Conference on May 17, 2012. Staff from the BNHP provided technical assistance to local maternal and child health agencies on breastfeeding.

The BNHP also developed the Breastfeeding Education for Iowa Communities training curriculum through the Iowa Breastfeeding Coalition in conjunction with the Iowa WIC Program and USDA. Trainings were held in 10 communities in FFY2012 with a total of 238 people trained.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Co-sponsoring the annual Iowa breastfeeding conference.				X
2. Bureau of Nutrition and Health Promotion require local agencies to spend a minimum of 20% on nutrition education of which 3% must be spent on breastfeeding.				X
3. Bureau of Nutrition and Health Promotion provides support to the state breastfeeding coalition, Iowa Breastfeeding Coalition.				X
4. Bureau of Nutrition and Health Promotion has been receiving USDA Peer Counseling grant funds since 2004.		X		
5. Continue to provide technical assistance to local maternal and child health agencies on breastfeeding.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

The BNHP, in partnership with the Bureau of Family Health, co-sponsored the 24th Annual Breastfeeding Conference on May 16, 2013. Staff members are continuing to provide technical assistance to local maternal and child health agencies on breastfeeding and continuing to promote and track the Breastfeeding Education for Iowa Communities training. A total of two trainings have been held thus far in FFY13 with 38 people trained.

c. Plan for the Coming Year

Infrastructure Building Services:

The BNHP and BFH will continue to co-sponsor the 25rd Annual Breastfeeding Conference in May 2014 and provide technical assistance to local maternal and child health agencies on breastfeeding.

The BNHP will evaluate if the training curriculum, Breastfeeding Education for Iowa Communities, needs to be updated. Staff will also evaluate how to promote and utilize the curriculum, The Business Case for Breastfeeding, which will be released in 2013.

Six local MH agencies are addressing breastfeeding through their grant activities. Activities include providing breastfeeding education and support to mothers at each MH visit or home visit. Local MH agencies collaborate with WIC agencies to provide education to WIC clients, counsel clients about infant feeding methods and give education about the benefits of breastfeeding. Agencies will also promote "World Breastfeeding Week" and offer a Breastfeeding Support Groups.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	99	99.5	99.6	99.7	99.3
Annual Indicator	98.7	98.7	99.2	99.1	99.4
Numerator	39545	38885	37838	37293	37799
Denominator	40052	39404	38151	37640	38022
Data Source	eSP	eSP	eSP	eSP	eSP
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	99.5	99.5	99.5	99.6	99.6

Notes - 2012

FFY12 data were obtained from the eSP™ newborn hearing screening database. The denominator represents the total number of children eligible for screening less those children that transferred to a birthing facility outside of Iowa, home birth families contacted, but the department had no response back and therefore are considered "lost" and those families who refused to have their children screened at the hospital. The numerator are those children that were eligible and received a birth screen.

Notes - 2011

FFY11 data were obtained from the eSP™ newborn hearing screening database. The denominator represents the total number of children eligible for screening less those children that transferred to a birthing facility outside of Iowa, home birth families contacted, but the department had no response back and therefore are considered "lost" and those families who refused to have

their children screened at the hospital. The numerator are those children that were eligible and received a birth screen.

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 annual indicator objective of 99.3 percent was met. Provisional data from the eSP™ newborn hearing screening data system indicates that 99.4 percent of newborns were screened for hearing loss before hospital discharge.

Infrastructure Building Services:

The Iowa EHDl program staff completed site visits to 80 birthing hospitals by the fall of 2012. There are 81 birthing hospitals total and the visits began in 2009. Upon analysis of individualized hospital data, it was noted that the visits resulted in a decrease in the number of children that referred (did not pass) their birth screen and the number of children missed prior to hospital discharge. In some cases, the referral rates dropped as much as a 12 percent. The EHDl program staff revised the quarterly reports that were emailed to each birthing hospital, detailing their progress in the last quarter, as well as their progress or lack of progress year to date. The reports have been an effective quality assurance tool as they have led to additional training and hospitals developing quality assurance goals related to the areas of concern highlighted in the reports.

The EHDl program continued to participate in a number of outreach and public education opportunities such as Grand Rounds at a Level III hospital and the program hosted a hearing loss symposium in September 2012. The symposium is for parents of children who are deaf or hard of hearing as well as early childhood providers, audiologists and ENTs. The evaluations of both activities were very positive and the Grand Rounds pre- and posttest evaluations showed marked improvement in knowledge regarding hearing screening, assessment and recommended follow up.

Iowa continued their work on the CDC iEHDl grant which assessed the feasibility of providing individual-level data beyond the aggregate data currently provided through the annual CDC Screening and Follow-up Survey. Iowa's EHDl database currently provides individual level data along with aggregate data for screening and diagnosis. In March 2012 the program added a case management component to their database which captures early intervention and family support referral and enrollment data. The new module shows level of effort to reach out to families needing further follow up which helps with further evaluation of the program components.

The EHDl program completed additional analysis regarding follow up efforts to parents and providers for children needing additional screening or an assessment. The program made modifications to the follow up program as a result. The process modifications showed a decrease in the number of children being moved to "lost" status by over 15% which indicates more children received recommended follow up. In addition, the number of referrals to family support also increased.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to hospital, Area Education Agencies, health care providers and private practice				X

audiologists.				
2. Continue to monitor eSP™ data for quality and completeness.				X
3. Use pediatric audiologists to provide technical assistance to facilities providing newborn screening and audiologist assessments.			X	X
4. Provide training to health care providers and early childhood professionals on childhood hearing loss and the importance of timely follow up.			X	X
5. Continue to evaluate the EHDI system of care, including physician, audiologist, and ENTs behavior and attitudes related to newborn hearing screening and follow up practices.				X
6. Provide care coordination to families of children who did not pass their hearing birth screen to ensure they receive an outpatient hearing rescreen or diagnostic assessment.		X		
7. Public education regarding newborn hearing screening and importance of timely follow up (newsletters, conferences, presentations).			X	
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

EHDI partnered with the National Center for Hearing Assessment and Management and Boys Town Research Hospital to survey local physicians in about attitudes, knowledge and behavior regarding newborn hearing screening and follow up.

EHDI partnered with Heartland Genetics Collaborative to survey ENTs and audiologists regarding genetics follow up and referrals.

EHDI audiology technical assistants provide training to reduce the number of children that are referred on the birth screen. EHDI staff began planning for visits to audiology clinics.

The EHDI program continues to work with the DE, Early ACCESS and AEAs to identify data sharing mechanisms and better data sharing strategies.

EHDI participates in the BFH data integration team. The BFH issued a request for information to explore integrating all MCH systems into one system, supporting the life course model.

Population-based Services:

The EHDI program continues to provide public education regarding newborn hearing screening and the importance of timely follow-up through newsletters, conferences, and presentations.

Enabling Services:

The EHDI program continues to contact families and PCPs of children that did not return for a hearing re-screen and/or obtain a diagnostic assessment to reinforce the importance of follow-up at well-child appointments. EHDI contacts the families and PCP of children with risk factors for hearing loss through letters to provide guidance regarding the recommended follow-up.

c. Plan for the Coming Year

Infrastructure Building Services:

EHDI staff will continue efforts to educate midwives, PCPs, audiologists, and ENTs about the importance of timely screening and follow-up for children who do not pass the initial screen or

have risk factors for late-onset hearing loss.

The EHDI staff will continue evaluation regarding the EHDI program's System of Care, including hearing screening and follow-up processes, referral, early intervention and family support. Evaluation will include analysis of the physician survey, ENT/audiology survey, and analysis of new data included in the new case management module (e.g. follow up effort). Evaluation results will be shared with the EHDI Advisory Committee and other partners to help guide policy and program development.

IDPH and CHSC will continue to work with Center for Disabilities and Development (CDD) audiologists to provide training or technical assistance to hospitals, AEAs staff, private audiology clinics and healthcare providers. Training will emphasize the importance of decreasing "refer" and "miss" rates and lost to follow-up numbers, as well as increase timely follow-up, including referral for diagnostic assessments, Early ACCESS and family support. Quarterly progress reports will be provided by IDPH to all birthing facilities comparing their statistics to the state, as well as hospitals the same level in an effort to improve best practices and quality reporting.

EHDI program staff will continue to recruit additional private practice clinics to report all screening or diagnostic assessment results to IDPH through the EHDI web-based data system versus paper reports.

The EHDI program will work with the Center for Genetics to issue a request for information to explore integration of the two web based data systems.

Population-based Services:

All birthing hospitals will provide universal newborn hearing screening services as required by law. The EHDI program will continue to participate in outreach and public education opportunities regarding the program.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	2.6	2.8	2.8	2.8	2.8
Annual Indicator	2.8	2.8	2.8	2.8	2.8
Numerator	19852	19969	20383	20321	20400
Denominator	709000	713155	727993	725767	728582
Data Source	Household Health Survey				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	2.8	2.8	2.5	2.5	2.5

Notes - 2012

FFY12 data were obtained from the 2010 Iowa Child and Family Household Health Survey for children 0-17 years.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 2.8 was met. Data from the 2010 Iowa Child and Family Household Health Survey shows that 2.8 percent of children in Iowa are uninsured.

Infrastructure Building Services:

The state hawk-i outreach coordinator exhibited hawk-i outreach information at several large venues, including school nursing and nurse practitioner conferences, the Iowa Governor's Conference on LGBTQ Youth, and several trainings for local county Farm Bureau Sales Associates. The state coordinator continued to be active in providing technical assistance to local school nurses and other qualified providers interested in becoming qualified entities that assist families in applying for presumptive eligibility coverage. Local outreach coordinators continued to receive training throughout the year assisting them with their outreach efforts and recruiting providers in their community to become qualified entities (QEs) in determining presumptive eligibility for children. The state hawk-i coordinator conducted on-site technical assistance visits and hosted a large statewide coordinator meeting in the fall.

Population-based Services:

In 2012, the Iowa Department of Human Services (DHS) continued to contract with IDPH to provide oversight of the local hawk-i outreach across the state. Child health agencies continued to provide localized outreach to four required focus areas: schools, medical and dental providers, faith-based communities, and diverse ethnic populations. Each year, outreach coordinators go beyond these four required focus areas to reach families who may have children eligible for Children's Health Insurance Program (CHIP) or Medicaid coverage. In light of recent reductions in the workforce and increasing unemployment rates, local outreach coordinators continued to focus on strengthening the information link to workforce development centers, temporary employment agencies, and community job loss rapid response teams. Coordinators also focused outreach efforts on retail businesses that patrons frequent as a result of a slow economy. These include laundromat, low-cost hair salons, and low-cost fast food chain restaurants.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhance outreach to special populations.		X		X
2. Continue to oversee the hawk-i outreach contract with local				X

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

b. Current Activities

Infrastructure Building Services:

Iowa's focus for Medicaid and CHIP continues to support efforts to align policies of multiple programs to allow for simplified and streamlined application processes. After the implementation of the dental only program and the presumptive eligibility for children, IDPH continues to be successful in collaborating with DHS and CMS to strengthen CHIP quality improvement activities related to increasing access to care and the use of preventative care.

Population-based Services:

Local outreach coordinators continue to educate families, community partners, and PCPs about Iowa's health insurance options for children.

Through the CHIPRA II Outreach and Enrollment, local outreach coordinators have utilized the "Get Covered. Get in the Game Campaign" materials to target coaches and athletic directors, and continue to work with school nurses to become qualified entities and identify uninsured teens.

Two local coalitions developed a texting campaign to reach teens. On a statewide level, the state hawk-i Outreach Coordinator will be providing hawk-i information to teens and families at the state wrestling and basketball tournaments, as well as several other statewide conferences and events.

Enabling Services:

Iowa's local outreach coordinators assist families to enroll in Medicaid or hawk-i through the presumptive eligibility program and assist families in navigating the Medicaid and hawk-i enrollment and renewal processes.

c. Plan for the Coming Year

Infrastructure Building Services:

Iowa's CHIP administrators indicated the program's primary focus for FFY2014 will be maintaining the CHIP program and the Presumptive Eligibility for Children Program. DHS is designing and implementing an Express Lane Eligibility (ELE) process that will enroll children who receive Food Assistance, but not Medicaid, into the Medicaid program. It is anticipated that the ELE will be expanded to include programs outside of DHS in years to come. The state hawk-i coordinator will work in collaboration with DHS to plan for ACA provisions.

Local hawk-i outreach coordinators will be required to continue outreach to health care providers, schools, the faith-based community, and diverse ethnic populations. Outreach coordinators will also focus on continuing to recruit QEs to become certified in making presumptive eligibility determinations for children in their communities. They will also continue outreach to teens through the strategies and resources developed in FFY2013 through the CHIPRA II Outreach and

Enrollment activities.

Population-based Services:

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

Enabling Services:

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

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

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	30	32	30	29.8	31
Annual Indicator	32.6	32.5	31.9	31.7	21.9
Numerator	10936	11773	11414	10911	16611
Denominator	33548	36225	35783	34420	75987
Data Source	CDC PedNSS	CDC PedNSS	CDC PedNSS	CDC PedNSS	IWIN Prevalence of Nutrition Risk
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	21.5	21	20.5	20	20

Notes - 2012

Analysis of PedNSS data for the WIC Program was discontinued after the year 2011. As a replacement, this measure will now utilize risk criteria as identified by the Iowa WIC Program and recorded in the State data base (IWIN). The results are compiled on an annual basis. Data is defined as > 85th percentile (At risk for becoming overweight) and >95th percentile (Overweight). These two groups were combined to tabulate the final percentage.

Notes - 2011

Data from 2011 PedNSS Data.

Notes - 2010

Data from 2010 PedNSS Data.

a. Last Year's Accomplishments

The FFY12 performance objective of 31.0 percent was met. Data from 2012 Prevalence of Nutrition Risk from the WIC Data System shows 21.9 percent of children ages 2 to 5 years receiving WIC services had a BMI at or above the 85th percentile. The PedNSS CDC data collection for WIC was discontinued at the end of 2011. From this time forward, prevalence data will be utilized for this measure. Even though the number of children in the Iowa WIC program is decreasing slowly, national data indicates that children in the WIC program are showing a gradual decrease in obesity numbers.

Infrastructure Building Services:

Local WIC programs continued to work with local vendors to increase the consumption of fresh fruits and vegetables. Through the Iowa Nutrition Network (INN) other food programs in Iowa continue to collaborate in this goal.

Local WIC agencies utilized the materials developed from a grant that focused on working with child care centers to limit screen time and encourage physical activity in nutrition education settings. These materials are often shared with other community programs.

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

WIC clinics in Northeast Iowa participated in the Healthy Weight Collaborative. Through this collaborative, monthly data was collected from the WIC clinic in Elkader on the number of BMI assessments completed and nutrition education provided. The group developed a referral form between the WIC program and school nurses, which was implemented through the PCP clinic Guttenberg. The PCP used an algorithm on what follow-up should occur, such as lab work or other referrals. Participants in the Healthy Weight Collaborative participated in motivational interviewing training and distributed "We Grow Healthy Kids" posters throughout Northeast Iowa.

Population-based Services:

BASICS contractors continue to work with elementary and preschools to increase fruit and vegetable consumption, drinking one percent and fat-free milk, and being physically active every day in children.

Enabling Services:

BASICS contractors continue working indirectly with parents of young children through distribution of materials that promote good nutrition and food preparation skills.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Utilize online training modules as a means to deliver nutrition education to low-risk participants.		X		X
2. Implement safe route to school projects in new school districts through the I-Walk program.				X
3. Through CTG, increase the number of school districts and child care centers with healthy food procurement and increased				X

physical activity.				
4. The Iowa Healthy Weight Collaborative will improve linkages between public health, PCPs, and communities to improve the rates of childhood obesity.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

WIC local agencies are all utilizing online training modules as a means to deliver nutrition education to low risk participants.

Iowa is implementing the Healthy Kids Act which outlines the following requirements:

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

I-Walk is in the process of implementing safe route to school projects in additional school districts.

The Iowa Healthy Weight Collaborative worked to improve the linkages between public health, PCPs, and communities to improve the rates of childhood obesity.

Population-based Services:

The INN School Grant Program contractors are providing monthly Pick a better snack nutrition education to over 20,000 students in 89 low-resource elementary schools.

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

c. Plan for the Coming Year

Infrastructure Building Services:

Local WIC agencies submitted action plans for the coming year. Some will focus on childhood obesity in children under 5 years old. The State WIC office will work with local agencies to share action plans addressing childhood obesity and continue to update modules in www.wichealth.org.

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

The WIC Farmers Market Program will continue to work with ISU Extension and local farmers to continue to increase redemption of Farmers Market checks.

The INN School Grant Program will continue to serve low-resource Iowa schools in the coming

year. The INN School Grant Program contractors will provide monthly Pick a better snack nutrition education to over 20,000 students in 89 low-resource elementary schools.

Iowa's Community Transformation Grant will continue to collaborate with the Department of Education to promote healthy food procurement practices and increase opportunities for physical activities in schools and child care facilities.

Three local CH agencies have activities related to reducing the percent of children with a BMI at or above the 85th percentile. Activities include utilizing IDPH Family Support Nutrition Training Resource Manual and Iowans Fit For Life resources to promote physical activity and nutrition at CH clinics in the service area, such as Pick a better snack & ACT handouts and posters.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	14	14	13	12	12
Annual Indicator	14.5	13.6	13.2	12.7	12.1
Numerator	5846	5387	5085	4859	4666
Denominator	40221	39662	38514	38204	38645
Data Source	Vital Statistics	Vital Statistics	Vital Statistics	Vital Statistics	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	11.5	11	10.5	10	9

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

a. Last Year's Accomplishments

The FFY12 performance objective of 12 was met. Data from 2012 Vital Statistics indicates that 12.1 percent of women smoked in the last three months of pregnancy.

Infrastructure Building Services:

IDPH staff and IME collaborated in a maternal health task force. Taskforce members continued using the Medicaid Match report to develop strategies to decrease the number of women who smoke during pregnancy. The taskforce developed a streamlined report and focused on reducing

tobacco use in women of child bearing age as well as reducing exposure to second hand smoke.

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

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

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Infrastructure Building Services:

Pregnant women are provided education about the benefits of not smoking during pregnancy and the risks to both themselves and their unborn child if they continue to smoke. Local programs also refer members to the Quitline Iowa and local resources in their county that may be available.

The Medicaid IDPH maternal health taskforce continues to work together on strategies to reduce smoking during pregnancy for Medicaid women. A new Medicaid provider letter was developed to improve communication with providers about payment for tobacco cessation services and NRT's for Medicaid eligible women.

The IDPH Director, Dr. Miller Meeks, signed a pledge with the ASTHO president that Iowa will work to reduce the rate of preterm births. A statewide strategic plan for obstetrical care includes tobacco cessation for women of child bearing age as one of the key strategies to reach our goal of reducing preterm births.

Enabling Services:

MH programs have continued to focus on encouraging women who are unwilling to quit to decrease the amount they smoke and not to smoke in the house and car to decrease the second hand smoke exposure to their newborns.

Seven local MH agencies have specific action plans related to smoking cessation. Activities

include screening all clients for tobacco use and referring those who smoke to Quitline Iowa.

c. Plan for the Coming Year

Infrastructure Building Services:

The smoking assessment tool currently being used by local MH programs only asks if the client currently uses tobacco products. IDPH plans to expand the assessment to include assessment of others who might be smoking in the home.

The Medicaid taskforce will continue to work on strategies for reducing smoking during pregnancy.

Five local MH agencies have activities related to reducing smoking during pregnancy. Activities include providing smoking cessation education to all MH participants at each prenatal and postpartum encounter, giving education about the benefits of quitting smoking at any time during pregnancy, training staff on tobacco cessation using the Ask, Advise, Refer Quit line Iowa model and coordinate care by referring clients to Quitline Iowa.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	9.8	12.7	9.5	11	11
Annual Indicator	12.9	9.7	11.5	11.6	11.7
Numerator	28	21	25	25	25
Denominator	216795	217380	216837	215834	213341
Data Source	Vital Statistics				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	10.5	10	9.5	9	9

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 11 was met. Data from 2012 provisional Vital Statistics indicates that the rate (per 100,000) of suicides among youths aged 15 through 19 was 11.1.

Infrastructure Building Services:

In the 2012 legislative session, bullying and suicide prevention became a focus because of several current bullying accidents that resulted in adolescents committing suicide. IDPH received \$50,000 to develop a needs assessment related to suicide prevention services and assign a coordinator to focus on bullying and suicide prevention at a state level.

IDPH began development of an adolescent health (AH) website, in partnership with Iowa State University Extension, to cover a variety of AH topics. The site was planned specifically for youth to receive age-appropriate and medically accurate information in areas such as sexual health, mental health, fitness and nutrition, substance abuse, and relationships.

The planning process of the Iowa DE Safe and Supportive Schools Program was completed. Thirty-five Iowa high schools across the State were funded to work on solutions to eliminate barriers to learning, including bullying and substance abuse.

BFH solidified a relationship with Iowa Collaboration for Youth Development (ICYD) (www.icyd.org) by working in partnership on AH issues, including bullying and mental health. BFH staff, in conjunction with other State agencies, participated on a SIYAC panel discussion and attended ICYD council meetings.

BFH continued educating communities to garner support for the Adverse Childhood Experiences (ACE) study. Some communities throughout the State have formed local collaborations to enhance partnerships and current programming to address risk behavior in youth.

Personal Responsibility Education Program (PREP) grantees, who deliver comprehensive evidence-based teen pregnancy prevention curricula to Iowa adolescents, identified a need to adapt each curriculum to include a lesson on mental health. BFH staff identified the SOS Signs of Suicide Prevention Program as an appropriate lesson to address this issue with Iowa youth, ages 10-19, participating in the program, both in school and community-based settings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuation of the IAMincontrol.org website in providing age appropriate and medically accurate information to Iowa youth.			X	
2. BFH staff will continue collaborative efforts with key partners surrounding adolescent mental health.				X
3. AH staff will become more involved with the steering committee for ACEs.				X
4. AH staff will continue to bring awareness to MCH agencies on adolescent issues, specifically mental health.				X
5. PREP grantees will continue to identify and provide effective suicide prevention education and referrals to Iowa youth.		X		
6. AH staff will continue to enhance their knowledge of adolescent mental health through professional development trainings.				X
7. Title X agencies will continue to screen for mental health through a coordinated intake process and provide necessary referrals.	X			

8. BFH staff will continue research to identify a standardized depression screening tool for adolescents to be used by Title V agencies.	X	X		
9.				
10.				

b. Current Activities

Infrastructure Building Services:

IDPH, in partnership with Iowa State University Extension, launched a new blog website for Iowa teens focusing on a variety of health issues. The website, IAMincontrol (www.IAMincontrol.org), offers information and resources on a variety of topics affecting adolescents.

IDPH is using the bullying and suicide prevention funding received during the 2012 Legislative session to implement and maintain a website specifically for bullying and suicide prevention. Your Life Iowa (www.yourlifeiowa.org) includes information, support and resources for teens and adults. BFH continues to partner with this initiative.

BFH staff has started working with current MCH agencies to bring AH awareness and education to their communities. Topics identified include teen pregnancy prevention and STIs, substance abuse and tobacco, and mental health, including bullying and suicide. Staff is researching screening tools for depression among adolescents to be used among MCH agencies. Title X agencies continue to screen for mental health as part of their intake process.

BFH continues its partnership with other IDPH bureaus and state agencies. BFH continues to work towards a more established relationship with Iowa DE Safe and Supportive Schools.

BFH will strengthen their knowledge on adolescent mental health issues through educational opportunities.

Population-based Services:

PREP grantees continue to deliver the SOS Signs of Suicide Prevention Program to Iowa youth.

c. Plan for the Coming Year

Infrastructure Building Services:

BFH will continue to solidify established relationships, strengthen MCH agencies on AH issues through trainings, resources and technical assistance and continue to partner with new and existing youth serving agencies.

BFH staff will research and identify a screening tool to be used at MCH agencies for depression in adolescents. Completion of this undertaking will allow for a consistent referral process among MCH agencies.

PREP grantees will continue to address mental health and suicide prevention through programming with Iowa youth.

BFH will continue to maintain and promote the IAMincontrol website.

AH staff will work to become more involved with the ACEs efforts by attending the statewide steering committee meeting. Staff will take the information from these meetings and work with local agencies and grantees to infiltrate the ACEs work in their communities. When local agencies are working as a collaborative effort, AH staff will encourage them to invite mental health professionals to take an active role in their AH coalitions.

Two local agencies have activities that include providing education to teenagers, caregivers, and schools about recognizing symptoms of depression, suicide ideation, and positive coping skills aimed at reducing risks.

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	2008	2009	2010	2011	2012
Annual Performance Objective	97	96	97	95	93
Annual Indicator	95.0	93.7	83.1	75.9	82.4
Numerator	420	384	339	268	310
Denominator	442	410	408	353	376
Data Source	Vital Statistics				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	83	84	85	86	87

Notes - 2012

FFY12 data were obtained from 2012 Vital Statistics data. In past years, infants born at level 2 and level 2 regional hospitals were inadvertently included in the data causing Iowa's percentage to be inflated. Missing data due to either missing hospital information or missing/implausible birth weight (<400 grams). The data collection was corrected for FFY12 and will be monitored for trends over the next several years.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics provisional data.

Revised for 2012: In past years, infants born at level 2 and level 2 regional hospitals were inadvertently included in the data causing Iowa's percentage to be inflated. Missing data due to either missing hospital information or missing/implausible birth weight (<400 grams). The data collection was corrected for FFY12 and will be monitored for trends over the next several years.

Notes - 2010

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

Revised for 2012: In past years, infants born at level 2 and level 2 regional hospitals were inadvertently included in the data causing Iowa's percentage to be inflated. Missing data due to either missing hospital information or missing/implausible birth weight (<400 grams). The data collection was corrected for FFY12 and will be monitored for trends over the next several years.

a. Last Year's Accomplishments

The FFY12 performance objective of 93 percent was not met. Data from 2012 Vital Statistics indicates that 82.4 percent of very low birth weight infants were delivered at facilities for high-risk deliveries and neonates. In past years, infants born at level 2 and level 2 regional hospitals were inadvertently included in the data causing Iowa's percentage to be inflated. The data collection was corrected for FFY12 and will be monitored for trends over the next several years.

Infrastructure Building Services:

IDPH continued to monitor the access to high risk care for both pregnant women and their infants in rural parts of the state, as community hospitals struggled to continue their birthing services and to maintain obstetrical, surgical, anesthesia, and round-the-clock coverage needed.

The Statewide Perinatal Program continued to conduct hospital site visits, individual education, and quality improvement initiatives.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Infrastructure Building Services:

Statewide Perinatal Program staff has continued to reinforce the Regionalized System of Perinatal Care in Iowa. Inter-hospital transports are encouraged if the necessary resources or personnel for optimal patient outcomes are not available at the facility currently providing care. When faced with preterm labor, transport of the mother in labor is recommended, if time allows.

There has been an increase in the number of Neonatologists practicing at Level II regional and Level II Regional Neonatology Centers in the state. This may lead to improvements in infant survival in Iowa's birthing hospitals.

Iowa code 641 chapter 150, which outlines Iowa's regionalized system of care, is being reviewed to consider changes to standardize levels of care to in light of newly published article by the American Academy of Pediatrics on Levels of Neonatal Care.

c. Plan for the Coming Year

Infrastructure Building Services:

High risk infants have higher mortality rates when born outside hospitals with the most specialized care. This fact is well understood in Iowa and is continually reinforced by the Statewide Perinatal Program in Iowa. Multiple factors, including hospital volume in rural areas and a decline in the number of birthing hospitals in Iowa, have contributed to a slight increase in

the travel time to a hospital with specialty care for some rural lowans. This can cause an increased number of very low birth weight (VLBW) babies being deliver in rural Level I hospitals. IDPH will continue to monitor access to care for rural lowans.

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	2008	2009	2010	2011	2012
Annual Performance Objective	80	76	77	78	86
Annual Indicator	75.9	74.3	75.5	84.5	84.0
Numerator	30513	29469	29069	31883	32289
Denominator	40221	39662	38502	37746	38423
Data Source	Vital Statistics				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	85	87	89	90	91

Notes - 2012

FFY12 data obtained from FY12 Vital Statistics data.

The FFY12 performance objective of 86 percent was not met. Data from 2012 Vital Statistics indicates that 84 percent of infants born to pregnant women received prenatal care in the first trimester. The local maternal health agencies with the lowest percent of early entry into prenatal care have the highest minority populations in the state. The Hispanic population in Iowa increased by 83.7 percent in the past decade, according to US Census Bureau Data. Maternal health agencies continue to provide education to Hispanic women on the importance of prenatal care is being provided; however, some Hispanic women had the understanding that you only would see the health care provider early in pregnancy if you had problems. Non-citizen status has also been a barrier to getting some women into early prenatal care.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

a. Last Year's Accomplishments

The FFY12 performance objective of 86 percent was not met. Data from 2012 Vital Statistics indicates that 84 percent of infants born to pregnant women received prenatal care in the first trimester. The local maternal health agencies with the lowest percent of early entry into prenatal care have the highest minority populations in the state. The Hispanic population in Iowa increased by 83.7 percent in the past decade, according to US Census Bureau Data. Maternal

health agencies continue to provide education to Hispanic women on the importance of prenatal care is being provided; however, some Hispanic women had the understanding that you only would see the health care provider early in pregnancy if you had problems. Non-citizen status has also been a barrier to getting some women into early prenatal care.

Infrastructure Building Services:

IDPH is working with March of Dimes to create a link to Title V MCH agencies from their website. Twenty-five percent of the local maternal health agencies have websites to assist with outreach. Several agencies are beginning to use Facebook and other social networking as effective outreach strategies. Many local agencies place PSAs about their services on their local radio stations.

Enabling and Direct Health Care Services:

IDPH will encourage agency staff to improve collaborative relationships with family planning agencies and PCPs who offer prenatal care. Local MH agencies are working with school nurses to keep nurses informed of agencies that provide free pregnancy testing. This relationship helps to increase the early identification of adolescent pregnancies. Outreach to all community sites that offer pregnancy testing to reach women as soon as possible will continue to be a primary focus. All local MH staff will complete training for the online presumptive eligibility application through the Iowa Medicaid Portal Access, which will streamline the application process.

All 21 local MH contract agencies had action plans related to early entry into prenatal care. Agencies' activities include providing care coordination services, partnering with local agencies/programs such as Storks Nest, developing public awareness campaigns, and working with vulnerable populations.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

Infrastructure Building Services:

IDPH continues work with March of Dimes to create a link to Title V MCH agencies from their website. Twenty-five percent of the local maternal health agencies will have websites to assist with outreach. Several agencies are beginning to use Facebook and other social networking as effective outreach strategies. Many local agencies place PSAs about their services on their local radio stations.

Enabling and Direct Health Care Services:

IDPH continues to encourage local maternal health agency staff to improve collaborative

relationships with providers who offer prenatal care. Local maternal health agencies are working with school nurses to keep nurses informed of agencies that provide free pregnancy testing.

Outreach to all community sites that offer pregnancy testing to reach women as soon as possible will continue to be a primary focus. All local maternal staff will complete training for presumptive eligibility.

All 21 local MH contract agencies have action plans related to early entry into prenatal care. Agencies' activities include providing care coordination services, partnering with local agencies/programs, developing public awareness campaigns, and working with vulnerable populations.

c. Plan for the Coming Year

Infrastructure Building Services:

IDPH will encourage agency staff to improve collaborative relationships with family planning agencies and PCPs who offer pregnancy testing. IDPH is also encouraging partnerships with school nurses who can link pregnant teens to local MH programs.

Enabling Services:

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

Twenty-one local MH agencies have action plans related to early entry into prenatal care. Agencies' activities include:

- Assisting clients with presumptive Medicaid eligibility determinations, if uninsured
- Collaborating with WIC clinics, medical providers, family planning agencies, free clinics to reach pregnant women
- Utilizing new and innovative methods for outreach and education to clients (i.e. social media and text messaging)
- Facilitating access to prenatal care for all pregnant women by providing care coordination that addresses geographic, cultural, socioeconomic, and organizational or transportation barriers unique to each county in the service area.

D. State Performance Measures

State Performance Measure 1: *The degree to which the state MCH Title V Program improves the system of care for mothers and children in Iowa.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			10	16	21
Annual Indicator			16	20	20
Numerator					
Denominator					
Data Source			Title V Program Index	Title V Program Index	Title V Program Index
Is the Data Provisional or				Final	Final

Final?					
	2013	2014	2015	2016	2017
Annual Performance Objective	21	22	23	24	25

Notes - 2012

Data Source: Title V Program Index scored by local MCH agencies, MCH Advisory Council and BFH staff.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 21 was not met. The Title Program V Index indicates a score of 20 was reached for this measure. The Iowa Department of Public Health (IDPH) and Child Health Specialty Clinics (CHSC) use the Title V Program Index as an instrument for measuring progress. The Title V Program Index, adapted from the National Initiative for Children's Healthcare Quality (NICHQ), is structured around six core Maternal and Child Health Bureau (MCHB) outcomes. The Title V Index for SPM 1 is included in the attachment.

Infrastructure Building Services:

Strategic leadership: BFH and CHSC leadership monitored the implementation of the Affordable Care Act (ACA) and the implications for Title V. Iowa's Children and Youth with Special Health Care Needs (CYSHCN) Director serves on the Association of Maternal and Child Health Programs (AMCHP) Board.

Partnerships across public and private sectors: BFH and CHSC continue to establish new relationships with partners related to medical homes. Staff maintains partnerships with Early Childhood Iowa (ECI), Iowa Medicaid Enterprise (IME), Iowa Chapter of the American Academy of Pediatrics (IA-AAP), Iowa eHealth Project, and the PI- CHI.

Quality Improvement (QI): BFH and CHSC staff will continue to provide technical assistance to MCH and CYSHCN programs on incorporating QI into all Title V programming. The BFH has several staff members that are trained in QI methods that are available to IDPH and local contract agency staff in developing QI activities.

BFH staff worked on a QI project with one local CH agency. The project was related to issues of communication between programs, collecting and sharing accurate and current demographic information for clients, and confusion about defining care coordination and the responsibilities associated with it.

These issues were addressed by several staff in the BFH. First, the local CH agency's staff each attended the child health one-day training, which includes modules specific to the database, informing, care coordination, and provision of direct care. Second, the agency's staff received technical assistance from individual program staff in the Bureau. Finally, agency staff representing each Child Health program completed a 15-question crosswalk questionnaire to determine duplication in services among programs, opportunities for collaboration, and training needs. The crosswalk also provided the agency with information as to how each program was providing care coordination for children and their families. The action plan following this questionnaire included action steps to address care coordination issues along with issues in communication and other topics.

Use of available resources: BFH and CHSC discretionary grants coordinators continue to inventory available resources and identify leveraging opportunities.

Coordination of service delivery: Staff identified opportunities for coordinated service delivery with ECI, WIC, and family planning. CHSC programming will continue to be coordinated with family support programs, health care organizations, and health care systems. Staff continues to identify opportunities to provide services through telehealth.

Data infrastructure: BFH and CHSC staff identify examples of effective data sharing to benefit the MCH populations. The SSDI coordinator advocates the Iowa Health Information Network (IHIN) for inclusion of MCH data.

BFH staff continues to plan for an integrated data system. The system will include maternal, child, oral health, family planning, and MIECHV data.

An attachment is included in this section. IVD_SPM1_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain partnerships with Iowa Medicaid, IA-AAP, Iowa eHealth, and other MCH related agencies/programs.				X
2. Provide TA to local MCH and CHSC programs, especially around life course and quality improvement				X
3. Continue to monitor the development of the Iowa Health Information Network (IHIN)				X
4. Develop business requirements for an integrated data system for MCH programs.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

Strategic leadership: BFH and CHSC Staff continue to communicate the goals and objectives of the Title V programs across the state. A workgroup was formed to develop materials to educating policy makers on the importance of the Title V program in reaching Iowa's most vulnerable populations and how Title V fits within the ACA.

Partnerships across public and private sectors: Staff follows progress being made related to the ACA to ensure Title V programs are integrated into the health home and with accountable care organizations (ACOs).

QI: BFH and CHSC continue to work with local providers on integrating QI strategies into their work plans.

Use of available resources: Iowa's Title V program will continue to seek out new funding opportunities, especially as they relate to integration into the ACA.

Coordination of service delivery: IDPH staff will develop baseline assessment of services for special populations and care coordination services. CHSC will maintain service delivery

improvements through telehealth.

Data infrastructure: BFH staff continues to monitor development of HIE for inclusion of MCH public health data and advocate for inclusion of MCH data in the IHIN. A Data Integration Coordinator was hired to lead planning related to an integrated MCH data. A Request for Information was released to determine if an existing data system is available to meet Iowa's Title V program's needs.

c. Plan for the Coming Year

Infrastructure Building Services:

Strategic leadership: Both the Title V Director and CYSHCN Director serve on the AMCHP Board and several staff members serve on AMCHP Committees. Through these roles, Title V leadership can help influence decisions made on behalf of the Title V program.

Partnerships across public and private sectors: Staff continues to follow progress being made related to the ACA to ensure Title V programs are integrated into the health home and with accountable care organizations (ACOs).

QI: BFH and CHSC continue to work with local providers on integrating QI strategies into their work plans.

Use of available resources: Utilizing the MCH Navigator training portal, State and local Title V staff will conduct the self assessment of the MCH Leadership Competencies to focus training and education opportunities. Iowa's Title V program will continue to seek out new funding opportunities, especially as they relate to integration into the ACA.

Coordination of service delivery: IDPH staff will monitor of provision of services for special populations and care coordination services. CHSC will maintain service delivery improvements through telehealth

Data infrastructure: Based on the results of the Request for Information, the BFH will release a Request for Proposals to acquire a data system that will me the integration needs of the Title V program, including maternal health, child health, home visiting, oral health, and family planning. The goal of the project is to reduce the burden of data entry on local Title V staff and replace aging data systems used by these programs.

State Performance Measure 2: *The degree to which components of a coordinated statewide system of care for CYSHCN are implemented.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			26	45	70
Annual Indicator			44	66	81
Numerator					
Denominator					
Data Source			CHSC Tool	CHSC Tool	CHSC Tool
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	83	85	87	90	95

Notes - 2012

CHSC Tool (a 4-part tool, including Title V Program Index as Part 4) – See Attachment for completed tool. The 2012 score is the third annual measurement of performance using this tool. The CHSC Tool measures program progress of four components of CHSC's system of care for CYSHCN: direct clinical services, care coordination, family-to-family support, and infrastructure building. The intent is that progress on this measure will positively impact the larger CYSHCN population and therefore the national performance measures for CYSHCN. It is important to note, however, that since the CHSC Tool is not population-based, progress on this tool does not directly correlate to progress/lack of progress on achieving the national performance measures for CYSHCN (all national performance measures are tracked using the population-based national survey of CYSHCN).

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 70 was met. The CHSC Tool, which includes the Title V Program Index, indicates a score of 81 was reached for this measure.

Infrastructure Building Services:

Collaborated with UI College of Public Health research project Prepkids to determine effectiveness of training protocol to assure families of CYSHCN are prepared for disasters.

Began to analyze MCH Navigator as a resource for new staff orientation and ongoing staff development.

Collaborated with one Federally Qualified Health Center (Fort Dodge) to plan for implementing community utility model using funding from HRSA for project titled "Innovative Evidence Based Models for Improving System Services for CYSHCN."

Developed virtual communication and social media resources and began planning to maximize internal and external communication.

Continued as an affiliate group of national "Help Me Grow" network.

Began process to pursue family support credentialing of the Iowa Family Support Network (home visiting) program for CHSC Family Navigators serving families in the CHSC Regional Centers.

Continued to lead Family to Family Iowa (F2F IA), Iowa's Health Information Center and network of 30-40 Iowa family advocacy groups and began conversation about transition of grant to family-run nonprofit organization.

Developed a care coordination training webinar that orients new CHSC staff to care coordination processes and tracking log. Developed Family Navigator training components.

Developed web-based modules for Center for Disease Control materials related to Learn the Signs Act Early materials through a competitive award from AMCHP.

Collected family impact data from families receiving comprehensive care coordination from CHSC Regional Centers or Family Support 360 Family Navigators.

Participated in obesity workgroup to better coordinate efforts of University of Iowa, CHSC, and IDPH.

Prepared written reports and oral presentations about CHSC's System of Care to share with University of Iowa and other state partners interested in the evidence-based model of care and to help shape model of care after the implementation of health care reform.

Created a collection of photographs of minority children and youth to use in CHSC printed materials.

Served as a planning partner for the annual Iowa Governor's Conference on Public Health to assure topics related to CYSHCN and disabilities were presented and CHSC is recognized as important aspect of Iowa's public health system.

Conducted a strategic planning workshop and created a CHSC 3-year strategic plan with three focus areas: 1) renewed shared leadership; 2) organizational efficiencies; and 3) an improved workplace environment that plans for continuity of services as the CHSC workforce ages and retires.

Collaborated with the IA-AAP to enhance interaction with public health initiatives for CYSHCN and primary care physicians.

Collaborated with University of Iowa leaders and other stakeholders to identify needs in training to best serve children in foster care and to identify children who have been abused.

Enabling and Direct Health Care Services:

Provided gap-filling direct clinical services (including telehealth), family-to-family support, and specialized care coordination for CYSHCN.

CHSC Liaison to Family Navigator for Hispanic families assisted with outreach to the Latino populations, prior to his resignation.

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

Studied need for additional telehealth services and payment mechanisms for those services.

An attachment is included in this section. IVD_SPM2_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to offer gap-filling direct clinical services, family-to-family support, and specialized care coordination for CYSHCN during health care reform and assist with policymaking as the new health care delivery system is designed and implemented				
2. CHSC Quality Improvement Advisors will train staff and implement ongoing processes to apply science of improvement techniques to various projects				X
3. Incorporate MCH Navigator resources into staff orientation and ongoing training.				X
4. Collaborate with AMCHP and six other Lifecourse states to select and implement new indicators.				X

5. Collaborate with the IA-AAP to identify potential areas for increased collaboration between CHSC and primary care physicians. Enhance relationship with IA Academy of Family Practice Physicians for medical home projects.				X
6. Examine ways to improving cultural competence and health literacy within CHSC care delivery. Assure all employees receive training in cultural competence and health literacy at orientation and throughout the year as needed.				X
7. Continue at least quarterly meetings for each of the four work groups of the CHSC System of Care to assure ongoing progress.				X
8. Analyze 2009-10 NSCSHCN and incorporate into ongoing CHSC strategic planning discussions and consider alternate or supplemental data measures for National Performance Measures				X
9. Articulate value of CHSC's clinical role as a partner in health homes for CYSHCN to assure a system of care for CYSHCN.				X
10. Maximize use of social media and new technology, including telehealth, to improve internal and external communication and service delivery.				X

b. Current Activities

Infrastructure Building Services:

Reviewing materials for cultural competence and appropriate reading level. Using the new age-based checklist to assist youth/families in transition.

Developing mechanisms to maximize internal and external communication through virtual resources.

Partnering with Project LAUNCH, IA-AAP, 1st Five, home visiting, and others to implement Help Me Grow components.

Identifying additional screening tools for CHSC clinicians to screen older children.

Customizing electronic medical record to include data regarding transition.

Training on motivational interviewing and facilitator skills for family team meetings.

Employing new staff to increase CHSC capacity to capture, analyze and use data.

Collaborating with interagency partners to: assure adequate services for screening and evaluation of children expected of child abuse; decrease prevalence of overweight/obese children and youth; study the effects of environmental toxins on child development, create recommendations for children's mental health and disability redesign; and create recommendations for early childhood systems integration.

Collaborating with AMCHP and 6 other Lifecourse states to identify new indicators.

Coordinating presentations on identifying own biases and cultural competence and recorded for future staff training.

Participating in AAP National Medical Home Project Advisory Council representing AMCHP and CYSHCN.

Participating on NASHP's Advisory Council and Annual State Health Policy Conference.

c. Plan for the Coming Year

Infrastructure Building Services:

Articulate value of CHSC's clinical role as a partner in health homes for CYSHCN to assure a system of care for CYSHCN.

Implement a survey of families to elicit feedback on all services provided in CHSC Regional Centers, not just family-to-family support.

Develop survey for all referring providers and PCPs regarding care of their patients seen in CHSC Regional Centers.

Examine ways to improving cultural competence and health literacy within CHSC's care delivery. Assure all employees receive training in cultural competence and health literacy at orientation and throughout the year as needed.

Continue to identify emerging clinical guidelines and screening tools and incorporate them into CHSC clinical practice.

Define crisis plans (behavioral vs. an emergency) for CYSHCN and assure that all families served by CHSC have a crisis plan.

Formalize into CHSC human resources processes, use of MCH Navigator as a resource for new staff orientation and ongoing staff development for all employees.

Develop CHSC policy regarding bullying and participate in state and national anti-bullying efforts.

Develop resources to assist families and youth in building self-advocacy skills, which may include handouts, social media, and website tools.

Ensure that communications reflect diverse populations of CYSHCN served by CHSC.

Continue to serve as a planning partner for the Iowa Governor's Conference on Public Health, assuring inclusion of topics related to CYSHCN and persons with disabilities.

Explore feasibility of creating a blog to improve communication between CHSC centers throughout Iowa. Implement use of other social media tools to improve internal and external communication.

Continue to collaborate with AMCHP and six other Life Course states to select and implement new indicators.

Continue to offer gap-filling direct clinical services, family-to-family support, and specialized care coordination for CYSHCN during the evolution of health care reform and assist with policymaking as the new health care delivery system is designed and implemented.

Continue to collaborate with the IA-AAP to identify potential areas for increased collaboration between CHSC and PCPs including early childhood brain development. Enhance relationship with IA Academy of Family Practice Physicians.

Coordinate the Regional Autism Assistance Program to assure a system of care for children with ASD and their families.

Continue to review CHSC data dashboards to respond with quality improvement efforts. Use the data repository to develop messages with internal and external stakeholders.

Continue to contribute to the children's mental health redesign and spread models of care that were developed in prior years using SAMHSA funding, to additional area of the state.

Continue to participate in National Improvement Partnership Network.

Continue Child and Youth Psychiatric Council project of Iowa to support PCPs serving youth with SED

State Performance Measure 3: *The degree to which Iowa's state MCH Title V program addresses health equity in MCH programs.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			5	15	19
Annual Indicator			13	18	18
Numerator					
Denominator					
Data Source			Title V Program Index	Title V Program Index	Title V Program Index
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	19	20	21	22	23

Notes - 2012

Data Source: Title V Program Index scored by local MCH agencies, MCH Advisory Council, and BFH Staff.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 19 was not met. The Title Program V Index indicates a score of 18 was reached for this measure. The Iowa Department of Public Health (IDPH) and Child Health Specialty Clinics (CHSC) use the Title V Program Index as an instrument for measuring progress. The Title V Program Index, adapted from the National Initiative for Children's Healthcare Quality (NICHQ), is structured around six core Maternal and Child Health Bureau (MCHB) outcomes. The Title V Index for SPM 3 is included in the attachment.

Infrastructure Building Services:

The IDPH Office of Minority and Multicultural Health (OMMH) continued to utilize the Unnatural Causes video series as a mechanism to educate on social determinants of health. BFH staff used the videos as a series of in-service workshops, training 35 staff members. The Unnatural Causes lending library usage increased 50 percent by local MCH agencies and other partners. IDPH also received funds for local MCH agencies to purchase their own copies of Unnatural Causes for agency resources.

The BHF purchased copies of The Life Course Game produced by cityMatCH (www.citymatch.org/lifecoursetoolbox) for all local MCH agencies and the bureau. The OMMH provided recommendations for use and shared information on the MCH Life Course toolkit and game for use within other health and community agencies.

Staff from the IDPH OMMH was selected to serve on US Department of Health and Human Services, Office of Minority Health (DHHS OMH) Regional Health Equity Advisory Committee/Region VII.

An attachment is included in this section. IVD_SPM3_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Twenty workshops/trainings were held which were inclusive of health equity, health disparities, impact on children, youth, women and families				X
2. Provided scholarships for purchase of "Unnatural Causes" video for local MCH agencies				X
3. Provided two displays at BFH/IDPH conferences on strategies for inclusion of relevant health equity information			X	
4. Serve on Early Childhood Iowa, Health Disparities committee				X
5. Substain the Region 3 Latino Women's Health Summit			X	
6. Serve on DHHS, OMH Regional Health Equity Advisory Council, Region VII		X		
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

Iowa was one of four states selected for a pilot study of the National Association of Chronic Disease Directors'(NACDD) Organizational Self-Assessment for Addressing Health Inequities Toolkit and Guidance. The pilot study was conducted with Division of Health Promotion and Chronic Disease Prevention for a self-assessment of addressing health inequities. Based on recommendations from Iowa and the three other participating states, the NACDD will make revisions to and disseminate the toolkit and guidance and nationally.

The OMMH will continue to promote the Unnatural Causes lending library and funding for purchase to MCH agencies. Staff will continue to integrate health equity/health disparities awareness and education within MCH programs, activities and trainings and will continue to provide education regarding the goals and objectives of the DHHS OMH National Plan For Action.

IDPH staff will continue membership on DHHS OMH Regional Health Equity Advisory Committee. The OMMH continues to provide TA and training/workshops to MCH agencies, partners, and other stakeholders on targeted areas of health disparities, cultural awareness, health equity, and changing demographics in Iowa.

c. Plan for the Coming Year

Infrastructure Building Services:

Staff from the IDPH OMMH will discuss how to increase partnerships to address community based/agency based health initiatives and collaboration with MCH agencies to address targeted disparities. During the BFH Fall Seminar, OMMH staff will present on the National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care. The CLAS Standards are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations.

IDPH staff is working with agencies in Hamilton, Humboldt, and Wright Counties to provide interpreter training. The OMMH has also helped establish a Native American cancer support group.

All local MCH agencies are required to address health disparities within their annual application. Activities include distribution of promotional materials in multiple languages, assisting with transportation and interpretation services, and other outreach activities.

State Performance Measure 4: *Percent of family planning clients (women and men) who are counseled about developing a reproductive life plan.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			10	39	61
Annual Indicator			38.9	60.1	71.2
Numerator			2678	11254	12814
Denominator			6881	18738	17996
Data Source			Ahlers Family Planning Data	Ahlers Family Planning Data	Ahlers Family Planning Data
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	72	73	74	75	76

Notes - 2012

FFY12 data were obtained from the Ahlers Family Planning data system.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 61 percent was met. Ahlers Data from 2012 indicates that 71.2 percent of family planning clients were counseled about developing a reproductive life plan.

Infrastructure Building Services:

During FY2011, Title X agencies expanded their counseling of family planning (FP) clients about reproductive life planning (RLP). This is evidenced by the change noted in the Annual Indicator above. Contractors for the Iowa Personal Responsibility Education Program (PREP) project began program implementation in spring 2011. Abstinence Education programs began program implementation in fall 2012.

A photo voice project was completed in one Title X agency to encourage youth participants to capture their interpretations of domestic and sexual violence through pictures.

In response to the ACA, funding was made available to Title X agencies to assist them in the implementation of electronic health records (EHR), to improve coding and billing procedures, and to improve documentation to achieve meaningful use.

Efforts continue to assist Title X agencies in navigating health care reform. Two Title X contractors have transitioned to EHR and are billing for meaningful use, one transitioned in January 2013, four are exploring opportunities to cost share by having one agency host the EHR server and the others have confidential record systems on that server. Another is also moving forward with transitioning to EHR.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expand RLP counseling to include FP clients visiting a clinic for any purpose	X	X		
2. Offer materials to WIC program staff and clinics to advocate RLP occur at WIC clinics, and continue to promote the Iowa Family Planning Waiver to WIC staff		X		X
3. Expand PREP programming, identifying target communities and population risk factors as they emerge				X
4. Explore application of RLP in Iowa's abstinence education programming				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

A website focused on adolescents, including the role of males in family planning decisions was implemented during FY12-FY13. The website (www.iamincontrol.org) has an expanded focus on healthy teen living, incorporating Iowa's PREP and Abstinence Education programs.

A Reproductive Life Planning Kit is being developed for distribution to all Title X and Title V contractors. The kit will be appropriate for parents to use with their children to initiate the discussion of sexual health and life goals.

The Iowa PREP and Abstinence Education programming continue in FY13. Iowa's programming use the curricula "Power Through Choices" to promote abstinence in Iowa's foster care youth residing in out of home placement situations. Both PREP and Abstinence Education programs also use the Teen Outreach Program Curriculum. In addition, PREP contractors are using the SiLHE and Wise Guys curricula to reach youth. Both PREP and Abstinence Education contractors will receive standardized RLP information and materials, including directions for documentation.

Five local MH agencies have action plans that address RLP. Activities include providing RLP to

all clients in the MH program.

c. Plan for the Coming Year

Infrastructure Building Services:

Iowa will again compete for Title X funding from the Office of Population Affairs. If successful, priority populations will be low-income minorities, adolescents and males. In addition, there will be significant focus on continuing the Reproductive Life Plan work, including consideration of an interactive website.

All Title X agencies will also be completing transitions to EHR, billing meaningful use indicators and beginning to participate in the IHIN. IDPH anticipates having a statewide system that will bridge services into health care reform. Work on effective, correct coding and billing activities will continue.

Title X agencies will participate in ACOs, partner with Federally Qualified Health Centers and assist clients to navigate health care reform. Efforts will continue to make sure that all men and women attending family planning clinics receive preconception care and other health screenings as appropriate.

Seven local MH agencies have action plans related to RPL. Activities include providing care coordination and verbal referrals to women in need of further family planning education and/or counseling; providing education at third trimester and post partum visits, including education about birth control methods; having birth control kits available at MH clinics, WIC clinics and local public health agencies, and at outreach/education classes; and training bi-lingual interpreters on RPL protocol to avoid potential language barriers due to different terminologies across cultures.

State Performance Measure 5: *The degree to which the health care system implements evidence-based prenatal and perinatal care.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				9	14
Annual Indicator			8	13	23
Numerator					
Denominator					
Data Source			Title V Index	Title V Index	Title V Index
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	24	24	25	26	27

Notes - 2012

Data Source: Title V Program Index. The 2012 Title V Index was scored by the Perinatal Guidelines Committee.

Notes - 2011

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

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 14 was met. The Title Program V Index indicates a score of 22 was reached for this measure. The Iowa Department of Public Health (IDPH) uses the Title V Program Index as an instrument for measuring progress. The Title V Program Index, adapted from the National Initiative for Children's Healthcare Quality (NICHQ), is structured around six core Maternal and Child Health Bureau (MCHB) outcomes. The Title V Index for SPM 5 is included in the attachment.

Infrastructure Building Services:

Strategic leadership: BFH staff assessed the willingness of the Statewide Perinatal Team and the Perinatal Guidelines Committee to provide leadership on a strategic plan. A strategic plan will be developed by the Iowa Obstetrical Care Taskforce (IOCT) will be shared with local MH contract agencies.

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

IOCT members were appointed by the IDPH Director and represent the following collaborative partners: Iowa Medical Society, Iowa Health Care Collaborative, IME, March of Dimes, Wellmark, Iowa Hospital Association, Association of Women's Health, Obstetrical and Neonatal Nurses, Hospital Engagement Network, Iowa Nurses Association, IDPH, Statewide Perinatal Team and several providers and hospital representative.

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

Use of available resources: BFH staff will collaborate with IME and IOCT to advance evidence-based strategies into provider requirements/recommendations. The MH program will continue to leverage medical subspecialty technical assistance through UI.

Coordination of service delivery: MH program staff will continue to assess the availability of care coordination services and services to special populations to ensure services are provided equitably across the state.

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

An attachment is included in this section. IVD_SPM5_Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Engage Iowa Medicaid and other third party payers in developing strategies for promoting evidence-based practices.				X
2. Continue to provide technical assistance to MCH programs on quality improvement methodology.				X
3. Partner with Title X Family Planning to promote preconception care and reproductive life planning and March of Dimes to reduce preterm births.				X

4. Monitor community based performance indicators for early entry into prenatal care and medical home for prenatal care				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

Strategic leadership: The IOCT is collaborating to design an evidence-based strategy that engages providers, reduces adverse outcomes and improves care for mothers and babies.

IDPH is participating in the Association of State and Territorial Health Officials (ASTHO) President's Challenge to decrease prematurity in the US by 8% by 2014. To achieve this goal, IDPH is partnering with the March of Dimes on the Healthy Babies are Worth the Wait campaign.

QI: BFH staff will continue to provide TA to MCH programs on QI methodology and to promote QI guidelines.

Use of available resources: BFH staff will collaborate with IME to advance evidence-based strategies into provider requirements and recommendations. The MH program will continue to leverage medical subspecialty TA/consultation available through the UI, partner with family planning to promote preconception care and RLP and March of Dimes to reduce preterm births.

Coordination of service delivery: MH program staff will continue to assess the availability of care coordination services and services to special populations to ensure services are provided equitably across the state.

Data infrastructure: IDPH is working to collaborate with the IOCT to link hospital discharge data and vital records birth files to track elective deliveries less than 39 weeks. The Medicaid Match Report also provides valuable data by linking Medicaid claims data and the birth file to monitor birth outcomes for Medicaid women.

c. Plan for the Coming Year

Infrastructure Building Services:

Strategic leadership: Statewide Perinatal Team and the IOCT will release its strategic plan in 2013. The main goals involve reduction of early elective deliveries, reduce preterm birth, and avoid adverse events. The mission is to guide, monitor and improve obstetrical care in Iowa. The vision statement is by 2018, to improve obstetrical and neonatal outcomes in quality, patient safety and cost.

Partnerships across public and private sectors: The Medicaid Maternal Health Task Force will continue to partner with IDPH. They are exploring methods to improve quality of care for pregnant Medicaid eligible women. Needs are identified through a matched data set that included Medicaid claims data and birth certificate data. IDPH is working on strategies to link hospital discharge data to birth file to improve data tracking of elective deliveries prior to 39 weeks gestation.

QI: BFH staff will continue to provide technical assistance to MCH programs on QI methodology and to promote QI guidelines through the Perinatal Newsletter and the BFH UPDATE.

Use of available resources: BFH staff will collaborate with IME to advance evidence- based strategies into provider requirements and recommendations (i.e., screening & risk assessment

tools, physician education, and policy development). The MH program will continue to leverage medical subspecialty TA and consultation available through the UI Carver College of Medicine. IDPH will continue to partner with Title X Family Planning to promote preconception care and reproductive life planning and March of Dimes to reduce preterm births.

Coordination of service delivery: MH program staff will continue to assess the availability of care coordination services and services to special populations to ensure services are provided equitably across the state.

Data infrastructure: The Iowa PRAMS will employ a mixed model approach for data collection. The mixed model approach combines two modes of data collection: mail and telephone. Up to three self-administered surveys are mailed to a randomly selected sample of women who gave birth to a liveborn infant in the Iowa. Women who do not respond to the mailings are contacted by telephone and encouraged to complete a telephone interview.

State MH programs play integral roles in collecting, analyzing, reporting and using health data to assess performance of the health system for women, and families and drive quality improvement initiatives. IDPH data is being used to track state efforts to reduce early elective inductions and c-sections.

State Performance Measure 6: *Percent of Medicaid enrolled women receiving preventive dental health services during pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			21	22	21
Annual Indicator			20.1	19.7	19.0
Numerator			3135	2970	2806
Denominator			15582	15093	14786
Data Source			Medicaid Match Report	Medicaid Match Report	Medicaid Match Report
Is the Data Provisional or Final?				Provisional	Provisional
	2013	2014	2015	2016	2017
Annual Performance Objective	21	23	24	25	25

Notes - 2012

FFY12 data were obtained from the 2012 Medicaid Match Report.

The FFY12 performance objective of 21 percent was not met. 2012 provision Vital Statistics data indicate that 18.9 percent of Medicaid enrolled women received preventive dental health services during pregnancy. The main barriers for pregnant women on Medicaid receiving dental care included difficulty in finding a dentist that accepts Medicaid, low priority given to dental care, misconceptions about the safety and appropriateness of dental care during pregnancy, and sporadic anticipatory guidance during prenatal care. In addition, dental providers are confused about which reimbursable services may be provided for pregnant women and also struggle with providers wanting to wait until after the pregnancy before providing services.

Notes - 2011

FFY11 data were obtained from the 2011 Medicaid Match Report.

Notes - 2010

FFY10 data were obtained from the 2010 Medicaid Match Report.

a. Last Year's Accomplishments

The FFY12 performance objective of 21 percent was not met. 2012 provision Vital Statistics data indicate that 18.9 percent of Medicaid enrolled women received preventive dental health services during pregnancy. The main barriers for pregnant women on Medicaid receiving dental care included difficulty in finding a dentist that accepts Medicaid, low priority given to dental care, misconceptions about the safety and appropriateness of dental care during pregnancy, and sporadic anticipatory guidance during prenatal care. In addition, dental providers are confused about which reimbursable services may be provided for pregnant women and also struggle with providers wanting to wait until after the pregnancy before providing services.

Infrastructure Building Services:

Oral Health Center (OHC) staff continued to work to link I-Smile™ strategies and best-practice principles within MH programming. I-Smile™ Coordinators provided assistance to local MH programs as a way to improve birth outcomes and the oral health of new moms. In October 2011, OHC staff completed two days of strategic planning. As a result, OHC is pursuing ways to expand oral health programs and advance oral health through policy development, which should positively impact the MH population. Results from the first year that oral health questions were included on the Barriers to Prenatal Care Survey will be compiled and reviewed to assist in determining future program activities. Direct service chart audits were conducted for a portion of MH contractors to ensure quality documentation and services.

Population-based Services:

OHC staff encouraged health promotion efforts by local MH agencies to further educate the public and MH clients about the importance of good oral health. Health promotion through the I-Smile™ program included targeted messages to mothers, informing them of the ability to transmit decay-causing bacteria to their children. A Facebook page was launched in May targeting moms.

Enabling Services:

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

Direct Health Care Services:

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

Table 4b, State Performance Measures Summary Sheet

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

9.				
10.				

b. Current Activities

Infrastructure Building Services:

OHC staff continues to look for additional ways to integrate MH issues within current I-Smile™ strategies. For quality assurance, OHC staff participates in direct service chart audits for MH contractors who provide direct dental services to clients, and review and revise the chart audit tool as needed. Medicaid paid claims, WHIS, and Barriers to Prenatal Care Survey data are reviewed to assist in determining program direction. OHC staff also participates on the IDPH PRAMS workgroup, incorporating data measures for oral health within the new system.

Population-based Services:

Local I-Smile™ coordinators and the OHC include messaging about oral health and pregnancy within health promotion efforts. A new Facebook page that specifically targets moms continues to add followers. Other target populations include obstetricians and gynecologists, dentists, and family practice practitioners. OHC is replicating a popular promotion for outreach to new parents in hospitals, initially funded through a foundation grant.

Enabling Services:

Twelve local MH agencies have action plans that address dental care for pregnant women. Agencies' activities include providing education on importance of dental care and referring clients to local dental clinics.

Direct Health Care Service:

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

c. Plan for the Coming Year

Infrastructure Building Services:

OHC will continue to work toward building systems that address the oral health needs of MH clients and link with the existing I-Smile initiative for children. The second year of oral health data from the Barriers to Prenatal Care Survey, as well as initiation of PRAMS will be used by OHC staff to consider program impacts and considerations for future program directions.

Population-based Services:

OHC staff will continue to offer preventive messages to moms on the I-Smile Facebook page. Other family health issues will also be incorporated. I-Smile coordinators will be encouraged to incorporate education for pregnant women within local health promotion efforts.

Enabling Services:

OHC staff will encourage contractors to assist MH clients to become enrolled on Medicaid or to find another payment source for dental care. I-Smile coordinators who are not yet qualified entities for presumptive eligibility will be encouraged to do so. OHC will also monitor dental care coordination services provided to MH clients as part of quality assurance reviews.

Direct Health Care Services:

Gap-filling preventive services may be provided by contractors as indicated by local need.

Twelve local MH agencies have action plans related to dental care for pregnant women. Activities include discussing with women the importance of dental care and good oral health at each prenatal and postpartum visit, providing education to dispel the myth that dental care during pregnancy is unsafe, and counseling Medicaid eligible women that dental care is a covered

benefit.

State Performance Measure 7: *Percent of Medicaid enrolled children ages 0-5 years who receive a dental service.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			43.7	46	46.9
Annual Indicator			45.8	46.7	52.3
Numerator			48307	50848	57280
Denominator			105429	108923	109479
Data Source			CMS 4.16	CMS 4.16	CMS 4.16
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	53	55	56	57	58

Notes - 2012

FFY2012 data were obtained from the 2012 CMS 416 report.

Notes - 2011

FFY2011 data were obtained from the 2011 CMS 416 report.

Notes - 2010

FFY10 data were obtained from the 2010 CMS 4.16 report.

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

a. Last Year's Accomplishments

The FFY12 performance objective of 46.9 percent was met. Data from the 2012 CMS 4.16 Report indicate that 52.3 percent of Medicaid-enrolled children ages 0-5 years received a dental service.

Infrastructure Building Services:

I-Smile Coordinators (ISC) submitted local oral health needs assessments to OHC in February. Each also included an oral health plan, based on the needs and assets identified. OHC staff reviewed each assessment and plan and provided technical assistance to contractors about ways to potentially improve on the process and also how to regularly incorporate the needs assessment process within local planning. Meetings continued between OHC, Iowa Medicaid Enterprise (IME), and pediatricians to pursue Medicaid reimbursement to medical practitioners for oral screenings; however, funding was not available from IME for the policy change. OHC staff spent two days of facilitated I-Smile strategic planning. To continue quality assurance of I-Smile and oral health services, OHC staff conducted site visits and also participated in direct service chart audits with local agencies.

Local I-Smile projects worked on leading community oral health coalitions, training health care providers, and organizing water fluoridation advocacy efforts. All ISC completed a dental public health curriculum developed last year by OHC and Des Moines University. The six modules focused on public health systems, policy development, surveillance, and health promotion.

Population-based Services:

OHC statewide promotion activities included sponsorship of Iowa Public Television children's

programming and distribution of materials recognizing National Children's Dental Health Month. ISC were also required to conduct local health promotion activities.

Enabling Services:

OHC staff assisted local CH agencies with care coordination protocols to ensure families receive the help they need to access dental care and also worked with ISC regarding the new policy which allows text messaging as a form of billable care coordination.

Direct Health Care Services:

Title V contract agencies worked with local WIC projects to ensure gap-filling preventive services were provided to children age two and younger. Services were also provided to older children, with particular emphasis on birth through age 5, in areas of the state with an identified need.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities

Infrastructure Building Services:

The I-Smile project is the basis for most of this measure's activities. To maintain quality and consistency, OHC staff will conduct required trainings for ISC. Contract requirements include developing partnerships with businesses, business organizations, civic organizations, and/or faith-based organizations to build local infrastructure. OHC staff participates on the ECI work group, identifying core health services for early childhood professionals. OHC staff provided education to the Iowa Dental Board about the importance of public health supervision of dental hygienists, leading to the addition of child care as an allowable setting.

Population-based Services:

The OHC continues to promote early and regular dental care through its website, material distribution, and social media outlets. These activities are supported through private grants. Title V contract agencies are also required to conduct oral health promotion as part of I-Smile.

Enabling Services:

ISC maintain and build local referral networks to ensure families are able to access services. To assist in this, OHC provides materials such as "first birthday" postcards that promote a child's initial dental visit and I-Smile ads that can be used in local newspapers.

Direct Health Care Services:

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

c. Plan for the Coming Year

Infrastructure Building Services:

The bulk of activities targeting this performance measure will be accomplished within the I-Smile project. By FFY2014, OHC staff will know whether the process for an evaluative assessment of I-Smile through the Robert Wood Johnson Foundation will occur. OHC staff will use results of focus groups conducted in FFY2013 to guide program and policy development. OHC staff will participate on the Community of Practice Care Coordination meetings, discussing strategies for expansion of 1st Five, MIECHV, and other health programs for children.

Population-based Services:

Health promotion activities will continue, with an emphasis on "first visit by first birthday".

Enabling Services:

OHC and Bureau of Family Health staff will work with local contractors to determine care coordination policy needs, then work with IME to address those needs.

Direct Health Care Services:

Gap-filling preventive services will continue through local contractors. All will be required to ensure that children ages 0-2 at WIC are served.

State Performance Measure 8: *Rate of hospitalizations due to unintentional injuries among children ages 0-14 years.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective			12.2	6.3	11
Annual Indicator			12.4	11.2	14.7
Numerator			733	676	885
Denominator			589813	603673	601376
Data Source			Iowa Hospital Association inpatient data	Iowa Hospital Association inpatient data	Iowa Hospital Association inpatient data
Is the Data Provisional or Final?				Final	Final
	2013	2014	2015	2016	2017
Annual Performance Objective	14.5	13.5	12.5	10.5	10

Notes - 2012

FFY12 data were obtained from hospital inpatient data from the Iowa Hospital Association.

Notes - 2011

FFY11 data were obtained from hospital inpatient data from the Iowa Hospital Association. Final data is available by the close of calendar year 2012. Data will continue to be monitored to track any shift in trends.

2011 Target was reset as part of the FFY12 application process, based upon provisional data. Final data was not obtained until after final submission, so the FFY11 target could not be reset.

Notes - 2010

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

a. Last Year's Accomplishments

The FFY12 performance objective of 11 was not met. Data from the Iowa Hospital Association indicate that the rate of hospitalizations due to unintentional injuries among children ages 0-14 was 14.7.

Infrastructure Building Services:

BFH worked with the Bureau of Disability and Violence Prevention to conduct annual surveillance of statewide injury trends. Results of the injury prevention survey of local Title V MCH contract agencies were used to share best practices at the local level. Three Child Health (CH) contract agencies developed specific action plans related to unintentional injuries. Activities included partnering with child care nurse consultants (CCNC) to evaluate child care facilities on health and safety issues, creating public awareness campaigns, providing health and safety education to families served, and car seat safety campaigns.

BFH staff served on the IDPH Healthy Homes and Lead Poisoning Prevention Advisory Council and its partnership workgroup. Best practice information on injury prevention for children was distributed to local Title V contractors, including numerous resources from the Children's Safety Network (CSN) and the Safe States Alliance. Staff also shared information on the Love Our Kids Grant designed to provide funding to rural areas to implement injury prevention initiatives for children. BFH also promoted the Annual Iowa Child and Youth Injury Prevention Conference.

BFH staff participated in CSN workgroup addressing unintentional injury. Conference calls were held with eight other states on topics including motor vehicle injury, prescription drug abuse among adolescents, safe sleep, and collaboration with partners.

BFH continued to promote health and safety assessments in child care settings. Educational sessions were provided for consultants and providers of child care that addressed immunizations, Shaken Baby Syndrome (SBS), safe sleep, and playground safety. Recommendations were made to the Iowa DHS Child Care Bureau regarding injury surveillance in child care. It was proposed that DHS seek authority to make mandatory the reporting of child death and medically attended injuries in child care settings to DHS within 24 hours. Recommended interim strategies included voluntary web-based reporting or active surveillance by regulatory staff and CCNCs of incident reports when onsite in child care facilities. A pilot study was recommended, involving a retrospective study of 2-5 years of child record reviews and/or use of a survey for provider input.

BFH staff continued participation on the Prevent Iowa SBS Team. The team, comprised of representatives from IDPH, Prevent Child Abuse Iowa, Iowa Department of Management, and Blank Children's Hospital continued implementation of Iowa's statewide program to prevent SBS. The Period of PURPLE Crying was selected as the educational program, which helps parents and caregivers understand the features of crying in normal infants that can lead to shaking or abuse. Nurses in Iowa's birthing hospitals provide education to parents. They receive a DVD and booklet to help them understand the serious nature of SBS, as well as techniques to prevent it. The National Center on SBS recognized Iowa as a 'Purple State' for statewide efforts to prevent SBS.

An evaluation of the Period of PURPLE Crying curriculum in Iowa birthing hospitals was completed. Key findings identified that the education sessions were effective in teaching parents about normal infant crying, the dangers of shaking an infant, and soothing and coping techniques. It also identified that nurses play an important role in program implementation; both nurse education and the DVDs are equally important components; all mothers benefit from the information; mothers need to be encouraged to share the DVD with other caretakers; and implementation of the program should be continued. A DVD for child care workers was developed to demonstrate how child care workers can reinforce education on the Period of PURPLE Crying. A webinar training targeted CCNCs, Child Care Resource and Referral staff, and DHS regulatory

personnel.

A public awareness campaign entitled Click for Babies and coordinated by the National Center for SBS was initiated. Volunteers were solicited to knit purple hats for newborns with a note to share key points of the SBS prevention project. Parents were encouraged to have their infant wear the hat and share the prevention message. In Iowa, knit-ins were held in Des Moines and Cedar Rapids.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor unintentional injury trend data for children.				X
2. Monitor legislation related to unintentional injury.				X
3. Disseminate injury prevention information to local Title V agencies, school districts, child care centers, and new mothers.			X	X
4. Promote education on Shaken Baby Syndrome.			X	X
5. Continue to work with other IDPH bureaus, state agencies, and partners to promote unintentional injury prevention.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services:

BFH continues to track statewide trends and monitor legislative initiatives. Staff participate on the Healthy Homes and Lead Poisoning Prevention Advisory Council.

BFH distributes best practice information to CH agencies including resources on safety hazards in child care, bicycle and water safety, child passenger safety, infant mortality, risky driver behavior, and pesticide poisoning. Three CH agencies are implementing plans that address childhood unintentional injury prevention.

Educational sessions are provided for consultants and providers of child care. Work continues with Iowa DHS on injury surveillance of child deaths and medically attended injuries in child care, including development of new rules for reporting. The Period of PURPLE Crying training has been adapted for child care providers. The Safe Sleep training and Injury Prevention Checklist are being updated. Training continues on injury prevention, emergency preparedness, medication administration, and food allergies.

Population-based Services:

The Period of PURPLE Crying program continues through parenting/birth classes, family physicians/pediatricians, social workers, licensed child care providers, and home visitors. An educational program designed by the National Center on SBS for secondary level students will be implemented. Program kits will be distributed to each AEA for use in schools. Information will be provided to school nurses and family consumer science teachers.

c. Plan for the Coming Year

Infrastructure Building Services:

BFH will continue to work with the IDPH Bureau of Disability and Violence Prevention to conduct an annual surveillance of statewide injury trends. State level legislation will be monitored. BFH

will continue its participation on the IDPH Healthy Homes and Lead Poisoning Prevention Advisory Council and partnership workgroup. The BFH will also continue to be involved in the Child Death Review Team and will be looking at trend data for unintended injuries for children.

BFH will promote the Annual Iowa Child and Youth Injury Prevention Conference. Best practice information on injury prevention for children will continue to be distributed to local Title V contractors and school districts. Key resources include those from Safe States and the Children's Safety Network.

BFH will continue to promote health and safety assessments in child care settings. The updated Injury Prevention Checklist will be used to assess providers under updated guidelines, best practices, and lessons learned over the past ten years of child care nurse consultation in Iowa. Educational sessions pertaining to health and safety will continue to be provided for consultants and providers of child care. Environmental health and preventing injury and illness related to environmental impacts on the health of children will receive a new focus in FFY 2014 with Iowa becoming an expansion State for Eco Healthy Child Care.

BFH staff will continue to promote reinforcement of messages families receive in the hospital about preventing SBS. Dissemination of the Period of PURPLE Crying(r) program to new mothers both prenatally and postnatally provides parents with information about the characteristics of normal infant crying, the dangers of shaking an infant, and techniques to soothe and cope with infant crying.

Population-based Services:

In FFY 2014, funding will dictate how many additional hospitals receive the DVDs and booklets. The goal is to get all Iowa birthing hospitals at a level of sustainability to continue this project. Training for early childhood staff, family support workers, and child care providers will continue.

The public awareness campaign 'Click for Babies' will continue to be supported. Volunteers will be solicited to knit purple hats for newborns that contain a note reinforcing the key points of the SBS prevention project.

Three local CH agencies have action plans related to unintentional injuries. Activities include utilizing Safe Kids USA safety posters to display at immunization clinics, WIC clinics, schools, faith based organizations, libraries, and physician office, conducting home safety checks for all families receiving home visits utilizing SAFE KIDS AT HOME Assessment Tool and assisting families to obtain needed safety devices, if funding is available. Local agency staff will also participate in health fairs and other community events to share information on child safety and injury prevention utilizing Safe Kids Worldwide information.

E. Health Status Indicators

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	6.7	6.7	7.0	6.5	6.6
Numerator	2683	2674	2688	2499	2559
Denominator	40221	39662	38514	38204	38686
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 - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

Narrative:

Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. For calendar years 2011 and 2012, the percent of infants born at a low birth weight remained stable at 6.5% and 6.6% respectively. This percentage has dropped from 7.2% in 2005 and 7.0% in 2010.

Data on this indicator are reviewed annually to identify trends and areas of concern. Because of the relationship between maternal smoking and infant low birth weight and the high proportion of pregnant Medicaid enrollees who smoke during pregnancy, IDPH has been working closely with our partners at Iowa Medicaid Enterprise to identify and reduce barriers to Medicaid recipient receipt of smoking cessation medications and other programs that support smoking cessation such as the Iowa Quit Line.

The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are receiving the appropriate level of care.

Additionally, as noted in Health System Capacity Indicator 5A, access to smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits was made available to Medicaid eligible pregnant women in response to data which reflected a high proportion of women who reported that they smoked during pregnancy. This policy change took effect January 2008.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	4.9	4.9	5.1	4.7	4.9
Numerator	1913	1888	1903	1752	1830
Denominator	38737	38246	37106	36902	37317
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 - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

Narrative:

Low birth weight is a high risk factor impacting the health of the infants. LBW infants are at higher risk for complication after birth, such as respiratory, metabolic and nutrition conditions that may require long hospitalization and can impact the child's future health and development. The percent of singleton infants born at a LBW in 2012 was 4.9%. This is essentially equal to the percent of singleton infants born at a LBW in 2011 (4.7%). The percent of singleton infants born at a LBW in 2005 was 5.4% and 5.1% in 2010. Because of the relationship between maternal smoking and infant low birth weight and the high proportion of pregnant Medicaid enrollees who smoke during pregnancy, IDPH has been working closely with our partners at Iowa Medicaid Enterprise to identify and reduce barriers to Medicaid recipient receipt of smoking cessation medications and other programs that support smoking cessation such as the Iowa Quit Line.

The Statewide Perinatal Care Team has been a strong force in making sure policies and practices at the birth centers are in place helping keep the LBW percentages low and ensuring that all women are receiving the appropriate level of care.

Additionally, as noted in Health System Capacity Indicator 5A, access to smoking cessation medication that is safe when taken during pregnancy, nicotine replacement drugs, and counseling during prenatal visits was made available to Medicaid eligible pregnant women in response to data which reflected a high proportion of women who reported that they smoked during pregnancy. This policy change took effect January 2008.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02A - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	1.2	1.1	1.3	1.1	1.1
Numerator	501	446	506	431	436
Denominator	40221	39662	38514	38204	38686
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 - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

Narrative:

The percentage of infants born at a very low birth weight percentage in Iowa has remained stable for the past several years. The percentage of infants born at a VLBW was 1.1% for calendar years 2011 and 2012. See #1 A and B for strategies that Iowa is implementing.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 02B - Multi-Year Data

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Indicator	0.9	0.8	1.0	0.8	0.8
Numerator	346	310	358	307	305
Denominator	38737	38246	37106	36902	37317
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 - 2012

FFY12 data were obtained from 2012 Vital Statistics data.

Notes - 2011

FFY11 data were obtained from 2011 Vital Statistics data.

Notes - 2010

FFY10 data were obtained from 2010 Vital Statistics data.

Narrative:

The percentage of infants born at a very low birth weight percentage in Iowa has remained stable for the past several years. The percentage of infants born at a VLBW was 1.1% for calendar years 2011 and 2012. See #1 A and B for strategies that Iowa is implementing.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	37948	33553	1549	222	917	52	1655	0
Children 1	158418	138522	7683	993	3494	248	7478	0

through 4								
Children 5 through 9	203268	179291	9541	1383	4306	297	8450	0
Children 10 through 14	202026	180460	8723	1592	4038	231	6982	0
Children 15 through 19	213341	191631	9611	1339	4567	217	5976	0
Children 20 through 24	222526	198244	10444	1384	7789	280	4385	0
Children 0 through 24	1037527	921701	47551	6913	25111	1325	34926	0

Notes - 2014

Narrative:

Historically, Iowa has been among the more homogenous states with respect to race and ethnicity, but the state is becoming notably more diverse, and young children are leading the way. Children of a race other than white and/or who are Hispanic or Latino represent 21 percent of Iowa's under-6 population and 17 percent of the 6-17 population in 2010, but only 2.9 percent of the 65-plus population. From 1990 to 2010, the young-child population in Iowa identifying as Hispanic or Latino more than doubled, and, in fact, people of Hispanic descent are now the largest minority group in the state. All other minority groups, including people who identify two or more races, have grown significantly as well. Iowa's population is projected to continue becoming more diverse over this decade, although at a slower rate than during the 2000s.

The growth of minority communities is a key component of overall population growth in Iowa. Without population growth among young children of color and/or of Hispanic or Latino descent, Iowa's young-child population would have declined statewide and in 70 of 99 counties. During the 2000s, a handful of suburban counties, primarily those around Des Moines, experienced very high growth rates among non-Hispanic white children, but the majority of counties experienced significant drops in this population.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	469240
Living in urban areas	474627
Living in rural areas	343591
Living in frontier areas	0
Total - all children 0 through 19	818218

Notes - 2014

Narrative:

Young people have left their farming communities behind and migrated toward urban centers in search of employment and other opportunities. According to data from the U.S. Census Bureau (2012), the population of urban counties in Iowa has increased 13.4 percent from 2000 to 2010. The population of rural counties in Iowa has decreased 3.1 percent during the same time period. In 2010, almost half of Iowa's population was located within ten urban counties with the remaining half spread over 89 rural counties.

F. Other Program Activities

The MCH Title V program has been extensively involved in providing leadership for changes in the service delivery system for children including but not limited to local Early Childhood Iowa Areas, the State Children's Health Insurance Program, Early Hearing Detection and Intervention, Newborn Metabolic Screening, Early ACCESS (IDEA, Part C), and the Iowa Medical Home Initiative. A list of formal and informal organizational relationships is located in the attachment for Organizational Structure section III-C. Contracts and memorandums of agreement are found in the attachment for this section, IV-F.

Family Planning activities are coordinated with the IDPH Family Planning Program and the Family Planning Council of Iowa, the Title X contractor for the state.

The following are other Child Health Specialty Clinic program activities:

1. State and regional staff are involved with planning and operation of local Early Childhood Iowa areas.
2. Staff contribute to course development and teaching for the University of Iowa College of Public Health MCH focus track students and other graduate students.
3. Staff participate in planning and providing experiences for leadership training in Iowa's Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program.
4. CHSC works with the Iowa Department of Human Services to assure quality care for CYSHCN enrolled in Medicaid and SCHIP programs and foster care.
5. Staff participate in planning and field-testing new approaches to delivering physical and behavioral health care services and consultation and nutrition services to community-based sites using telemedicine techniques.
6. CHSC partners with other Iowa public health professionals to co-plan and sponsor the Annual Iowa Governor's Conference on Public Health.
7. Staff participate in a Department of Human Services effort to assure appropriate screenings, evaluations and ongoing medical care for children enrolled in Iowa's foster care system.
8. Staff lead quality improvement efforts within Iowa's statewide system of early hearing detection and intervention for newborns and infants, based on principles obtained by participating in the National Improvement in Child Health Quality (NICHQ) learning collaborative.
9. Staff participate in an MCHB-supported Department of Public Health effort to establish a comprehensive early childhood system.
10. Staff participate in a Department of Human Services effort to assure healthy child mental development by improving early childhood screening practices among primary care providers.
11. Staff participate in IDEA Part C program planning and quality assurance projects and lead efforts to investigate the roles of social determinants of health, as well as home-based toxic exposures on early childhood development.
12. Staff serve in an advisory capacity to the Department of Public Health data integration initiative.

13. Staff serve in an advisory capacity for the Department of Public Health initiative to improve the "provider safety net" (community health centers, rural health clinics, and free medical clinics) for medically underserved Iowans, with a special emphasis on investigating the fit between the medical home model and various safety net providers, especially free medical clinics.

14. Staff serve in an advisory capacity on the Children and Families Congenital and Inherited Disorders Advisory Committee, Iowa Council for Early ACCESS, Iowa Medical Home Advisory Committee, Council for Maternal and Child Health, Iowa Autism Council, and the Prevention and Chronic Care Management Advisory Council and Clinicians.

15. CHSC's Director is a President of the Iowa Chapter of the American Academy of Pediatrics, American Academy of Pediatrics EHCI Task Force, and AMCHP Board of Directors.

16. CHSC is represented on the Center for Disabilities and Development "Community Partners Advisory Committee" which seeks to improve community outreach, advocacy, and services to Iowa's citizens with disabilities.

17. The CHSC Regional Autism Assistance Program promotes training health care providers and educators in early detection and intervention strategies for children with autism and other disorders on the autism spectrum. CHSC parent consultants assist parents of children with ASD in learning Applied Behavior Analysis (ABA) techniques via a National Institute of Mental Health grant to the Centers for Disabilities and Development at the University of Iowa.

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

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

G. Technical Assistance

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

Iowa has integrated the ACE survey questions into the BRFSS survey and will be getting preliminary data in the fall 2012. Technical assistance may be requested for analysis of the ACE survey questions. The technical assistance would be requested to do additional analysis that would drill deep into the data at a county level or regional level. Iowa is also interested in technical assistance from another state, such as Washington or Oklahoma on implementation at the community level.

Iowa is requesting technical assistance support to build capacity of data assessment and analysis related to child death review data. Support is needed to continue and expand analysis of the data from the child death review system. The focus would be on developing specific profiles, reports and measures for department maternal and child health programs and community-based initiatives. In addition, the department needs technical assistance in managing case files and entering data into the system. Iowa will use the data to inform the 2015 Title V needs

assessment.

In January 2014, Iowa will begin the 2015 Needs Assessment process. Iowa is requesting technical assistance for a consultant to facilitate state and local meetings and provider and consumer focus groups.

One major component of Iowa's Title V program at the state and local level is developing strategies to address cultural competency and working with diverse cultures. Iowa would like to work with staff from the University of Northern Iowa Project EXPORT to develop Iowa's capacity to assure Title V serves all ethnic minority groups and is working on system level strategies to address cultural competency.

Iowa recognizes the opportunity to build public health capacity for MCH through professional development focused on emerging issues and the changing political landscape including increased recognition of social determinants of health and health equity. Assistance is requested to support a presenter of Iowa's Governor's Conference on Public Health to be held in April 2014.

Iowa will seek technical assistance to help develop a population-based data collection systems that can supplement the NSCH/NS-CSHCN, especially in the interim years. Assistance is needed to advise about funding and data collection issues. National Surveys are conducted every ~5 years, but for many children's health initiatives, seeing interim data to measure progress would greatly enhance our responsiveness to needs, as well as quality improvement. Iowa will seek assistance from states that are collecting yearly population-based child health data, more specifically someone who works on the Autism and Developmental Disabilities Monitoring Network (ADDM).

CHSC will develop trainings, to be presented via Webinar, on financing special health care needs, including information on the Home and Community Based Waiver system, applying for Medicaid, applying for Social Security, and the new Insurance Exchange. Some families are unfamiliar with these topics and Family Voices Indiana has been active in this area.

CHSC is developing a Family Advisory Council. CHSC is unfamiliar with this process, so will seek technical assistance from a health department who has had success in developing a similar council.

CHSC would like assistance in developing a self-study or group study curriculum for nutrition training, similar to Three Nutrition-Based Curricula available online at: www.pacificwestmch.org CHSC currently uses this website for training dietitians, pediatricians, nurses and other staff, but it is specific to Washington State. We desire a training that uses the information provided by Washington State, but tailoring resources as needed for Iowa.

CHSC will develop an interactive "Roadmap to Services" for CYSHCN to be housed on its website and to be accessible to families and Family Navigators. Some families and new Family Navigators are find the complicated network of services and creating a guide for the website will help this.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	6159375	5109559	6442068		6536122	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	5531822	5154683	5350187		5670857	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	0	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	3947332	4380323	3852092		5558142	
6. Program Income <i>(Line6, Form 2)</i>	475000	404052	350000		472000	
7. Subtotal	16113529	15048617	15994347		18237121	
8. Other Federal Funds <i>(Line10, Form 2)</i>	8066628	8210965	13566821		12517428	
9. Total <i>(Line11, Form 2)</i>	24180157	23259582	29561168		30754549	

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

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	1583901	1479146	1641918		1683481	
b. Infants < 1 year old	280137	283565	301710		268698	
c. Children 1 to 22 years old	8876848	8783985	9056884		10694019	
d. Children with	4766105	3883558	4387297		4984385	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	606538	618363	606538		606538	
g. SUBTOTAL	16113529	15048617	15994347		18237121	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	0		150000		0	
d. Abstinence Education	860686		860594		823680	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	175000		190000		635045	
j. Education	156400		156400		588326	
k. Home Visiting	0		7740642		7345869	
k. Other						
HRSA					294399	
Iowa DHS					547076	
OPA					1333033	
SAMHSA					850000	
Autism			154326			
CCHT-Intgr. Comm.			86489			
CDC Stillbirth	270000		270000			
CHIPRA			324766			
Early ACCESS-CHSC			211376			
EPSDT - HCBS IS			547076			
Family Planning	1301484		1333033			
Newborn Hearing-HRSA	300000		270000			
PRAMS			190046			
Prjct LAUNCH/Connect	957281		982073			
CCC- SAMHSA	2299435					
ECCS -HRSA	140000					
Family Participation	130000					
Family to Family	95700					
Home Visiting	1140642					
Newborn Scrn Surv	140000					

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

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	3989929	4177716	4691978		4426360	

II. Enabling Services	3252930	3107536	2963776		3581960	
III. Population-Based Services	1715982	1517768	1476974		1782376	
IV. Infrastructure Building Services	7154688	6245597	6861619		8446425	
V. Federal-State Title V Block Grant Partnership Total	16113529	15048617	15994347		18237121	

A. Expenditures

Form 3, State MCH Funding Profile, shows \$5,109,559 in federal Title V fund expenditures. Expenditures followed the spending plan which relied on carry forward funds from the FFY 11 award. Due to a decrease in the state's award for FFY12, carry forward funds were necessary to maintain local and state programs at current levels for maternal health and child health.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY12 in the amount of \$15,048,617. Of this amount, \$5,109,559 was funded by federal Title V. Figure 1 in the attachment displays the distribution of Title V expenditures by population served. The state match is reported at \$5,154,683. This exceeds both the state match requirement of \$4,831,803 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 \$2,092,652 or approximately 41 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at \$1,249,085 or 24 percent of the federal block grant funds expended for the year. Administration expenditures of \$599,543 represent 12 percent of the federal Title V expenditures to date. In order to complete the expenditure report for FFY12, IDPH pulled fiscal data in February 2013 and do not reflect the expenditures for FFY12 after that date. IDPH anticipate to fully expend FFY12 funding within the spending plan by July 2013.

In the attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to infrastructure continue to increase for MCH compared to the proportional of funds directed to direct services. Continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state partnership.

The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with OMB Circular A-133. The most recent report is for the period July 1, 2011 to June 30, 2012. The Iowa Department of Public Health had two findings in the 2012 audit related to internal controls; however, these findings were not related to Title V expenditures. The report is submitted to the federal clearinghouse by the state Auditor's Office.

An attachment is included in this section. VA - Expenditures

B. Budget

The FFY14 Title V appropriation is projected to be \$6,536,122, based on the President's budget and the final FFY13 award before sequestration. As itemized in the budget attachment, this

expected allocation is budgeted as follows: \$1,359,399 (20.8%) for maternal health services; \$268,698 (4.1%) for infant health services; \$2,107,541 (32.2%) for child health services; \$2,193,946 (33.6%) for services to children with special health care needs; and \$606,538 (9.3%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. In the attachment, Figure 5 illustrates the budget plan for the FFY13 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is \$5,670,857. Iowa continues to exceed the state maintenance of effort of \$5,035,775, established in 1989 and exceeds the required match of \$4,902,092.

The total budget for the federal-state partnership is projected to be \$18,237,121. Attachment, Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of service, as well as population group served.

Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Infrastructure Building Services

Estimated budget for continuing development of core public health functions and system development are \$8,446,426 or 46.3 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 22 percent of local maternal health funds. In addition, it will include contract services with the University of Iowa, Departments of Pediatrics, Perinatal Review Team, Healthy Child Care Iowa, EPSDT dental and IDPH 1st Five Initiative. CHSC's budget for infrastructure building services is estimated at \$1,675,465 (33.6 percent of the CYSHCN budget).

Population-based Services

The federal-state partnership expenditures for continuation of population-based services are estimated at \$1,782,376, which represents approximately 9.8 percent of the total partnership budget. IDPH funds budgeted in this category include state funds for STD testing, immunization, lead poisoning prevention, and birth defects and audiological services. This category also includes 10 percent of the funding for local child health agencies and 8 percent of local maternal health funds. IDPH projects expenditure of \$1,416,322. CHSC's budget for population-based services is estimated at \$281,329 (5.6 percent of the CYSHCN budget).

Enabling Services

The federal-state partnership expenditures for continuation of enabling services are estimated at \$3,581,960 representing 19.6 percent of the partnership budget. This category includes 43 percent of the funding for local child health agencies and 30 percent of local maternal health funds. Healthy Families toll free information and referral line, TEEN Line, hawk-i Outreach, and EPSDT are included in this category. CHSC's budget for enabling services is estimated at \$1,492,357 (29.9 percent of the CYSHCN budget). CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Direct Health Care Services

The federal-state partnership expenditures for continuation of direct care services are estimated at \$4,426,360. This represents approximately 24.3 percent of the partnership budget. The amount includes 14 percent of the funding for local child health agencies and 41 percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment, and dental sealant projects; OB indigent program, and child vision screening. CHSC projects a direct care budget of \$1,535,234 or approximately 30.8

percent of the CYSHCN budget.

Other federal funding has increased in Iowa over the past several years. Increases in funding include MIECHV Formula and Expansion and PRAMS funding.

Other federal funds directed toward MCH include:

State Systems Development Initiative (HRSA/MCHB)

Early Childhood Comprehensive Systems Grant (HRSA/MCHB)

Title X Family Planning

Early ACCESS (IDEA, Part C)

Iowa Stillbirth Surveillance Project (CDC)

Iowa Newborn Screening Surveillance Project (CDC)

Early Hearing Detection and Intervention (CDC and HRSA)

Project LAUNCH (SAMHSA)

Personal Responsibility Education Program--PREP (ACF)

Maternal, Infant, Early Childhood Home Visiting (HRSA/MCHB)

Pregnancy Risk Assessment Monitoring System (PRAMS) (CDC)

Abstinence Education (ACF)

An attachment is included in this section. VB - Budget

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.