

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **IA**

APPLICATION YEAR: **2005**

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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.

B. FACE SHEET

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

C. ASSURANCES AND CERTIFICATIONS

See attachment for Assurances and certifications.

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 June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

/2005/The Iowa Maternal and Child Health (MCH) Advisory Council members represent a wide spectrum of providers, consumers, parents, and policy makers that are concerned with MCH issues. Members were asked to assist in the establishment of the Title V priority needs and performance measures. The Council endorsed the state plan at their June 17, 2004 meeting (see the attachment for the complete membership list and by-laws). The MCH Advisory members were also asked to provide public comment via the IDPH web site.

The BFH Grantee Committee is comprised of representatives from all 36 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.

For the third year, public input was obtained via the IDPH web site. The 2005 proposed priorities, annual report, performance measures, and program activities were posted from June 1-10, 2004. A memo was sent to a diverse group of over 300 persons and agencies interested in MCH issues. Over 30 people sent comments and suggestions.

The final version of the application incorporates comments and recommendations received from the public comment.

This year, family input was primarily being obtained through the MCH Advisory Council, the CHSC Parent Consultant network, and the Dept. of Education's Part C family advisory group.//2005//

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Introduction. Since this is an interim report, portions of the narrative where descriptions of changes to last year's report are designated with */2005/ and //2005//* and the text is in italics. This procedure allows for quick determinations of differences from year to year without the need to find the previous year's application and compare the narratives to discover what changes have been made.

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

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

Changes in demography. Estimates from the U. S. Census Bureau show that growth in Iowa during the 1990s is confined to two pockets: one in and around Des Moines in the center of the state and the other in the Cedar Rapids-to-Iowa City corridor towards the East. Meanwhile, 45-50 percent of Iowa's 99 counties are expected to continue to lose population. Nearly 20 percent of Iowa's rural counties could lose up to five percent of their 1990 population by 2010. This rural-to-urban shift is seen as a result of small towns that are no longer able to survive and meet the needs of surrounding communities.

/2003/ 2000 U.S. Census Bureau shows that Iowa's population changed from 2,776,755 in 1990 to 2,926,324 in 2000. One-third of Iowa's 99 counties are expected to lose population.

/2005/ 2000 U.S. Census Bureau shows that Iowa's population changed from 2,926,324 in 2000 to 2,944,062 in 2003. Two-thirds of Iowa's counties are estimated to lose population. The Hispanic immigrants population continues to grow. There was a 2.8 percent increase in the Hispanic population from 2000 to 2002, compared to 0.4 percent increase of Iowa's overall population.//2005//

Employment and Population Changes. In 1999 Iowa's unemployment rate dropped to its lowest monthly rate in many years. (2.5 percent) The rate had been on a decline since the beginning of the decade. The number of unemployed is so low that leaders fear there will not be enough workers available to fill the jobs that will be developed in the coming years. This concern has encouraged employers to seek new employees from other states and counties. The influx of workers has created a need for interpreters and health information in many different languages.

The most notable population change is the increase in Hispanic immigrants. Census estimates show that residents of Hispanic origin increased from 1.2 percent in 1990 to two percent in 1998. This group has shown the largest growth of any minority group in the state, increasing 67 percent from 1990 to 1998.

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

Refugees from Eastern European countries, especially Bosnia, as well as immigrants from other countries brought more school aged children. From 1993 to 1999, enrollment of students with limited English proficiency increased from 3785 to 9160, which is an annual increase of 12 percent.

/2002/ Iowa's employment rate is still at its lowest yearly rate in 2000 at 2.6 percent. The Iowa 2000 Census indicates that residents of Hispanic origin increased from 1.2 percent in 1999 to 2.8 percent in 2000. This group has shown the greatest growth of any minority group in the state, increasing 133 percent from 1990 to 2000.

From 1993 to 2000, the number of student enrollment of limited English proficient students has increased from 3,785 to 11,248, which has tripled in seven years.

/2003/ Iowa's unemployment rate is still at its lowest yearly rate in 2001 at 3.3 percent. Seven Iowa Counties had an increase in Hispanic population to 10 times more than 10 years ago. In three of the seven counties, residents of Hispanic origin constitute more than 10 percent of the total population. In 2001, limited-English-proficient students (K-12) increased to 13,460 from 11,248 in 2000.

/2004/ The unemployment rate for Iowa has slightly increased to four percent in 2002, which is still lower than the national average. Residents of Hispanic origin make up the fastest growing ethnic group in Iowa. In 2001, live births to Hispanic women made up 5.9 percent of all births, more than double the proportion in 1990.

//2005/ The unemployment rate for Iowa has increased to 4.5 percent in 2003.//2005//

Poverty. The percentage of families in Iowa living at or below the federal poverty level has been declining since 1990. Data from 1996-1998 show the overall average poverty rate for Iowa families is 9.4 percent. The ratio of women to men in poverty is 1.4 to 1.0, which closely approximates the national figure.

/2002/ Data from 1996-1999 shows that Iowa has the 9th lowest poverty rate in the nation, with 7.5 percent below the federal poverty level. However, this still shows about 211,000 people are defined as poor by federal poverty level.

/2003/ Data from the 2000 Census show that Iowa has a 9.9 percent poverty rate. This means that about 290,000 people are still defined as poor by federal poverty standards. Using the 1998-2000 average, Iowa's poverty rate is lower than shown in the 2000 Census report, at 7.9 percent.

/2004/ The 2001 Census estimates that Iowa's poverty rate is 7.4 percent.

//2005/ The percentage of families in Iowa living at or below the federal poverty level has continued to decline. Data from 2002 shows the overall average poverty rate for Iowa families is 7.3 percent, which equates to 9.1 percent of Iowans.//2005//

Welfare Reform. On October 1, 1993, Iowa replaced Aid to Families with Dependent Children (AFDC) with a comprehensive welfare reform program known as the Family Investment Program (FIP). A central element of FIP is the requirement that welfare recipients carry out individual plans for self-sufficiency, called Family Investment Agreements (FIAs). When a FIP household fails to sign or follow the terms of an FIA they are considered to have chosen a Limited Benefit Plan (LBP). In the first LBP there is no period of reduced benefits, no set period of ineligibility, and the person who chooses the LBP can reconsider by signing an FIA at any time to stop the LBP. For second and subsequent LBPs chosen by the same person or by either parent in a two parent household, there is a six-month minimum period of ineligibility. When the six-month period ends, ineligibility continues until the person who chose the LBP reapplies for FIP, reconsiders by signing an FIA, and completes 20 hours of work or another approved PROMISE JOBS activity. FIP recipients and other people whose income is considered for FIP are now automatically eligible for state Child Care Assistance without regard to that program's eligibility requirements and waiting list.

Since welfare reform began, the number of recipients decreased by approximately 10,000 each year, from 95,000 in 1994 to 65,000 in 1997. Concerns about potentially detrimental effects of the LBP on

children spurred policy makers to require that the Iowa Department of Human Services (DHS) systematically monitor the well-being of children in families that enter the LBP. In response to these requirements, DHS established the Well-Being Visit Program. DHS and the Iowa Department of Public Health (IDPH) administer this program in conjunction with local public health agencies throughout Iowa's 99 counties. These local agencies employ registered nurses and social workers to conduct well-being visits. The primary purpose of well-being visits is to support families in their move to being self-supported. A secondary purpose is to check on the well-being of children in the families, including linking children and families with health and human service needs to appropriate community resources. Acceptance of a well-being visit is voluntary on the part of the client. Priority is placed on completing a face-to-face visit with the client and the client's children in the home. In 1999, 3,069 well-being visits were completed. Fifteen percent of the visits were done over the phone, 17 percent were completed in the home with the child present, five percent were complete in the home without the child present, and about two percent were done at an alternate site. During the well-being visits, 2172 referrals were made for various services: 18 percent were referred to the food pantry, 15 percent for heating assistance, 13 percent for Medicaid, and 13 percent for housing assistance.

/2002/ In 2000, 1,731 well-being visits were completed in Iowa. The decrease from last year is due to a decreased number of people going on FIP services. Thirty percent of the visits were done over the phone, 54 percent were completed in the home with the child present, 14 percent were completed in the home without the child present, and about three percent were done at an alternate site. During the well-being visits, 1,434 referrals were made. Twelve percent were referred to the food pantry, nine percent for heating assistance, five percent for Medicaid, and seven percent for housing assistance.

/2003/ The well-being visiting program was not contracted out and Department of Human Services kept the option to provide visits to families going off FIP services.

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

/2003/ Iowa was one of five states and one community to receive a technical assistance grant to help strengthen and expand Iowa's state and local partnership for providing quality care and education for young children in Iowa. The Technical Assistance Grant comes from North Carolina Smart Start National Technical Assistance Center. The grant started in January of 2002 and will continue through January 2004. The grant is not a cash grant to Iowa but rather resources worth up to \$150,000 including; On-call coach, information and referral, site visits, mentoring program, conference calls, Smart Start Resource material, and Smart Start Speaker Bureau.

The following recommendations were designed to build upon and strengthen what Community Empowerment has already accomplished and to assist the initiative in moving to the next level of development:

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

/2004/ Community Empowerment formed a core early care, health, and education stakeholder group. The purpose of the stakeholder group is to be an advisory group to the early care, health, and education system. The stakeholders include representatives from public and private entities throughout the state. The functions of the stakeholder group is to review, design, and participate in cross functional proposals, understand all parts of the system, create and update plan, agree on common language for the system, develop a menu of best practices, encourage relationships across disciplines, and be a resource to the system.

In 2002, Community Empowerment convened the core stakeholder group to gather input on the visions, goals, indicators, and strategies for an early care, health, and education framework. (See the attachment for a description of the system results planning framework). Community Empowerment held regional sessions with over 250 stakeholders for input on the goals and indicators. The core stakeholders reconvened and reviewed all the input from the regional meetings, built solid support for goal statements and began to define strategies (refer to the attachment for the vision and goal statements). The following groups have endorsed the vision and goals; AEA Directors of Special Education, AEA Early Childhood Network, Bureau of Family Health Child Health Advisory Team, Bureau of Family Health Women's Health Team, Central Iowa Regional Child Care Resource and Referral, Dept. of Education Early Learning Team, Dept. of Human Rights Administration, Dept. of Human Services Administration, Early ACCESS Regional Coordinators, Early Childhood Special Education Network (AEA), FaDSS Council, Head Start Collaboration Office, Iowa Childcare and Early Education NetWork, Iowa Early ACCESS Council, Iowa Empowerment Board, Iowa Maternal and Child Health Advisory Council, Mental Health and Developmental Disabilities Commission, Special Education Advisory Panel, the State Childcare Advisory Council, and the State Board of Health.

The Bureau of Family Health will partner with Community Empowerment to develop an early childhood plan through the HRSA Early Childhood Comprehensive Systems grant. Key personnel from IDPH are the project director and coordinator. The State Empowerment Team will serve as the coordinating body of the grant. The plan will promote the development of community-based comprehensive systems of services that assure coordinated, family centered, and culturally competent care for children.

/2005/ The Early Childhood Iowa Stakeholder group has been working on the goals, indicators, and strategies of the early care, health, and education system. The stakeholder members are responsible for taking the goals, indicators, and strategies back to their constituents to get buy in. The Early Childhood Comprehensive Systems grant is in the second year of the planning grant and IDPH will be applying for an implementation grant for July 2005.

The Early Childhood Iowa Stakeholder members have developed six component workgroups to help move the system planning forward. The six component workgroups are: 1. Quality services and programs; 2. Public engagement; 3. Resources and funding; 4. Results accountability; 5. Governance and planning; and 6. Professional development. See attachment for the Early Childhood Stakeholder documents.//2005//

Perinatal Guidelines. The 1998 Legislature directed the Iowa Department of Public Health (IDPH) to develop and maintain statewide perinatal guidelines. State guidelines were available previously; however, the new administrative rules were written with input from the public and the Perinatal Advisory Committee. These rules, effective March 17, 1999, allow for voluntary participation by hospital, and define the criteria for perinatal level designation.

State Child Health Insurance Program. In response to the federal initiative of State Children's Health Insurance Programs (SCHIP), the 1998 Iowa Acts, Chapter 1196, authorized health care coverage for specified uninsured children in Iowa. Legislation created a SCHIP plan that expanded Medicaid eligibility to children whose family incomes were up to 133 percent of the federal poverty level. Medicaid expansion began on July 1, 1998. Initial estimates predicted an additional 15,500 children would be covered based on this expansion. /2004/ As of March 2003, 14,495 children have been

enrolled in Medicaid expansion.

Iowa also chose to establish a separate private insurance plan for children with a family income between 133 percent and 200 percent of the poverty level. This Plan, called hawk-i (Healthy and Well Kids in Iowa) began January 1, 1999. Federal estimates indicated 40,000 Iowa children were potentially eligible for hawk-i. Reports from March 2003 indicate that 13,143 children have enrolled in hawk-i since its inception.

//2005/ As of May 2004, 14,270 children have enrolled in Medicaid expansion. Reports from May 2004 indicate that 16,812 children were enrolled in the hawk-i program.//2005//

Dr. Jeffrey Lobas, Director of Child Health Specialty Clinics is a member of the Clinical Advisory Committee of the hawk-i Board. Dr. Lobas also is the Chair of the Subcommittee for Children with Special Health Care Needs (cshcn). The Clinical Advisory Committee made recommendations to the hawk-i Board during the June 2001 board meeting. The board approved the Clinical Advisory Committee's recommendations and passed them on to the 2002 General Assembly. These recommendations were not adopted. The cshcn subcommittee addresses health coverage issues faced by children with special health care needs and their families. The committee's goal focuses on collecting data to develop a quality assurance plan in response to the special needs populations and access to health insurance.

In July 1999, the Family Health Bureau became a Robert Wood Johnson Foundation (RWJ) grantee for Iowa's Covering Kids Project (CK), an initiative that increases access to health care for low-income children. The goals of the project are to: 1) design and conduct outreach programs in pilot communities to help identify and enroll children into Medicaid or hawk-i; 2) simplify the enrollment process; and 3) coordinate existing coverage programs for low-income children.

//2002/ Income guidelines have been changed to between 134 percent to 200 percent of the poverty level. Federal estimates indicated Iowa has potentially 45,000 children eligible for hawk-i. Reports from March 2001 indicate 9,580 children have enrolled in hawk-i since January 1, 1999.

//2003/ The final grant year for the Robert Wood Johnson, Covering Kids Project is July 1, 2001 -- June 30, 2002. However, RWJ has extended the same Covering Kids grant goals by offering funding for a four year grant entitled, "Covering Kids and Families" (CKF), which builds on Covering Kids efforts. CKF priorities in year one include: 1) Conduct a statewide assessment to identify school districts currently including insurance questions in their free and reduced school lunch forms; 2) Continue to convene the task force that focuses on barriers to health insurance access to children and make comprehensive recommendations for removing these barriers; 3) Identify key pre-service health care professional education programs in the state and conduct a survey to assess the degree to which health insurance programs are incorporated into the curriculum.

//2004/ The Department of Human Services presented a study regarding updated projections for hawk-i and Medicaid. The purpose of this study was to determine the number of children who are eligible for hawk-i and to project the future growth of enrollment for SFY 2003 and SFY 2004. It is estimated there are 32,500 children in Iowa eligible for hawk-i or Medicaid. The estimated year-end enrollment for hawk-i for SFY 2003 is 18,000 and for SFY 2004 is 22,000. The 80th Iowa General Assembly passed legislation that eliminated the six-month waiting period for families to access hawk-i. The legislation will require the Department of Human Services to monitor the fiscal effects of eliminating the six-month waiting period.

DHS also approached IDPH to be the contractor for providing oversight for hawk-i grassroots outreach. This new responsibility is placed in the same bureau where Covering Kids and Families is placed, however, they will continue to operate as separate programs. The new outreach structure under IDPH began implementation November 1, 2002. All 26 local contract child health agencies provide outreach coverage for all 99 counties. A full-time state hawk-i Outreach Coordinator was hired in February 2003.

Covering Kids and Families priorities in year two included: 1) Collaborate with the Department of Education to design strategies encouraging school districts to send to hawk-i a list of families who identified interest in a hawk-i application from the insurance questions incorporated in the free and reduced school lunch forms; 2) Continue to convene the task force that focuses on barriers to health insurance access to children and make comprehensive recommendations for removing these barriers; and 3) Facilitate a statewide outreach task force for outreach coordinators and child advocates doing hawk-i and Medicaid outreach.

//2005/ Collaboration has continued between the Department of Public Health and the Department of Human Services to provide grassroots outreach and enrollment for hawk-i. Outreach efforts coordinated through IDPH and the local child health agencies have been very successful. This collaboration will continue to guide successful outreach to uninsured families in Iowa. Initial outreach efforts focused on four areas: schools, faith-based, medical providers, and underserved populations. These efforts have expanded to areas of businesses, workforce, tax sites, and many other areas. During September, the Lt. Governor traveled across Iowa to lead seven community roundtable discussions about hawk-i outreach strategies. The roundtables were very well attended by a variety of community representatives, including school nurses, medical providers, ministers, insurance agents, legislators, workforce agencies, and childcare organizations. Local press also attended all roundtables. State staff and local coordinators assisted the Lt. Governor's staff in coordinating the community roundtables. The roundtables were a success and a great opportunity to showcase the hawk-i program. Iowa's hawk-i Outreach Coordinators were honored with the Governor's Above and Beyond Award. This award recognizes persons connected to childhood public health or the delivery of health care to children in Iowa.//2005//

HRSA State Planning Grant Iowa is one of 32 states awarded a significant federal grant to assist in developing and examining options to expand access to affordable health insurance. Iowa was awarded a HRSA State Planning Grant from the US Department of Health and Human Services in the fall of 2000. Subsequently, additional funds were awarded for 2001-02. Iowa's grant is managed by the Department of Public Health. The grant's goals include:

1. Building a complete and data-driven picture of Iowa's uninsured population,
2. Building a complete and data-driven picture of Iowans' beliefs on expanding access to health insurance,
3. Designing coverage options that will incorporate data on the uninsured Iowans' beliefs regarding expanding access to health insurance,
4. Creating a strategy to achieve the goal of expanding access to health insurance, and
5. Preparing reports to the Secretary (of the Department of Health and Human Services) that can be used by other states to expand access to affordable health insurance to their citizens.

IDPH Strategic Plan Summary In 1998, the IDPH developed the Iowa Department of Public Health's 2000-2005 Strategic Plan. This document resulted from several stages of review, analysis, and planning that involved over 100 staff members and representatives from the department's contractors, boards, and commissions. The Strategic Plan outlines goals in four areas: the Public Health System, Internal Government, Image and Communication, and Health Status. The Strategic Plan contains strategies, outcomes, and measures for each goal. The goals include:

1. Using existing and evolving technology and standards for the delivery of public health services and information,
2. Improving the capacity of local board of health and other public health partners to address public health needs and implement the core public health functions,
3. Understanding and responding to the needs and health concerns of all Iowans,
4. Eliminating health disparities, and
5. Improving access to services for underserved populations, especially those who remain at increased risk of illness and premature death.

provides educational opportunities for Title V agency-led teams in Iowa. The Data Use Academy enhances data use skills through a practice-based yearlong learning experience presented by the Section on Child Health Policy at the Department of Pediatrics, University of Nebraska Medical Center (UNMC). Through DUA participation, Iowa's MCH programs increased their capacity to lead efforts to improve the health of vulnerable populations through the effective use of data. The Academy replicates the highly effective CityMatCH MCH Data Use Institute sponsored nationally by UNMC. In order to be accepted, MCH teams must demonstrate support of the local board of health and Title V agency, the importance and feasibility of the proposed project, and team membership representing the three data use components (policy, program, and data).

/2004/ Four Iowa teams began the year long DUA educational process in October 2002. The teams chose projects centering on women's health literacy, public health practices in child care, early childhood data integration, and linkage of care coordination activities.

/2005/ Two Iowa teams are participating in the Data Use Academy (DUA) process. One team is focusing on early childhood and the other is focusing on meth use in college-aged women.//2005//

Children with Special Health Care Needs. Child Health Specialty Clinics (CHSC) is Iowa's Children with Special Health Care Needs Program supported by Title V funds. The CHSC administrative office is located at the University of Iowa. CHSC supports 13 regional centers throughout the state. Regional centers provide and manage a number of services for children with special health care needs, including subspecialty clinics, care coordination services, technical assistance activities, and planning and evaluation functions. Additionally, CHSC works closely with the state MCH Director to implement and develop programs to serve all of Iowa's children.

/2004/ There are now 14 CHSC regional centers.

/2005/ Capacity reduction will occur in July, 2004 when, as an adjustment to federal and state budget reductions, CHSC regional center staffing will be reduced statewide to 0.8 FTE. Additionally, one professional position in the Iowa City administrative office has been furloughed and another resigned professional position will not be filled. Capacity increase occurred in FFY04 when the CHSC Director, Jeffrey Lobas, MD, received a 0.2 FTE appointment as the Medical Director for the Division of Health Promotion and Chronic Disease Prevention of the Iowa Department of Public Health.//2005//

The process for developing CHSC priorities continues to use focus groups of staff, community leaders, parents, and advisory councils at the regional centers. There were at least two statewide meetings for regional coordinators and directors of programs where discussions regarding priorities occurred. Management staff utilized a SWOT analysis in developing a strategic direction for CHSC. There have also been regular planning meetings with the Department of Human Services regarding children with special health care needs and regular meetings with the Departments of Public Health and Education defining the needs of this population.

/2003/A new agreement with the Department of Education distributes Part C technical assistance support primarily among nine designated CHSC staff. The previous agreement supported a single full-time technical assistant. The new agreement better represents the breadth of early intervention activity performed by CHSC state and community staff.

/2004/The "2000 Iowa Child and Family Household Health Survey" and the "National Children with Special Health Care Needs Survey" are population-based data sources that have also contributed to the program planning and problem prioritization process. Hypothesis generation and statistical testing may be used to direct and refine interventions addressing identified priority needs. The Household Health Survey, using the FACCT screener, revealed different prevalence rates of cshcn among racial/ethnic groups (White -- 17 percent; African-American -- 19 percent; Hispanic -- 14 percent; and Asian -- 9 percent). The significance of these rate differences is uncertain.

/2005/Additional newly reported survey findings help CHSC understand the insurance status of Iowa families with cshcn./2005//

A number of important issues were identified through this process. Child and adolescent mental health continues to be one of the biggest concerns within the state, and a number of groups have met to discuss possible solutions. Quality of care for cshcn enrolled in managed care continues to be a concern. The Subcommittee to the hawk-i Board for Children with Special Health Care Needs made recommendations to the board and to the state legislature and continues to develop details regarding these recommendations.

/2002/ The Subcommittee continues to meet and to work with the Board and Legislature.

/2003/ The Subcommittee has completed its work and will not meet unless reconvened by the Board.

/2004/ There are current efforts to improve quality of care by allowing families to voluntarily disenroll cshcn from Medicaid Managed Care and reenroll them in traditional fee-for-service Medicaid. In keeping with Title V's infrastructure building responsibility, additional longstanding cshcn-related needs are now being intensively addressed. First, the "Creston Behavioral Health Program" is implementing an innovative approach to increasing behavioral health services access for children in a predominantly rural area in southwest Iowa. Second, the "Continuity of Care Program" is improving communication and care coordination regarding cshcn who are discharged from the Children's Hospital of Iowa back to community-based care resources. Third, the "Iowa Medical Home Initiative" is working to establish medical home models statewide for cshcn in primary care pediatric and family medicine practices. These system development activities are all occurring with planning assistance and financial support from other state and local organizations.

/2005/ All of the above infrastructure building projects are undergoing structured evaluations to guide planning decisions related to project sustainability. The Continuity of Care Program and the Iowa Medical Home Initiative, in particular, will undergo economic analysis as one component of the evaluation.

CHSC is also involved in a couple of new system development projects - the Early Childhood Comprehensive Systems project funded by MCHB and the Assuring Better Child Health and Development project funded by the Commonwealth Fund./2005//

B. AGENCY CAPACITY

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

PREVENTIVE AND PRIMARY CARE FOR PREGNANT WOMEN, MOTHERS, AND INFANTS
Members of the BFH Women's Health Team have extensive experience working with women of childbearing age. The Women's Health Team provides direction, oversight, and monitoring for the 30 local maternal health and/or family planning contract agencies who provide services in Iowa. Systems development activities are coordinated with the IDPH Family Planning Program, the Family Planning Council of Iowa, hospitals, schools, local boards of health, providers of adolescent health programs, and statewide women's health initiatives. Technical support is provided to local maternal health and family planning agencies. Contracts are managed with the University of Iowa Hospitals and Clinics

(UIHC), Departments of OB/GYN and Pediatrics. The MH Community Health Consultant coordinates activities with the Healthy Start Project managed by Visiting Nurse Services of Des Moines.

/2005/ During FFY2004, a Women's Health Advisory Committee convened for the first time. This group advises and assists IDPH on aspects of women's health issues across the lifespan. The first quarterly meeting was held October 14, 2003./2005//

Maternal Health Centers. Twenty-six local maternal health contract agencies provide services to all 99 counties in Iowa. (see attachment for the MH agency map) Local maternal health agencies provide prenatal and postpartum care to low-income women, and other women in need. Services include risk assessment, psychosocial screening, referrals, care coordination, education, delivery planning, postpartum visits, and presumptive eligibility for Title XIX. Outreach efforts include community-based strategies for hard to reach populations, with special emphasis on informing residents of available services. Modes of delivery of the medical components of prenatal care include traditional clinic settings, purchase of services from private practitioners, and agreements with local hospitals. Performance standards have been developed to ensure the provision of quality maternal health service throughout the state. Maternal Health Centers also complete a Quality Assurance Matrix evaluating the provision of enhanced services, and conduct Direct Care Chart Audits on an annual basis.

The Statewide Perinatal Care Program provides training of health care professionals, development of care standards, consultation for regional and primary providers, and evaluation of quality of care through the state's 98 Perinatal Care Hospitals. Through a contract with the University of Iowa Hospitals and Clinics, these services are provided to all hospitals that perform deliveries. More intensive services are directed toward the state's three tertiary care centers and 19 secondary care centers.

Infant Mortality Prevention Center. The Infant Mortality Prevention Center was formed in 1993 after national data indicated a high infant mortality rate in Polk County, Iowa. The center consists of a local division, housed in Des Moines within the Visiting Nurse Services/Healthy Start Project. A MCH Consultant Neonatologist provides consultation to the center, and an infant mortality consortium of consumers, physicians, health care providers, social workers and legislators provides direction for the Center's activities. The center provides a locus for new infant mortality prevention strategies and a resource for implementing the Iowa Child Death Review Team recommendations. Local division initiatives consist of reduction of smoking in at-risk families, SIDS education, and substance abuse prevention.

Abstinence Education. Through Iowa's Section 510 Abstinence Education Program, local contractors have developed projects in 14 of the 28 maternal health regions. These projects promote asset development in youth and improved communication between children and parents. Contractors deliver abstinence only education through informational programs, mentoring programs, media presentations, and curriculum-based educational programs. Evaluation efforts through an agreement with the University of Iowa School of Social Work are used to strengthen programming. /2002/ Local community-based coalition-building activities continue to be emphasized. /2003/ The award of SPRANS Abstinence Education funding will allow for expansion of Iowa's Section 510 Abstinence Education program at both the state and local levels.

/2005/ IDPH will continue its two abstinence education programs, Section 510 and SPRANS. Section 510 will fund 10 agencies that will provide curriculum-based programs, community involvement activities, mentoring, media campaigns, asset building activities, workshops, informational programs, parent involvement, and peer education. SPRANS will fund three community-based agencies that will provide programming through curriculum-based instruction, community involvement, and mentoring components. Both programs will continue project evaluation./2005//

Healthy Families Iowa. The Healthy Families Iowa program is named Healthy Opportunities for

Parents to Experience Success (HOPES). It is a comprehensive home visiting program designed to promote healthy, safe and self-sufficient families. The state grant funded HOPES is available from fourteen agencies in nine counties. Eleven of the fourteen agencies have been awarded the national Healthy Families Credentials, which assures the services are provided at the national researched and proven level of quality. Pregnant women or families with a newborn are screened for risk factors indicating poor outcomes for the children and family. HOPES is offered to the families at high risk and participation is voluntary.

PREVENTIVE AND PRIMARY CARE FOR CHILDREN

Child Health Advocacy Team. Members of the Child Health Advocacy Team have extensive experience working with child and adolescent health issues. The team provides direction and oversight to 26 local child health contract agencies covering all 99 counties in Iowa(see attachment). Program activities include cooperative efforts with the Oral Health Bureau, Bureau of Disease Prevention and Immunization, Bureau of Lead Poisoning Prevention, Bureau of Nutrition, Center for Congenital and Inherited Disorders, Early ACCESS (Iowa's Infant and Toddler Early Intervention Program), Medicaid Administrative Claiming, Early Hearing Detection and Intervention, Empowerment, Early Periodic Screening, Diagnosis and Treatment (EPSDT), Adolescent Health, Family Planning, Healthy Child Care Iowa, ABCD II Infant Mental Health, Covering Kids and Families, and hawk-i Outreach.

Child Health Centers. Through contracts with IDPH, child health agencies are charged with developing health programs that are responsive to the needs of the community. The MCH Performance Standards described previously are used to ensure the provision of quality child health services throughout the state. The child health agencies focus on population-based services and infrastructure building in the community. Contract agencies work with managed care organizations to build partnerships to improve care coordination services at the local level. Other activities of contract agencies include medical home assurance, family education about service availability, outreach for uninsured children, dental access improvement, and direct care where access is limited. /2002/ Local MCH contractors are required to address national and state performance measures in their annual action plans.

Oral Health Program. The Oral Health Bureau (OHB) promotes health behaviors to reduce the risk of oral disease. The OHB staff offers consultation and assistance to MCH agencies in meeting the oral health needs of the women and children they serve. The OHB also monitors and evaluates MCH agency dental programs and project data to assure objectives and standards are being met. Child health centers receive funding to provide limited preventive and restorative dental care for their Title V clients through agreements with local dentists. MCH agencies also encourage families to seek dental care for children beginning at age one, and many child health centers provide fluoride varnish and dental screening programs for children less than 5 years of age. The OHB manages the fluoride mouth rinse program, with students in over 150 elementary and middle schools participating in weekly fluoride mouth rinsing.

/2003/ Maintaining the focus on preventive care for children, the Bureau will offer four school-based dental sealant program RFAs to begin in October, targeting schools with high enrollments of children who are uninsured, underinsured, or on Medicaid. School dental cards are available through the Oral Health Bureau to public health agencies, schools, and dental offices to emphasize the importance of regular dental care. The IDPH Division of Health Protection and Environmental Health oversees the administration of the community water fluoridation program.

/2005/ The Oral Health Bureau will continue to assist MCH agencies in meeting the oral health needs of the women and children they serve. Bureau staff will provide consultation to the Access to Baby and Child Dentistry (ABCD), ABCD-enhanced, and school-based dental sealant programs. Emphasis will also be placed on assisting local public health agencies in assessing oral health needs of their county populations as Community Health Needs Assessment and Health Improvement Plan activities are carried out in all 99 counties. Recruitment of a public health dental director will be a priority for the bureau./2005//

Healthy Child Care Iowa(HCCI). HCCI is a campaign to improve the health and safety of Iowa children in child care settings. Iowa has 58 child care health consultants (CCHC). Five regional CCHCs work full time and have communication and mentoring responsibilities for the part-time CCHCs in their region. Funding for CCHC positions comes from MCHB, Child Care Developmental Funds, state Empowerment funds, and Head Start/Early Head Start. Iowa's Title V grants to local agencies require them to support registered nurses as child care health consultants.

/2003/ Iowa data are transmitted to the Quality Enhancement Project for Infants and Toddlers at the University of North Carolina. Iowa offers CCHC training for registered nurses using the National Training Institute for Child Care Health Consultants curriculum. Consultation is provided on inclusive child care for children with special health care needs.

/2005/ Iowa has trained 110 child care health consultants (CCHC). Seventy-nine consultants remain active. The hiring of a regional child care health consultant (RCCHC) for the vacant position in southeastern Iowa should be completed by July 2004. The new RCCHC will attend the National Training Institute for Child Care Health Consultants. Funding for CCHC positions comes from MCHB, Child Care Developmental Funds, state Empowerment funds, and Head Start/Early Head Start. Twenty-five of the 26 Title V local contract agencies have a CCHC.//2005//

Health Leadership Iowa. Using CISS/COG funding, Health Leadership Iowa developed the capacity of state and local MCH/CHSC personnel. The project significantly assisted in the transitioning from direct care to core public health functions. /2003/ Funding for this grant expired at the end of September 2001. Sustainability activities include the ongoing MCH Section of the IPHA and the focus on core public health functions at the annual conference.

Child Death Review Team. The Child Death Review Team (CDRT) reviews death records of all Iowa children from birth through six years of age who died during the previous calendar year. CDRT recommendations are listed in Appendix F. /2002/ The CDRT will review records of Iowa children up to 17 years old who died during the previous year.

Sudden Infant Death Syndrome Program. Autopsies are required by the IDPH on all children two years old and younger who die unexpectedly. A contractual agreement with the Iowa SIDS Alliance covers printed information, community presentations, grief counseling, and referral services. Grief counseling is provided within the county of death by public health nursing staff. A peer contact (another SIDS parent who is trained in grief support) provides assistance through the first year of grief following the infant's death. The Iowa SIDS Alliance operates six grief support groups.

Genetic Program. /2002/ IDPH was awarded a grant in June of 2001 by the MCHB Genetics Services Branch to implement recommendations in the state genetics plan. Collaborators include the Birth Defects Institute, the Iowa Neonatal Metabolic Screening Program, the Iowa Birth Defects Registry, the Bureau of Vital Records, the Bureau of Information Management, and the Bureau of Family Health.

/2005/Funding for the Genetics Implementation Grant through MCHB Genetic Services Branch expired on May 31, 2004. Grant activities for the newborn metabolic screen matching and data integration will continue under other grant funding. Funding exploration for the Iowa Birth Defects Registry parent notification system will continue, as this project has been beneficial in providing resource information about programs and services that families of children with birth defects may be eligible for.//2005//

Early Hearing Detection and Intervention. Through collaborative efforts with IDEA, Part C funds, a 28E Agreement exists between IDPH and the Iowa Center for Disabilities and Development for the management of Iowa's newborn hearing screening system. Child Health Specialty Clinics administers a HRSA Maternal and Child Health Improvement Projects Grant and collaborates with the IDPH on

implementation of this grant. IDPH and the Center for Disease Control and Prevention have entered year three of a five-year cooperative agreement to continue development of this system and develop a surveillance system for screening follow-up.

//2005/ Collaborative efforts with the Iowa Center for Disabilities and Development continue through a 28E agreement for the management of Iowa's newborn hearing screening system. CHSC has entered the final year of a HRSA Maternal and Child Health Improvement Projects Grant and collaborates with the IDPH on implementation of this grant. IDPH and the Centers for Disease Control and Prevention have entered year four of a five-year cooperative agreement to continue development of this system and develop a surveillance system for screening follow-up.//2005//

School Based Youth Services Programs. The BFH supports Iowa's School Based Youth Services Program (SBYSP) coordinated through the Department of Education. The SBYSP encourages the establishment of youth centers in or near schools for service delivery to families. BFH staff assists with the health component of the program. /2002/ The 2000 Iowa Legislature altered the appropriation for SBYSP resulting in the elimination of the state level infrastructure. However, BFH technical assistance remains available upon request by the 26 programs that remain viable.

Iowa Communities and Schools/Health Promotion Initiative. This initiative strives to increase the number of health-promoting communities and schools in the state. Strategies include strengthening state partnerships, building capacity, examining public and private resources, and using research to create improvement. /2003/ Results include strengthening the health component of technical assistance to schools.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

As described previously, Child Health Specialty Clinics (CHSC) uses an organizational structure of 14 regional centers to provide family-centered, community-based, coordinated services to Iowa children with special health care needs (cshcn) and their families.

Direct Clinical Services. Specialty outreach clinics provide pediatric specialty services that are unavailable in local areas or inaccessible to low-income families. Cardiac clinics evaluate heart disease and assist with local prevention programs. Orthopedic clinics provide specialized exams, diagnostic procedures, and intervention recommendations for conditions such as scoliosis and leg length discrepancy. /2004/ There are fewer cardiac and orthopedic clinics as a result of ongoing needs assessments. Ear, nose, and throat (ENT) clinics serve children with problems such as chronic hearing loss, chronic ear infection, nasal obstruction, voice problems, and problems of airway obstruction. /2003/ ENT clinics have been discontinued due to increased presence of community-based providers. Cystic fibrosis clinics provide interim evaluation, care planning, and counseling for children treated for cystic fibrosis at the University of Iowa Hospitals and Clinics (UIHC). /2002/ Cystic fibrosis (CF) clinics will be discontinued as of FFY02 due to adequate service provided by Iowa's designated Cystic Fibrosis Centers. Muscle disorder clinics provide follow-up recommendations for pediatric care, genetic counseling, and physical therapy for children with genetically determined muscle disease. /2003/ Pediatric rheumatology clinics have been discontinued due to the lack of physician availability. Cleft lip and palate clinics serve children who require postoperative monitoring, especially for multiple surgical repairs. /2003/ Cleft lip and palate clinics have been discontinued under Title V support and reinstated under the UIHC Clinical Outreach Program. Diabetes-endocrine clinics provide follow-up for youth with insulin-dependent diabetes mellitus and other growth and endocrine disorders. Hemoglobinopathy clinics provide evaluations and family education for children with sickle cell disease, thalassemia, and other hemoglobinopathies. Down syndrome clinics provide clinical and educational services for families having a child with Down syndrome. /2003/ Down syndrome clinics occur irregularly in response to community request for services. Gastrointestinal clinics provide evaluation for children with medical problems such as failure-to-thrive, tube feedings, diarrhea, constipation, liver disease, and pancreatitis. ***//2005/ As a response to budget reductions, CHSC support for specialty outreach clinics will be terminated. Alternative providers will be sought.//2005//***

Integrated Evaluation and Planning Clinics (IEPC) provide community-based, multidisciplinary clinical evaluations and care planning services for children with physical, behavioral, emotional, developmental, and learning problems. Clinic staffing includes a pediatric nurse practitioner or nurse clinician, a contracted medical consultant, an Area Education Agency psychologist and/or speech and hearing professional, a Department of Human Services social worker, and others. /2004/ CHSC nutritionists may also staff the IEPC. Due to limited partner agency resources, not all disciplines serve at all clinic sites. **/2005/ As a response to budget reductions, CHSC support for community-based nutrition services will be terminated. An alternative is being planned.//2005//**

The High Risk Infant Follow-Up Program assesses the developmental needs of infants and toddlers who are at-risk due to psychosocial or biological risk factors. These services are available in most regional centers where CHSC pediatric nurse practitioners provide developmental assessments and physical exams. /2003/ The name of the service has been changed to "CHSC Birth to Five Services". /2004/ Parent education and nutrition services are also available in the Birth to Five Program.

Care Coordination Services. CHSC's Home and Community Care Planning Program serves children with very complex chronic health problems, including technology assistance needs. /2002/ This Program is now called the "Health and Disease Management (HDM)" Unit. The HDM Unit is designed to help the family evaluate the child's needs and obtain services. Since 1985, CHSC has had an agreement with Iowa DHS to assist with care coordination of children and youth with special health care needs eligible for the Medicaid Home and Community-Based Services III and Handicapped Waiver. General care coordination is also available for CHSC patients and families. CHSC offers care coordination services to children applying for benefits under the Supplemental Security Income (SSI) Program. Other care coordination activities include school reentry programs, a hemoglobinopathy comprehensive care program, a clinic transportation arrangement, a Prader-Willi syndrome community outreach program, an EPSDT care coordination service, and a hemophilia care coordination service. /2002/ The school reentry programs and the clinic transportation arrangement have been discontinued. /2003/ A new care coordination program, "Continuity of Care," has been established to improve linkages and outcomes for cshcn discharged from the Children's Hospital of Iowa to community-based services. /2004/ If the evaluation shows positive outcomes, the Continuity of Care Program may be expanded to other major medical centers in Iowa. **/2005/ The Creston Behavioral Health Program provides intensive care coordination to improve outcomes for cshcn with behavioral problems.//2005//**

Family Support Services. CHSC offers family-centered services based on the recognition that the family is constant in the child's life while the service system and its personnel fluctuate. Family-centeredness also honors the racial, ethnic, cultural, and socioeconomic diversity of families. /2002/ The Family Participation Strategic Initiative Team was initiated in FFY00 to study the administrative and clinical structures by which families participate in CHSC programs. This group played a major role in the CHSC strategic planning process for the year. /2003/ The Family Participation Strategic Initiative Team completed its work. A Family Participation Coordinator was hired to maintain family participation data, explore resources, conduct needs assessments, develop training materials, promote collaboration, assure family participation, and advocate for families. The CHSC Parent Consultant Network (PCN) utilizes parents of children with special health care needs to serve as regional center consultants to other parents and families. /2003/ The PCN has grown to 11 individuals serving 14 regional centers. The Family Participation Coordinator initiated monthly PCN meetings with agenda items designed to boost networking and to increase parent participation in CHSC decision-making. /2004/ The PCN has grown to 16 individuals. The Family Participation Coordinator position is now outsourced to a statewide family advocacy organization. This will maximize collaboration with other family organizations. **/2005/ The CHSC Family Participation Program is in the process of being reviewed and restructured.//2005//**

Purchase of Services for Low-Income Families provides family financial support for the purchase of pancreatic enzymes for children with cystic fibrosis, special dietary formula for mothers and children

with inherited metabolic disorders, and diagnostic studies for children with hemophilia. IOWA COMPASS Toll-Free Hotline is a statewide information and referral database for people with disabilities, their families, and other community members. It is partially supported by CHSC with programmatic information and an annual financial contribution for operations. /2004/ CHSC no longer financially supports IOWA COMPASS, although is still represented on the database.

Infrastructure Building Services. CHSC staff is involved with a variety of activities to improve service system quality and capacity. /2002/ The CHSC Director sits on the executive team for Iowa's Part C (Early ACCESS) Program. The Bureau of Special Education of the Iowa Department of Education supports CHSC's Regional Autism Services Program. Services include training community-based Autism Resource Teams regarding needs of children with autism. The program links with the Autism Society of Iowa and the Iowa Department of Human Services. Behavior management strategies, social skill development, and vocational training are major training areas. CHSC regional offices offer autism screening for children 3-13 years old. /2002/ The CHSC regional centers now offer autism screening for children from birth to 13 years old. /2003/ The linkage of the Regional Autism Services Program with the Department of Human Services is no longer active. CHSC, the Center for Disabilities and Development, and the Iowa Department of Public Health cooperatively plan training for regional nutrition consultants. /2003/ Nearly one-fourth of referrals for nutrition consultation are from the Area Education Agencies as part of early intervention services. /2004/ The Center for Disabilities and Development is Iowa's University Center for Excellence in Developmental Disabilities Education, Research, and Service. (UCEDD). Other training and consultation activities include spinal screener training, nursing student training, school health enhancement, MCH leadership training, and consultation to childcare providers. **/2005/ Current CHSC training services are varied and occur in partnership with state agencies and state universities./2005//**

The Iowa Leadership Education in Neurodevelopmental and Related Disabilities (ILEND) Program develops leaders to improve systems of care for children with special health care needs through graduate education and post-graduate training. /2003/ CHSC participates in ILEND didactic and experiential learning. CHSC staff provides seminars describing emerging issues and infrastructure-building efforts specific to the cshcn population. The Iowa UCEDD focuses on building community capacity so that all Iowans with disabilities can participate as members of their communities. Goals focus on self-determination, education, health, employment, housing, and community support. **/2005/ CHSC will have a greater role in assuring Title V-related experiential learning for ILEND trainees./2005//**

/2004/ Program evaluation, quality assurance, needs assessment, and information technology improvement continue to receive resources and recognition as essential public health services. Examples include evaluation of the IEPC service; development of new Attention Deficit Hyperactivity Disorder clinical care guidelines; hypothesis generation and testing using Iowa Child and Family Household Health Survey data; and development of telehealth services to expand access to pediatric behavioral health services. **/2005/ Formative evaluations of the Iowa Medical Home Initiative and the Healthy & Ready to Work Project have been completed and presented at state and national conferences./2005//**

CULTURALLY COMPETENT CARE FOR MCH POPULATIONS

The Iowa Department of Public Health maintains the Special Populations Access (SPA) Workgroup as an internal committee to increase the cultural competence of the department. The SPA Workgroup advises the IDPH Special Populations Access Coordinator. /2004/ The SPA Coordinator offers an internal lecture series for IDPH staff and external technical assistance to local contract agencies. The SPA Workgroup has developed a manual explaining federal regulations regarding immigrant access to health benefits. IDPH also maintains a Minority Health Program to address minority population health issues. Housed within the Bureau of Family Health, the program focuses on collaboration, networking, and resource sharing within IDPH and throughout the state. The Minority Health Program provides a liaison to the projects described below. /2004/ The IDPH Minority Health Program, renamed the Office of Minority Health, has been elevated within the IDPH organizational structure to the Division of Community Health. **/2005/ The Minority Health Program has increased the capacity**

to provide training to MCH agencies on cultural diversity/sensitivity and health disparities and educational awareness workshop presentations at local and statewide MCH related conferences and seminars. Various agencies have also requested and received staff training in the area of cultural awareness on an individual agency basis. Diverse resources and networking have been enhanced through the use of increased communication between the Minority Health Program and local contract agencies.//2005//

The Minority Health Liaison serves as a resource person for IDPH programs, especially those programs that have goals and objectives to address the needs of women, children and families of our minority, immigrant and refugee populations. Resources are inclusive of educational materials, outreach, and networking to access for services. The Minority Health Liaison position continues to provide a cohesive mechanism for the connection between various program goals and objectives through effective communication and collaboration.

Minority Health Advisory Board. In January 2000, the Minority Health Advisory Task Force was convened in response to legislative concern about African American infant mortality and the desire of IDPH to collaborate with representatives from the minority populations. The task force was asked to provide recommendations pertaining to health care access and service delivery with input received directly from minority populations. /2003/After recommendation by the task force, the Minority Health Advisory Board was established in September 2002 with statewide representation from the African American, Latino, Asian/Pacific Islander, and Native American populations, as well as refugee and immigrant groups.

Local Minority Health Coalitions. Five minority health coalitions were developed with funding from the HRSA Office of Minority Health. At the completion of the one-year funding cycle, three local coalitions continued to address health issues of the diverse populations within their counties. Representatives from the three coalitions serve on the statewide Minority Health Advisory Board. /2004/The Woodbury County Minority Health Coalition collaborated with Morningside College to present the Disproportionate Minorities in Incarceration Conference in April 2003. The IDPH Minority Health Liaison, City Council Representative, and Chair of the Woodbury County Minority Health Coalition are discussing future endeavors related to minority health and education.

Tobacco Control Diversity and Disparities Workgroup. Iowa was one of fourteen states awarded a CDC grant for a statewide workgroup that meets monthly to address tobacco use in diverse populations. /2004/ IDPH tobacco programs increases their policy group membership to include more youth from diverse populations. **/2005/ The CDC Tobacco Control Diversity and Disparities grant cycle was completed. The goal of the workgroup strategic planning process was completed and their strategic plan was submitted to CDC within designated time frames. The Minority Health Program continues to work with the IDPH Division of Tobacco Use, Prevention, and Control to address disparities among tobacco use and abuse and education and awareness within diverse populations. We have been successful in increasing participation of minority youth attending the annual JEL summit and have gained additional diverse representation on the youth advisory committee.//2005//**

Insured Success Pilot Project. Insured Success, collaboration of health care coverage advocacy groups, works to increase health insurance knowledge of diverse populations. In conjunction with the Polk County Minority Health Coalition, Insured Success is planning a pilot project with Latino immigrants.

Interstate Collaboration. /2004/ The Iowa Office of Minority Health and the Missouri Office of Minority Health will co-sponsor a Region VII Minority Health Conference. Additional activities of the office include conference lectures related to disparate health issues, technical assistance to local agencies, interdepartmental collaboration on program development, statewide health initiatives, and national and regional advisory board participation.

/2005/ National Participation in Cultural Competence Efforts. CHSC provides a staff member to

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 with special health care needs (cshcn) program. Statutory authority identified in the Code of Iowa (Chapter 135, Iowa Administrative Code 641, Chapter 76) provides further reference for the purpose and scope of Iowa's program. Legislative authorization for state expenditure of federal funding under the federal block grant is identified in House File 737 of the 2000 Session of the Iowa General Assembly. Contracts between IDPH and CHSC outline the responsibilities of both agencies for fulfilling the mandate for maternal and child health services. Copies of the contracts are available upon request. Additional State of Iowa statutes relating to MCH and cshcn programs are listed in the attachment.

The IDPH Division of Community Health 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. The tables of organization can be found at <http://intranet.idph.state.ia.us/documents/dept-to/dept-to-4-22-03.pdf>. The TO's illustrate the relationship of the division and the bureau within IDPH. 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 seen organizational change. A new director of IDPH was appointed in May 1999. There are seven divisions within the IDPH structure. They are the Division of Administration, Division of Communication, Planning and Personnel, Division of Community Health, Division of Epidemiology, EMS, and Disaster Preparedness, Division of Health Promotion, Division of Healthy Protection and Environmental Health, and the Division of Tobacco Use, Prevention and Control.

/2002/ The Deputy Director of the Iowa Department of Public Health, Mary Weaver, resigned in June 2001 and was replaced by the chief of the Center for Local Public Health Services and Health Improvement, Julie McMahon. Julie McMahon is now the director of the Division of Community Health.

/2003/ As a part of IDPH reorganization the Family Service Bureau (FSB) was changed to the Bureau of Family Health (BFH) in the Community Health Division, effective in April 2002. Dr. Ed Schor resigned in January 2002 to take a position with the Commonwealth Foundation, leaving the IDPH medical director position vacant.

/2004/ Dr. Mary Mincer Hansen was appointed director of IDPH in March 2003. Jane Colacecchi will serve as the Department's Deputy Director. Dr. Hayley Harvey resigned as Dental Director in October 2002 and the position is vacant.

/2005/ Jane Colacecchi resigned from her position as Deputy Director of the Iowa Department of Public Health. With the change in leadership of Dr. Hansen, it became obvious that IDPH needed to reorganize to better align programs and have an organizational structure that provides for integration throughout the department. This reorganization will also contribute to our working with other local, state, and federal organizations to effect necessary positive and sustainable changes in both the public health system and the public's health. The current table of organizations can be found at <http://www.idph.state.ia.us/to.asp>. The Division of Community Health has been changed to the Division of Health Promotion and Chronic Disease Prevention effective July 1, 2004. The Department continues to recruit for a dental director.//2005//

Responsibility for coordinating Iowa's program for cshcn is administered by the IDPH Division of

Community Health 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.

Bureau of Family Health. Public health functions relating to the health of mothers, children, and families are centered in the Bureau of Family Health (BFH). Organizational structures within BFH include the Women's Health Team and the Child Health Advocacy Team. Areas of work for these teams include system planning, standards of care development, contract management, and coordination of health-related services. Both teams collaborate with the Iowa Department of Human Services (DHS), the Iowa Department of Education (IDE), and the Iowa Regents Universities. The BFH contracts with local Child Health and Maternal Health agencies and health care providers to manage MCH programs at the local level. Listings of current contractors are located in Attachment IIB IIE. The BFH collaborates with the Oral Health Bureau and the Bureau of Nutrition (also branches of the Division of Community Health, IDPH) to issue a joint request for proposal (RFP). The RFP is issued to groups interested in providing public health services at the community level for Child Health, Maternal Health, Family Planning, and WIC. The RFP requires contracts to link with Center for Local Public Health Services and Health Improvement, Health Care Access, Disease Prevention and Immunization and the Lead Screening Program. Selection is based on applicant ability to meet criteria in the areas of access, management, quality, coordination, and cost. /2002/ FFY02 was the second year of IDPH division-level collaboration on the five-year local contracts for SFY2000-SFY2005. A combined request for application (RFA) was issued to current grantees. /2003/ FFY03 was the third year of collaboration as a combined request for application (RFA) was issued to grantees. /2004/ FFY04 is the fourth year of the combined request for application issued to local contract agencies. **/2005/ This is the last year of the combined request for application./2005//**

Child Health Specialty Clinics. The responsibility for family-centered, community-based, coordinated care for children with special health care needs is placed in the Child Health Specialty Clinics (CHSC) statewide system of regional child health centers. Since 1976 the regional child health 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. The centers are staffed and advised by nurse practitioners, nutrition consultants, parent consultants, community education staff, and human services staff. **/2005/ Due to budget reduction adjustments, community-based nutrition consultants will no longer be supported. Alternative sources for nutrition services will be investigated./2005//** A map of the CHSC Regional Centers is located at www.uihealthcare.com/chsc. Each regional center offers direct clinical services, care coordination services, family support services, and various infrastructure-building services.

Administration of Programs Funded by Block Grant Partnership Budget. IDPH is responsible for the administration of all programs carried out with allotments under Title V. Abstinence Education programs funded by Title V Section 510 and Special Programs of Regional and National Significance (SPRANS) are coordinated within the Bureau of Family Health (BFH). A joint project coordinator is responsible for both abstinence education budgets and is assisted by two program planners. A project director housed in the BFH administers the State Systems Development Initiative (SSDI) funds awarded to Iowa. A nurse clinician functions as a liaison between the IDPH Bureaus of Family Health and Information Management and serves as the SSDI project director. SSDI staffers work closely with their peers in the IDPH Division of Community Health who administer a grant from the MCHB Genetics Services Branch that also focuses on data integration. A project coordinator in the BFH directs the administration of Iowa's Community Integrated Service Systems (CISS) grant that supports health and safety in early care and education programs.

/2005/ A community health consultant in the BFH serves as the coordinator for the Assuring Better Child Health and Development - ABCD II grant from the National Academy of State Health Policy. The grant is a collaboration with DHS Medicaid, Center for Disabilities and Development, and the Iowa Department of Public Health./2005//

Child Health Specialty Clinics manages several funding opportunities under the Iowa Medical Home

Initiative (IMHI) that strives to assure that all Iowa cshcn are enrolled in a medical home. A three-year MCHB grant to CHSC will facilitate the establishment of medical homes for cshcn in selected pediatric and family physician practices. A three-year MCHB grant to the Iowa Academy of Family Physicians (IAFP) supports a multi-county effort to establish medical homes for young children. A central strategy of an MCHB-funded adolescent transition grant to CHSC is enrollment of adolescents with special health care needs in medical homes.

/2005/The Iowa Part C Program (Early ACCESS) also supports the IMHI through a contract with CHSC under the Early ACCESS Comprehensive System of Personnel Development (CSPD) Program.//2005//

Iowa's Early Hearing Detection and Intervention Program is a collaborative effort. Child Health Specialty Clinics administers a HRSA MCH Improvement Projects Grant to improve the system of newborn hearing screening and follow-up in Iowa. In addition, the Iowa Department of Public Health is developing a surveillance and monitoring system through a cooperative agreement with the Centers for Disease Control and Prevention. /2004/ A bill was passed by the legislature, and signed by the governor, that will mandate newborn hearing screening in Iowa beginning in January 2004. The bill requires that all newborns be screened for hearing loss prior to discharge from hospital and that the results be reported to IDPH. The program director, within the BFH, is responsible for implementing this new requirement.

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

/2004/ The IDPH Bureau of Family Health, in collaboration with the Community Empowerment branch of the Iowa Department of Management, applied for a HRSA State Maternal and Child Health Early Childhood Comprehensive Systems Grant. Through this funding, state and local stakeholders hope to prepare a single comprehensive plan for developing Iowa's early childhood system. The project director and coordinator are located in the BFH. ***/2005/ A project coordinator in the BFH directs the coordination of the Early Childhood Comprehensive System Grant (ECCS). The purpose of the grant is to develop a plan for building a single comprehensive early childhood system in Iowa. An Early Childhood Iowa Stakeholder group serves as the advisory group for the grant. The grant is a collaboration of IDPH, DHS, DE, DHR, and DOM. The State Empowerment Team coordinates the grant activities.//2005//***

D. OTHER MCH CAPACITY

The administrative office for Iowa's Title V program is located in the capitol complex in close proximity to the State Capitol in Des Moines, Iowa. The IDPH employs the Bureau of Family Health Chief, a Division Medical Director, and 22 professional and 5 support staff who manage the functions of Iowa's Title V program. The department contracts with 26 maternal health agencies and 26 child health agencies to provide community-based MCH services throughout the state (maps are located in III-B attachments). For additional information about the responsibilities and structure of the local contract agencies see section 3B. /2004/ The IDPH Bureau of Family Health Medical Director position is vacant. The Bureau has hired four additional staff to coordinate discretionary grants awarded to Iowa. /2004/

/2005/ A Medical Director for the Division of Health Promotion and Chronic Disease Prevention has been hired. Dr. Jeff Lobas, Director of Child Health Specialty Clinics, will serve as the

Medical Director at 20 percent of his time. //2005//

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

The program for cshcn is an administrative responsibility of the IDPH Division of Community Health, managed through a contract with the University of Iowa, Department of Pediatrics, Child Health Specialty Clinics (CHSC). CHSC has both central and regional staff. The table of organization (III-C attachment) displays staff members by position. Of the total staff complement, 26 individuals are housed in the central administrative offices at the Iowa City regional center. The remaining 85 staff members are housed in or associated with the other 13 CHSC regional centers. ***//2005/ Due to budget-related staff reductions, there are now 21 staff in the central administrative offices in Iowa City and 76 staff in the other 13 regional centers.//2005//*** The regional centers are located in the state's population centers. Most Iowans are within a one-hour drive from a regional center.

Planning, evaluation, and data analysis functions are shared among professional and support staff. One professional staff member has educational and experiential background in epidemiology and evaluation and is designated to take a lead role in coordinating these activities.

Parents of cshcn are represented on staff by a full time family support program coordinator in the central office and 13 contracted parent consultants affiliated with the regional centers and the central office. A list of parent consultant activities appears in the attachment. The family support program coordinator oversees the statewide network of parent consultants by designing training, monitoring activity, and updating resource information. The parent consultants undergo a structured training experience to prepare them for their roles as information resources, problem solving assistants, and peer supports. *//2003/* The family support program coordinator, now called the family participation coordinator, works half-time. There are 11 parent consultants representing eleven of the 14 CHSC regional centers. *//2004/* The Parent Consultant Network has grown to 16 individuals. The family participation coordinator position is now outsourced to a statewide family advocacy organization. This will maximize collaboration with other family organizations.

//2005/ The contract arrangements for leadership of CHSC's family participation program are currently being reviewed to maximize cost-effectiveness.//2005//

The CHSC Policy and Planning Unit is responsible for a variety of infrastructure-building activities, as well as providing other central and regional office staff with training opportunities for increasing infrastructure building skills. There are additional, not yet implemented, administrative changes being considered for the purpose of facilitating the programmatic shift from direct care provision toward service coordination and infrastructure building. Although specifics are currently unknown, the changes will generally support the decentralization of services in order to match other state "devolution" initiatives. *//2003/* Program decentralization has continued with the designation of four "area coordinators," each a community-based CHSC nurse with management responsibilities for three to four geographically proximate regional centers. Each area coordinator annually submits regional plans and resource requests for the regional centers they oversee. An additional staff member has joined the Policy and Planning Unit, and has primary responsibility for program evaluation and data management and analysis.

//2005/ Programmatic adjustments in response to federal and state budget reductions include proposed elimination of support for specialty outreach clinics and community-based nutrition consultation services. Withdrawal of support will be accompanied by involvement in assuring filling of any resulting gaps. In the Iowa City administrative office, two professional positions in the Policy and Planning Unit will remain unfilled, as will the position of a retiring nurse

coordinator. Across the CHSC regional centers, staffing will, on average, be reduced from 1.0 to 0.8 FTE. Reductions in Department of Human Services funding for CHSC care coordination for Waiver Program enrollees will require reduction of staff and increase in caseloads. Additional capacity may be built with increased attention to appropriate billing for pediatric nurse practitioner services.//2005//

Senior level management employees are M. Jane Borst, chief of the IDPH Bureau of Family Health and Dr. Jeffrey Lobas, director of Child Health Specialty Clinics. Their qualifications appear in brief biographies attached to this section.

E. STATE AGENCY COORDINATION

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

Special Supplementary Nutrition Program for WIC. The statewide WIC program is integrated with MCH services at the state and local levels. The Bureau of Nutrition coordinates the nutrition components of MCH projects and provides staff assistance to both state and local MCH programs. Training, consultation, and educational programs are provided for all MCH programs. The Iowa Lactation Task Force, a statewide coalition, includes private sector and public health professionals who provide technical assistance to the WIC program, MCH, family planning, public health nursing/visiting nurse agencies, and private health care providers. **/2005/ Because of IDPH reorganization, the new name for the Bureau of Nutrition was changed to the Bureau of Nutrition and Health Promotion.//2005//**

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

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

EPSDT Care for Kids. The Bureau of Family Health (BFH) provides services for the EPSDT Care for Kids program. Under an agreement with the Department of Human Services, child health agencies are approved as EPSDT screening centers. Each month EPSDT care coordinators call families newly enrolled in Medicaid to inform them about the need for immunizations, dental visits, and periodic well child visits. The statewide toll-free Healthy Families Line links families with an EPSDT care coordinator who provides assistance with access to medical and dental care. Care coordinators partner with local physicians to ensure that children receive the comprehensive screening requirements of the program. BFH staff members provide technical assistance to EPSDT care coordinators in developing care coordination skills, determining the cost for informing and care coordination activities, utilizing computer support for the software program, and facilitating community meetings. Training workshops are held annually.

/2002/ Emphasis this year has been on improving access to dental health services to assure that children receive at least one EPSDT preventive dental visit. /2003/ Access to oral health services

continues to be a primary concern. The Department of Human Services (DHS) has authorized Title V community-based screening centers to allow dental hygienists to be reimbursed for initial oral health screens, sealant applications, and fluoride varnish applications.

/2004/ Access to oral health services continues to be a primary concern. The Access to Baby and Child Dentistry (ABCD) program funds will be used for a statewide expansion of the Iowa ABCD Program. The goal of the ABCD Program is to improve access to dental services for low-income children ages 0-20 years, with emphasis on ages 0-5 years. After successfully piloting the program through four MCH Title V agencies during FY 1999-2002, the program was offered statewide during FY03. Twenty MCH agencies applied and were funded (based on the number of Medicaid eligible children in their service areas). Through innovative outreach, education, care coordination, and preventive services the program will raise oral health awareness and improve access for many low-income children throughout Iowa.

EPSDT Care for Kids spring conference provided the opportunity for the Title V local contract agency staff and Healthy Child Care Iowa (HCCI) Child Care Health Consultants to collaborate on improving health outcomes for children in their communities. This is the first year of collaboration with HCCI staff, enhancing the content of the annual event.

The EPSDT staff worked with Lead Bureau staff to address areas of the state in which blood lead testing is low. The Child and Adolescent Reporting System (CAREs) and the Lead Bureau's database (STELLAR) were used to identify children who had not received a blood lead test. The team was able to identify, through the CAREs database, if the child had identified a medical provider. The team then drafted letters to the child's medical provider and the community-based Title V care coordinator. The letters explained the need for blood lead testing and asked the physician to perform a blood lead test at the child's next scheduled visit. The goal of the project is to build physician awareness of the need for blood lead testing and to alert the Title V care coordinator of the children in need of follow-up for blood lead testing.

EPSDT care coordination services expanded through partnerships between the local Title V contract agency and youth shelter services in four communities in Iowa. These partnerships enhance the services provided to a vulnerable population and increase the awareness of what each agency has to offer. Negotiations between IDPH and one of the Medicaid managed care organizations continue. The goal is a memorandum of understanding for the local MCH contract agencies to receive reimbursement for services provided to the organization's enrollees.

Healthy and Well Kids in Iowa (hawk-i). /2004/ In October 2002, the Department of Human Services contracted with IDPH to provide grassroots outreach and enrollment for hawk-i (Iowa's SCHIP). In November 2002, IDPH amended contracts with the 26 local agencies providing Title V child health services to perform hawk-i outreach and enrollment activities. Through an RFA process, agencies described plans for outreach to the medical community, schools, vulnerable populations, and faith-based organizations. Applicants described plans to coordinate with state sponsored activities on a consistent statewide message and to convene community stakeholders to build capacity. A statewide outreach coordinator position was added to the IDPH Bureau of Family Health to provide oversight and assist with statewide program development.

/2005/ Effective collaboration has continued between the Department of Public Health and the Department of Human Services to provide grassroots outreach and enrollment for hawk-i. Outreach efforts coordinated through IDPH and the local child health agencies have been very successful. This collaboration will continue to guide successful outreach to uninsured families in Iowa. Initial outreach efforts focused on four areas: Schools, Faith-based, Medical Providers, and Underserved Populations. These efforts have expanded to areas of businesses, workforce, tax preparation sites, and many other areas. During September, the Lt. Governor traveled across Iowa to lead seven community roundtable discussions about hawk-i outreach strategies. The roundtables were very well attended by a variety of community representatives, including school nurses, medical providers, ministers, Farm Bureau agents, legislators,

workforce agencies, childcare organizations, and more. Local press also attended the roundtables. State and Local Coordinators assisted the Lt. Governor's staff in coordinating the community roundtables. The roundtables were a success and a great opportunity to showcase the hawk-i program.//2005//

Preventable Diseases Program. The Disease Prevention and Immunization Bureau administers the program for vaccine preventable diseases. Vaccines are available to local health departments and child health agencies for required childhood immunizations. The Iowa State Immunization Information System, a web-based registry, now serves the state's public sector clinics. The Bureau of Family Health, the Disease Prevention and Immunization Bureau, and Department of Human Services collaborate to promote statewide utilization of the registry in both public and private clinics.

/2002/ Implementation of the registry in the private practice sector is scheduled to begin in late 2001. The computer system will enable the state to acquire population-based immunization data.

/2003/ The Disease Prevention and Immunization Bureau began enrolling private physicians in March 2002 with a focus on Vaccine for Children providers.

Childhood Lead Poisoning Prevention Program. Since nearly 40 percent of the state's housing was built prior to 1950, the IDPH recommends that all Iowa children under the age of six receive routine blood lead testing. Local contract agencies, local health departments, and private practitioners test children. Through continuing education programs, IDPH educates private practitioners about the importance of testing children for lead poisoning. Case management of children with lead poisoning is a collaborative effort of the Childhood Lead Poisoning Prevention Program, the Bureau of Family Health, local contract agencies, and local health departments. /2004/ See Needs Assessment for updated information.

/2004/ Center for Local Public Health Services and Health Improvement. Established in January of 2002 to strengthen the public health delivery system in Iowa at both the state and local level. This will be achieved through strengthening the capacity of Iowa's local boards of health who, through local health departments, public health agencies, programs and services, strive to create healthy people in Iowa communities.

The center will promote and support development of public health infrastructure at the local and state level to assure that Iowa's public health system has the capacity to be responsive to current and emerging public health issues. /2004/

Iowa Birth Defects Institute/Center for Genetics. The Birth Defects Institute (BDI), in partnership with the University of Iowa and health care providers throughout the state, provides comprehensive genetics services. IDPH manages the five BDI programs with assistance from the Birth Defects Advisory Committee. The five programs are the Iowa Newborn Metabolic Screening Program (INMSP), the Expanded Maternal Serum Alpha-fetoprotein Screening Program (MSAFP), the Regional Genetic Consultation Service (RGCS), the Neuromuscular and Related Genetic Disorders Program, and the Iowa Birth Defects Registry (IBDR). See National Performance Measure #1 for additional information about the INMSP. 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 IBDR 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 provides them with resource information. /2004/ The parental notification system includes a resource brochure, notification letter, response card, frequently asked questions sheet, consent to release or exchange information form, and a memo to physicians/nurse practitioners. A follow up component is

being developed. Initial mailing of the parental notifications is planned for May 2003. The IBDR works to develop mechanisms to enhance IDPH access and utilization of birth defects surveillance data. IDPH is also working with the various early intervention programs including IDEA-Part C (Early ACCESS), Title V, IDPH Child Health Advocacy Team, and parent groups to ensure that the IBDR data is made available for them to use for program planning.

/2005/ The IBDR parental notification system began in June 2003. Since inception, 739 families have received the notification packet. As a result of these mailings, referrals have been made to RGSC, Child Health Specialty Clinics, Early ACCESS, and the Parent Training and Information Center. Matching of newborn metabolic screening and birth certificate records is performed to identify unscreened newborns. Follow-up is made with the birthing facility and/or physician's office to arrange for screening of missed newborns. The INMSP and IBDR collaborates with the Child Death Review Team to decrease unnecessary contact of families whose child has died. Newborn screening education to nursery managers, lab managers, and health care providers is provided through the quarterly Heel Stick News and the INMSP Healthcare Practitioner's Manual found on the web site. /2005//

Unintentional Injury Prevention. Staff members from BFH collaborate with the Governor's Traffic Safety Bureau on the Children/Youth Occupant Safety Leadership Committee. In FFY99 the Governor's Traffic Safety Bureau funded a full time position in the Bureau of Emergency Medical Services (EMS) to coordinate efforts to provide communities with technical assistance regarding child safety seat usage. BFH coordinates with EMS regarding injury prevention on the "Love Our Kids" Task Force. "Love Our Kids" license plates are sold throughout the state, and proceeds fund statewide injury prevention projects. BFH collaborates with the Bureau of Disability Prevention within IDPH. /2002/ Iowa saw an increase in seat belt and child restraint system use for FFY99. Despite these increases it is important to note that currently only two percent of Iowans who utilize child restraint systems do so correctly. /2003/ See NPM #8 for updated information on the 2001 Iowa Child Passenger Restraint Survey Results.

Coordinated School Health Initiative. This project encouraged development of community-school health advisory councils. It was a collaboration between the public health community, the American Cancer Society (ACS), and corporate sponsors such as Blank Children's Hospital, Iowa Health Systems, and Pioneer Hi-Bred International, Inc. Title V contributed funding and staff time to the project. /2002/ The ACS funded six Iowa pilot projects. Local ACS volunteers and staff members of Iowa State University Extension assisted BFH in training. /2003/ The BFH negotiated an agreement with ACS for reprinting and distribution resources. This agreement facilitated the distribution resources nationwide and supported the ACS goal of promoting the establishment of community-school health advisory councils.

Early ACCESS. Early ACCESS is a federal program under the Individuals with Disabilities Education Act (IDEA, Part C). In Iowa the program is an interagency collaboration between the Iowa Department of Education, the Iowa Department of Public Health, the Iowa Department of Human Services, and CHSC. The system is a partnership between families with young children, birth to age three, and providers from local public health, human service, education, and child health specialty agencies. Partnerships also exist for families with other public or private service and resource providers. The Iowa Department of Education is the lead agency, as appointed by the Governor of Iowa for the implementation and maintenance of the system. A state level multidisciplinary council, the Iowa Council for Early ACCESS (IDEA), advises and assists the Iowa Department of Education in the implementation of Early ACCESS.

Federally Qualified Health Centers. Iowa currently has six designated Federally Qualified Health Centers (FQHC) in Council Bluffs, Davenport, Des Moines, Ottumwa, Sioux City, and Waterloo. An additional FQHC is opening in Burlington. Two of the six designated centers have subcontracts with IDPH for community-based child health centers. The remaining four FQHCs collaborate with the designated Title V agencies in their area.

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

College of Public Health, University of Iowa. Founded in 1999, the College of Public Health strives to be a comprehensive public health resource for the state of Iowa. The college consists of five academic departments addressing Biostatistics, Community and Behavioral Health, Epidemiology, Health Management and Policy, and Occupational and Environmental Health. Degree programs include the MPH, MS, MHA, and PhD. The college is home to 25 centers that focus research efforts on critical public health topics. /2004/ A Public Health Certificate Program was initiated in summer 2002 with scholarships available for qualified applicants beginning in summer 2003.

Des Moines University. The Master of Public Health program at Des Moines University (DMU) began in 1999 and received full accreditation from the Council on Education for Public Health in 2002. The MPH program is offered at a number of sites around the state. A dual degree program offers students the opportunity to obtain both the MPH and MPA. A Graduate Certificate in Public Health is also offered. /2004/ DMU is developing courses for web-based delivery to accommodate the needs of Iowa's rural public health work force.

Child Health Specialty Clinics. The Child Health Specialty Clinics (CHSC) administrative offices are located at the University of Iowa in Iowa City. This 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, and over the statewide fiberoptic communication network. Health professions students learn about community-based service delivery through participation in direct care specialty clinics, care coordination services, and infrastructure-building activities. The CHSC relationship with the University also finds benefit in tapping of information technology resources, financial management services, public policy expertise, and research design and program evaluation consultation.

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

1. The IDPH Bureau of Family Health: 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 Department of Education, Division of Vocational Rehabilitation, Disability Determination Services Bureau: to define responsibilities related to applicants and recipients under age 16 of the Supplemental Security Income Program (SSI) and under age 22 who need specialized health services regardless of SSI eligibility.
3. The Iowa Department of Human Services: to define responsibilities of the parties in assessment, planning, and care coordination activities for recipients of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) of the Iowa Medical Assistance Program (Title XIX).
4. The Iowa Department of Human Services: to define responsibilities of the parties in assessment, planning, and care coordination activities for applicants and recipients of the Home and Community-Based Services (HCBS) ? III and Handicapped Waiver Program of the Iowa Medical Assistance Program (Title XIX). /2004/ A revised agreement is in progress due to consolidation of several waiver programs./2004/
5. The Iowa Departments of Public Health, Education, and Human Services and the Office of the Lieutenant Governor: to delineate the roles and responsibilities of each of the parties related to the implementation of the provisions of I.D.E.A., Part C including principles of family involvement, coordination of resources, and nonduplication of services. /2002/ An updated Part C agreement is

currently being formulated. /2003/ This agreement continues to be crafted. /2004/ The agreement is complete and interagency work is now occurring on a quality improvement monitoring system.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Iowa has made progress with the many of the Health System Capacity Indicators through SSDI funding over the past 2 years. Iowa has formalized important structures which have strengthened the MCH data integration infrastructure. The two-year Iowa MCH Data Enhancement Project sparked the formation of the Data Integration Steering Committee, composed of mid-level managers, and the MCH Data Team, composed of database managers. These new organizational structures have provided a routine mechanism for strengthening the knowledge base and communication of key members of the state-level data workforce. As a result, Iowa's MCH program is positioned to move forward on data integration initiatives at the same time that administrative support of these initiatives is seen.

Health Systems Capacity Indicator #01 (formerly Core Health Status Indicator #01)
The rate of children hospitalized for asthma (10,000 children less than five years of age).

The report for HSCI #01 appears on Form 17.

Health Systems Capacity Indicator #02 (formerly Core Health Status Indicator #02A)
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen.

The report for HSCI #02 appears on Form 17.

Health Systems Capacity Indicator #03 (formerly Core Health Status Indicator #02B)
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

The report for HSCI #03 appears on Form 17.

Health Systems Capacity Indicator #04 (formerly Core Health Status Indicator #03)
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.

The report for HSCI #04 appears on Form 17.

Health Systems Capacity Indicator #05 (formerly Core Health Status Indicator #06)
Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

The report for HSCI #05 appears on Form 18.

Health Systems Capacity Indicator #06 (formerly Core Health Status Indicator #07)
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

The report on HSCI #06 appears on Form 18.

Health Systems Capacity Indicator #07 (formerly Developmental Health Status Indicator #04)
The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

The report on HSCI #07 appears on Form 17.

Health Systems Capacity Indicator #08 (formerly Block Grant Performance Measure #1)

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

The report on HSCI #08 appears on Form 17.

Health Systems Capacity Indicator #09(A) (formerly Core Health Status Indicator #08)

The ability of States to assure that the Maternal and Child Health program and Title V agency have access to policy and program relevant information and data.

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

Health Systems Capacity Indicator #09(B) (formerly Developmental Health Status Indicator #05)

The ability of States to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month

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

Health Systems Capacity Indicator #09(C) (new)

The ability of States to determine the percent of children who are obese or overweight.

The report on HSCI #09(C) appears on Form 19.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

//2005/The annual plan for FFY05 placed 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 maternal and child health while maintaining essential community-based direct care services. During FFY03, 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 cshcn focused on assuring specialty services to children and families, integrating data systems, balancing private and public partnerships, and integrating community-based services.//2005//

B. STATE PRIORITIES

Direct Health Care and Enabling Services:

1. Establish an integrated system of comprehensive mental health services for children in Iowa. In CHSC's "Problem Prioritization Process", number one of 29 ranked problem areas was the provision of needed mental and behavioral health services by providers specializing in child and adolescent mental and behavioral health. Supporting the need was a 7th place ranking assigned to the goal of implementing a comprehensive community-based system of services for all Iowans with a mental illness or disorder.
2. Assure quality services for children with special health care needs enrolled in managed care plans. This quality-related problem received a midlevel ranking in the CHSC "Problem Prioritization Process". However, because of persistent and growing concern for issues of quality, especially regarding cshcn enrolled in managed care plans, this problem received special priority. This concern is further supported by results of the CHSC "Family Need and Satisfaction Survey" showing a relationship between quality and satisfaction. Also contributing to the high priority are the growing collaboration and mutual concerns of the Iowa Department of Human Services and CHSC. /2004/ This priority need has lessened due to the Department of Human Services policy to disenroll cshcn from Medicaid managed care plans in favor of fee-for-service plans. A new medical home implementation initiative has the goal of improving care quality for all cshcn served by primary care practices, whether managed care or fee-for-service.
3. Assure continuity of health care and related services for pregnant women and children ages 0-21. A review of submitted individual county needs assessments revealed a collective top priority of "access to continuous services for women of childbearing age and children from birth to adulthood". This priority need is related to and consistent with the national priority need for all children with special health care needs to have a medical/health home.
4. Assure access to dental treatment services for children in Iowa. The problem of access to dental treatment has been a persistent problem in Iowa as evidenced by a 4th place "Problem Prioritization Process" ranking by Bureau of Family Health and Oral Health Bureau staff and a 1st place ranking by a wide array of MCH stakeholders attending the annual State MCH conference. Developmental Health Status Indicator #4 supports access to dental treatment being a priority problem.

Population-Based Services:

5. Increase participation of infants in programs that provide monitoring and follow-up for the at risk population. Improving follow-up programs for at risk infants attained a 2nd place ranking in CHSC's "Problem Prioritization Process". This problem area remains significant because of the extreme importance of early intervention for children with developmental delay and the continuing

fragmentation of early identification and follow-up programs.

6. Reduce health disparities among pregnant women and children. This continuing national priority need was ranked among the top six problem areas facing Iowa's MCH target population. The significant racial disparities in Iowa for low birth weight and infant mortality in the face of relatively low overall low birth weight and infant mortality rates suggests this is a priority need.

7. Improve the fitness of children. This priority need is a modified continuation of the priority need from the last planning cycle that sought to "improve community capacity to serve children with obesity." Although ranked 13th of 14 problem areas, further discussion among staff interpreted the ranking as a reflection of intervention difficulty and not public health importance. Dedication to the importance of public health involvement and a focus on fitness elevated this problem's priority.

Infrastructure Building:

8. Enhance data collection, management, analysis, and utilization to support identification and investigation of health problems affecting women, children, and families. Scores on the Health Systems Capacity Indicator #9A and the CHSC "Strategic Direction Assessment Process" elevated this problem area to the level of a priority need. A similar priority need was in force during the last planning cycle; however, insufficient progress was made toward the goal. Data capabilities remain essential for rational program planning, documentation, and accountability.

9. Improve the preparation of families to meet the physical, emotional, and social needs of their children. The MCH stakeholders attending the year 2000 annual State MCH conference ranked parent readiness as the 3rd most pressing priority for the MCH target population. This ranking has been consistent over the several years that this particular assessment method has been employed.

10. Increase development and use of quality improvement strategies applicable to general medical care of pediatric patients with special health care needs. In the CHSC "Problem Prioritization Process", this problem area was ranked at the midpoint of the 29 item problem list. However, subsequent group planning discussions elevated the priority for the reason of a well-begun, but incomplete intervention for this problem. Also, quality issues pertaining to cshcn have been consistently gaining importance at national and state levels. Finally, the CHSC "Family Needs Satisfaction Survey" highlights the relationships of service quality and family satisfaction with health services, especially in the circumstances of severely affected children or low family income. /2004/ CHSC Leadership recommends SPM #9 be deleted because it is not substantively different from the NPM #3 (Medical Home) in that the primary purpose of a medical home is to improve the quality of care provided to cshcns served in a primary care setting.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

The performance objective of 99.5 percent was met. Data provided to the Birth Defects Institute and the Iowa Neonatal Metabolic Screening Program (INMSP) indicates that 99.7 percent of all Iowa newborns are screened for genetic and metabolic conditions. The remaining .3 percent can be attributed to parental refusal, neonatal death, out-of-state transfers, and missed screens.

Infrastructure Building:

A quarterly newsletter (Heel Stick News) was developed to provide information about newborn

screening activities. The target audience for the newsletter includes nurse managers, lab managers, physicians, physician assistants, nurse practitioners, midwives, hospitals, and birthing centers.

The INMSP Healthcare Practitioner's Manual on the Center for Congenital and Inherited Disorders web site was updated. This manual is a guide created to help the practitioner comply with Iowa rules and to better understand the Iowa Neonatal Metabolic Screening Program. The manual includes information on specimen collection, when to obtain a second sample, frequently asked questions, and additional helpful information. The web site for the Center for Congenital and Inherited Disorders is www.idph.state.ia.us/genetics.

Population-Based:

The Iowa Neonatal Metabolic Screening Program is a fee-for-service program that provides laboratory, follow-up, consultative, and educational services. Responsibility for the Neonatal Metabolic Screening program is assigned to the University Hygienic Laboratory. All newborns and infants born in Iowa are screened for medium chain acyl Co-A dehydrogenase deficiency, phenylketonuria, and other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry; hypothyroidism; galactosemia; hemoglobinopathies; congenital adrenal hyperplasia; and biotinidase deficiency.

b. Current Activities

Infrastructure Building:

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

Beginning in July 2004, quarterly reports will be generated and provided to each birthing facility in Iowa. The reports will contain the facility's individual screening activities and the screening activities of the entire state.

The Iowa Neonatal Metabolic Screening Program is collaborating with the Child Death Review Team to develop a notification system for child deaths to decrease unnecessary contact of families.

The 2004 General Assembly enacted legislation effective July 1, 2004 which renames the Birth Defects Institute. The new name will be the Center for Inherited and Congenital Disorders. Additionally, the Center will be relocated with the Bureau of Chronic Disease and Prevention Management.

Population-Based:

The program continues to investigate the possibility of including additional disorders in the newborn metabolic screening panel. One of the disorders being considered by the Birth Defects Advisory Committee and the IDPH is cystic fibrosis.

IDPH was awarded a cooperative agreement from CDC in September 2002 to perform surveillance and long term follow up of disorders identified by MS/MS. The program is currently working on protocol with CDC and the state of Oregon.

c. Plan for the Coming Year

Infrastructure Building:

The Iowa Neonatal Metabolic Screening Program will continue to improve the capacity to ensure uniform short-term follow-up and to monitor identified newborns through adulthood.

The program will develop interstate agency agreements with neighboring states for sharing of newborn screening data.

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)*

a. Last Year's Accomplishments

The FFY03 performance objective of 59.2% was not assessable because the population-based national CSHCN survey is not yet scheduled to be repeated. Based on the survey's previous administration, the FFY02 indicator value = 58.5 percent.

Infrastructure Building:

In FFY03, the CHSC Family Participation Coordinator was hired through the ASK Resource Center. CHSC promoted involvement of the its Family Participation Coordinator in program leadership. This included full participation with the CHSC Leadership Council as it addressed all manner of problem solving and program planning.

The Family Participation Coordinator attained two roles with the Iowa Medical Home Initiative (IMHI): 1) membership on the IMHI Core Advisory Group (along with a representative of Family Voices of Iowa), and 2) participation as a "family participation advisor" on the IMHI facilitation teams working directly with primary care practices.

The Family Participation Coordinator took initial steps in defining roles and building skills of the community-based CHSC Parent Consultant Network.

Hiring the Family Participation Coordinator through the ASK Resource Center created awareness of a CHSC/ASK collaborative relationship within the wider community of health, education and human services agencies and providers, policy makers, and family organizations.

b. Current Activities

Infrastructure Building:

In FFY04, active and essential family participation continues with both the Iowa Medical Home Initiative Core Advisory Group and the medical home facilitation teams working directly with primary care practices.

Through connection to additional family networks and listserves, the CHSC Family Participation Coordinator has facilitated greater access to information and more opportunity for networking for CHSC Parent Consultants. The result is linkage with other family coordinators and consultants leading to increased parent-to-parent interaction, resource and information sharing, and educational opportunity.

Training and meeting schedules for the CHSC Parent Consultant Network were established. Topical trainings occur approximately monthly and occur both in-person and via the fiberoptic

network. The Family Participation Coordinator helped secure stipends and expense reimbursement from a variety of sources to support participation of Parent Consultants in training and professional development activities.

The Family Participation Coordinator is expected to lead the family input component of planning for the upcoming CSHCN component of the Title V 5-year statewide needs assessment.

Due to current budget difficulties, CHSC has begun reassessing its contract with the ASK Resource Center, under which the Family Participation Coordinator position is funded. The highest goal will be to assure CHSC's continued presence in statewide family-centered advocacy efforts.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, CHSC will renew efforts to define roles, expectations, and standards for performance of the Parent Consultant Network. The Network remains an underutilized resource that has substantial potential for improving the enabling and infrastructure building activities of the Title V CSHCN Program.

Encourage creation of communication plans between CHSC regional center staff and families to facilitate exchange of information regarding clinic services and relevant public policy issues.

Consider creation of family advisory groups at the regional level to improve family participation in local needs and satisfaction assessments, as well as in program development and evaluation processes.

Explore and pursue options for increased financial support for Parent Consultant participation in professional development opportunities and infrastructure building activities.

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)

a. Last Year's Accomplishments

The FFY03 performance objective of 58.2% was not assessable because the population-based national CSHCN survey is not yet scheduled to be repeated. Based on the survey's previous administration, the FFY02 indicator value = 57.1 percent.

Infrastructure Building:

In FFY03, the Iowa Medical Home Initiative (IMHI) began facilitating establishment of medical home models in three primary care pediatric practices. Each practice completed a self-assessment using a standardized instrument, selected an initial quality improvement goal, and participated in evaluation data collection.

A Core Advisory Group for the IMHI began formulating specific roles and responsibilities. The advisory group includes representation from families, providers, and payers. It was agreed that the group should discuss and help solve barriers to medical home implementation. Additionally, specific task-oriented subgroups were proposed as a strategy to further accomplish larger medical home project goals.

A contract was formalized with the Iowa Academy of Family Physicians for the full-time services of an IMHI project coordinator. Special attributes of the project coordinator include

experience with rapid cycle improvement methods - suitable for busy medical practices - and established relationships with the family practice community.

b. Current Activities

Infrastructure Building:

In FFY04, the three participating primary care clinics all progressed towards their practice improvement goals with assistance from the Iowa Medical Home Initiative (IMHI) facilitation team. The three clinics - all pediatric practices - are referred to as Phase I Partner Clinics because they receive the first and most intensive facilitation experience and the closest evaluation scrutiny. The IMHI is still seeking to include a family practice clinic as an additional Phase I Partner Clinic.

Three additional part-time project staff have been hired to serve as nurse advisors on the project facilitation teams. These staff will be instrumental in all project expansion activities.

The Core Advisory Group has established 6 task subgroups to further the overall goal of enrolling all Iowa's children with special health care needs in medical homes by 2010. The task subgroups address the general areas of: screening, sustainability, advocacy, financial barriers, quality, and satisfaction.

The IMHI evaluation team released a comprehensive formative evaluation report. The report includes information regarding perceptions of the facilitation team, the practice teams, and the Core Advisory Group. Common themes and perceptions are identified and recommendations for mid-course project method adjustments are made.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, it is expected that up to 20 additional primary care practices will be engaging in establishing themselves as medical homes. Fewer resources will be available per participating practice; therefore, different facilitation and evaluation strategies will be employed. The next wave of participating practices will be collectively referred to as Phase II practices.

If additional funding can be secured, an economic analysis will be added to the overall IMHI evaluation design. The economic analysis will produce a model that can predict a range of costs and benefits associated with operating a practice that can be defined as a medical home.

The IMHI is a collaborator on a couple of other system development grants, both of which will accelerate activities in FFY05. The Early Childhood Comprehensive Systems grant from MCHB and the Assuring Better Health Care and Development grant from the Commonwealth Fund both seek to improve outcomes for young children. Medical homes, by definition, should be instrumental resources in the early identification, referral, and follow-up activities necessary to assure the best health and developmental outcomes for young children.

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)*

a. Last Year's Accomplishments

The FFY03 performance objective of 63.9% was not assessable because the population-based national CSHCN survey is not yet scheduled to be repeated. Based on the survey's previous administration, the FFY02 indicator value = 64.5 percent.

Enabling Services:

In FFY03, CHSC facilitated the elective transition of 22 families of children with special health care needs from Medicaid managed care to traditional Medicaid. This activity is based on families' preference for and greater satisfaction with Medicaid fee-for-service plans.

Infrastructure Building:

WellMark Blue Cross / Blue Shield was a consistent participant on the Iowa Medical Home Initiative Core Advisory Group. WellMark's participation is essential to generate, deliberate, and implement sustainable office-based quality improvements for children with special health care needs enrolled in primary care practices.

b. Current Activities

Enabling Services:

In FFY04, CHSC facilitated the elective transition of 70 more families of children with special health care needs from Medicaid managed care to traditional Medicaid.

Infrastructure Building:

The University of Iowa Public Policy Center released a report detailing the health and dental insurance status of Iowa children, including children with special health care needs. The data was obtained from the Iowa Child and Family Household Health Survey, a statewide population-based random sample survey supported by an MCHB State Systems Development Initiative grant.

CHSC provides a staff representative to the Covering Kids and Families Coalition. The Coalition is supported by a Robert Wood Johnson grant and has the overall purpose of increasing health care coverage for Iowa's children and families. The focuses for this year include improving cultural competence and providing community-based resource directories to families.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, CHSC intends to participate in a study to analyze the effects of care coordination services provided for enrollees in Medicaid Waiver Programs. Study results should help guide and prioritize Medicaid resource allocation and contracts.

The Iowa Medical Home Initiative will consider inviting additional 3rd party payers to participate with the Core Advisory Group. Wider participation from the health insurance industry would be advantageous in creating strategies to assure growth and sustainability of the medical home model within the primary care practice environment.

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)

a. Last Year's Accomplishments

The FFY03 performance objective of 79.4% was not assessable because the population-based national CSHCN survey is not yet scheduled to be repeated. Based on the survey's previous administration, the FFY02 indicator value = 77.8 percent.

Infrastructure Building:

In FFY03, a preliminary cost analysis was performed on the Continuity of Care Program. The Continuity of Care Program is a cooperative effort of CHSC and the Children's Hospital of Iowa to improve coordination of services for families, both within the hospital and between the hospital and home communities. The cost analysis demonstrated major cost savings based on length of stay reductions, especially for certain diagnoses and conditions.

Direct Services and Infrastructure Building:

CHSC initiated an effort to connect all 14 regional centers via a web-based videocamera network to improve access to services for families. The effort was funded through a partnership with Magellan Behavioral Health Corporation. Magellan contributed community reinvestment funds and CHSC planned a pilot project using telehealth access to behavioral services for children living in an underserved rural area.

b. Current Activities

Enabling Services:

In FFY04, the Continuity of Care Program expanded its number of enrolled patients to approximately 300. A detailed database of enrolled patients contains extensive demographic, diagnosis, hospital experience, and cost data. Presentations have been made to senior staff of the Children's Hospital of Iowa documenting program benefits to patients, families, local providers, and the hospital.

Direct Services and Enabling Services:

The Creston Behavioral Health Program began enrolling children with severe behavioral problems. Intensive care coordination and telehealth consultations with child psychiatry form the foundation of this effort to improve access and quality. Plans are underway to use additional Magellan Behavioral Health Corporation community reinvestment funds to upgrade the telehealth technology and to further increase access to mental health specialty care.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, the evaluation of the Creston Behavioral Health Program should be complete to the extent of guiding establishment of mental health access initiatives at additional sites. A key outcome variable in the evaluation analysis is level of need for behavioral health services. The hypothesis is that the Creston Behavioral Health Program will decrease need for high intensity psychiatric services, including hospitalizations. It is also anticipated that program enrollees will experience substantial improvements at home and in school.

The Continuity of Care Program will seek resources to expand patient enrollment through surveillance of additional hospital-based units and clinic areas. Despite the growth of the program, there are still children with complex health and mental health problems who are not being served due to program capacity limitations. Both grant and institutional funding are being investigated as possible sources of additional support.

Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)

a. Last Year's Accomplishments

In FFY03, there was no performance objective. This is because the previous national CSHCN survey was unable to produce a reliable state-specific estimate for this performance measure. In FFY02, Iowa chose to report the national performance measure indicator value of 5.8%.

Iowa hopes that a reliable state indicator estimate is obtained when the national survey is repeated.

Infrastructure Building:

In FFY03, Iowa's Healthy and Ready to Work (HRTW) project collaborated with Waterloo schools, business partners, and supported employment providers to match adolescent participants with pre-employment and employment experiences. This has resulted in 20% of HRTW participants gaining workplace experience through the project.

Evaluation methods and instruments were designed to assess system-level and individual changes, both in the project and in a matched comparison group.

Enabling Services:

The HRTW project is located in Waterloo, IA and provides customized care coordination to approximately 45 enrolled youth with special health care needs.

b. Current Activities

Infrastructure Building:

In FFY04, the HRTW project sponsored three seminars addressing medical technology in the classroom and workplace. The purpose of the seminars was to build linkages between medical providers, employers, and educators for the ultimate benefit of increasing independent living opportunities for adolescents with special health care needs.

Enabling Services:

A 0.5 FTE licensed social worker joined the HRTW staff. This will allow augmented care coordination, especially for project participants with emotional/behavioral needs.

A 10-session health and wellness program titled, "Living Well and Staying Healthy" was offered to the approximately 45 participants in the HRTW project. The program was originally titled, "Living Well with a Disability", but was retitled and subsequently promoted by the HRTW Youth Advisory Council.

c. Plan for the Coming Year

Enabling Services:

In FFY05, the HRTW project intends to continue enrolling participants and providing customized care coordination and work-based experiences. Parents of participating youth will have opportunity to receive their own training through a collaborative arrangement with local education agencies.

Infrastructure Building:

Evaluation data will be analyzed to uncover "best practices" that can be used and disseminated to advance transition services for youth with special health care needs. One target audience for these improved practices will be the new local medical home practice, People's Community Health Clinic. Other primary care practices will also be invited to receive the HRTW evaluation findings and recommendations.

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.

a. Last Year's Accomplishments

The performance measure of 90 percent was met. Data from FFY03 indicate that 91.4 percent of the children assessed in public health sector clinics were appropriately immunized by age two.

Infrastructure Building:

Collaborative efforts continue between IDPH's Bureau of Family Health, Immunization Bureau, and the Department of Human Services to improve population-based immunization tracking in Iowa.

Two significant pieces of legislation regarding immunizations were enacted by the 2003 General Assembly. In April 2003, legislation was passed allowing nurse practitioners and physician assistants to sign medical waiver forms. In May 2003, legislation adding varicella as a required immunization was passed. Children 18 months of age or older and are enrolled or attempting to enroll in a licensed child care center must receive at least one dose of varicella vaccine, or have a reliable history of natural disease. Children who are four years of age or older and are enrolled or attempting to enroll in a public or non-public school must receive at least one dose of varicella vaccine if born on or after September 15, 1997, or have a reliable history of natural disease.

Population-Based:

Eight local child health contract agencies are targeting immunization issues in their communities. The following list describes representative local action plans.

1. Provide immunization information to area child care providers through the Healthy Child Care Iowa Coordinator.
2. Develop a media campaign, including brochures, to increase the immunization rates for diverse populations.
3. Coordinate with area doctor's offices to update records of children that have moved or gone elsewhere to identify their new medical home.

b. Current Activities

Infrastructure Building:

Funding is provided to public health agencies and community health centers for immunizations. Some agencies will be conducting satellite clinics and collaborating with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics to provide immunizations. Private medical providers are encouraged to use the Immunization Registry Information System. (IRIS) The Bureau of Immunization's goal is to enroll 100 new providers. Training and in-services will be provided to VFC (Vaccine for Children) providers. Local child health agencies continue to monitor immunization status and offer counseling to families receiving EPSDT care coordination services. This includes Title XIX/Medicaid clients not served by an HMO.

c. Plan for the Coming Year

Agencies will be encouraged to provide immunizations at WIC clinics when possible. A computer tape match between WIC and Immunization records will identify children enrolled in WIC who are not up-to-date on immunizations. WIC will then support the parents in making arrangements for immunizations. The number of private providers using the IRIS immunization data system will continue to increase. Schools will be connected to the IRIS system in the future. Local child health agencies will continue to monitor immunization status and offer counseling to all families served by EPSDT fee for services and Medipass and Title V.

a. Last Year's Accomplishments

The FFY03 performance objective of 16 per 1,000 was met. Iowa's 2003 provisional data indicates that the birthrate for teenagers aged 15-17 years old was 14.9 per 1,000.

Infrastructure Building:

In FFY03 Iowa continued its participation in the Abstinence Education Program under Section 510 of Title V of the Social Security Act. Continuation funding was made available to existing contractors through a non-competitive application process. Program development continued within three categories of projects, including local contract Title V maternal health agencies, education pilot projects, and community pilot projects. Additionally, IDPH was awarded funding under the Special Projects of Regional and National Significance (SPRANS) Abstinence Education program. Funding for FFY03--05 supports programs for adolescents ages 12 through 18 years that promote curriculum based instruction, community involvement, and mentoring. IDPH partnered with three rural local MCH agencies to develop the SPRANS project.

Enabling Services:

Section 510 Abstinence Education programming was delivered through a variety of strategies including informational programs for youth and parents, mentoring programs, development of media resources, and implementation of abstinence-only curricula.

Family Planning efforts included engaging teenagers through outreach and educational programs. The educational programs stressed the value of abstinence, encouraged adolescents to talk with their parents about sexuality issues, emphasized responsible decision-making skills, avoidance of coercive sexual activity, and provided information related to pregnancy and STD/HIV prevention, including all contraceptive methods. IDPH contracts with eight community-based Title X sub-grantees to serve 45 of the state's 99 counties. IDPH collaborates with the other state-level grantees to support staff continuing education and outreach activities.

Direct Services:

A focus of Title X programming was to provide clinical services to sexually active adolescents. One of the goals for the IDPH Title X program is to increase the number of adolescents served by 25 percent (2003 data 204). This has been an objective for the past five years and will continue as an objective for the next four years. In the past five years, the number of adolescents served has increased annually.

b. Current Activities

Infrastructure Building:

In FFY04, Iowa continued its participation in Section 510 Abstinence Education. Continuation funding was made available to existing education and community pilot projects as an extension of the FFY98-02 project period. IDPH also received funding for the project period of FFY03-07 (under federal continuing resolution). Funding was allocated to community-based agencies through a competitive application process. The SPRANS project is implementing a system for collecting participant data pertaining to federal performance measures. Eight local MCH contract agencies are involved in abstinence education.

Senate File 2326 of the 79th Iowa General Assembly directed IDPH and the Iowa Department of Human Services (DHS) to discuss the feasibility of combining adolescent pregnancy prevention programs under one department. Representatives of the two departments and community stakeholder organizations for adolescent pregnancy prevention conducted a feasibility study during several meetings in October and November 2002. The adolescent pregnancy prevention programs included in the feasibility study were Section 510 Abstinence Only Education, SPRANS Abstinence Only Education, and Adolescent Pregnancy Prevention

and Services to Pregnant & Parenting Teens. The feasibility study findings suggest that relatively few benefits can be expected from implementing a plan to combine the state's Abstinence Only projects and Adolescent Pregnancy Prevention programs under one state agency.

Iowa's Medicaid agency, the Department of Human Services, submitted a Medicaid 1115 waiver for family planning services. The waiver request extends Medicaid coverage for family planning for 24 months postpartum for women whose delivery was covered by Medicaid. The waiver request also provides Medicaid covered family planning services to women ages 13 -- 44 whose income is at or below 200 percent of poverty. In addition, the waiver provides for eligibility determination by Family Planning clinics.

Enabling Services:

Section 510 Abstinence Education programming is delivered through a variety of strategies including informational programs for youth and parents, mentoring programs, development of media resources, and implementation of abstinence-only curricula. Section 510 Abstinence Education programming continues as in FFY03. SPRANS projects were curriculum-focused that included an emphasis on community involvement.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, Iowa will continue to participate in the Section 510 Abstinence Education Program. Funding will be made available to existing local contractors through a continuation application process. A contract will be established with the University of Iowa Social Work Department for program evaluation. The SPRANS project will convene a Statewide Steering Committee for Abstinence Education. Information for the project will be shared through web site development, poster displays, and development of a newsletter.

Direct Services:

Title X funding will continue to be used to provide clinical services to sexually active adolescents. Family planning contract agencies have specific activities to reach adolescents by partnering with schools, holding extra clinics at convenient times for adolescents, and including adolescents on their advisory committees.

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

a. Last Year's Accomplishments

The FFY03 performance objective of 42 percent was not met. A statewide survey conducted during the 2003-04 school year indicated that 39.9 percent of children in third grade have at least one dental sealant in a permanent molar. The survey also indicated that 33.3 percent of Iowa's third graders do not have dental insurance and that it had been more than three years since 6.9 percent of the third graders had seen a dentist. Survey methodology and additional findings are reported in the attachment.

Infrastructure Building:

Local child health agencies contracted with local dental providers to complete the sealant prevalence survey. This approach increased child health program visibility and contact with both providers and schools. These agencies are also encouraged to emphasize use of dental sealants for preventing tooth decay. Five child health agencies contracted with the Oral Health Bureau (OHB) in FFY2003 to implement school-based sealant programs. Infrastructure-

building activities in these communities included increased awareness of the importance of oral health, increased dental provider participation within public health programs, formation of oral health task forces, and collaboration with other community partners to find funding for oral health projects. Use of the school-based sealant data is used by the OHB for grant-writing and public awareness campaigns (e.g. informing governor's office of oral health needs). The program data and survey data is available at www.idph.state.ia.us/hpcdp/oral_health_content.

Enabling Services:

Age appropriate informing and care coordination provided by child health agencies includes information on dental sealants. In FFY2003, an English/Spanish brochure about dental sealants was developed and printed by the OHB and made available to child health agencies, to be used to educate the families they serve.

Direct Services:

In FFY2003, 192 children used Title V dental vouchers to receive dental sealants. The school-based sealant programs placed 15,446 sealants on molars of 2,755 children in second through seventh grades. Fifty-seven percent of the children receiving sealants through these programs were uninsured or on Medicaid, which is nine percent less than in FFY2002.

b. Current Activities

Infrastructure Building:

The Oral Health Bureau developed and conducted a sealant prevalence survey, using local child health contract agencies, to assess the ability of children to access preventive dental care. In its sixth year, the survey included all new schools, in hopes of confirming past survey results. The Public Health Dental Director position continues to be vacant and recruitment activities are continuing.

Population-Based:

In FFY2004, the OHB has been able to expand the school-based sealant program to seven contractors. The program targets second through seventh grades in schools with a high percentage of uninsured, underinsured, and/or Medicaid-enrolled children. Through December, 7,776 sealants have been placed for nearly 1,400 children, including 419 children with no insurance and 402 with Medicaid coverage.

Enabling Services:

The OHB conducted a survey of health, care, and educational programs/agencies within the state to determine the oral health education materials currently in use and what materials may be needed. This information will be used in FFY2005 to assist the bureau in assessing how they can meet the educational needs of public health agencies that serve children and families.

c. Plan for the Coming Year

Infrastructure-building:

The OHB will continue to investigate additional ways to increase funding for school-based sealant programs. It is anticipated that the Public Health Dental Director position will be filled. A new rule change by the Iowa Board of Dental Examiners, which allows public health supervision for dental hygienists, will include annual reporting of dental hygiene services to the OHB. These annual reports will be assessed to help determine the need for and ability to access preventive dental services, such as sealants.

Population-Based and Enabling Services:

School-based dental sealant contractors will continue to provide follow-up and care coordination for children participating in their programs, including identifying families that may

qualify for Medicaid or hawk-i and assisting those families with enrollment. Local contract agencies will continue to be encouraged to use dental vouchers for sealants.

Direct Services:

Four contractors will be in their final year of the project period for school-based dental sealant programs. The bureau hopes to be able to fund at least one additional program in FFY2005.

Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

a. Last Year's Accomplishments

The FFY03 performance objective of 3.4 per 100,000 was not met. Iowa 2003 provisional data indicates that the rate of death to children aged 14 years and younger caused by motor vehicle crashes was 4.5 per 100,000.

Infrastructure Building:

Regional health consultants for Healthy Child Care Iowa participated in a one-day workshop on child safety restraints. The central Iowa SAFE KIDS Coalition led a well-coordinated effort to improve Iowa's restraint law. The legislation moved forward throughout the session, but did not pass this year.

Population-Based:

The Bureau of EMS focused on minority populations by partnering with injury prevention stakeholders across the state. Motor vehicle restraint safety information was provided to child-care providers, parent advocate groups, and allied health care providers. "Buckle Up" campaign materials were distributed in both English and Spanish.

Enabling Services:

Child passenger safety check-up events were provided in several formats across the state. "Fitting Iowans for Life" provides consumers with a permanent location where they can receive occupant safety education. These sites have trained volunteer staff to check child restraint systems. They provide educational opportunities for parents and caregivers to decrease misuse of child passenger safety seats.

Two local contract child health agencies had action plans that targeted car seat safety. Some activities included:

1. Providing car safety restraint training for local staff in southwest Iowa by a certified car seat technician.
2. Coordinating with Community Empowerment Areas to purchase car seats to use at checkpoint events.
3. Providing car seat checks at WIC clinics.

Direct Services:

The Emergency Medical Services for Children program worked to provide matching resources to meet the needs of children with special needs as they are integrated within the community. Family-centered-care by out-of-hospital providers is being implemented. EMS agencies are working in collaboration with discharge entities to plan for emergency care outside the hospital. The American Academy of Pediatrics information form for children with special health care needs has been distributed statewide.

b. Current Activities

Infrastructure Building:

The Bureau of EMS is the lead agency in development and implementation of data linkages. A statewide trauma system registry contains data, which is being linked to targeted statewide databases. The data coordinator in the Bureau of EMS monitors integration of ITS technology. Implemented a new data collection system that will capture the needed data and will also allow for easier data acquisition for reports.

Efforts to provide on-going project funding have produced financial and in-kind support from the Rural Access to Medical Devices grant, State Farm insurance agents, EMC Injury Prevention conference funding, Ford Boost Up America, NE-IA Kiwanis Foundation, and the National Highway Traffic Safety Administration. The Bureau is also partnering with EMC Insurance to provide an annual injury prevention conference.

A child restraint law was passed this year. The law states that a child under one year of age and weighing less than 20 lbs. shall be secured in rear-facing child restraint system. A child under six years shall be secured by a child restraint system. A child at least six and under eleven years shall be secured by a child restraint system or safety belt. An eighteen month education phase started on July 1, 2004.

The child death review team has been asked to provide analysis of deaths of children ages one to fourteen years that are involved in motor vehicle crashes.

Population based:

The University of Iowa Injury Prevention Research Center conducted the 2003 Iowa Child Passenger Restraint Survey. At 37 locations across the state, 5,772 children under the age of six years were observed in motor vehicles. A total of 4,584 or 84.1 percent of the children were properly restrained, which is an increase of 7.9 percent over the 2002 survey.

Population based services:

A "Boost Your Booty" campaign will be kicked off in an effort to increase awareness of appropriate and proper use of booster seats. A multi-media campaign consisting of television, radio, and print public service announcements was developed and geared for children, parents, and caregivers. The focus and goal of the campaign is: 1) to see the statewide child passenger survey results show an increase in booster seat use in 2004; 2) to see a decrease in Iowa's death and injury numbers related to motor vehicle crashes of children; and 3) remind adults to always be sure children traveling in motor vehicles are properly fitted in an appropriate child safety seat system for their size and age.

c. Plan for the Coming Year

Infrastructure Building:

Regularly scheduled certification training will be continued during the upcoming fiscal year. To date, four trainings have been scheduled along with the annual CPS Refresher Update.

The EMSC program, IEMSA, and Blank Children's Hospital will collaborate to provide pediatric education for out-of-hospital providers. This education will assist physicians in local communities to provide health care for children with special needs.

The "Boost Your Booty" Campaign will continue public awareness of the new child safety restraint law.

discharge.

a. Last Year's Accomplishments

The performance measure for FFY03 of 61 percent was met. Data collected on the Iowa Newborn Metabolic Screening Profile showed that 66 percent of infants were being breastfed. The Iowa Newborn Metabolic Screening Profile reports feeding methods at the time of hospital discharge. The data are available through the University of Iowa Hygienic Lab.

Enabling services:

IDPH co-sponsored the annual breastfeeding conference with Iowa Health Systems. IDPH provided leadership for the Iowa Lactation Task Force (statewide breastfeeding coalition).

b. Current Activities

Infrastructure Building:

The IDPH contract requires local contract agencies to expend a minimum of 20 percent of the total Special Supplemental Nutrition Program for WIC funds on nutrition education, including a minimum of three percent of the WIC funds to be spent on breastfeeding promotion and support.

The Special Supplemental Nutrition Program received a grant from Using Loving Support to Build a Breastfeeding-Friendly Community, for the period of June 2002 through September 2003 with an amendment of \$25,000 through September 2005. The grant focuses on increasing breastfeeding rates in Iowa by educating local contract agencies and health care professional staff using a train the trainer approach. Trainings were held in May and September of 2003 with the final training in May 2004.

Direct Services:

Twenty-six of the local contract agencies have implemented action plans targeting community-based breastfeeding promotion and support. The following list represents local action plans.

1. Complete the certificate for breastfeeding education.
2. Collaborate with local OB physicians to increase breastfeeding rates.
3. Provide breastfeeding education and support to African American and Hispanic populations.
4. Meet and present breastfeeding educational/promotional packets to area businesses.
5. Train staff and local health care professionals with a basic breastfeeding training.

c. Plan for the Coming Year

Infrastructure Building:

The annual breastfeeding conference will be held in August 2005. Conferences and workshops will be offered to provide breastfeeding training opportunities at the local level. Bureau of Nutrition staff will provide technical assistance on breastfeeding to the local contract agencies. Local Maternal Health contract agencies will continue to develop and implement community-based strategies for breastfeeding.

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

a. Last Year's Accomplishments

The performance objective of 88 percent was met. IDPH conducted a survey of all OB hospitals requesting aggregate newborn hearing screening data. Data from 48 out of the 89 hospital survey respondents indicated that 16,682 newborns out of 17,837 births were screened for hearing loss prior to discharge. The screening rate is 93 percent. A data system to collect

population-based numbers is being implemented. In the absence of the population-based data, a synthetic estimate was used to determine the number of newborns who have been screened for hearing impairment before hospital discharge.

Infrastructure Building:

During FFY03, the Iowa legislature passed a law mandating newborn hearing screening and reporting of results to IDPH. The Iowa Early Hearing Detection and Intervention Advisory Committee participated in developing administrative rules that direct implementation of this law.

IDPH issued a Request for Information (RFI) regarding selection of an electronic reporting system for the EHDI program. The information gathered through the RFI process was used to develop a Request for Proposals (RFP) for a new EHDI reporting system. IDPH selected a reporting system in early 2004 and is now working toward implementing the system in hospitals, area education agencies, and audiology offices across the state. The data collected will be used for statewide surveillance activities and to track individual babies' progress.

IDPH and the Centers for Disease Control and Prevention entered year four of a five-year cooperative agreement to continue development of a statewide data system. IDPH is working in collaboration with IDEA, Part C (Early ACCESS), Title V, and the Center for Disabilities and Development (CDD) in Iowa City to develop this system.

The Electronic Birth Certificate (EBC) will be the primary reporting mechanism when it becomes available. When the EBC is implemented, data will be collected on the number of infants screened prior to discharge, the results of the screening tests, and where infants were referred for follow-up, if applicable. Until that time, the EHDI program will continue to use a stand-alone reporting system.

Enabling Services:

IDPH contracted with CDD for audiologists to provide technical assistance for establishing newborn hearing screening programs in hospitals and Area Education Agencies (AEAs). In response to Iowa's growing immigrant population, Spanish language brochures were made available to parents.

b. Current Activities

Infrastructure Building:

A law mandating newborn hearing screening and the reporting of screening results to IDPH became effective on January 1, 2004. Hospitals, area education agencies, audiologists, and other health care professionals providing newborn hearing screening, rescreen, and/or diagnostic services are reporting their results to IDPH. IDPH is working closely with Early ACCESS (Iowa's IDEA, Part C program) to assure that families have access to appropriate follow-up services for their children.

IDPH convenes the Iowa Early Hearing Detection Intervention Advisory Committee quarterly. This committee played a key role in advocating the legislation and was integrally involved in the development of administrative rules. Committee members continue to discuss and resolve program issues as they arise.

Following the RFP process, IDPH selected eScreeenerPlus™ (eSPTM) as the software for web-based Early Hearing Detection and Intervention surveillance. Hospitals and audiologists will be able to use eSPTM to manage their screening programs and to report data to the State. eSP? makes an integrated hearing record available to public health and medical professionals simultaneously.

Enabling Services:

In March 2004, the Iowa EHDI program held its first family conference. Approximately 30 families attended the Parent Conference for Families with Children who are Deaf or Hard-of-Hearing to learn more about issues affecting children with hearing loss.

A conference designed for professionals involved in EHDI activities will be held in September 2004. This conference is intended to educate professionals about Iowa's newborn hearing law, to update participants' skills, and to inform them of best practices.

IDPH continues to work with CDD audiologists to provide technical assistance for establishing and maintaining newborn hearing screening programs in Iowa.

c. Plan for the Coming Year

Infrastructure Building:

During FFY05, IDPH will complete statewide implementation of the electronic reporting system for newborn hearing data. Referral and follow-up procedures will be continually reviewed and updated to better serve families.

Enabling Services:

In FFY05, emphasis will be placed on implementing quality universal hearing screening programs in all birthing hospitals. IDPH will continue to work with CDD audiologists to provide training to hospital and AEA staff across the state. Care coordination activities will be coordinated with Early ACCESS.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

Infrastructure Building:

The performance objective of 5 percent was not met. The updated Census data shows that 8.6 percent of the children in Iowa are without health insurance. Between October 2002 and September 2003, the hawk-i and Medicaid programs experienced numerous policy changes, resulting in changes in administrative rules and numerous program level simplification elements were implemented. These changes have helped increase the pool of eligible families for hawk-i, and have further simplified the enrollment process for both Medicaid and hawk-i. As of September 2003, enrollment for Medicaid Expansion was 13,592 and enrollment in hawk-i was 15,435.

In July 1999, the Family Health Bureau became a grantee for the Covering Kids Project, a national initiative to increase access to health care for low-income children. After completion of Covering Kids in June 2001, the Robert Wood Johnson Foundation (RWJ) extended the same Covering Kids grant goals by offering funding for a four year grant entitled, Covering Kids and Families (CKF), which builds on Covering Kids efforts. CKF priorities in the past year included: conducted a statewide assessment to identify school districts currently including insurance questions in their free and reduced school lunch forms, continued to convene the task force that focuses on barriers to health insurance access for children, made comprehensive recommendations for removing these barriers, identified key pre-service health care professional education programs in the state, and conducted a survey to assess the degree to which health insurance programs are incorporated into the curriculum.

Highlights from Covering Kids and Families from 2002-2003 are listed below.

1. Coordinated back-to-school media campaign.

2. Continued to develop the standardized application form for the Free and Reduced Food Program for school and early childhood programs.
 3. Continued to facilitate the statewide Outreach Task Force.
 4. Distributed a report of findings, recommendations, and issue briefs on Medicaid and hawk-i to the 2003 General Assembly.
 5. Developed a family education packet that includes information for families about the value and concept of health insurance.
 6. Coordinated a statewide training for childcare professionals working with local providers about insurance options.
 7. Assisted in redesign of the hawk-i application resulting in a consumer friendly, easy to complete application in both English and Spanish.
- DHS, the state agency that administers hawk-i, approached IDPH to be the contractor for providing oversight for hawk-i grassroots outreach. This new responsibility is placed in the same bureau where CKF is placed; however, they will continue to operate as separate programs. The new outreach structure under IDPH began implementation November 1, 2002. All 26 local child health contract agencies provide outreach coverage for all 99 counties. A full time state hawk-i outreach coordinator was hired.

b. Current Activities

Infrastructure Building:

The CFK Grant from RWJ focuses on expanding outreach and enrollment activities to uninsured children, and has the same goals as its predecessor, the Covering Kids Project.

The Department of Human Services continues to contract with Iowa Department of Public Health for hawk-i outreach services. The Bureau of Family Health continues to administer agreements with the local child health agencies to provide outreach for hawk-i. Collaboration occurs at the local level through the identification of community needs and resources. The local child agencies are required to work with vulnerable populations, businesses, faith based, schools, and health care providers.

Highlights of current CKF activities are listed below.

1. Coordinate back-to-school outreach campaigns with local projects and additional targeted sites.
2. Develop a model curriculum for insurance education at the secondary level.
3. Continue to facilitate the statewide Outreach Task Force.
4. Distribute a report of findings, recommendations, and issue briefs on Medicaid and hawk-i to the 2004 General Assembly.
5. Conduct an assessment of identified Child and Adult Food Care Program contract providers to determine which agencies participate in sending lists of families who have expressed interest in receiving information about hawk-i from the free and reduced lunch forms.
6. Coordinate a training for childcare professionals working with local providers about insurance options for uninsured families and their role in hawk-i outreach.
7. Identify state agencies willing to partner in developing a plan to promote children's health insurance.

Enabling Services:

As of January 2004, enrollment for Medicaid expansion was 14,298, and enrollment in hawk-i was 16,078. Specific strategies for all local outreach coordinators focused on partnerships with school-based, faith-based, special populations, and health care providers.

Population-Based:

HCCI newsletters included hawk-i (SCHIP) application forms for Medicaid and hawk-i. The newsletters were disseminated to childcare providers who passed the information on to the families they served.

c. Plan for the Coming Year

Infrastructure Building:

CKF priorities will include collaboration with the Department of Education to design strategies encouraging school districts and child care facilities to send hawk-i a list of families who identify interest in a hawk-i application on the free and reduced school lunch forms, continuing to convene the Now Task Force and Outreach Task Force, and assessing the degree to which health insurance programs are incorporated into the curriculum for pre-service health professionals.

A fourth statewide training will inform childcare professionals about insurance options for uninsured families and child care professionals' roles in supporting hawk-i outreach.

Local contract agencies will be encouraged to distribute materials designed by the CKF Project and DHS.

Covering Kids Now task force will advocate for a benefit package for the hawk-i program. The benefit program will provide comprehensive benefits including preventive services. CKF staff will facilitate a statewide outreach task force for child advocates doing hawk-i and Medicaid outreach.

Enabling Services:

In FFY05, outreach to hard-to-reach special populations will be enhanced to improve access to quality health insurance. Local coordination and collaboration between agencies will be improved to eliminate duplication. The hawk-i grassroots outreach program will engage traditional and nontraditional statewide stakeholders to conduct hawk-i outreach.

BFH staff members will provide educational opportunities for local contract agency staff to develop skills in assessing the numbers of children not insured and who are not eligible for Medicaid or the hawk-i program, and to create a community plan for providing care for those children.

BFH staff will offer a statewide hawk-i Outreach Conference for local contract agency hawk-i outreach coordinators to discuss program issues and outreach strategies. Other outreach activities will include identifying children eligible for hawk-i; notifying families of the program, where and how to enroll, and how to maintain insurance coverage as they move between programs.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

This performance objective of 92 percent was met in FFY03. Of Iowa children who were eligible for Medicaid, 98.5 percent received a service paid by the Medicaid program. There were 198,485 eligible children during FY02 and 195,915 received at least one screen.

Infrastructure Building:

Through the Access to Baby and Child Dentistry program, Title V child health local agencies are eligible to receive funding to increase access to dental care for Medicaid eligible and other low-income children by building community infrastructure. The ABCD program was expanded to 20 local child health agencies serving 78 counties.

The EPSDT Informing and Care Coordination Handbook was updated. The annual EPSDT

Care for Kids conference provided community partners the opportunity to focus on the basic components of informing and care coordination.

In 2001, the Child Health program implemented a web based data system called the Child and Adolescent Reporting System-CAReS. By FFY03, routine quarterly and annual CAReS reports were provided to each local contract agency addressing activities in the their service area. The CAReS reports were designed with extensive local input through the Data Subcommittee of the MCH Grantee Committee.

Enabling Services:

Outreach activities facilitated enrollment of children in Medicaid and ensured access to services following enrollment. EPSDT Informing and Care Coordination, HCCI, and Medicaid Administrative Claiming programs promote these activities. The EPSDT Care for Kids coordinators, in each of the local contract agencies, informed newly eligible families of available Medicaid services, reminded them of the importance of regular well child care, and assisted them in overcoming barriers to receiving services. In FFY03, EPSDT Care for Kids coordinators provided services to 102,344 Medicaid-eligible children. The toll-free Healthy Families Line and TEEN Line, sponsored by IDPH and DHS, provided families with information about services provided by Medicaid. Callers were connected directly to the Care for Kids Coordinators in their communities. The Healthy Families Line received 2,708 calls related to the Care for Kids Program.

Limited access to dental health services continued to be a concern in Iowa. In FFY03 39 percent of Medicaid eligible children received a dental service. DHS included a mechanism for dental hygienists employed by local contract agencies to be reimbursed for dental screenings.

b. Current Activities

Infrastructure Building:

In FFY04, contract negotiations resumed with an Iowa Medicaid managed care provider to add MCH contract agencies as preferred providers for HMO covered child health services including care coordination. This resumption of discussions followed a yearlong lapse of activity.

Medicaid managed care providers continue to demonstrate limited knowledge of the principles of care coordination resulting in client calls to local Title V agencies.

An annual report to the Medicaid Director advises the HMO's refusals enters into agreements for reimbursing care coordination services provided to HMO enrolled clients.

The EPSDT Team participated in development of the application to the National Academy for State Health Policy for ABCD II funding. This application promotes a public-private system of collaborative practice that focuses on prevention, early recognition, and early intervention to promote healthy mental development of children birth to age three within Iowa's Medicaid program. ABCD II project was initiated in January 2004.

HCCI has field-tested the Child Care Health Consultant Encounter log to begin collecting process data.

Population-Based:

After a one-year lapse due to decreased funding, HCCI again assessed child health care access and safety using a standardized assessment tool. Each child's health record was assessed for presence of medical home, health insurance status, and care received per EPSDT periodicity schedule. Children with identified needs were referred to local contract agencies.

c. Plan for the Coming Year

Infrastructure Building:

Plans for the coming year will focus on strengthening the interagency collaboration and statewide infrastructure. Local EPSDT care coordinators will be encouraged to improve community linkages with local Medicaid providers for referrals and follow-up for Medicaid children.

Iowa's will continue implementation of the ABCD II initiative. Emphasis is on preventive developmental services for all Medicaid eligible children (ages 0-3) to include developmental/mental health surveillance, standardized developmental/mental health assessment, family risk screening and assessment, anticipatory guidance and care coordination. The initiative is a collaborative effort of the Iowa Department of Human Services (Medicaid), IDPH the Iowa Prevention of Disabilities Policy Council, the Child Health Specialty Clinics, the University of Iowa Center for Disabilities and Development, and Iowa Chapters of the Academy of Family Physicians and the American Academy of Pediatrics.

CAReS database and electronic record system enhancements will continue to improve the utility for local policy development and program planning.

Healthy Child Care Iowa will disseminate the Child Record Review reports. Child Care Health consultants will be trained in the use of the Child Record Review.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

The performance objective of 1.3 percent was met. The 2003 provisional data show that the overall very low birth rate was 1.2 percent. The very low birth weight rate for Blacks has improved, but significant efforts are still needed to address the very low birth weight rates for the Black community.

Population-Based and Enabling Services:

The five-year goals and objectives sought to reduce Iowa's low birth weight rate to an incidence of no more than five percent of live births, and the very low birth weight rate to no more than one percent of live births by September 30, 2000. Provisional data show that the overall low birth weight rate for 2002 was 6.6 percent.

Beginning in FFY98, reducing racial disparities was the focus of efforts to decrease the incidence of very low birth weight. The Black population is the target for these efforts. Provisional data reflects steady progress. In 1998, the rate of Black low birth weight was 13.1, and rate of very low birth weight was 4.2 (per 100 live births). Provisional data for 2002 shows the Black low birth weight rate as 10.4 percent, and the rate for Black very low birth weight as 2.2 percent.

b. Current Activities

Infrastructure Building:

IDPH continues to provide leadership for activities that influence delivery of prenatal services. BFH staff continue surveillance such as the Barriers to Prenatal Care survey and the Women's Health Information System (WHIS) to identify deficiencies in the health care delivery system. Participation on task forces, councils, and other groups such as the March of Dimes Premature Birth Prevention Campaign also continues.

Enabling Services:

IDPH continues to provide leadership for local maternal health contract agencies' prenatal care and health care coordination programs for pregnant women, and work with other agencies to decrease risk factors such as smoking and substance abuse during pregnancy. Local contract agencies conducted outreach activities to improve access to services for hard-to-reach and vulnerable populations. Four local contract agencies have implemented action plans targeting low birth weight. Four additional local contract agencies have action plans that address smoking cessation for pregnant women. Based on the Bureau of Family Health recommendations the Department of Human Services implemented a change in Medicaid Administrative Rules to allow reimbursement for local travel for pregnant women to attend medical appointments. This should help eliminate transportation as a barrier to access for some women.

c. Plan for the Coming Year

Infrastructure Building:

Program activities for FFY04 will include:

1. Continue to monitor the Barriers to Prenatal Care survey and WHIS data for unintended pregnancies, entry into prenatal care, risk factors, and socioeconomic factors.
2. Evaluate the data to identify disparities and analyze information about the probable reasons for disparities.
3. Advocate for improved access to early prenatal care for undocumented (immigrant) women and women in vulnerable populations.
4. Work to reduce the preterm birth rate. Continue collaboration with the March of Dimes Premature Birth Prevention Campaign and other initiatives.

Enabling Services:

1. IDPH will continue to work with local contract agencies to provide care coordination, health education, psychosocial evaluation, nutritional assessment, and referrals at the local level.
2. IDPH will work with Iowa's Medicaid program to implement coverage for local transportation services for pregnant women.

All 26 local maternal health agencies will provide enhanced service to low-income pregnant women.

Direct Care:

Four local maternal health agencies are providing direct health care services.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

Infrastructure Building:

The FFY03 objective of 13.7 was met. Iowa's 2003 provisional data indicated that the suicide rate for youths aged 15-19 was 8.9.

Education on youth suicide was included in the Bureau of Family Health/Child Health Specialty Clinics Fall Seminar for grantees and staff. The child death review team began investigating deaths of youth. A Suicide Prevention Strategy Group was formed in the state. The group has six subcommittees focusing on media awareness, mental health/substance abuse, community awareness, lethal means restriction (gun control), professional practices, and methodology. A suicide awareness training was provided for residence assistants at Drake University.

Population-Based:

TEEN Line and the Healthy Families Line are health information and referral lines, not crisis lines; however, staff members intervene and refer if they receive a crisis call. BFH staff worked with members of the Iowa Collaboration for Youth Development to provide a youth forum focusing on suicide. Community awareness, media releases, and training sessions were conducted throughout the state.

Information about helping students cope with the anniversary of 9/11 and the war in Iraq was distributed to school administrators and school nurses. Emphasis was placed on psychosocial assessment.

b. Current Activities

Infrastructure Building:

IDPH staff collaborated with state-level school health staff in the development of effective school-based youth development prevention programs and with groups and agencies addressing related risk factors, such as substance abuse, mental health disorders, and access to lethal means of suicide. Staff members researched promising strategies and contacted states that have made progress in their youth suicide prevention efforts. IDPH continues to participate in the development of a state youth suicide prevention plan based on the Surgeon General's Call to Action. The steps in this plan are categorized as awareness, intervention, and methodology (AIM). IDPH staff members encouraged local contract agencies to engage in activities consistent with the AIM strategy. The Child Death Review Team continues to examine records of children whose cause of death is ruled as a suicide.

Population-Based:

MCH contract agencies are encouraged to integrate youth suicide prevention information into their programs. The adolescent coordinator participated in the Region VII Suicide Prevention Conference in Denver, Colorado. IDPH will educate the public and professionals about the scope of the problem and effective prevention strategies. A brochure which includes facts about youth suicide, behavior associated with depression and suicide and intervention strategies is available on the web and in print.

c. Plan for the Coming Year

Infrastructure:

IDPH continues to participate in the statewide Suicide Prevention Strategy Group (SPSG). The group is currently working on a proposal for establishing an Iowa Suicide Prevention Center. If awarded funding, Title V staff will participate in project implementation.

Population-Based:

The SPSG will facilitate community meetings and offer suicide prevention training to interested communities. Some schools have expressed interest in the use of suicide prevention rating scales. They will be encouraged to use research based tools with proven effectiveness and assure system capacity to provide services to identified individuals.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

a. Last Year's Accomplishments

The performance objective of 65 percent has been met. Of the 406 very low birth weight infants delivered in 2002, 64 percent were delivered at Level III facilities, and 23 percent were born in Level II Regional facilities. Eighty-seven percent of very low birth weight infants were born in a Level II Regional or a Level III facility. The number of recognized Level III perinatal centers

remained at three, while Level II Regional facilities were seven, and Level II facilities were 12. Eight-nine (89) hospitals provided maternity services.

b. Current Activities

Infrastructure Building:

IDPH continued the established contract with the Iowa Statewide Perinatal Care Program. Activities included continuation of regular meetings of the Perinatal Guidelines Advisory Committee; consultation to all Level II, Level II Regional, and Level III hospital nurseries and obstetrical departments on at least a bi-annual basis; administrative consultation to hospital and health related groups; coordination with the High-Risk Infant Follow-up Program; on-site review of medical records, assessment of educational needs of staff and physicians, and presentation of educational programs; and evaluation of effectiveness of the Statewide Perinatal Care Program through review of preterm birth rates and location of preterm deliveries.

The Guidelines for Perinatal Centers published by the Perinatal Guidelines Advisory Committee on behalf of IDPH is in the process of being updated and revised. The Guidelines are distributed to all Iowa perinatal hospitals and provide guidance on services provided by the different designated perinatal center level facilities.

Population-Based:

During FFY04, publication of the Iowa Perinatal Newsletter continued on a quarterly basis. The annual perinatal care conference for physicians and staff of Iowa maternity hospitals was held.

c. Plan for the Coming Year

Infrastructure Building:

IDPH will continue the contract with Iowa State Perinatal Care Program. The Statewide Perinatal Care Program will also publish updated Guidelines for Perinatal Centers and ensure consistency with standards of care of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Enabling Services:

In FFY05, outreach education will be provided for all healthcare staff in lower-level hospitals through tertiary hospitals. IDPH will develop an email distribution list of nurse managers of all hospitals providing maternity services to communicate updated standards, educational opportunities, and provide networking opportunities.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

a. Last Year's Accomplishments

The performance objective of 88 percent has been met. Preliminary data for 2003 show the percent of women entering prenatal care in the first trimester was 88.7 percent.

Infrastructure Building:

In 1998, Iowa established a more specific annual objective, "By September 1998, increase the proportion of Black pregnant women entering prenatal care in the first trimester from 56 percent in 1993 to 73 percent in 1998." This objective is aimed at eliminating disparities, and targets the population of pregnant Black women. This objective was met in 1999, and progress continues to be positive. The rate for 2003 is 78 percent.

b. Current Activities

Infrastructure Building

Agencies also identify strategies for coordinating with other community programs. Fourteen of the local contract agencies have implemented an action plan targeting prenatal care for women in their community.

Population-Based, Enabling Services, and Direct Care:

Direct care, enabling, and population-based program activities are provided by 26 local contract agencies serving all 99 counties. MCH agencies provide services to facilitate early entry into prenatal care including Medicaid presumptive eligibility determination, care coordination, and case management including follow-up, and case-finding and outreach with a focus on high-risk women.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, data from the birth certificate and Women's Health Information System will be used to determine the population in need of specific efforts. IDPH staff members will continue to promote communication and collaboration between local maternal health agencies, other local agencies, and local providers for maternal referral. Integration of maternal health services with Special Supplemental Nutrition Program for WIC, child health programs, family planning services, and DHS programs will also continue. IDPH staff members will support and monitor local contract agencies' vulnerable population action plans, and will advocate for improved access to early prenatal care for undocumented (immigrant) women. All local contract agencies are required to submit an action plan targeting vulnerable populations in their communities.

Enabling Services:

Title V funding for geographically accessible maternal health agencies will be continued. Local maternal health contract agencies will continue to provide presumptive eligibility to pregnant women and comprehensive, community-based, culturally competent, and family-centered care. IDPH will also work with the Iowa Department of Human Services to plan and implement Medicaid coverage for local transportation services for pregnant women to travel to medical appointments.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Continue to match newborn metabolic screening records with birth certificates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. Continue to provide follow-up services to ensure that babies who were missed receive a screen.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Develop a quarterly newsletter (Heel Stick News) to improve the newborn hearing activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Update the INMSP Healthcare Practitioner's Manual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to convene the Newborn Screening Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Define roles and responsibilities of the new CHSC Family Participation Coordinator.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Recruit parent(s) of a CSHCN to be part of the Iowa Medical Home Initiative facilitation team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Involve CHSC parent-consultants in assisting families receiving Ill & Handicapped Waiver services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Increase family participation in strategic planning with an emphasis on the next needs assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Reevaluate the roles, leadership structure, and financial support for the entire CHSC Family Participation Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Continue support for the initial practices participating in the Iowa Medical Home Initiative (IMHI) facilitation experience.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue evaluation activities to document processes and outcomes of medical home building efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Review and redefine the purpose of stakeholders on the IMHI Core Advisory Group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Plan expansion of the IMHI beyond the initial participating primary				

practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Recruit consultant expertise to guide development of an economic analysis methodology.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Detail the activities necessary to accomplish the IMHI vision and priority goals established in the ffy04 strategic planning retreat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Plan and organize an in-state learning collaborative for primary care practices interested in pursuing a medical home standard of practice.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Collaborate with the Early Childhood Comprehensive Systems and the Assuring Better Child Health and Development grants.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. Continue availability of the CHSC Director to CSHCN-related advisory committees for the Iowa SCHIP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitor disenrollment of CSHCN from managed care Medicaid and reenrollment in fee-for-service.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assess satisfaction among families who convert from managed care to fee-for-service plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to deliberate with insurers strategies to reimburse providers for services provided under medical home practice standards.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Participate in a planned study of the outcomes of care coordination provided to enrollees of the Ill and Handicapped Waiver Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Investigate the possibility of and support for developing shared management protocols applicable to CYSHCN enrolled in a large commercial insurance program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Proceed to implement an evaluation strategy for the Continuity of Care Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Seek support to maintain, possibly to expand, the Continuity of Care Program supported by economic, health outcome, and family/provider satisfaction data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue enrollment of children with behavioral problems into the Creston Behavioral Health Program.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

4. Increase enrollment of children with behavioral problems into the control groups needed to evaluate processes and outcomes of the Creston Behavioral Health Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Expand use of telehealth technology to increase ease of access to community-based physical and behavioral services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Link the Health & Ready to Work Project to the Iowa Medical Home Initiative, especially at People's Community Health Clinic in Waterloo.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Recruit employers to provide workplace and community service experiences for transitioning youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Participate in multi-state sharing of adolescent transition system development efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Offer the "Living Well with a Disability?" Program to adolescents with special health care needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Provide community-based parent empowerment training for parents of transitioning youth.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Evaluate the transition project to uncover and share "best practices."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue provision of care coordination services to enrolled adolescents.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Continue to promote the use of IRIS to private medical providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide training and in-service to VFC providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Promote EPSDT Care Coordinator protocols for immunizations history reviews and appropriate referrals.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Work with schools and child care providers on the varicella legislation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provide Title X services and education for adolescents.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Continue community-based programs under Section 510 Abstinence Education.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue expansion of SPRANS Abstinence Education programs within Iowa school districts.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Monitor local agency activities and promote sharing of "best practice."	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Conduct annual sealant prevalence survey with third graders.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Contract with at least five local agencies for school-based sealant programs.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Continue infrastructure building activities to increase awareness of the importance of oral health issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide technical assistance to local contract agencies on oral health issues.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Train health consultants for HCCI on child safety restraints.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide child passenger safety check-ups at events across Iowa.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Match resources to needs of children w/special health care needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Continue to advocate for legislation supporting better child restraint requirements.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Co-sponsor annual breastfeeding conference.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to participate in the Iowa Lactation Task Force.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitor local contract agency action plans for breastfeeding promotion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Conduct train the trainer events with using "Loving Support" to build a breastfeeding support group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Implement a new statewide data system for newborn hearing screening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to convene the EHDI Advisory Committee.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to provide technical assistance to hospital screening programs and Area Education Agencies.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Monitor reported screening rates and referral follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement administrative rules and monitor for compliance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Increase collaboration with Early ACCESS (IDEA, Part C) for enhanced service coordination for children with hearing loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Design and conduct outreach programs in pilot communities that identify and enroll eligible children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Coordinate training with the HCCI consultants on health care insurance issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Develop family education packet on the importance of healthcare insurance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Coordinate statewide and local hawk-i outreach efforts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement local outreach activities through local contract agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Provide technical assistance to local contract agencies providing local hawk-i outreach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Monitor local contract agencies action plans related to hawk-i outreach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Improve CAREs data for utility of policy development and program planning.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue EPSDT training and technical assistance for the local contract agencies EPSDT coordinators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with EPSDT coordinators to improve community linkages with local Medicaid providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Monitor local contract agencies action plans related to preventive health services for children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

15) The percent of very low birth weight infants among all live births.				
1. Monitor Barrier to Prenatal Care surveys and WHIS data for unintended pregnancies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Evaluate data to determine disparities and analyze information as to probable reasons.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue the provision of care coordination, health education, & psychosocial evaluation.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Continue to collaborate with the March of Dimes Premature Birth Prevention Campaign, and other initiatives.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Advocate for improved access to early prenatal care for undocumented (immigrant) women.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Continue to provide technical assistance to local contract agencies that have actions plan for LBW.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Use the TEEN Line & Healthy Families Line for health information and referrals.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide education and resources to local contract agencies on suicide prevention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Serve on the Suicide prevention strategy group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Participate in developing a state youth suicide prevention plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Publish the updated Guidelines for Perinatal Center, and assure consistency with standards of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide outreach education, for all health care staff in lower-level hospitals.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Develop an email distribution list of nurse managers of all hospitals				

providing maternity services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue the Iowa Perinatal newsletter on quarterly basis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Assess birth certificate and WHIS data to determine the population in need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide presumptive eligibility to pregnant women through the Title V Maternal Health Agencies.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Support and monitor local MCH program's vulnerable population action plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Advocate for improved access to early prenatal care for undocumented (immigrant) women.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Provide services that are comprehensive, community-based, culturally competent, family centered through the Title V.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Continue to integrate MH services with WIC, child health programs, family planning services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of children served by Title V, excluding CSHCN, who report a medical home. (SPM #3 - Form 11)*

a. Last Year's Accomplishments

The FFY03 target objective of 55 percent for this measure was met (FFY03 indicator value = 55 percent). The indicator value was obtained from the Child and Adolescent Reporting System (CAREs).

Population-Based:

Title V served 116,935 clients and 64,215 of them (55 percent) were considered to have a medical home. For this measure, a medical home is defined as: clients who report having a usual source of medical care available 24 hours a day, seven days a week, that maintains the client's record.

b. Current Activities

Infrastructure Building:

The annual EPSDT Care for Kids Workshop was held in April 2004. During the workshop, local contract agencies and their subcontractors attended a number of sessions focusing on the importance of assisting families in establishing medical homes.

In May 2004, statewide CAREs training was conducted. This training emphasized the importance of linking families with a regular medical care provider. The training also covered the importance of clinical record documentation.

Population-Based:

Local contract agencies developed strategies to promote medical homes for pregnant women and children. Thirteen local contract agencies implement specific action plans to address medical home issues. Some activities include:

1. Educating parents about the importance of a medical home.
2. Working with area physicians to increase knowledge about Medicaid, hawk-i, and the importance of a medical home.

Iowa's statewide hawk-i outreach coordinator continues to assist local contract agencies in performing hawk-i outreach and enrollment activities. Outreach continues to focus on the medical community, schools, and faith-based organizations. During October 2003, the Lt. Governor traveled across Iowa to lead seven community roundtable discussions about hawk-i outreach strategies. The roundtables were attended by a variety of community representatives, including school nurses, medical providers, ministers, insurance agents, legislators, and child care providers.

c. Plan for the Coming Year

Infrastructure Building:

Bureau of Family Health (BFH) staff will continue to work with Child Health Specialty Clinics (CHSC) staff members as they implement the Iowa Medical Home Initiative for CSHCN (refer to NPM #3 for more information). Lessons learned from the project will be reviewed to determine recommendations for local child health agencies. BFH staff will provide technical assistance to local contract agencies.

Population-Based:

BFH will continue to support thirteen local contract agencies in implementing action plans for promoting medical homes.

Enabling Services:

IDPH will continue to work with DHS, the Child Care Resource and Referral system, Community Empowerment, Head Start, and local contract agencies to improve data linking and reporting efforts. IDPH will also continue to promote collaboration between private health clinics and local contract agencies to establish medical homes for children. The community health consultants within the Bureau of Family Health will encourage local child health contract agencies to obtain and record accurate data in the CAREs database.

State Performance Measure 2: Percent of low income children ages 1-4 enrolled in child health centers who have completed a referral to a dentist. (SPM #4 - Form 11)

a. Last Year's Accomplishments

The FFY2003 performance objective of 23 percent was not met. The FFY2003 data shows that

4.5 percent of children ages one through four completed a referral to a dentist. This is a proxy value, based on the number of children ages one through four using Title V dental funding for dental care, determined through quarterly dental data reports, and the total number of children enrolled in Title V ages one through four, determined through the Child and Adolescent reporting System (CAREs).

Infrastructure Building:

The Oral Health Bureau (OHB) supported activities to increase statewide awareness of the need for children to have regular dental care before the age of five. Activities included: oral health trainings for local WIC staff, MCH agency staff, and Healthy Child Care Iowa consultants; coordination with local WIC agencies to allow screenings by dental hygienists at WIC clinics; coordination with state and local Head Start organization to emphasize need for good oral health for Early Head Start and Head Start children and families; and the expansion of the Iowa Access to Baby and Child Dentistry (ABCD) program to be available to all child health contractors, with a focus on improving access to oral health services for children ages 0-5 years. In addition, the OHB web site was updated to include several state oral health data resources, in an effort to provide local public health agencies more easily accessible information.

Enabling Services:

Oral Health Bureau staff participated in the state's annual EPSDT conference for local child health contract agencies. A breakout session on informing and care coordination for dental services was provided. The OHB also updated oral health brochures and education materials available to local contract agencies, in addition to working with WIC in development of new materials. The OHB web site was updated to include additional materials, including Spanish translation of some materials.

b. Current Activities

Infrastructure building:

The number of ABCD contracts has increased to 22 of 26 local child health contract agencies. Also, the OHB received funding through HRSA to improve the state and local infrastructure for oral health during the current fiscal year. Funding has been used to create an ABCD Enhanced project with four contractors implementing infrastructure-building activities based on ABCD best practices, including use of a Spanish translator and development of dental continuing education courses for local dental providers. The OHB is improving state infrastructure through increased involvement with Head Start and its oral health workgroup, as well as providing input into early childhood initiatives within IDPH. Oral Health Bureau staff presented information at the MCH grantee conference in October, outlining infrastructure-building activities that grantees may incorporate into their work plans. The OHB received technical assistance from a consultant from the Association of State and Territorial Dental Directors. The consultant provided information and tools to guide the state and local communities with oral health assessment and data analysis.

Enabling Services:

The OHB has begun to receive quarterly reports through CAREs that convey the number of dental services provided by local child health contract agencies. Through assessment of these reports, staff will work with agencies to assure families are being provided appropriate and comprehensive assistance with oral health services. A survey has been implemented that will allow the OHB to determine the types of oral health education materials and services that several state programs serving children currently use and those that are needed. This information will assist the OHB in meeting those needs to improve agencies' abilities to support and educate families.

Direct Services:

In FFY2004, all 26 local child health contract agencies are using some of their dental funds for

direct dental services. These services include treatment provided in a dental office for child health clients and/or costs associated with dental hygienist direct services (screenings, fluoride, varnish applications) provided through the agency. Currently, 15 agencies employ dental hygienists.

c. Plan for the Coming Year

Infrastructure Building:

The Oral Health Bureau will continue to monitor contracts and provide technical assistance for the ABCD and ABCD-Enhanced programs being implemented in 22 local child health contract agencies. OHB staff will participate in the National Oral Health Conference in the spring, sharing state program successes and learning about other states' program ideas, in order to strengthen state infrastructure and oral health programming. The OHB will continue to participate with the Head Start oral health workgroup to implement action plans created at an oral health summit in the spring of 2003, with the goal of improving access to oral health services for children ages 0-5 years. Also, due to a new rule change through the Iowa Board of Dental Examiners, which allows public health supervision for dental hygienists, the bureau will be collecting data regarding services provided by hygienists in public health. Portions of the data will allow assessment of services available to children under the age of 5.

Direct Services:

In FFY2005, we anticipate that local child health contract agencies will be using dental funds for direct dental services, including those provided in a dental office and those provided by dental hygienists within public health. The majority of the services provided by dental hygienists are for children at WIC clinics and in Head Start / Early Head Start.

State Performance Measure 3: Degree to which key data are collected, managed, analyzed, and utilized for assessment of the determinates and consequences of the health status of women, children, and families. (SPM #8 - Form 11)

a. Last Year's Accomplishments

The FFY03 performance objective of 67 points was met. A score of 70 points was achieved on the rating scale in FFY03, up from 66 points in FFY02. Iowa has demonstrated steady improvement in the statewide MCH data infrastructure in recent years.

Infrastructure Building:

During FFY03, analysis of the 2000 Iowa Child and Family Household Health Survey continued, with a focus on regional data and minority health data. Analysis results were presented at two statewide conferences to local contract agencies.

The MCH Data Integration Steering Committee and the MCH Data Integration Team met quarterly in FFY03. Both groups demonstrated positive results related to increased knowledge of individual members and strengthening of the MCH data infrastructure.

The Data Subcommittee of the MCH Grantee Committee has met for five years to discuss issues related to the statewide data reporting systems. Group members from local contract agencies provided insightful feedback to state program staff throughout the year. The Data Subcommittee recommendations were incorporated into the upgrade of the Women's Health Information System (WHIS). The committee developed user reports for the Child and Adolescent Reporting System (CAREs). The distribution plan for these reports included a quick turnaround to local contract agencies each quarter.

Four Iowa teams, totaling 18 individuals from state and local MCH entities, took part in the

University of Nebraska Data Use Academy (DUA) during FFY03. The focus of the DUA training was to increase the data skills and capacity of the team members. The Iowa Youth Survey was a joint effort conducted by the IDPH Division of Health Promotion, Prevention, and Addictive Behaviors; Iowa Department of Education, Office of Drug Control Policy; Iowa Department of Human Rights, Criminal and Juvenile Justice Planning and Statistical Analysis Center; and Iowa Workforce Development. Students in the 6th, 8th, and 11th grades across the state were surveyed about their attitudes and experiences regarding substance abuse and violence, and their perceptions of their peer, family, school, neighborhood, and community environments. During FFY03, local communities were able to utilize Iowa Youth Survey analyses in determining local priorities and program planning.

b. Current Activities

Infrastructure Building:

In FFY04, Iowa's major MCH data systems were evaluated for usability of the information returned to the users. The quarterly meetings of the MCH Data Integration Steering Committee and the MCH Data Integration Team continued. Summary analysis of the 2000 Iowa Child and Family Household Health Survey was completed with a report on Iowa's health insurance status and planning began for the 2005 resurvey.

In FFY04, the Data Subcommittee of the MCH Grantee Committee continues to focus on the local users of the MCH data systems. Subcommittee members from local contract agencies continue to inform state program staff about information the local users need.

Two Iowa teams, totaling seven individuals from local MCH entities, are participating in the University of Nebraska Data Use Academy (DUA) during FFY04. The focus of the DUA training is to increase the data skills and capacity of the team members. As part of the training, these two teams initiated research projects focusing on substance abuse prevention among college-age students and improvement of the health and well being of families with children ages zero to five.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, local and state stakeholders will evaluate the design and methodology of the Iowa Child and Family Household Health Survey (HHS). Redesign of the HHS will be completed in preparation for resurvey in the fall of 2005.

Quarterly meetings of the MCH Data Integration Steering Committee and the MCH Data Integration Team will continue.

In FFY05, the Data Subcommittee of the MCH Grantee Committee will focus on the local users of the MCH data systems. Subcommittee members from local contract agencies will inform state program staff about information the local users need. State program staff will continue to identify strategies to provide timely information to the local contract agencies.

State Performance Measure 4: *Degree to which Iowa's providers of general medical care services to CSHCN use quality improvement strategies in their practices. (SPM #9 -Form 11)*

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 5: *Percent of counties that report screenings and referrals for behavioral problems in young children ages 3-5. (SPM #11 - Form 11)*

a. Last Year's Accomplishments

Infrastructure Building:

In 2003, the survey of public health administrators indicated that 50 percent made referrals for children ages 3-5 for mental health and/or behavioral care in the last year. This does not meet the performance objective of 65 percent.

Since 2001, an annual survey of the public health administrator in each county provided a needs assessment about screening, referrals, access, and quality of services for mental health and/or behavioral problems for young children.

IDPH collaborated with DHS, the state's Medicaid agency, to apply for an ABCD II grant through National Academy for State Health Policy (NASHP). The application was submitted in September 2003 and selected for funding effective January 2004.

b. Current Activities

Infrastructure Building:

The survey of public health administrators will be repeated in the summer of 2004. Care guidelines for Primary Care physicians were developed, specifically on ADHD.

The Creston Behavioral Health Program through CHSC, received funds from Magellan Behavioral Health to purchase web cameras to use for telepsychiatry, consultations with physicians, and other clinic services such as family counseling and translation services. This program serves as a pilot project in the provision of care coordination to children with behavioral health needs and in providing psychiatric evaluations and medication monitoring. Staff is utilizing telehealth to provide these services to children between the ages 3 and 5.

The CHSC Creston Regional Center received a DHS Wraparound Grant to plan services to meet the needs of children with Serious Emotional Disturbance (SED) in Union County. This is a seven-month grant ending September 30, 2004. The focus will be on formalizing a care coordination approach among those working with a child who has SED, no matter what age they are. Planned efforts include the initiation of a child-serving coalition in Union County to explore a system of care approach to meet the needs of children with SED from birth to age 21.

CHSC offered nine statewide trainings over the Iowa Communications Network (ICN) with audiences made up of physicians, social workers, nurses, teachers, and other professionals. Topics focused on issues with children's mental health, including: reactive/attachment disorders, anxiety disorders, depression and suicidal tendencies, cognitive behavioral interventions, and nonverbal learning disorders in children.

Iowa's application for the ABCD II grant was approved. Work began in January with the core team including staff from IDPH, DHS, CHSC, and the Center for Disabilities and Development. A multi-disciplinary panel was created and is charged with recommending a valid

developmental and mental health screening tool, reviewing Medicaid policies, and creating/recommending anticipatory guidance for parents. The health maintenance form continues to be evaluated and assessed by the members of this panel with plans for its use in the ABCD II pilot sites.

Direct Services:

One local contract agency implemented an action plan that addressed mental health. Some activities included:

1. Continuing to assess maternal health clients for mental health/maternal depression and expand to assess child health clients for mental/behavioral health concerns.
2. Coordination and collaboration with other community partners providing mental health education opportunities.

c. Plan for the Coming Year

Infrastructure Building:

CHSC will continue to use telehealth to reach more patients and families needing mental health care. Additional care plans will be created and distributed for other disorders.

The ABCD II grant will support the final development of the Health Maintenance Form and the recommendation of screening tools to physicians and local child health contract agencies. Two demonstration sites will be chosen and will begin using the recommended public-private partnership models to enhance the delivery of services to children and expand upon linkages between service providers. Practitioners will be trained on use of the recommended screening tools, child health agencies will incorporate child developmental services into their action plans, and the anticipatory guidance materials will be available through the Healthy Families Line.

State Performance Measure 6: *Percent of children estimated as being at-risk who receive monitoring and follow-up services at age 12 months. (SPM #13 - Form 11)*

a. Last Year's Accomplishments

The FFY03 performance objective of 50.0 percent for this measure was not met (FFY03 indicator value = 7.4 percent). It must be noted that this performance measure is concerned with the at-risk infant population. Unfortunately, the data from the Part C Program used to calculate the indicator value reflects infants determined to be already developmentally delayed. Thus, the performance indicator numerator (age-specific Part C enrollment count) is disproportionately small relative to the performance indicator denominator (estimated total number of at-risk infants). Because the Iowa Part C database currently only tracks developmentally delayed infants and not at-risk infants, we are currently unable to offer a more relevant indicator measure for this state priority.

Infrastructure Building:

In FFY03, CHSC continued close collaboration with Iowa's Part C Program (Early ACCESS) to improve the early intervention system for children 0-3. The majority of CHSC input was in the area of developing accountability, quality assurance, and monitoring systems. Input into screening and evaluation procedures was also made.

Early ACCESS contracted (under the Early ACCESS Comprehensive System of Personnel Development funds) with CHSC to improve the performance of primary care physicians regarding early identification and referral. The Iowa Medical Home Initiative was the chosen context for the contract.

CHSC continued planning a structure for its "Birth to Five Program", a program dedicated to early childhood health and development. Beyond the direct and enabling services provided to children and families, an expanded effort was made to be involved with state and local infrastructure-building efforts.

b. Current Activities

Infrastructure Building:

In FFY04, CHSC continued to partner with Early ACCESS and to refine its own Birth to Five Program. These established efforts are now being enhanced by participation in two new grants dedicated to improving early childhood health and development. CHSC serves in an advisory capacity to both the Early Childhood Comprehensive Systems project (funded by the federal MCHB) and the Assuring Better Child Health and Development project (funded by The Commonwealth Fund). These projects intend to design comprehensive systems of early detection and early intervention for both health and mental health issues. Both projects collaborate with the Iowa Medical Home Initiative because of the important role that primary care physicians have in assuring early childhood health and development.

c. Plan for the Coming Year

Infrastructure Building:

In FFY05, CHSC expects to continue partnering with the Early ACCESS Program and expanding the role of its own Birth to Five Program. Both programs will be developing more comprehensive, accurate, and useful data systems. This is essential for monitoring the effectiveness of statewide early childhood system development efforts. As a signatory party to the Early ACCESS Agreement, CHSC will maintain representation on the Early ACCESS Data Development Technical Advisory Committee. Once operational, the Early ACCESS database will be instrumental in creating an integrated, comprehensive, and efficient statewide early childhood care system.

State Performance Measure 7: *Ratio of black to white preterm births. (SPM #14 - Form 11)*

a. Last Year's Accomplishments

Population-Based and Enabling Services:

Preliminary 2003 data indicates that this performance objective of 1.2 was not met. The black-to-white preterm birth ratio in 2003 was 1.4.

b. Current Activities

Infrastructure Building:

The state's Child Death Review Team reviews infant death records, analyzes data, examines trends, and provides recommendations for program planning. Work with the March of Dimes Premature Birth Prevention campaign continues.

Population-Based:

Iowa's Healthy Start Program, located in Polk County, provides prenatal services for minority and low-income populations in select areas of high infant mortality.

Enabling Services:

In programming prenatal services for pregnant women, Bureau of Family Health staff and the

26 local contract agencies address case finding and outreach to minorities and hard-to-reach populations, care coordination, referrals, and targeted case management. Local contract agencies specifically target minority populations in their annual action plans.

c. Plan for the Coming Year

Infrastructure Building:

The Women's Health Information System (WHIS) will monitor the effectiveness of minority outreach activities of the local contract agencies. The WHIS system will monitor the provision of prenatal services, including enhanced services, to minority populations. The BFH Women's Health (WH) Team will examine factors proven to put women at risk for preterm delivery such as substance abuse, smoking, high blood pressure, and infection. The WH Team will work with IDPH's Office of Minority Health and representatives of minority populations to reduce preterm birth rates. IDPH will collaborate with the Department of Human Services to promote enhanced services for pregnant women. Local contract agencies will again be encouraged to provide targeted outreach to minority populations. Collaboration will continue with the March of Dimes to advocate for prematurity prevention activities.

State Performance Measure 8: *Percent of WIC clients, age 2-5 years, that are overweight at or above the 95th percentile as defined by the PedNSS. (SPM #15 - Form 11)*

a. Last Year's Accomplishments

The FFY03 objective of 7.9 percent for this measure was not met. The prevalence of overweight (weight/height >95th percentile) in children ages 2 -- 5 years remained at 10.3% as reported by the Pediatric Nutrition Surveillance System (PedNSS).

Infrastructure Building:

Increases in childhood obesity in the WIC population paralleled nationwide trends in children of all ages. Tracking of overweight children in the Special Supplemental Nutrition program for WIC continues via the PedNSS. The Youth Risk Behavior Survey (YRBS) tracked BMI based on self-reported height and weight, as well as diet and physical activity of high school aged youth.

The IDPH Health Promotion Group has a mission to ensure that internal programs coordinate nutrition and physical activity messages and programs. A survey found 12 programs promote physical activity and 13 programs aimed to prevent overweight and obesity. IDPH staff continued to participate in the Iowa Partners for Healthy Kids which brings together representatives from state-wide organizations working with children and assists in the promotion of a healthy school environment. The Iowa Fit Kids Coalition met quarterly.

Population-Based:

The Iowa Fit Kids Coalition (IFKC) successfully developed networks for sharing information. A child obesity list serve has expanded to 80 members. Practitioners in public health, child care, schools, and other areas are receiving regular information on obesity issues. IFKC collaborated with Iowa Dental Hygienists, Iowa Dietetic Association, and the Iowa School Food Service Association to develop a PowerPoint presentation to promote a healthy school environment with community and parent groups. IDPH staff provided technical assistance to the Iowa Department of Education for the implementation of the free fruit and vegetable program. Additionally, information is shared with other health professionals at the Iowa Dietetic Association Conference, the Spring Public Health Conference, and the Governor's Barn Raising for Public Health conference.

b. Current Activities

Infrastructure Building:

The Iowa Department of Public Health reintroduced legislation to collect data on heights and weights in schools. More interest was shown this year, but legislators expressed a desire for a more comprehensive bill. IDPH staff looks forward to discussions with legislators to improve the bill. Iowa WIC staff were surveyed on attitudes and practices for obesity prevention and found that training is needed on the feeding relationship.

IDPH is positioned to receive funding from the Centers for Disease Control and Prevention to build capacity for physical activity, nutrition, and obesity prevention. The Iowa Fit Kids Coalition, the Iowa Action for Healthy Kids team, BASICS grants from the Iowa Nutrition Network, and the 5 -- A --Day, Pick a better snack campaign, all continue to be active and to seek opportunities to collaborate across programs.

Enabling Services:

The Lighten Up Iowa program, a six-month competition to promote active lifestyles and healthy weight, is in its second year and has expanded to include youth teams. In 2004, Iowa Dietitians, Dental Hygienists, and other health professionals will begin providing presentations to local decision makers such as local school boards, PTAs, and other community groups on the importance of the school health environment.

Seven local contract agencies implemented action plans that target childhood obesity. Another five agencies address nutrition education and physical activity. Some activities include:

1. Development of nutrition education materials that target childhood obesity.
2. Working with area school districts to develop nutrition and physical fitness activities.
3. Providing nutrition education to parents in the community.

c. Plan for the Coming Year

Infrastructure Building:

The prevalence of overweight children will continue to be tracked through PedNSS and YRBS. An advisory group will be formed through the CDC capacity building grant to write a state plan on the promotion of nutrition and physical activity. IFKC plans a statewide survey of health programs to determine how, when, and where nutrition and physical activity programs are being implemented.

Population--Based:

Nutrition consultants will be assisting in the Color Me Healthy training for child-care providers. The Pennsylvania WIC obesity prevention modules being studied by the Fit Kids Coalition will be rolled out at the August, 2004 Iowa WIC Conference. IDPH, along with support from the Iowa Medical Society, is developing obesity prevention procedures for physician's offices.

State Performance Measure 9: *Percent of families of 1-year-old children enrolled in WIC who have participated in parenting education. (SPM #16 - Form 11)*

a. Last Year's Accomplishments

Last year's accomplishments:

The performance objective of 20 percent was not met. The percent of parents of one-year-old children who had attended a parenting education class was 14.8 percent. An additional five

percent of the parents were interested in receiving information about available parent education classes.

Infrastructure Building:

Through the Early Childhood Comprehensive Systems grant, IDPH staff focused on parenting education and family support. Staff have been collecting national and state level definitions of parenting education and family support. An assessment of family support and parenting education offered at the local level was updated.

b. Current Activities

Infrastructure Building:

Parenting education is a critical component within the Early Childhood Comprehensive Systems grant. IDPH staff members and the Early Childhood Core Stakeholder group are working on activities related to parenting education and family support. The Quality Services and Program workgroup, within the Early Childhood Core Stakeholder group, is in the process of developing common terminology for the Stakeholder group to approve.

Population-Based:

One local contract agency implemented an action plan targeting parenting education. Some activities include:

1. Adapting culturally appropriate messages about SIDS education and smoking cessation.
2. Coordinating with Community Empowerment and Child Care Resource and Referral to offer parenting education opportunities.
3. Increasing knowledge of staff to know what parenting education opportunities are available within the community.

Enabling Services:

A roundtable on the parenting education data was presented at the Bureau of Family Health ? Child Health Specialty Clinics Fall Seminar in October 2003. The attendees provided feedback on the data and a reaction to the questionnaire. The need for improved collaboration between local contract agencies, family support service workers, and prenatal care providers were discussed.

A breakout session was also conducted at the 2004 Spring Public Health Conference. Title V local contract agencies, CHSC staff, and public health professionals shared successful linkages at the community level between prenatal care providers, family support, and early care providers. The attendees also discussed their role in making these connections and fostering them. Comments from the session and two best practice items were shared with participants.

c. Plan for the Coming Year

Infrastructure Building:

IDPH staff members will work with the Early Childhood Stakeholder group and Quality Services and Programs workgroup to convene the leadership of family support service providers. The purpose of the meeting is to improve collaboration between family support networks, share the family support definition, and help attendees become more aware of programs being offered throughout Iowa. The meeting is being planned for October 2004.

Staff will also investigate the establishment of a central point of access to link families to support services. The staff will work closely with the 2-1-1 referral system that provides referrals to nearly all of Iowa's 99 counties.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) Percent of children served by Title V, excluding CSHCN, who report a medical home. (SPM #3 - Form 11)				
1. Engage the state's AAP chapter and state agencies in promoting medical homes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop recommendations for CH agencies based on lessons learned with CHSC medical home project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue to provide TA to local contract agencies to improve coordination with local medical providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Encourage local contract agencies in obtaining and recording accurate data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Conduct statewide CARES training to local contract agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Bureau of Family Health staff will serve on the Iowa Medical Home Initiative Core Team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of low income children ages 1-4 enrolled in child health centers who have completed a referral to a dentist. (SPM #4 - Form 11)				
1. Offer ABCD contracts to all local child health contract agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide technical assistance for informing and care coordination services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide training to other healthcare professionals via HCCI, WIC, and Community Empowerment.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Allow CH contractors to use Title V dental funds for infrastructure in addition to direct care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Improve state infrastructure through increased involvement with Head Start and the early childhood grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

3) Degree to which key data are collected, managed, analyzed, and utilized for assessment of the determinates and consequences of the health status of women, children, and families. (SPM #8 - Form 11)

1. Complete the dissemination of the Household Health Survey Health Insurance report.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Plan for the 2005 Iowa Child and Family Household Health Survey.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Evaluate the major MCH data systems for usability.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue the MCH Data Integration Steering Committee and the MCH Data Integration Team.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue the MCH Grantee Data Committee and make recommendations for CARES and WHIS databases.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Degree to which Iowa's providers of general medical care services to CSHCN use quality improvement strategies in their practices. (SPM #9 -Form 11)				
1. SPM #9 has been discontinued	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of counties that report screenings and referrals for behavioral problems in young children ages 3-5. (SPM #11 - Form 11)				
1. Repeat survey of Public Health Administrators to assess screening and referrals for children 3-5 years.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to monitor CHSC mental health services in Creston and Ottumwa.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

3. Investigate opportunities for additional resources and program development.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Implement the ABCD II project and develop a panel of mental health providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to evaluate the health maintenance form using the ABCD II panel members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of children estimated as being at-risk who receive monitoring and follow-up services at age 12 months. (SPM #13 - Form 11)				
1. Collaborate with Part C to develop performance indicators to monitor early intervention services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Use the Iowa Medical Home Initiative to improve physician performance in screening and referrals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Integrate CHSC's Birth to Five Program and Part C to improve tracking for at-risk infants/toddlers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Review and recommend developmental screening instruments and standards for early childhood services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Collaborate with the Early Childhood Comprehensive Systems grant (MCHB) and the Assuring Better Child Health and Development grant (Commonwealth Fund).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Serve on the technical advisory committee for development of the Part C Early ACCESS Data System.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Ratio of black to white preterm births. (SPM #14 - Form 11)				
1. Use the WHIS data system to monitor monthly outreach activities of the local agencies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Monitor risk factors for pre-term delivery, such as substance abuse and smoking.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Continue collaboration with DHS to monitor and promote enhanced services for pregnant women.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Encourage targeted outreach to minority populations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

5. Continue collaboration with the March of Dimes to advocate for prematurity prevention activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to collaborate with the Office of Minority Health at IDPH.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Support and monitor local contract agencies vulnerable populations action plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percent of WIC clients, age 2-5 years, that are overweight at or above the 95th percentile as defined by the PedNSS. (SPM #15 - Form 11)				
1. Develop guidelines for WIC staff to address obesity issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Provide technical assistance to Dept of Education on the implementation of the free fruit and veggie program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Provide technical assistance to local contract agencies with action plans related to childhood obesity.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop a list serve to disseminate childhood obesity information.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Continue to participate in the Iowa Partners for Healthy kids and the Iowa Fit Kids Coalition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of families of 1-year-old children enrolled in WIC who have participated in parenting education. (SPM #16 - Form 11)				
1. Investigate opportunities for improve collaboration among Iowa and national family support groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with stakeholders to develop common terminology for parenting education services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Collaborate with the 211 initiative to assess the central point of access services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Work with local contract agencies on improving linkages with prenatal care providers and family support providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Bring together Iowa's family support leadership to discuss family support definitions and best practices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.				

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. 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 Community Empowerment Areas, the State Children's Health Insurance Program, and welfare reform. A listing of formal and informal organizational relationships is located in IVE attachments.

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 IDPH Title X clinic map is located in the IIIIE Attachment.

Following are other CHSC program activities:

1. State and regional staff are involved with development of local boards for Community Empowerment Areas and have been involved closely in program planning and resource allocation in the communities.
2. The Director is working closely with the newly established College of Public Health at the University of Iowa to develop a Masters in Public Health in the Family and Child area. An MCH focus track, highlighted by a new MCH survey course, will be developed with assistance from the College of Public Health. /2004/ The first MCH course was offered spring semester of 2003. An MCH focus track is not yet established./2004/ ***/2005/A Maternal, Child, Family Health Focus Area is now officially established within the College of Public Health./2005//***
3. Several staff members participate in planning and providing experiences for leadership training in the ILEND (Iowa Leadership Education in Neurodevelopmental Disorders) program. The CHSC Director is the co-director of the ILEND grant.
4. CHSC jointly plans with the Iowa Departments of Human Services and Public Health to assure quality care for cshcn enrolled in Medicaid Managed Care and SCHIP Programs. The SCHIP Board has requested the CHSC Director develop plans for: 1) a cshcn identification method; 2) an approach to care coordination for cshcn enrollees; 3) an extended benefits package for cshcn enrollees; and 4) quality assessment indicators applicable to cshcn enrollees. /2004/ Medicaid Managed Care now gives families of cshcn the option to disenroll from managed care and reenroll in traditional fee-for-service Medicaid. The rationale is better care quality and family satisfaction./2004/
5. Two new regional centers are now operating -- one in Des Moines serving central Iowa and another in the Johnson County area serving Cedar Rapids and the University of Iowa's Children's Hospital of Iowa.
6. Staff members collaborate with the Department of Public Health and the Iowa State University Extension Service to improve the leadership skills of community-based service providers under a CISS grant titled, "Health Leadership Iowa" /2004/ This grant has expired. CHSC participated in the final project evaluation assessing growth in staff leadership./2004/
7. Staff members collaborate with the Department of Public Health and City MatCH (University of Nebraska) to plan a continuing education experience for Title V program leaders to build skills in data utilization and core public functions. The Data Use Academy is underway and four teams from Iowa's Title V Program are participating.

8. Staff members participate in planning and field-testing new approaches to delivering health care services and consultation to remote geographic sites using telemedicine techniques. /2004/The current focus is on using telehealth to increase access to behavioral health services. A demonstration project is underway in Southwest Iowa./2004/ **/2005/All 14 CHSC regional sites are now equipped with telehealth webcam and monitor capabilities./2005//**
9. Staff members participate in constructing and implementing a long-range statewide public health blueprint titled, "Healthy Iowans 2010", which is modeled after "Healthy People 2010" **/2005/Staff members serve as the team leaders and facilitators for the Healthy Iowans 2010 midcourse review. The midcourse review will be completed by January 2005./2005//**
10. CHSC is represented on the newly formed "Iowa Community Health Advocates" coalition that seeks to improve the ability of the public to effectively contribute to public health policy. /2004/ The focus of this coalition has shifted to providing training and field experiences to new and established public health professionals./2004/
11. Staff members direct a SPRANS grant project to create innovative systemic approaches to transitioning cshcn from school to successful employment and independent living.
12. A reorganization of CHSC services into a decentralized modality is improving infrastructure building activities locally and regionally. **/2005/Further strategic reorganization, including revision of staff responsibilities, is being implemented due to budget reductions./2005//**
13. Staff members collaborate with the Departments of Public Health and Human Services in designing a statewide model for inclusive child care.
14. Staff members serve on a multidisciplinary collaborative work group to develop a statewide system of mental health services for children. **/2005/Several staff are also participating in the Assuring Better Child Health and Development project (supported by the Commonwealth Fund) designed to improve early detection and intervention for young children, 0-3, at risk for behavioral problems./2005//**
15. CHSC is coordinating a statewide effort to assure that every Iowa child with special health care needs is enrolled in a medical home by 2010.
16. The Continuity of Care program, supported by Medicaid Administrative Claiming funds, has the goal of improving the effectiveness and efficiency of care for cshcn as they transition from medical center hospital-based care to community-based care.

F. TECHNICAL ASSISTANCE

The BFH received a request for technical assistance from two local MCH contract agencies in northwest Iowa. The agencies requested TA regarding health services for Hispanic children and families. The TA addressed: 1. Conducting health related outreach to families with children (how to's); 2. Improving birth outcomes for mothers and infants (how to approach health teaching with families); and 3. Improving health outcomes for children (how families can use preventive health services for their children). The primary presenter requested by the MCH agency was Dr. Maxine Hayes of Washington state. The consultant from Iowa's office of minority health also presented. The training held in northeast Iowa on September 27, 2002.

/2004/ Iowa's state Title V program is receiving technical assistance from HRSA CompCare to evaluate its statewide regionalized perinatal care system. CompCare's contracted TA provider - Health System Research (HSR) - is conducting a two-fold evaluation. The first evaluation component involves a written survey mailed to head nurses of each maternity hospital in the state. The second

component is a telephone survey of a representative sample of obstetricians, pediatricians and family practitioners who provide services affiliated with the maternity hospitals. The survey instrument for both components was written by HSR with input from the state Title V director, the state maternal health consultant, and the director of the statewide perinatal care program. The survey asks for comments and feedback from these individuals regarding their perceptions of the various activities and programs that comprise the statewide regionalized perinatal care system. The results of the surveys will be analyzed by HSR and available in August of 2002. These findings will be used to assess the current efficacy of the system, and for planning future activities.

The BFH is requesting technical assistance to pay expenses for a guest speaker at the Early Care, Health, and Education Congress on November 18 and 19, 2003. The Bureau and Community Empowerment are sponsoring a Early Childhood Research Summit through the HRSA Early Childhood Comprehensive Systems Grant. The planning committee would like to invite Dr. Ed Schor to help facilitate the Research Summit.

BFH and CHSC also are requesting technical assistance to pay the honorarium for a guest speaker at the 2004 Public Health Conference to discuss developing evaluation components and advancing the Core Public Health Functions in Public Health. The annual conference is March 30 and 31, 2004 in Ames, IA.

CHSC is requesting technical assistance to support face-to-face consultation between the designated evaluation staffs of the Iowa and California medical home implementation initiatives. Well-designed and informative evaluation studies are crucial to successful implementation and adaptation of new medical home models of service delivery for cshcn. California, like Iowa, is implementing their medical home initiative with primary care practices characterized by a diversity of provider arrangements and financial support mechanisms. Also like Iowa, the California initiative is using external, university-based evaluation expertise. The Iowa initiative would benefit from learning the California approach to evaluating a variety of possible process and outcome variables. Additionally, any agreement on common approaches to evaluation methods and selection of evaluable data elements could potentially strengthen national-level understanding of medical home model implementation.//2004/ ***/2005/The Iowa Medical Home Initiative (IMHI) evaluation team has developed a sophisticated evaluation methodology suitable to the specific planning and implementation activities of the IMHI and chose to not pursue this avenue of technical assistance.//2005//***

/2005/ The Bureau of Family Health is requesting Title V technical assistance funding to support the Iowa MCH Data Capacity Project, an SSDI-funded project. The purpose of the federal State Systems Development Initiative (SSDI) is to assist state maternal child health (MCH) and children with special health care needs (cshcn) programs in building state and community infrastructure that results in comprehensive, community-based systems of care for all children and their families. The Iowa MCH Data Capacity Project focuses on Title V Block Grant Health Systems Capacity Indicator #9(A): the ability of States to assure that the Maternal and Child program and Title V agency have access to policy and program relevant information and data. The project is designed to strengthen system-level data capacity to support the development of systems of care at the community level.

During SSDI project period 9-30-01 to 9-29-03, key MCH data partners joined together to address important issues and strengthened collaboration through the work of the newly-designed MCH Data Integration Steering Committee (DISC) and the MCH Data Team. Growth has been evident in the organizational process and dynamics of these two groups. Though the groups made progress in the first year, further system-level growth is possible through enhancement of group capacity and accountability. During the next SSDI project period (9-30-03 to 9-29-06) SSDI goal three proposes to strengthen the capacity of the MCH data workforce to meet data system development, maintenance, and integration needs.

To accomplish SSDI goal three, the organizational process and dynamics of both groups will

be scrutinized and opportunities for growth identified. A central theme will be the convergence of diverse business needs toward grouped needs. The DISC group can make system-level changes with its stated purpose to provide a "forum for decision-makers of MCH data partners to guide system changes for data linkage and integration." Each quarterly DISC agenda will call for a report on improvement in the integration of Iowa data system reporting and analysis functions. The MCH Data Team provides the implementation structure for potential system changes identified by the DISC group.

The responsibilities of the DISC group and the MCH Data Team will be increased in relation to MCH data system revisions and enhancements. Improvement in statewide data linkages will be driven largely through the efforts of these two key MCH data groups.

Title V technical assistance is requested to assist with capacity-building activities related to SSDI goal three. Capacity-building activities will focus on increasing the knowledge of key individuals in the DISC group and the MCH Data Team through peer-to-peer best-practice educational opportunities. Peer-to-peer consultation will be sought from states that have made progress in statewide data linkages through successful data integration projects. Consultants will be asked to offer educational opportunities in Iowa to maximize participation by DISC and MCH Data Team members.

Iowa is requesting technical assistance to pay the honorarium for a plenary speaker at the 2005 Public Health Conference. The theme for the conference is _____. The annual Public Health Conference will take place March 29-30, 2005 at the Scheman Center in Ames, Iowa.

The Bureau of Family Health is requesting technical assistance to pay expenses for a speaker at the SCRIPT (Supporting Changes & Reform In Interprofessional Preservice Training in Iowa) Symposium. The symposium is jointly sponsored by the Department of Education, SCRIPT Team, and the Early Childhood Comprehensive Systems (ECCS) grant. The conference is scheduled for April 2005. The focus will be on integrating preservice training into the health field curricula. The ECCS project coordinator serves on the SCRIPT Team.//2005//

V. BUDGET NARRATIVE

A. EXPENDITURES

See Forms, 3, 4, and 5

Form 3, State MCH Funding Profile, shows a federal allocation expenditure of \$8,131,192. Variance for budget range from --17 percent in maternal health to +13.5 percent in Children with Special Health Care Needs. The maternal health variance can be explained by decrease in staff at the state level in response to proposed budget reduction. For Child with Special Health Care Needs, the variance can be attributed to maintaining current service level and implementation of new program development. Contracts with CHSC for MCH Block Grant funds are written for two-year contract periods. Consequently, federal funds not expended in year one of this contract do not meet the DPH Fiscal Bureau's definition of unobligated funds and, therefore, were not included in the reported unobligated balance.

Form 4, Budget Detail by Types of Individual Served, reports partnership expenditures for FFY 2003 in the amount of \$17,050,932. Of this amount, \$8,131,192 was funded by federal Title V. The state match is reported at \$6,785,644. This exceeds both the state match requirement and the maintenance of effort requirement. Federal Title V funds expended for infant and child health primary and preventive care was \$2,612,747 or 32 percent of the total Title V expenditures. The Federal Title V expenditure for Children with Special Health Care Needs is reported at \$3,680,051 or 45 percent of the federal block grant funds expended for the year. Administration expenditures of \$363,160 represent four percent of the federal Title V amount.

Expenditures for FFY03 exceed Block Grant budgeted amounts. This can be attributed to a decrease in state funds directed by the General Assembly. Other variances are explained by efforts to maximize the use of other funding sources and recognize Title V as the payor of last resort. In the attachment, Figure 1 depicts the distribution of federal Title V expenditures by types of individuals served.

In the attachment, Figure 2 displays the distribution for the combined federal-state partnership expenditures.

Form 5, State Title V Program Budget and Expenditures by Types of Services, continues to show a gradual shift from the Direct Care Category to the Enabling Services Category. The variances are attributable to intentional program changes as reflected in the state plan. Additionally, continued improvement has been achieved in reporting on expenditures by pyramid level.

In the attachment, Figure 3 reflects Title V expenditures by pyramid level and Figure 4 illustrates the distribution for the combined federal-state.

B. BUDGET

The FFY05 Title V appropriation is projected to be \$6,760,133 and a carryover amount at \$796,731 for a total of \$7,556,864. As itemized in the attachment, this expected allocation is budgeted as follows: \$1,727,507 (23%) for maternal health services; \$264,960 (3%) for infant health services; \$2,621,534 (35%) for child health services; \$2,428,840 (33%) for services to children with special health care needs; and \$514,023 (6%) for program administration. These budgeted amounts include carryover amounts that will be expended in FFY05. 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 FFY05 Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

Completion of Budget Forms

See forms 2, 3, 4 and 5 in supporting documents and the attachment.

The projected state match is \$5,679,015. Iowa continues to exceed the state maintenance of effort from 1989 of \$5,035,775. The FFY05 budget projections are based on a federal allocation of \$6,760,133, plus \$796,731 unobligated. The projected state and local funds exceed the required match and maintenance of effort.

Iowa strives to maintain an unobligated balance of approximately \$500,000 to avoid interruptions in essential services that could occur in the event of an unanticipated delay in funding. Additionally, unobligated funds will be used on an as-needed basis to prevent an interruption in essential services affected by a reduction in state funding.

The total budget for the federal-state partnership is projected to be \$15,128,507. This figure, as well as the following breakout by level of services, includes the unobligated balance of \$796,731 from FFY04. In the attachment, Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of service as well as population group served.

Direct Services. The federal-state partnership expenditures for continuation of direct care services are estimated at \$3,504,392. This represents approximately 23 percent of the partnership budget. The amount includes 16 percent of the funding for community based child health agencies and three percent of community based maternal health funds. In addition, this category includes HOPES Home Visiting; Birth Defects Institute and Regional Genetics Services; dental treatment and dental sealant pilot projects; and the OB indigent program. CHSC projects a direct care budget of \$1,372,899 or approximately 26 percent of the CSHCN budget. Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Enabling Services. This category includes 26 percent of the funding for community based child health agencies. It also includes 100% of child health local match funds. Fifty-six percent (56) of community based maternal health funds are for enabling. Healthy Families toll free information and referral line and the Teen Line are included in this category. CSHCN services in this category include EPSDT III and Handicapped Waiver Services. The amount of budget for Enabling Services is \$4,978,786 (33 percent).

Population Based Services. IDPH funds expended in this category include state funds for STD testing, immunization, and lead poisoning prevention. This category also includes 22 percent of the funding for community based child health agencies and 10 percent of community based maternal health funds. Iowa anticipates expenditures of \$1,612,141, which represents 11 percent of the total partnership budget. IDPH projects expenditure of \$1,278,806 (plus the related administrative costs of \$92,524), and CHSC projects a budget of \$240,811 or approximately five percent of the CSHCN budget.

Infrastructure Building Services. Estimated expenditures for continuing development of core public health functions and system development are \$5,033,188 or 33 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal health, child health and EPSDT. This category includes 36 percent of the funding for community based child health agencies and 31 percent of community based maternal health funds. In addition, it includes contract services with the University of Iowa, Departments of Pediatrics and OB/GYN for infant mortality prevention activities and child health systems development consultation. CHSC's budget for infrastructure building services is estimated at \$924,448 (17 percent of CSHCN budget).

Other federal funds directed toward MCH include a Special Project of Regional and National Significance (Healthy and Ready to Work); the State Systems Development Initiative; a Community Integrated Service System project (Healthy Child Care); a Community Integrated Service System

project - Early Childhood Comprehensive Systems Grant; Integrated Comprehensive Women's Health Services in State MCH Programs - AWARe; Medical Home Initiative for Children with Special Health Care Needs; Title X Family Planning; Abstinence Education Initiative- Section 510 and SPRANS; Early Intervention Services (IDEA - Part C); and Early Hearing Detection and Intervention (CDC and HRSA).

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.