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Welcome to the Crawford County Home Health, Hospice & Public Health (CCHHH&PH) Annual Report for fiscal year of July 1, 2015 through June 30, 2016. Each year the employees of Crawford County Home Health, Hospice & Public Health work together to prepare this report.

Crawford County Home Health, Hospice & Public Health meets the community's needs through providing public health, home health, hospice, and homemaker services. Crawford County Home Health, Hospice & Public Health has been Medicare certified since May of 1974 and Hospice certified since May of 1999. Public Health services have been provided to the citizens of Crawford County since 1951. The agency is a non-profit organization serving under the direction of the Crawford County Board of Health and receives financial support from the Crawford County Board of Supervisors.

Crawford County Home Health, Hospice & Public Health believes in the human rights of each individual, the value of life and the goal of achieving the highest standard of health possible for each individual served. The agency believes that the services provided are an important part of the health care delivery system. It is also believed that a home environment in many cases can enhance and encourage individuals to strive for optimal health. To achieve this goal, coordination and planning must involve the health care provider, other service providers, and education to the client and/or family. Optimum quality care is important to meet the community health needs by providing services from prenatal through the end-of-life for the diverse population in Crawford County.

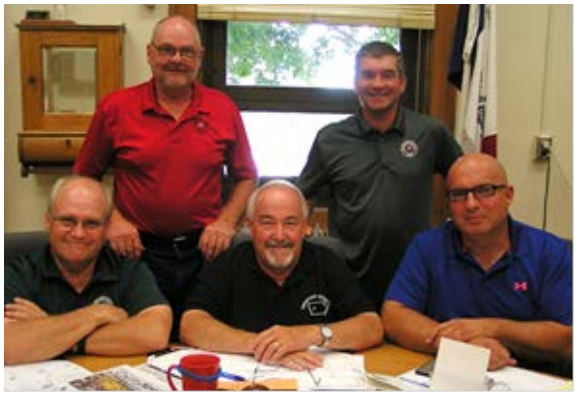
Acknowledgements

Crawford County Home Health, Hospice & Public Health extends their appreciation to all of those who serve as members of the Board of Health and the Board of Supervisors. The staff would like to thank the Boards for the time and support given to the agency.

BOARD OF HEALTH

Douglass Soseman, DDS
Patty Ritchie
Tim Weber, RPh
Michael Luft, DO
Marcy Larson, BSN RN

Ritchie, Larson, Soseman, Weber (Luft absent)

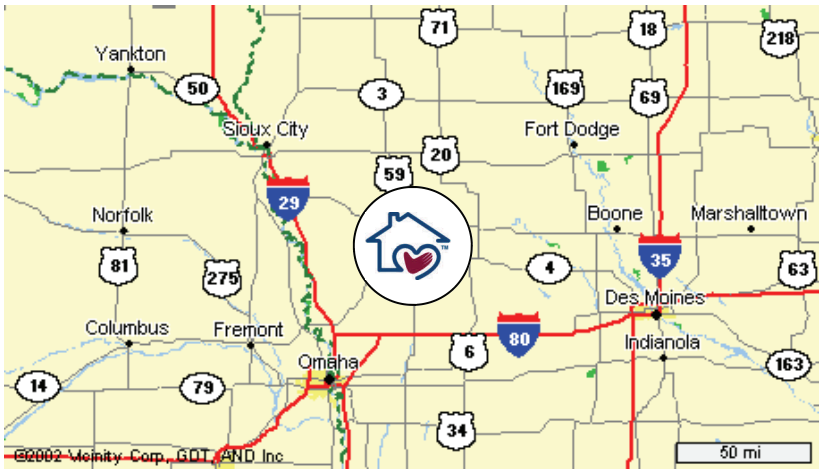


Skoog, Kuhlmann, Blum, Schultz, Ulmer

BOARD OF SUPERVISORS

Steve Ulmer
Eric Skoog
Cecil Blum
Randall Kuhlmann
Kyle Schultz

Providing the highest quality of care and meeting the needs



of the community in the most cost effective way.

Year End Summary

2015

2016

CRAWFORD COUNTY HOME HEALTH, HOSPICE & PUBLIC HEALTH
STATISTICS

THREE YEAR COMPARISONS

HOME HEALTH	FY16	FY15	FY14
Home Health Admits	90	94	81
Home Health Discharges	100	95	85
Home Health Nursing Visits	1771	1777	1976
Therapy Visits	205	277	152
Evaluation Visits	53	63	62

HEALTH AIDE			
Health Aide Admits	34	33	22
Health Aide Discharges	35	33	24
Health Aide Visits	1822	1876	1676

HOSPICE			
Hospice Admits	60	59	81
Hospice Deaths or Discharges	62	58	81
Hospice RN Visits	581	596	833
Hospice SW Visits	313	366	301
Hospice HA Visits	194	144	255
Nurse Practitioner Visits	1	0	3

HOMEMAKER PERSONAL CARE			
Personal Care Admissions	16	27	23
Personal Care Discharges	34	37	16
Personal Care RN Supervision Visits	72	142	143
Personal Care Homemaker Visits	1247	2281	2177

Total Home Care Visits	10211	11285	10888
Served in P.H. Programs	3510	3899	3899

HOMEMAKER	FY16	FY15	FY14
Homemaker Admits	48	29	33
Homemaker Discharges	20	28	27
Homemaker Visits	2588	2114	2062

WAIVER PROGRAMS			
Elderly Waiver Admissions	2	2	3
Elderly Waiver Discharges	3	3	3
Elderly Waiver HM Visits	988	1132	849
Brain Injury SCL Visits	0	0	4
Brain Injury CDAC Visits	0	0	52
ID SCL Visits	0	0	2
CM Elderly Waiver Visits	247	361	341
CM Elderly Waiver Admissons	7	5	4
CM Elderly Waiver Discharges	7	4	9

PUBLIC HEALTH			
1 x Mom & Baby Visits	0	3	6
Immunizations for Children	415	552	503
Adult Hep B	16	9	18
Blood Pressures Taken	590	733	802
Vision Checks	0	3	18
Seasonal Flu Shots	313	384	431
TB Latent / Non Active Clients	7	10	26
TB Direct Observation Clients	4	2	2
TB Skin Tests	69	44	59
Disease Investigations	16	18	5
Family STEPS Visits	645	859	758
FS- Not Home/Not Found	54	79	74
Promise Jobs Visits	176	58	117
Lead Screenings	13	23	34
Family Planning Clinic Visits	182	120	252
Family Planning Pick Up Visits	259	288	405
Child Health Clinic Visits	85	93	107
Maternal Health Visits	45	16	21
Care for Yourself	60	51	51
CCNC Visits (Unduplicated)	71	86	86
I-Smile Screenings	212	176	176

HEALTH MAINTENANCE	FY16
Health Maintenance Admits	10
Health Maintenance Discharges	0
Health Maintenance Nsg Visits	73

2015-2016 Grants & Contracts

HCCMS - Maternal/Child Health/Family Planning/CCNC/I-Smile/*hawk-i*
October 1, 2014 - September 30, 2015 ~ $356,174
October 1, 2015 - September 30, 2016 ~ $305,893

HCCMS - CCNC - Crawford, Buena Vista & Sac Counties Early Childhood Iowa
$21,356

HCCMS - Oral Health - Crawford, Buena Vista & Sac Counties Early Childhood Iowa
$6,893

HCCMS - CCNC - Boost-4-Families Cass, Mills & Montgomery Early Childhood Iowa
$3,500

HCCMS - Oral Health - Boost-4-Families Cass, Mills & Montgomery - Early Childhood Iowa
$3,975

HCCMS - CCNC - Harrison, Monona & Shelby Early Childhood Iowa
$48,629

HCCMS - Oral Health - Harrison, Monona & Shelby Early Childhood Iowa
$11,439

HCCMS - Cervical Cancer Screening
$1,500

HCCMS - 1st Five HMDI
October 1, 2014 - September 30, 2015 ~ $104,050
October 1, 2015 - September 30, 2016 ~ $106,221

HCCMS - School-Based Dental Sealant Program
October 1, 2014 - September 30, 2015 ~ $15,000
October 1, 2015 - September 30, 2016 ~ $15,000

HCCMS – Children at Home Program (Crawford and Harrison Counties)
$49,999

HCCMS - Dental Wellness Community Outreach
January 30, 2015 - June 30, 2017 ~ $25,468

HCCMS - Dental Wellness Community Outreach (Taylor and Montgomery Counties)
January 30, 2015 - June 30, 2017 ~ $10,828

HCCMS - Lemonade For Life
$3,375

HCCMS – Promoting Social-Emotional Health in At-Risk Families
$2,128.86

2015-2016 Grants & Contracts

Family STEPS - Crawford, Buena Vista & Sac Counties Early Childhood Iowa
$146,748

Prevent Child Abuse Iowa
Family STEPS ~ $19,658

Local Public Health Services Contract (LPHSC)
$59,443

Public Health Emergency Preparedness
PHEP ~ $27,277
HPP (Pass Thru to CCMH) ~ $10,660

EMS (Pass Thru to CCMH)
$9,433

Emergency Response Multi-Year Program
Ebola ~ $5,955

Immunization
January 1, 2015 - December 31, 2015 ~ $16,904
January 1, 2016 - December 31, 2016 ~ $12,157

Elderbridge Agency on Aging
Homemaker ~ $15,000
Personal Care Homemaker ~ $4,500
Respite ~ $2,250

DrAlTo - Community Partners for Protecting Children (CPPC)-Decategorization
$4,950

Baby's Boutique - Community Partners for Protecting Children (CPPC)-Decat
$2,500

Iowa Care for Yourself Program (Cass County BOH holds Grant)
ICFY ~ $7,500
Outreach ~ $1,000

DHS – Interpreter Case Management Services
$2,000

IDPH-TB Medical Services & Direct Observation Therapy
$150

IDPH-Intermediate Quality Improvement (1 day training)
$725

Board/Coalition Membership & Representation

	Attended By:
All Agency — 6-8 times/year	All Staff
BOH — 6 times/year & as needed	Laura, Alan, Terra/Karen, Lynette, & Kim
BOS — monthly & as needed	Laura, Lynette, & Kim
Cass Early Childhood Iowa (ECI) — quarterly	Jen M, Whitney, & Kim
CCNC Regional Meeting — quarterly	Whitney
Crawford, Buena Vista & Sac Counties ECI — 10 times/year	Laura & Kim
Crawford County Child Abuse Prevention Council — 6 times/year	Laura & Kim
Crawford County Coalition — 6 times/year	Laura & Kim
Crawford County Drug, Alcohol & Tobacco Coalition (Dr AlTo) — quarterly & as needed with activities	Laura & Kim
Crawford County Health Care Coalition — as needed	Laura & Kim
Crawford County Wellness Coalition — quarterly & as needed	Laura & Kim
Crawford HCCMS Team Meeting — 6 times/year and as needed	HCCMS Staff
Crawford & Sac Counties Decategorization — 10 times/year	Laura & Kim
Cultural Diversity — monthly	Laura & Kim
Denison Elementary School Business Partner — quarterly	Laura & Kim
Epi Update — yearly	Amy H
1st Five Consortium — 2 times/year webinar, 2 times/year in person	Lori/Nikki
1st Five Open Mic Webinar — monthly	Lori/Nikki
Family Planning Directors — 2 times/year	Kim
Family STEPS Crawford Staffing — monthly	Amy T, Jen C
Family STEPS Tri-County Staffing — quarterly	Amy T, Jen C, Laura, & Kim
hawk-i Outreach Taskforce — 2 times/year	Kim

Attended By:

HCCMS Administrators — as needed	Kim, Laura, Monica, & Contractors
HCCMS Family Planning — quarterly	Kim, Monica, & Contractors
HCCMS MCH Meetings — as needed	Kim, Monica, & Contractors
HMS Early Childhood Iowa — quarterly	Jen M, Whitney, & Kim
Home Health/Hospice Staffing — 2 times/month & as needed	Lynette & Staff
Homemaker/Waiver Staffing — monthly	Jan, Kay, HCA Staff & Lynette/Laura as needed
Hospice IDT — every other week	Lynette, Christina, Emilee, Kay & Other Disciplines
Hospice & Palliative Care Association of Iowa District Meetings — bi-monthly	Lynette & Hospice Staff
Hospice & Palliative Care Association of Iowa — Fall Conference	Lynette & Hospice Staff
IDPH Preparedness Advisory Committee (PAC) — quarterly	Laura
Immunization Update — yearly	Amy H/Deb
Iowa Alliance in Home Care (IAHC) District Meetings — quarterly	Lynette
Iowa Alliance in Home Care (IAHC) — Spring Conference	Lynette
Iowa Counties Public Health Association (ICPHA) — bi-monthly teleconference with 2 times/year in person	Laura & Kim
I-Smile — 3 times/year	Jen M
Job Corps Bi-Annual Industry Council — 2 times/year	Laura
MCH Regional IDPH Grantee Meetings — 3 times/year	Kim
MCH/FP IDPH Grantee — Fall Conference	Kim
Public Health Advisory Council — bi-monthly	Laura
Regional Nurse Administrator Meetings — quarterly	Laura, Lynette, & Kim
Rural Referral Network — monthly	Laura, Lynette, & Kim
WIT Nurse Advisory Council — quarterly	Laura

Other trainings and discipline specific meetings as needed

Staff Introductions & Organizational Charts

2015

2016

Administrator

Laura Beeck, BSN RN started in the agency in June 2000 and acted as the agency Administrator until her resignation in October 2015. At that time, Laura changed to PRN/On-Call status to assist with the transition of Administrators.

Co-Administrator / Home Health & Hospice Director

Lynette Ludwig, BSN RN started in the agency in September 2002 as a part-time Waiver Case Manager/Staff Nurse. In February 2005, Lynette became the full-time Home Care and Hospice Coordinator. She took on the role of Co-Administrator in January of 2016 and now helps direct all aspects of the Agency, as well as representing the Board of Health and agency on numerous committees and coalitions. Lynette works full-time.

Co-Administrator / Public Health Director/ HCCMS Director

Kim Fineran, BSN RN started in the agency in April 2008 as the HCCMS Project Director for the Maternal/Child Health and Family Planning Programs. She also supervised the Public Health programs. Kim became Co-Administrator in January 2016 and helps direct all aspects of the agency and represents the Board of Health and agency on numerous committees and coalitions. Kim works full-time.

Finance Manager

Alan Schramm, BA started in the agency in June 2007 as Finance Manager. He oversees all financial aspects of the agency. Al works full-time.

Nurses

Debra Birks, BSN RN started in the agency in December 2012. She works part-time with the HCCMS & Crawford EPSDT Programs.

Kara Bral, MSN RN started in the agency in December 2010 and is a Home Care and Hospice nurse. Kara works part-time.

Gayle Chapman, RN started in the agency in July 2007 working part-time with the HCCMS & Crawford EPSDT Programs.

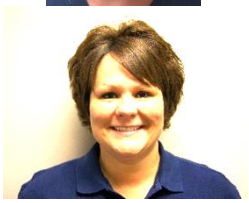
Jennifer Chapman, BSN RN started in the agency in November 2001. She is a Family STEPS support worker and assists with other Public Health programs as needed. Jennifer works full-time.

Kim Feser, RN started in the agency in January 1993 and is a Home Health and Hospice Nurse. Kim works full-time.

Shelley Moreland, LPN started in the agency in September 2008 working with the Care for Yourself (CFY), HCCMS & Crawford EPSDT, and Immunization Programs. She works part-time.

Janet Schroeder-Brus, RN started in the agency in September 2012 as a Home Health and Hospice Nurse. Janet works full-time.

Mary Schwery, RN started in the agency in May 2016 as a Public Health Nurse. She works in a variety of public health programs as well as with HCCMS Family Planning. Mary works full-time.



Amy Trucke, LPN started in the agency in October 2007. She is a Family STEPS support worker and assists with other Public Health programs as needed. Amy works full-time.

Jan Vonnahme, RN started in the agency in August 2009 as a Home Care and Hospice Nurse. In December 2009, Jan left the Home Care & Hospice Programs to serve as the Case Manager for Waiver Programs. Jan works part time.

Alyssa Willenborg, RN started in the agency in February 2013 as a Home Health and Hospice Nurse. Alyssa works full-time.

Christina Woerdehoff, BSN RN started in the agency in April 2014 as the primary Hospice Nurse, but assists with Home Health as needed. Christina works full-time.

Nurse Practitioner

Jill Kierscht, ARNP started in the agency in October 2011 providing face-to-face assessments and for Hospice clients. She also provides other assistance for Hospice clients, such as medication orders. Jill works part-time.

Jennifer Muff, ARNP started in the agency in March 2015 providing clinical services for HCCMS Family Planning program. Jennifer works PRN/on-call.

Social Workers

Emilee Lakner, BSW started in the agency in October 2013 as the Hospice Social Worker. Emilee works full-time.

Janette Clausen, LBSW started in the agency in July 2004 working as a Hospice Social Worker. In 2006, Janette's status changed to PRN/on-call.

Dental Hygienist

Jennifer Macke, RDH started in the agency in July 2014 as the HCCMS I-Smile Coordinator. Jennifer works part-time.

Sharon Davidson, RDH started in the agency in March 2008 working with the HCCMS Five County I-Smile Dental Program part-time. In May of 2014, Sharon changed to PRN/on-call.

Home Care Aides

Kay Blunk, HCA started in the agency in May 1988. Kay is the Homemaker Case Manager and Home Care Aide Scheduler. She also provides data entry for Home Care and Hospice. Kay works full-time.

Susan Boettger, HCA started in the agency in April 1987. Susan assists with agency audits and also fills in for the Homemaker Case Manager & HCA Home Care Aide Scheduler. Susan works full-time.

Jayne Gehling, HCA started in the agency in February 1985. Jayne works full-time.

Bill Greteman, HCA started in the agency in February 1994. Bills works part-time.

Carol Meyer, HCA started in the agency in June 2010. Carol works part-time.

Kate Neumann, HCA started in the agency in February 1994. Kate works full-time.

Ruth Parker, HCA started in the agency in March 2010. Ruth works full-time.

Nichole Toang, HCA started in the agency in May 2016. She works part-time.

Clerical & Interpreter Staff

Nikki Ahart started in the agency in September 2015 as a part-time Outreach and Care Coordinator. In December 2015, she took over the 1st Five Coordinator position. Nikki works full-time.

Karen Doncheski started in the agency in December 2015. She serves as the Administrative Assistant. She is also support staff to the Board of Health. Karen completes the data entry for time studies, processes payroll for the agency and assists with other programs as needed. Karen works part-time.

Ashley Eggers, BA started in the agency in June 2006. She assists HCCMS with clerical and billing duties. Ashley works part-time.

Rocio Fernandez started in the agency in January 2010 as an Interpreter. She is a bilingual receptionist and works with the Child Health and EPSDT programs. Rocio works full-time.

Marcy Melby started in the agency in May 2016. She assists HCCMS with clerical and billing duties. Marcy works full-time.

Monica Neumann started in the agency in May 2000. She works as the HCCMS Finance and Project Assistant. Monica works full-time.

Maria Saldana started in the agency in September 2015 as an Interpreter. She works part-time.

Renae Schneider, RDA started in the agency in June 2016. She is the Outreach/Dental Wellness Plan Coordinator and assists with oral health services as a Registered Dental Assistant. Renae works full-time.

Jodi Utech started in the agency in December 2013 as the Medical Biller. Jodi works part-time.

Kelly Weltz started in the agency in 2007. Kelly works as the agency receptionist and assists with other agency programs as needed. Kelly works full-time.

PRN/On-Call Staff:

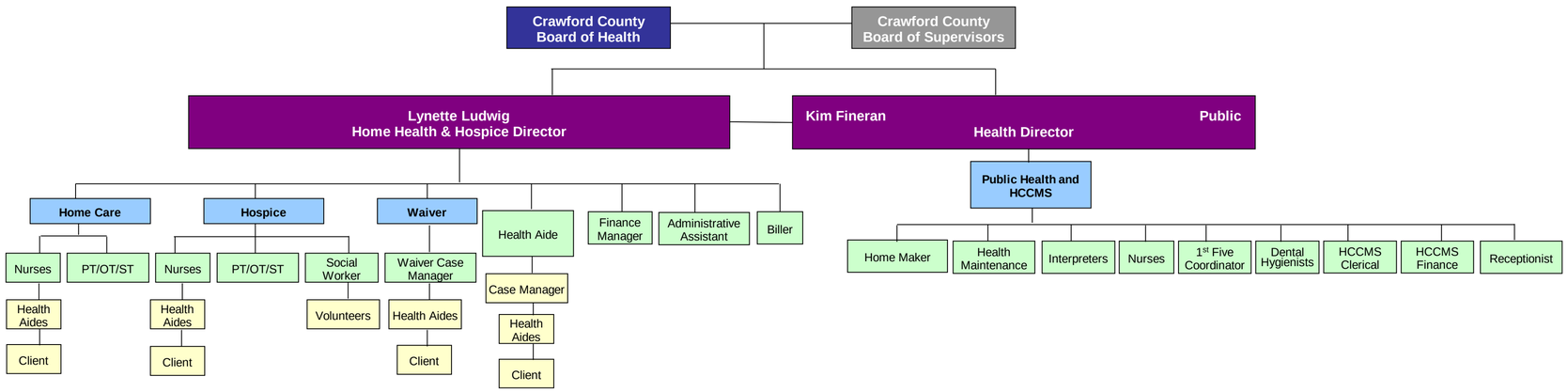
Linda Edelman, BSN RN
Yesica Perez Zavala
Vanesa Sanchez

Left Agency Employment in FY16:

Fatima Arellano-Interpreter-Employed August 2014 to June 2016
Peggy Cole, BA-Family Planning Assistant-Employed April 2015 to December 2015
Iliana Del Valle-Interpreter-Employed October 2015 to March 2016
Sara Duncklee-Outreach Coordinator-Employed February 2015 to August 2015
Juanita Garcia-Interpreter-Employed December 2012 to September 2015
Amy Hartwig, BSN RN-Public Health Nurse-Employed May 2013 to March 2016
Lori Hoch, RN-1st Five Coordinator-Employed September 2008 to December 2015
Gloria Ramirez Madera-Interpreter-Employed February 2016 to March 2016
Maria Sanchez-Interpreter-Employed September 2014 to September 2015
Terra Sell, BSBA-Administrative Assistant-Employed July 2014 to January 2016
Whitney Urich, BSN RN-Child Care Nurse Consultant-Employed April 2015 to December 2015

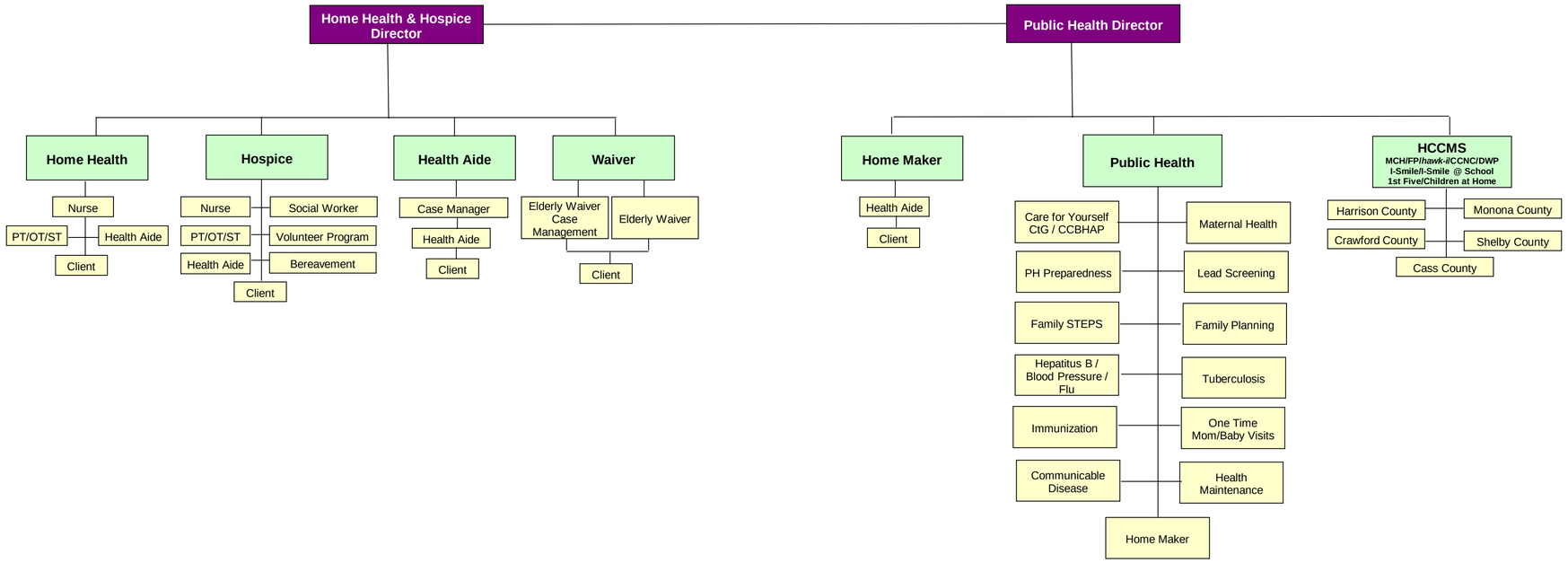
CRAWFORD COUNTY HOME HEALTH, HOSPICE & PUBLIC HEALTH

Agency Organizational Table



CRAWFORD COUNTY HOME HEALTH, HOSPICE & PUBLIC HEALTH

Program Organizational Table



Financial Reports

2015

2016

Statement of Activities (YTD)
Crawford County Home Health, Hospice & Public Health
For the Month Ended June 30, 2016

	Department 13	Department 12				
	HCCMS	Hospice	Home Health Public Health & Health Aide	Homemaker	Department 12 Total	Agency Total
Expenses:						
Direct Patient/Program:						
Salaries and benefits	$ 182,883	$ 204,833	$ 642,738	$ 187,013	$ 1,034,584	$ 1,217,467
Therapy (PT/OT/ST)	$ -	$ -	$ 20,200	$ -	$ 20,200	$ 20,200
Supplies/materials	$ 62,429	$ 5,730	$ 3,745	$ 179	$ 9,654	$ 72,083
Medications/vaccinations	$ -	$ 15,938	$ 6,331	$ -	$ 22,269	$ 22,269
Services and insurance	$ -	$ 4,346	$ 1,215	$ -	$ 5,561	$ 5,561
Hospital, nursing, other contracted	$ 123,303	$ 35,789	$ -	$ -	$ 35,789	$ 159,092
Mileage & transportation	$ 11,104	$ 4,734	$ 14,892	$ 11,647	$ 31,273	$ 42,377
Medical waste disposal	$ -	$ 61	$ 344	$ -	$ 405	$ 405
Donations, pass through, other reimb.	$ -	$ 5,533	$ 796	$ -	$ 6,328	$ 6,328
Accounting & other consulting services	$ -	$ 2,543	$ 2,543	$ -	$ 5,086	$ 5,086
Cost Report Settlements	$ -	$ -	$ -	$ -	$ -	$ -
Indirect Patient/Program:					$ -	$ -
Education and training	$ 10,776	$ 9	$ 1,765	$ -	$ 1,774	$ 12,550
Ads and publications	$ 2,848	$ 961	$ 4,421	$ 1,320	$ 6,702	$ 9,550
Pass through	$ -	$ -	$ 23,128	$ -	$ 23,128	$ 23,128
Uniforms	$ 288	$ 116	$ 620	$ 208	$ 945	$ 1,234
Overhead and administrative:					$ -	$ -
Salaries and benefits	$ 219,960	$ 58,945	$ 254,453	$ 21,571	$ 334,969	$ 554,928
Board of Health	$ -	$ -	$ -	$ -	$ -	$ -
Office administration	$ 8,249	$ 2,547	$ 12,840	$ 2,211	$ 17,598	$ 25,847
HR & Employee Medical	$ 181	$ 265	$ 1,216	$ 319	$ 1,800	$ 1,981
Industry pubs. & dues	$ 35	$ 1,911	$ 3,677	$ 27	$ 5,616	$ 5,651
Telecommunications	$ 1,716	$ 1,304	$ 4,308	$ 1,252	$ 6,863	$ 8,580
Information technology	$ 23,672	$ 8,721	$ 13,042	$ 1,760	$ 23,523	$ 47,195
Office equipment	$ 11,011	$ -	$ 18,153	$ -	$ 18,153	$ 29,165
Maintenance and repairs	$ 282	$ 423	$ 1,576	$ 503	$ 2,502	$ 2,784
Rent	$ -	$ -	$ -	$ -	$ -	$ -
Settlements, fines and adjustments(paybacks)	$ 41	$ -	$ 3,103	$ -	$ 3,103	$ 3,144
Repay Temp Loan from Fund 0040 - FP	$ 38,061	$ -	$ -	$ -	$ -	$ 38,061
Net Program expense	$ 696,839.04	$ 354,711.02	$ 1,035,106.44	$ 228,008.63	$ 1,617,826.09	$ 2,314,665.13
Budgeted Amount :	$ 968,022.00	$ 360,459.00	$ 1,205,312.00	$ 265,067.00	$ 1,830,838.00	
					88%	
Revenues:						
Third party payers:						
Medicare	$ -	$ 164,976	$ 75,863	$ -	$ 240,839	$ 240,839
Medicare Advantage Plans	$ -	$ -	$ -	$ -	$ -	$ -
Medicaid	$ 92,360	$ 40,985	$ 141,552	$ 19,036	$ 201,573	$ 293,933
Medicaid Care Organizations	$ -	$ -	$ 16,720	$ 1,305	$ 18,026	$ 18,026
Other Insurance	$ 52,917	$ -	$ 41,219	$ 223	$ 41,442	$ 94,359
Private pay	$ -	$ -	$ 23,595	$ 36,580	$ 60,175	$ 60,175
Restricted grants and program revenues	$ 531,156	$ -	$ 298,316	$ 44,407	$ 342,723	$ 873,879
Donations and fundraising	$ 262	$ 3,489	$ 650	$ -	$ 4,139	$ 4,401
Pass through	$ -	$ -	$ -	$ -	$ -	$ -
Temporary Loan from Fund 0040 - FP	$ 19,710	$ -	$ -	$ -	$ -	$ 19,710
Reimbursement of money paid	$ 434	$ 277	$ 2,474	$ 137	$ 2,887	$ 3,321
Net Program revenues	$ 696,839.24	$ 209,726.29	$ 600,389.79	$ 101,688.05	$ 911,804.13	$ 1,608,643.37
Budgeted Amount :	$ 968,022.00	$ 327,000.00	$ 720,721.00	$ 124,795.00	$ 1,172,516.00	
					78%	
County tax dollars used	$ (0.20)	$ 144,984.73	$ 434,716.65	$ 126,320.58	$ 706,021.96	$ 706,021.76
Budgeted Amount :	$ -	$ 33,459.00	$ 484,591.00	$ 140,272.00	$ 658,322.00	
					107%	

Statement of Activities (YTD)
Crawford County Home Health, Hospice & Public Health
For the Month Ended June 30, 2016

HCCMS FAMILY PLANNING FUND

FUND 0040

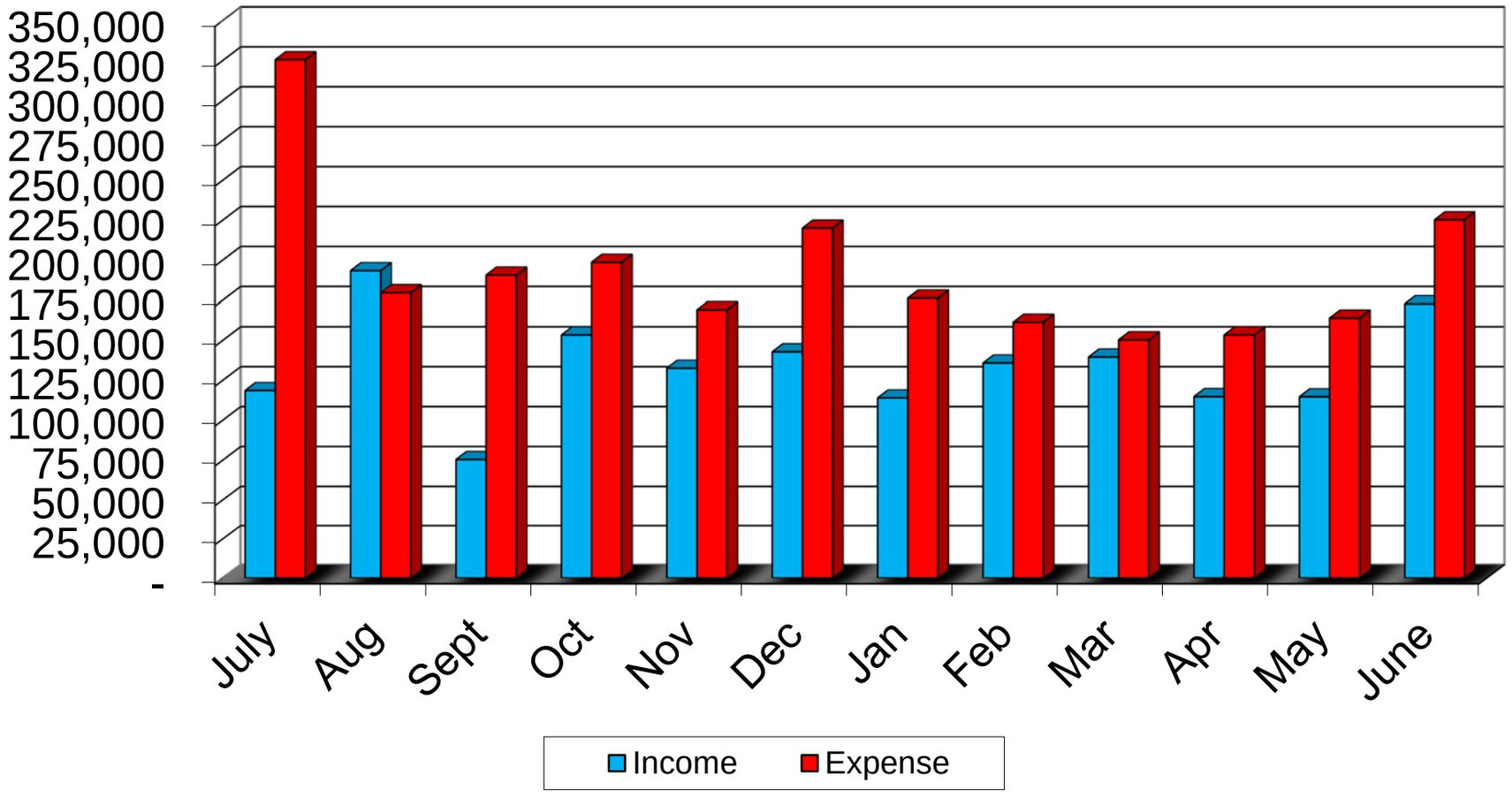
		HCCMS Family Planning
Beginning Fund Balance:	$	193,399.21
Expenses:		
Temporary Loan to Fund 0001 Dept 13 - HCCMS	$	19,710.13
	$	-
	$	-
Net Fund Expenses:	$	19,710.13
Revenues:		
Family Planning Pass Back from Myrtue Memorial Hospital	$	-
Repayment of Temporary Loan from Fund 0001 Dept 13 - HCCMS	$	-
Interest Income	$	127.05
Net Fund Revenues:	$	127.05
Ending Fund Balance:	$	173,816.13

Original Transfer from Myrtue was $192,025.03

Actual Income and Expense By Period

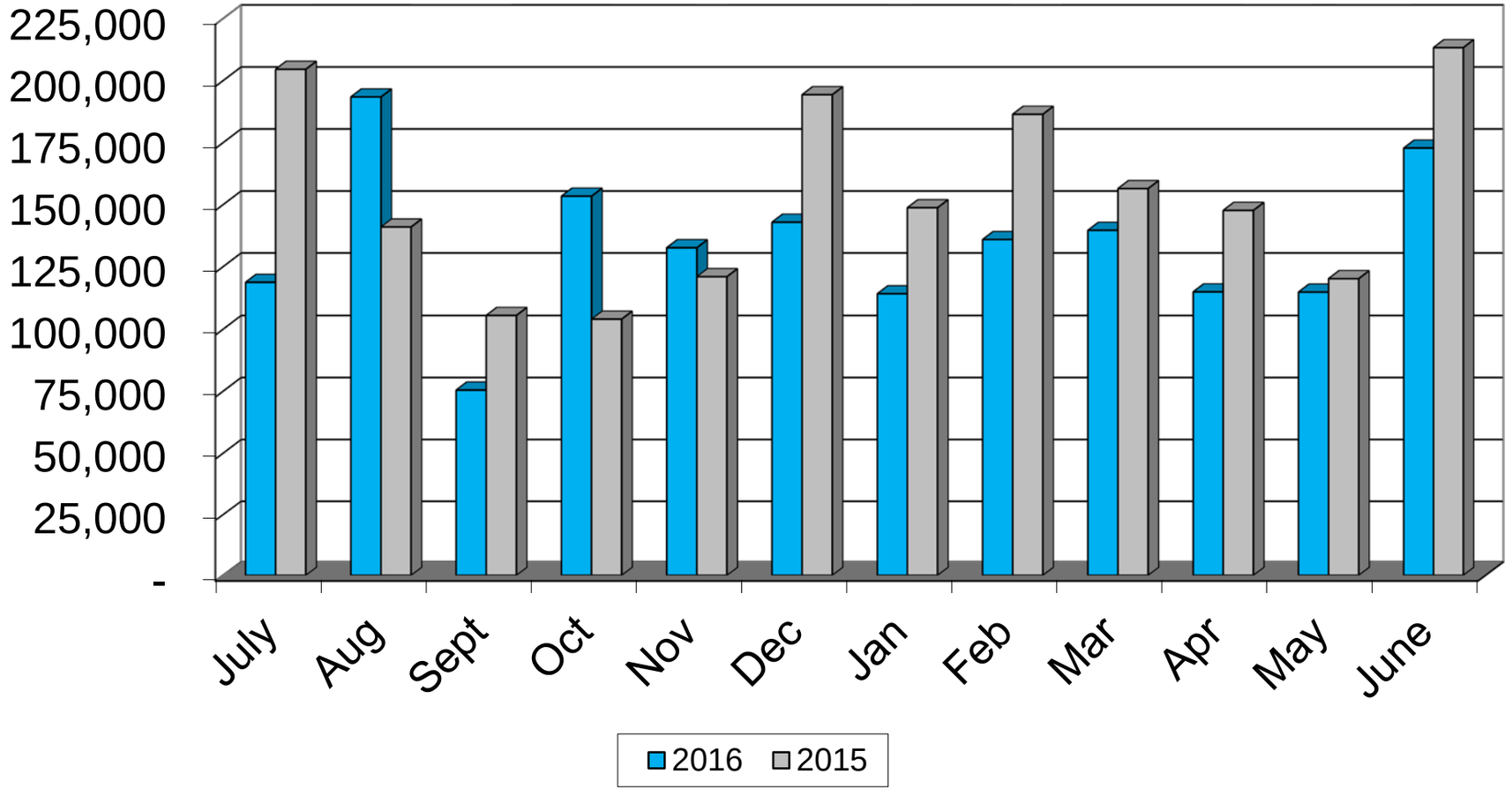
Fiscal Year 2015-2016

Income:	July	August	September	October	November	December	January	February	March	April	May	June	Actual YTD Total	Budgeted Totals	Actual % of Budget	Average Per Month
Nursing	31,835	88,623	34,574	50,125	58,747	54,023	39,677	41,752	72,073	27,534	54,813	46,614	600,390	720,721	83.3%	50,032.48
Homemaker	5,495	8,021	3,922	11,294	8,853	8,698	9,227	8,197	8,262	13,235	8,183	8,301	101,688	124,795	81.5%	8,474.00
Hospice	5,425	28,231	11,501	18,729	10,994	8,826	17,269	25,552	20,857	25,514	12,402	24,426	209,726	327,000	64.1%	17,477.19
Dept. 12	42,754	124,876	49,997	80,148	78,594	71,546	66,173	75,501	101,192	66,284	75,399	79,340	911,804	1,172,516	77.8%	75,983.68
HCCMS (13)	75,940	68,550	25,465	73,279	54,052	71,384	47,896	60,432	38,458	48,563	39,351	93,469	696,839	968,022	72.0%	58,069.93
TOTAL AGENCY	**118,694**	**193,426**	**75,463**	**153,427**	**132,646**	**142,930**	**114,070**	**135,933**	**139,650**	**114,847**	**114,750**	**172,809**	**1,608,643**	**2,140,538**	**75.2%**	**134,053.61**
Expense:																
Nursing	136,281	88,441	85,135	87,065	79,451	101,745	80,094	68,555	68,818	70,822	69,830	98,869	1,035,106	1,205,312	85.9%	86,258.87
Homemaker	23,661	17,720	19,291	17,111	17,318	22,980	18,082	17,082	17,166	16,384	16,609	24,604	228,009	265,067	86.0%	19,000.72
Hospice	40,194	21,598	24,897	23,581	20,964	36,854	32,949	33,358	27,282	24,419	27,087	41,527	354,711	360,459	98.4%	29,559.25
Dept. 12	200,136	127,759	129,323	127,758	117,734	161,580	131,125	118,995	113,266	111,625	113,526	165,000	1,617,826	1,830,838	88.4%	134,818.84
HCCMS (13)	125,416	51,923	61,340	70,922	51,364	58,498	45,220	42,439	37,183	41,833	50,447	60,254	696,839	968,022	72.0%	58,069.93
TOTAL AGENCY	**325,551**	**179,682**	**190,663**	**198,680**	**169,097**	**220,078**	**176,345**	**161,434**	**150,450**	**153,458**	**163,974**	**225,253**	**2,314,665**	**2,798,860**	**82.7%**	**192,888.76**
Tax Asking 12:	**157,382**	**2,883**	**79,326**	**47,610**	**39,140**	**90,033**	**64,952**	**43,494**	**12,075**	**45,341**	**38,128**	**85,659**	**706,022**	**658,322**	**107.2%**	**58,835.17**
Tax Asking 13:	**49,476**	**(16,627)**	**35,874**	**(2,357)**	**(2,689)**	**(12,886)**	**(2,676)**	**(17,993)**	**(1,275)**	**(6,729)**	**11,096**	**(33,215)**	**(0)**	**-**		**0.00**



Actual Income By Period
Fiscal Year Comparison

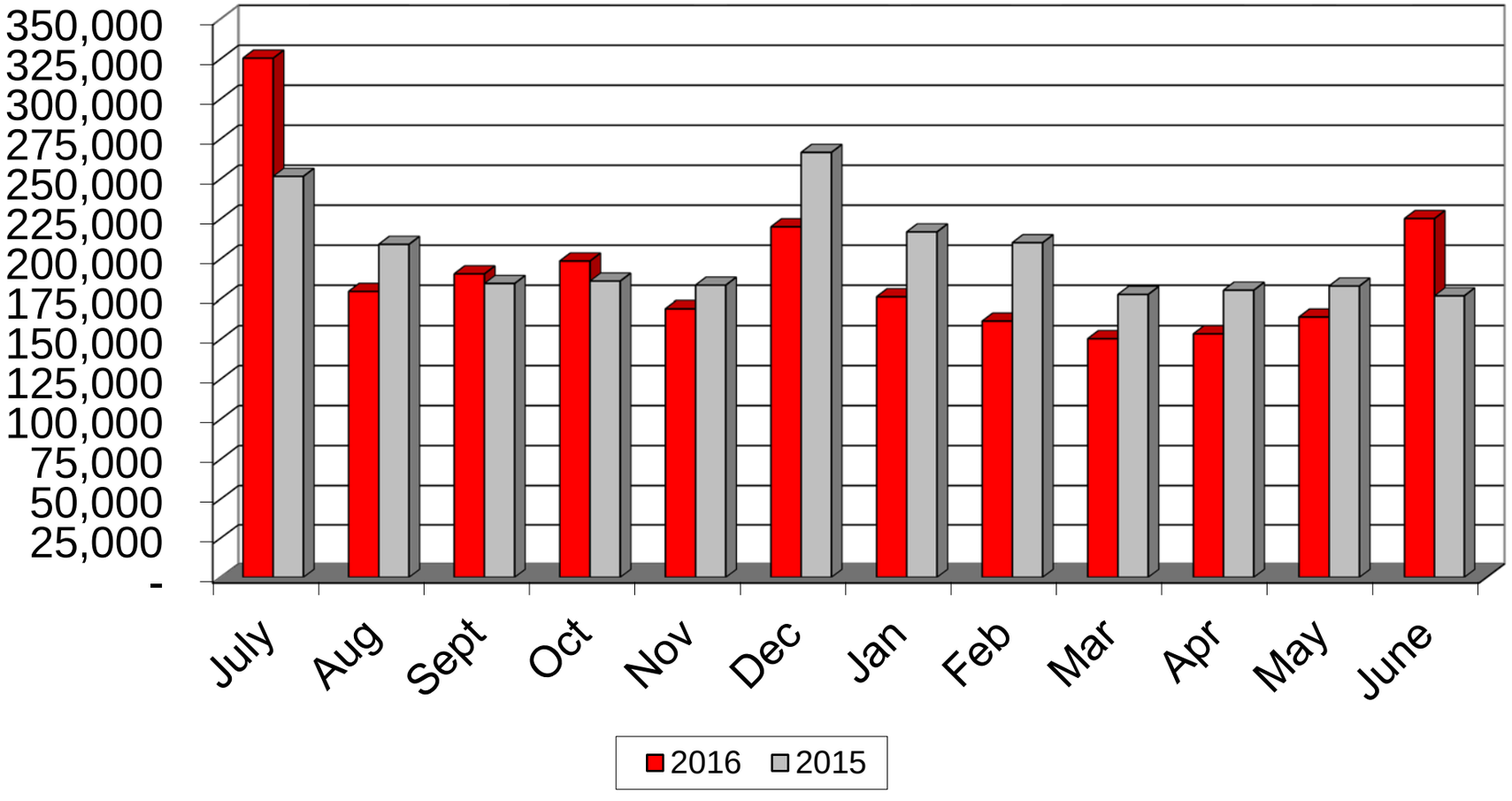
2016	July	August	September	October	November	December	January	February	March	April	May	June	Actual YTD Total	Budgeted Totals	Actual % of Budget	Average Per Month
Nursing	31,835	88,623	34,574	50,125	58,747	54,023	39,677	41,752	72,073	27,534	54,813	46,614	600,390	720,721	83.3%	50,032.48
Homemaker	5,495	8,021	3,922	11,294	8,853	8,698	9,227	8,197	8,262	13,235	8,183	8,301	101,688	124,795	81.5%	8,474.00
Hospice	5,425	28,231	11,501	18,729	10,994	8,826	17,269	25,552	20,857	25,514	12,402	24,426	209,726	327,000	64.1%	17,477.19
Dept. 12	42,754	124,876	49,997	80,148	78,594	71,546	66,173	75,501	101,192	66,284	75,399	79,340	911,804	1,172,516	77.8%	75,983.68
HCCMS	75,940	68,550	25,465	73,279	54,052	71,384	47,896	60,432	38,458	48,563	39,351	93,469	696,839	968,022	72.0%	58,069.94
TOTAL AGENCY	**118,694**	**193,426**	**75,463**	**153,427**	**132,646**	**142,930**	**114,070**	**135,933**	**139,650**	**114,847**	**114,750**	**172,809**	**1,608,643**	**2,140,538**	**75.2%**	**134,053.61**
2015																
Nursing	82,340	68,938	38,739	40,469	60,191	77,730	31,899	54,601	66,014	46,566	70,057	67,934	705,478	671,737	105.0%	58,789.82
Homemaker	11,590	5,670	5,223	19,837	9,264	10,809	10,327	8,405	12,491	9,946	9,876	11,059	124,496	111,031	112.1%	10,374.64
Hospice	28,475	20,337	22,644	6,591	7,489	14,119	16,584	43,896	29,493	30,281	1,375	26,023	247,307	502,700	49.2%	20,608.90
Dept. 12	122,405	94,946	66,606	66,896	76,944	102,658	58,810	106,901	107,998	86,793	81,308	105,016	1,077,280	1,285,468	83.8%	89,773.36
HCCMS	82,181	46,064	38,944	37,174	44,034	91,668	89,959	79,535	48,486	60,901	38,855	108,288	766,089	829,957	92.3%	63,840.73
TOTAL AGENCY	**204,585**	**141,010**	**105,550**	**104,070**	**120,978**	**194,326**	**148,769**	**186,436**	**156,484**	**147,694**	**120,163**	**213,304**	**1,843,369**	**2,115,425**	**87.1%**	**153,614.09**



Actual Expense By Period

Fiscal Year Comparison

2016	July	August	September	October	November	December	January	February	March	April	May	June	Actual YTD Total	Budgeted Totals	Actual % of Budget	Average Per Month
Nursing	136,281	88,441	85,135	87,065	79,451	101,745	80,094	68,555	68,818	70,822	69,830	98,869	1,035,106	1,205,312	85.9%	86,258.87
Homemaker	23,661	17,720	19,291	17,111	17,318	22,980	18,082	17,082	17,166	16,384	16,609	24,604	228,009	265,067	86.0%	19,000.72
Hospice	40,194	21,598	24,897	23,581	20,964	36,854	32,949	33,358	27,282	24,419	27,087	41,527	354,711	360,459	98.4%	29,559.25
Dept. 12	200,136	127,759	129,323	127,758	117,734	161,580	131,125	118,995	113,266	111,625	113,526	165,000	1,617,826	1,830,838	88.4%	134,818.84
HCCMS	125,416	51,923	61,340	70,922	51,364	58,498	45,220	42,439	37,183	41,833	50,447	60,254	696,839	968,022	72.0%	58,069.92
TOTAL AGENCY	**325,551**	**179,682**	**190,663**	**198,680**	**169,097**	**220,078**	**176,345**	**161,434**	**150,450**	**153,458**	**163,974**	**225,253**	**2,314,665**	**2,798,860**	**82.7%**	**192,888.76**
2015																
Nursing	123,386	86,563	84,489	85,114	84,964	118,835	84,317	84,000	83,533	82,513	82,836	82,953	1,083,503	1,208,722	89.6%	90,291.90
Homemaker	21,570	18,534	19,058	18,615	19,312	25,315	18,569	19,490	18,777	18,502	18,777	17,491	234,010	239,231	97.8%	19,500.85
Hospice	35,558	25,281	25,868	28,520	23,723	32,747	38,910	38,836	25,724	27,390	20,719	22,728	346,003	413,274	83.7%	28,833.62
Dept. 12	180,515	130,379	129,415	132,248	127,999	176,896	141,796	142,325	128,034	128,406	122,331	123,172	1,663,516	1,861,227	89.4%	138,626.37
HCCMS	71,122	78,741	55,210	53,897	55,627	89,704	75,103	67,810	49,735	52,031	60,712	53,757	763,449	829,957	92.0%	63,620.79
TOTAL AGENCY	**251,637**	**209,120**	**184,625**	**186,146**	**183,626**	**266,601**	**216,900**	**210,135**	**177,768**	**180,436**	**183,043**	**176,929**	**2,426,966**	**2,691,184**	**90.2%**	**202,247.16**



FISCAL YEAR - 2015-2016	BUDGET	BUDGET AMENDED	ACTUAL	OVER / UNDER BUDGET
INCOME:	1,172,516	-	911,804	
EXPENSE:	1,830,838	-	1,617,826	
TAX ASKING:	658,322	-	706,022	47,700

FISCAL YEAR - 2014-2015	BUDGET	BUDGET AMENDED	ACTUAL	OVER / UNDER BUDGET
INCOME:	1,285,468	-	1,077,280	
EXPENSE:	1,861,227	-	1,663,516	
TAX ASKING:	575,759	-	586,236	10,477

FISCAL YEAR - 2013-2014	BUDGET	BUDGET AMENDED	ACTUAL	OVER / UNDER BUDGET
INCOME:	1,315,900	-	1,151,206	
EXPENSE:	1,795,400	-	1,631,477	
TAX ASKING:	479,500	-	480,271	771

FISCAL YEAR - 2012-2013	BUDGET	BUDGET AMENDED	ACTUAL	OVER / UNDER BUDGET
INCOME:	1,226,440	-	1,239,760	
EXPENSE:	1,671,440	-	1,600,530	
TAX ASKING:	445,000	-	360,770	(84,230)

FISCAL YEAR - 2011-2012	BUDGET	BUDGET AMENDED	ACTUAL	OVER / UNDER BUDGET
INCOME:	1,235,843	-	1,241,212	
EXPENSE:	1,660,843	-	1,646,723	
TAX ASKING:	425,000	-	405,511	(19,489)

FISCAL YEAR - 2010-2011	BUDGET	BUDGET AMENDED	ACTUAL	OVER / UNDER BUDGET
INCOME:	1,460,999	-	1,198,597	
EXPENSE:	1,788,199	-	1,621,592	
TAX ASKING:	327,200	-	422,995	95,795

Home Health Program

2015

2016

Home Health

Program Description

The Home Health nurses assess health care needs, provide teaching on a new diagnosis, assist with an acute or chronic illness, provide and/or teach wound care with dressing changes, assist with medication management, give injections, and assist with IV therapy and pain control. Rehabilitation services such as Physical Therapy, Occupational Therapy, and Speech Therapy through contracted therapists are also coordinated by the nurse. Reimbursement for services rendered is through Medicare, Medicaid, Private Insurance, Local Public Health Services Contract funds, Title XIX Waivers, Private Pay, or County. The Home Health nurses are available 24 hours/day to meet the needs of the current clientele and to accept referrals for new clients.

Program Update

This past year the agency completed 1771 skilled nursing visits, a decrease of 6 visits from last year. There were 90 admissions, 100 discharges, and 53 evaluation visits. The top five referral sources for agency services this past year were, in descending order of number of referrals: out-of-town hospitals, families/clients, CCMH Clinic/City Center physicians/providers, nursing homes/Assisted Living Facilities, and Crawford County Memorial Hospital. Other sources of referrals included infusion companies, out of town physicians, Mental Health, and other programs within the agency such as the Homemaker department or the Waiver nurse.

The agency continues to submit HHCAHPS, or Home Health Consumer Assessment of Provider Systems, data. All Medicare certified Home Health agencies which meet certain criteria are required to contract with one of several vendors to provide Medicare and Medicaid skilled home health clients with a satisfaction survey, or risk losing 2% of Medicare revenue. The survey is administered by a vendor of the agency's choice and requires a financial outlay by the agency, which is not reimbursed by Medicare. Crawford County Home Health, Hospice & Public Health continues to work with Deyta for this service. Each month, the home care coordinator and the finance manager gather the requested information to transmit on to Deyta. Deyta then sends the surveys to selected clients. The survey is mailed back to Deyta. Deyta compiles the information gleaned from the returned surveys and the agency is able to access that information by computer.

Home Health Value-Based Purchasing (HHVBP) started gathering data in the nine states required to participate, including Iowa. A significant amount of time was required by the Home Health Director and other staff in listening to preparatory webinars and setting up accounts in the CMS system in which to

input various data. Data will be compared to a baseline and future payments for the next five years will be determined by certain outcomes.

A large change in the way Iowa Medicaid does business had a substantial effect on agency programs this year. Iowa Medicaid Enterprises (IME) and the Department of Human Services (DHS), in conjunction with Governor Branstad and the Iowa Legislature, turned Iowa Medicaid services over to three private insurance companies. There had initially been 4 private companies selected, but one of them was found to be too fraught with fraud and was eliminated. The changes required that most Iowa Medicaid recipients had to choose, or were assigned to, one of the companies which would then provide their Title 19 insurance to them. Medical providers had to contract with the companies of their choosing in order to be able to bill for Medicaid services for their clients. This privatization of Medicaid was initially set to take effect on January 1, 2016, but CMS (the Centers for Medicare and Medicaid Services) found that the companies were not adequately prepared at that time and the go-live date was postponed to April 1. The contracting process proved onerous and the agency continues to have problems with adequate reimbursement from the companies.

Staffing Patterns

Current Home Health Nursing staff: Lynette Ludwig, BSN RN, Home Care Director; Kim Feser, RN; Kara Bral, MSN RN; Janet Schroeder-Brus, RN; and Alyssa Willenborg, RN. Christina Woerdehoff, BSN RN, who is the primary Hospice nurse assists with Home Health as needed.

Client Satisfaction Comments

Because of the HHCAHPS being sent out and the ability to make short anonymous comments, there have been less comments coming into the agency via our old Client Satisfaction format. Comments which are submitted are brief and tend to be repeated by the same individuals (the HHCAHPS can be sent our every 6 months to long term clients). Comments have always been positive but recent comments mirror those of last year.

Goals for the last fiscal year were:

Continue to update the Policy/Procedure book and infection control program with the assistance of Kara Bral and Janet Brus.
Unmet*, *Ongoing

Perform chart audit activities internally as Carol Peterson is currently not available to assist us.
Met and Ongoing

Continue with Home Health Value Based Purchasing related audits and other requirements.
Partially Met and Ongoing

Goals for the next fiscal year are:

Learn and improve on processes for
HHVBP data collection and submission.

Director and nurses will meet quarterly for chart audit activities.

Director will become familiar with proposed changes to Medicare Conditions of Participation which may take effect in the next year.

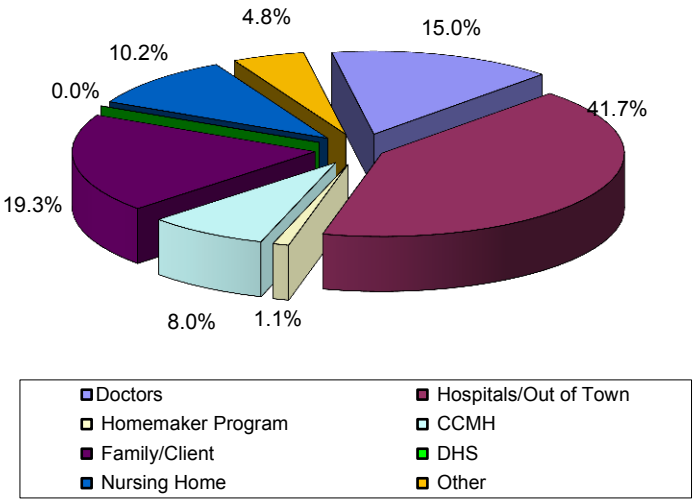
Director to attend educational offerings related to OASIS C-2 changes taking effect in January 2017, in order to educate nursing staff regarding changes.

Home Health Skilled Nursing Audit Summary
FY 2015-2016

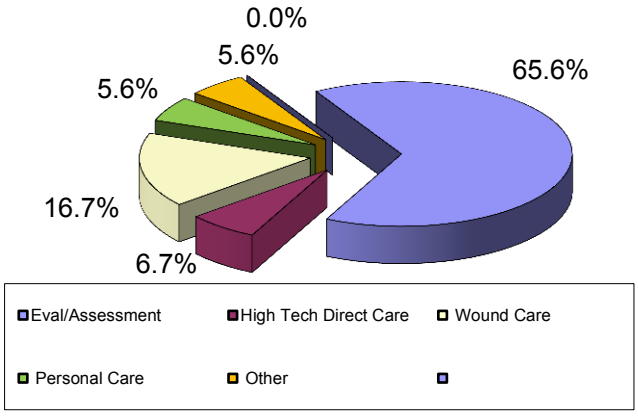
The Home Health supervisor reviews the Medicare and Medicaid charts and new admit worksheets and care plans as clients are admitted and also reviews certain items in new and current charts at the time that the monthly HHCAHPS data is entered. The nurses are showing improvement in their care plan worksheets and making sure their care plans are more all-inclusive of client needs, abilities and goals. The HHBVP outcomes data tracking will add another layer of necessary chart audits. The goal is for the Home Care Director to meet with the nurses on a quarterly basis so that all of them can share the chart-auditing functions.

Home Health: Referrals, Admissions, & Discharges

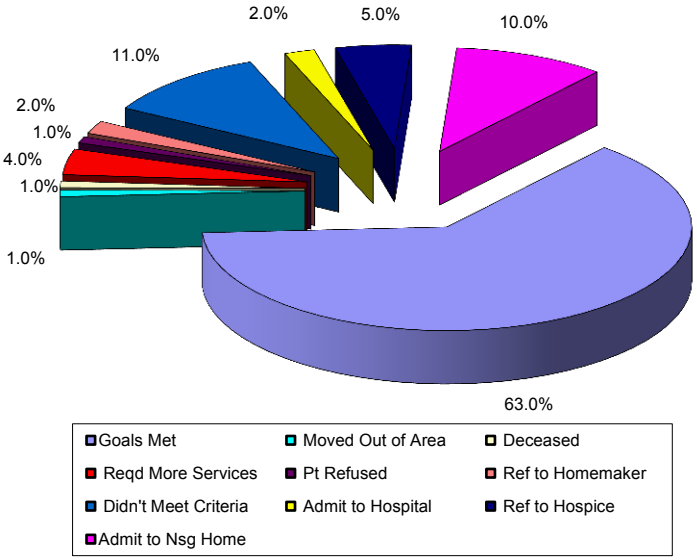
	14-15	15-16
Referrals		
Doctors:		
CCMH Medical Clinic	20	22
Dr. Crabb/City Center	4	Incl. above
Manning Family Healthcare	0	0
Crawford County Clinic	2	0
Other Physicians	11	6
Hospitals/Out-of-Town	92	78
CCMH	23	15
Family/Client	29	36
DHS	1	0
Other Agency Program	3	2
Nursing Home/Assisted Living	29	19
Mental Health	0	2
Other	7	7
Total Referrals	**221**	**221**



	14-15	15-16
Primary Reason for Admission		
Eval/Assessment	67	59
High Tech Direct Care	8	6
Injections	0	5
Wound Care	17	15
Title-19 Personal Care	2	5
Other	0	0
Total Admissions	**94**	**90**



	14-15	15-16
Primary Reason for Discharge		
Goals met	67	63
Moved out of area	3	1
Deceased	0	1
Required more services	4	4
Pt. refused services	1	1
Ref. to Other Agency Service	0	2
Didn't meet criteria	5	11
Admitted to Hospital	1	2
Referred to Hospice	4	5
Admit to Nsg Home	10	10
Total Discharges	**95**	**100**



Hospice Program

2015

2016

Hospice

Program Description

Hospice is a program of palliative and supportive services which provides physical, psychological, social, and spiritual care for dying persons and families. Services are provided by a medically supervised interdisciplinary team of professionals. Care is coordinated for all community resources. Bereavement services are available to the family. Services provided are based on client and family need. Hospice provides support and care for persons in the last six months of incurable disease so the person may live life fully and be as comfortable as possible. The Hospice nurses are available 24 hours a day to meet the needs of the clientele and family, as well as to accept referrals for new clients. Hospice services can be provided in the client's home, assisted living facility, nursing home or hospital.

Program Update

For FY 2015-2016 there were 60 admits, 1 more than last year. There were 62 total discharges, 58 through death and 4 due to no longer meeting the Hospice criteria or per client choice. There were 581 nursing visits, 313 social worker visits, 194 health aide/homemaker visits and 1 Nurse Practitioner face-to-face visit. The average length of stay for this fiscal year was 14.35 days. This is nearly 1 week less than last year. The average daily census remained at 3.5 clients, the same as a year ago.

Volunteer Program: There were ten active Hospice volunteers during this fiscal year. The volunteers have provided 95.5 hours of service during the year, a decrease of 9 hours from the previous year. Social Worker Emilee continues to put in valuable time to improve our Volunteer program, doing trainings and recruitments efforts often. Volunteers are utilized per client/family request and also assist with clerical functions in the office. Emilee continues active efforts to recruit and train new volunteers.

Fund Raising: The primary fund raiser for Hospice is the annual Tree of Lights Campaign. This is done with the assistance of Crawford County Memorial Hospital (CCMH). Every November the Christmas tree is set up in the hospital lobby, a small remembrance ceremony is held and donations can be sent to Hospice in memory of a loved one. The loved one does not need to have been on Agency Hospice services. A Hospice board, made up of five community volunteers, along with the Hospital Foundation of Crawford County, oversees the donations. The donations are used by Hospice for expenses such as the Hospice roses that are sent to the funeral homes or families following each death, birthday bouquets for Hospice clients and other smaller expenses. This board will meet as necessary to approve requests from Hospice for larger sums, such as might be incurred from an uninsured client, or other large expenses.

Bereavement Program: Bereavement planning begins upon admission. The Hospice nurse, social worker, pastoral counselor (chaplain) and/or other team member offers support and reassurance at the time of death or shortly thereafter. A red rose is sent to the funeral home or to a family member following the death and the Hospice team members involved with the client attempt to attend the visitation and/or funeral of the client. Phone contact is made with the family to identify problems or concerns. Families who want bereavement support are placed on a mailing list and receive the monthly *Journeys* newsletter published by the Hospice Foundation of America. The newsletter contains excellent articles related to grief and the grieving process. Follow-up phone calls are made to assess how families are coping. The Hospice Social Worker is available if families need additional support or one-on-one visits. The Hospice Chaplain provides follow-up visits as needed for spiritual support. The Hospice team provides a memorial service for families, held in November. Hospice has a lending library of resources, videos and information for anyone interested. The program provided 70 families with bereavement support throughout the year. An average of 79 *Journeys* newsletters are sent out each month, most going to families of Hospice clients but are also sent to others who request the newsletter. In addition to internal bereavement activities, the Hospice Social Worker is involved in a Grief Recovery Group, and 8-week program open to anyone in the community and surrounding area with bereavement needs. Two 8-week sessions were held this fiscal year along with a special one-time meeting in November to focus on coping with the holidays.

Staffing Patterns

Current Hospice staff: Lynette Ludwig, BSN RN is the Hospice Director. Christina Woerdehoff, BSN RN is the primary Hospice nurse but clients are seen by other nurses Kim Feser, RN; Kara Bral, MSN RN; Janet Schroeder-Brus, RN; and Alyssa Willenborg, RN. Jill Kierscht, ARNP continues to do the mandatory face-to-face visits that are required prior to any Hospice client's third recertification period. The face-to-face visit can be performed by a doctor or a non-physician practitioner, such as an advanced practice nurse. Jill also attends Interdisciplinary Team meetings and assists with clients as needed. Emilee Lakner, BSW, is the full-time Social Worker. The Social Worker also coordinates Bereavement services and the Volunteer Program. The agency continues contracts with Plains Area Mental Health Center to provide a Master Social Worker. This Social Worker consults and collaborates with the Hospice Social Worker on a regular basis. Agencies that do not have a Master Social Worker must have this relationship with a Master Social Worker per the Medicare Hospice regulations. Dr. John Ingram continues as the Hospice Medical Director. Lue Baker, a lay minister, continues with the agency for Hospice Chaplain services. Other disciplines such as Occupational Therapy, Physical Therapy, Speech Therapy, and Dietary are consulted on an as-needed basis. Hospice Aides are used as needed. The Hospice Volunteers provide many hours to meet the needs of the Hospice clients and families.

Client Satisfaction Comments

"Thank (volunteer). She was there his final hours and gave us support when we needed it. It was very nice she was there."

"Christina was always so helpful with any questions I had and making sure (client) had everything he needed. (Client) and I both enjoyed Emilee's visits. Thank you to both of you."

"They were caring and helpful. I would definitely encourage people to use this wonderful service. When I was not able to be with my sister who had no family, never married and much older, I was thankful for the help to her and replacement for me at times especially when she died….Very caring and knowledgeable. Appreciated their help and care."

"They were God's blessing."

"All of the team were excellent."

"Please thank them all. They were very dedicated people."

Hospice Audit Summary

The Hospice supervisor continues to track and submit HIS data (Hospice Item Set). HIS items focus on quality-based measures to assure proper pain assessment and treatment, assessment and treatment of shortness of breath, and other comfort measures. HIS also attempts to assure that Hospice discusses various options of end-of-life care with clients and families, to include spiritual concerns, hospitalization and life-sustaining measures. These data are gathered, documented and submitted on all Hospice clients, regardless of pay source. CMS is considering adding additional information to the HIS in future years.

Goals for last fiscal year are:

Continue community marketing and outreach of Hospice services.
Ongoing

Continue to increase and improve use of Hospice volunteers.
Met and Ongoing

Offer continued volunteer trainings as interest warrants.
Met and Ongoing

Continue to improve on current QAPI projects and implement new projects as needs are assessed.
Met and Ongoing

Goals for next fiscal year are:

Continue community marketing and outreach of Hospice services.

Continue to increase and improve use of Hospice volunteers.

Offer continued volunteer trainings as interest warrants.

Continue to improve on current QAPI projects and implement new projects as needs are assessed.

Home Care Aide Program

2015

2016

Home Care Aide

Program Update

The purpose of the Home Care Aide program is to assist the individual to remain at home as long as safely possible through RN supervised services of a Home Care Aide (HCA).

A Home Care Aide is a trained and supervised paraprofessional who provides a wide variety of services to individuals from complex personal care needs to assistance with minimal basic housekeeping.

Staffing Patterns

CCHHH&PH currently employs seven Home Care Aides. There is one full-time HM Case Manager/HCA Scheduler (Kay Blunk), four full-time Home Care Aides (Susan Boettger, Jayne Gehling, Kate Neumann and Ruth Parker) and three part-time Home Care Aides (Bill Greteman, Carol Meyer, and Nichole Toang).

Home Health Aide

Home Health Aide services are provided by Home Care Aides under the direct supervision of an RN working under physicians' orders. Health Aides provide assistance with personal cares such as bathing, hair care, dressing, TED hose application, ambulating, exercises, and medication assistance/compliance. These services are provided until the client no longer meets the skilled nursing criteria or a higher level of care is required, such as nursing home placement. These services can also be provided in the evening and on the weekends, as directed by the RN. Reimbursement is provided by Medicare, Medicaid, and Private Insurance.

Home Health Aide Program	2014 – 2015	2015 – 2016
Number of Visits	1876	1822
Number of Hours	1392.00	1280.50
Number of Admissions	33	34
Number of Discharges	33	35

*Information includes Hospice Aide services.

Client Satisfaction Comments

"Thanks so much you've been such a great help to us."

"They are good."

Home Health Aide/Hospice

Home Care Aides participate in the Hospice program by providing the same Home Health Aide services to the Hospice client such as personal cares, but also provides companionship or respite services as needed. These services are provided in the client's home, nursing home or in the hospital. Hospice Aides provide cares supervised by the Hospice Nurse. Services for the client are coordinated by the Hospice Interdisciplinary Team (IDT). These services are funded through Medicare, Medicaid and Private Insurance.

HHA/Hospice Program	2014 – 2015	2015 – 2016
Number of Visits	142	210
Number of Hours	111.25	163

Homemaker

Homemaker services are provided to the elderly or disabled who need assistance with maintaining activities of daily living such as housekeeping, laundry, groceries, or meal preparation. A doctor's order is not necessary for these services, and the person does not need to be homebound. These services are not Medicare or Medicaid funded but are Private Pay, based on a sliding fee scale. The sliding fee scale considers a person's income and medical expenses to determine the fee for service. Additionally, Local Public Health Services Contract funds, Elderbridge Agency on Aging funds and County funds are used to support services to the client. Respite services (providing a break for a primary caregiver) are funded through Elderbridge Area Agency on Aging or through Private Pay and are only available during office hours.

Homemaker Program	2014 – 2015	2015 – 2016
Number of Visits	2114	2706
Number of Hours	2210.50	2587.75
Number of Admissions	29	48
Number of Discharges	28	20

Client Satisfaction Comments

"Very, very satisfied, she took the time to bathe me. She was very pleasant and made me feel relaxed. Very comfortable with her, would recommend her again."

"Very pleasant and give your agency high recommendations for services and delivery."

"Always happy and we loved having them here. Always better after his shower."

"Very helpful!"

"They did everything well"

"They are dedicated people."

Homemaker Personal Care

The Homemaker Personal Care program provides hands-on personal care services to clients. The Personal Care program applies to clients who need assistance with care such as bathing, hair care, dressing assistance, TED hose application or other hands-on care, but do not have a skilled need such as nursing or therapy. This program does require a doctor's order, as well as RN supervision of the Home Care Aide on an every two month basis. Homemaker Personal Care is paid for privately per sliding fee scale, as well as through Local Public Health Services Contract funds and County funds. The Agency discontinued the Homemaker Personal Care program on April 1, 2016.

HM/Personal Care Program	2014 – 2015	2015 – 2016
Number of RN Supervision Visits	142	62
Number of Homemaker Visits	2281	1247
Number of Homemaker Hours	1399.75	758.25
Number of Admissions	27	16
Number of Discharges	37	34

Goals for this fiscal year were:

Improve HCA documentation of client's cares and needs.
Ongoing

Continue to update competency checklist for each HCA.
Ongoing

Improve communication skills in reporting client's status to Case Manager/Nurse. Aides will report significant changes in their clients to the nurse immediately or as soon as possible.
Ongoing

Continue regular in-services to educate the HCA staff on topics relating to appropriate care of the client's.
Ongoing

Goals for next fiscal year are:

Monitor supervision of HCA in the Hospice program.

Continue to update competency checklist for each HCA.

Improve flexibility within the HCA staff, allowing for backup with illness and absenteeism.

Continue regular in-services to education the HCA staff on topics relating to appropriate care of the clients.

Improve communication from RN's to HCA's regarding newly admitted clients or client changes.

Homemaker Chart Audits
2015-2016 Discharge Audits

Total Audits:16

	Sections To Audit	Yes	No	NA
1	Face sheet complete	100%		
2	Initial assessment complete	100%		
3	Health history complete with diagnosis/medications	100%		
4	Ongoing assessments complete according to state regulation	56%	6%	38%
5	Initial Plan of Care	100%		
6	Update Plan of Care according to state regulation	50%	6%	44%
7	Financial Sheet & Release complete and updated annually	31%	13%	56%
8	Emergency Medical Plan complete	93%	6%	
9	Safety Plan complete	100%		
10	Referral Sheet complete	100%		
11	Assignment sheet complete & matches Plan of Care includes hours/frequency	56%	44%	
12	Review of Assignment sheets	100%		
13	Introduction of HCA if has not been done in home	100%		
14	Supervisory notes complete with documentation of problems & how it was handled, conferences, and updates	100%		

	HCA Demonstrates the Following	Yes	No	NA
1	Progress notes complete	100%		
2	Service time matches hours & frequency	56%	44%	
3	Progress notes dated and signed	100%		
4	Arrival and Departure time complete	100%		
5	Reports problems to CM/Nurse according to agency policy and procedure	100%		
6	Documents why services were refused	50%	50%	

Comments: None

Homemaker Chart Audits
2015-2016 Ongoing Audits

Total Audits:33

	Sections To Audit	Yes	No	NA
1	Face sheet complete	100%		
2	Initial assessment complete	100%		
3	Health history complete with diagnosis/medications	100%		
4	Ongoing assessments complete according to state regulation	39%	12%	49%
5	Initial Plan of Care	100%		
6	Update Plan of Care according to state regulation	39%	9%	52%
7	Financial Sheet & Release complete and updated annually	27%	12%	61%
8	Emergency Medical Plan complete	93%	6%	
9	Safety Plan complete	100%		
10	Referral Sheet complete	100%		
11	Assignment sheet complete & matches Plan of Care includes hours/frequency	85%	12%	3%
12	Review of Assignment sheets	100%		
13	Introduction of HCA if has not been done in home	100%		
14	Supervisory notes complete with documentation of problems & how it was handled, conferences, and updates	100%		

	HCA Demonstrates the Following	Yes	No	NA
1	Progress notes complete	100%		
2	Service time matches hours & frequency	85%	15%	
3	Progress notes dated and signed	100%		
4	Arrival and Departure time complete	100%		
5	Reports problems to CM/Nurse according to agency policy and procedure	100%		
6	Documents why services were refused	76%	24%	

Comments: None

Homemaker

Client Outcome Chart Audit Upon Discharge

A. Source of Referral:

5	Self/Family	0	Nursing Home
0	Friend/Neighbor	0	FP/WIC/MCH
0	Physician	2	Homemaker
1	Hospital	7	PHN
0	Social Services	0	Other

B. Primary Reason for Admission:

0	Personal Care	0	Transportation
13	Home Maintenance	2	Respite
0	Preventive/Protective	0	Other
0	Financial Mgt/ Budgeting		

C. Primary Reason for Discharge:

3	Goals Met	1	Refused Services
1	Moved Out of Area	0	Home Health Aide
2	Deceased	0	Significant Other Provides Care
8	Higher Level of Care	0	Other

D. Client Level of Care

Dependent:

YES	NO	
1	14	Admission
3	10	Discharge
0	2	Deceased

Needs Assistance with ADLs:

YES	NO	
15	0	Admission
11	2	Discharge
0	2	Deceased

E. Safety

Knows Safety Measures:

YES	NO	
15	0	Admission
13	0	Discharge
0	2	Deceased

Safe Environment:

YES	NO	
15	0	Admission
12	1	Discharge
0	2	Deceased

HCBS Waiver Programs

2015

2016

Elderly Waiver &
Elderly Waiver Case Management

Program Description

Elderly Waiver services have been offered by Crawford County Home Health, Hospice & Public Health since September 1996. Elderly Waiver is a Medicaid program made available to any person who is age 65 and older who meets two criteria: nursing home level of care and income that does not exceed 300% of poverty. Level of care is determined by the Iowa Medicaid Enterprises (IME) and income eligibility by the Iowa Department of Human Services. For the person who meets both criteria, the goal is to provide enough services for the elderly person to remain in his or her own home as long as possible. CCHHH&PH offers case management, nursing, health aide and homemaker services to eligible clients. Services which Elderly Waiver clients are eligible for include: Adult Day Care, Assistive Devices, Case Management, Chore Services, Consumer Directed Attendant Care, Emergency Response System, Home and Vehicle Modifications, Home Delivered Meals, Home Health Aide, Homemaker Services, Mental Health Outreach, Nursing Care, Nutritional Counseling, Respite, Senior Companions, Transportation and Consumer Choices Option.

Since October of 2006 CCHHH&PH has been an independent Case Management Provider for the Elderly Waiver. The Case Manager is in charge of identifying and coordinating Elderly Waiver services with the client and service providers. Annual review and assessment is performed to assure program eligibility.

Related to changes with Medicaid due to IME and DHS turning services over to the Managed Care Organizations (MCO's), the Waiver Case Manager has had to learn a whole new system for referrals and data input this year. ISIS will have limited use in the future, as each MCO has its own referral system.

Program Update

At the end of this fiscal year, CCHHH&PH is serving 18 Elderly Waiver Case Management clients and provides Homemaker services to 12. It is required that a minimum of one monthly contact be made with the client and quarterly a face-to-face contact must occur.

Elderly Waiver Homemaker	FY 2014-2015	FY2015-2016
Number of visits	1132	988
Number of hours	1347.25	1246.75

Elderly Waiver Case Management	FY 201402015	FY 2015-2016
Number of visits	361	247
Number of hours	736.83	772.58

Staffing Patterns

Jan Vonnahme, RN is the Case Manager for the Elderly Waiver program. The Case Manager takes referrals, performs assessments, facilitates the Level of Care form with the physician for eligibility for the program, assists with identifying the needs of the client, coordinates services to assure that the identified needs are met, makes monthly contacts and facilitates quarterly follow-ups. All RNs who admit clients to the Home Health know of the Elderly Waiver program and refer these clients when appropriate. In addition the agency receives referrals through the Individualized Services Information System (ISIS) where clients have applied for the Elderly Waiver program through DHS. CCHHH&PH nurses and HCA's meet the needs of the clients who qualify for the Elderly Waiver.

Public Health Programs

2015

2016

Baby Boutique

Program Description

Crawford County Home Health, Hospice & Public Health continues to operate Baby Boutique. The boutique is a monthly program designed to support and promote healthy births, happy babies and families in Crawford County. The program offers educational opportunities for pregnant mothers and families that have children under the age of one.

Baby Boutique receives generous donations from community grants, area churches and organizations throughout the year to help support the program and the families of Crawford County.

Participants in the Boutique must be pregnant and/or have a child/children younger than 1 year of age. The Boutique allows participants to "spend" points on a variety of baby items such as cribs, car seats, diapers, wipes, bottles, blankets, and any other basic necessities needed for baby. Participants can earn points in various ways including, but not limited to: early prenatal care, well child physical exams and immunizations as recommended by their doctor, parenting classes, WIC, obtaining high school diploma or GED, assisting in the store with interpreting and by attending the monthly classes offered by the program.

Program Update

At the end of this fiscal year there were 65 families that participated in the Baby Boutique program and 28 families were on the active list. Families included 43 Hispanic, 19 Caucasian, 2 Asian and 1 Black. Approximately 799 Crawford County families have been served since the Boutique opened in 2002.

The Boutique classes are held on the 4th Monday of each month with the store opening from 3:00 pm to 6:00 pm. The Classes include a variety of topics that are offered in both English and Spanish with the aid of an interpreter as needed from 4:00 pm to 5:00 pm.

Staffing Patterns

The Program is coordinated by two Public Health Nurses, Jennifer Chapman, BSN RN and Amy Trucke, LPN, as well as, Staci Gallup with Northwest AEA. An interpreter from the agency provides translating for the educational classes and paperwork as needed.

Blood Pressure Screening

Program Description

The Blood Pressure Screening program is a health promotion service in which blood pressures are taken in a clinic setting, at the office or at an outreach site. The purpose of the service is to detect elevated blood pressures and refer the person to a physician as needed. If the blood pressure is elevated, the individual is instructed to see a medical provider and/or follow-up with additional blood pressure checks in the future. Education is provided regarding hypertension and diet.

Program Update

The agency has provided several screening clinics in the community in the past year. There were 457 blood pressures taken in 2015-2016 as compared to 733 blood pressures taken in 2014-2015.

Charter Oak Senior Center	49
Denison Senior Center	68
Dow City Senior Meals	50
Heritage Heights	41
Oakwood Apartments	48
Realife Apartments	162
Office	39
Total	**457**

Staffing Patterns

Amy Hartwig, BSN RN, was the coordinator for the Blood Pressure Screening program until her resignation in March 2016. Kim Fineran, BSN RN provided oversight for this program until Mary Schwery, RN was hired in May 2016. Walk-in services in the agency are provided by various RN and LPN staff. Clinic sites throughout the county are staffed by a trained Home Care Aide.

Iowa *Care for Yourself*

Program Description

The Iowa *Care for Yourself* program (CFY) services are a part of a national program whose mission is to reduce risks from breast, cervical, and cardiovascular health issues through early detection, education, and coalition building. UnityPoint at Home/Cass County Public Health is the lead agency for the multi-county project that includes Crawford County.

CFY program services include clinical breast exams, mammograms, pelvic exams, cervical cancer screenings, height and weight measurements, blood pressure checks, and other screenings, diagnostic testing, and follow-up. Women may enroll for services if they:

- Are between the ages of 40-64 years of age;
- Are 65 years old or older and have not enrolled in Medicare Part B;
- Are under 40 years old and have a breast lump or other signs of breast cancer; and
- Meet program income guidelines

Due to budget cuts, enrollment slots allocated to Crawford County have decreased over the last several years. To ensure that more women have access to services, local enrollment has been limited to those women who have not received services within the last three years. Because the CFY program mandates that a percentage of women must be rescreened yearly, occasionally there will be women who receive services yearly.

Program Update

In fiscal year 2015-2016, the agency was allocated 50 slots for women to receive services. Due to increased demands for program services, Crawford County was given an additional 10 slots. All of the 60 allocated slots were used.

Crawford County Breast Health Awareness Program

Crawford County Breast Health Awareness Program funds raised by local groups are available for women who do not qualify for the CFY program. These funds may be used for mammograms. Mammograms and radiology services are provided by Crawford County Memorial Hospital and Iowa-Nebraska Radiology Consultants at Medicaid rates.

Check the Girls

Check the Girls, a local program based in Dunlap, also provides funds for mammograms and other diagnostic services in Crawford and surrounding counties. This program works closely with the CFY program.

Staffing Patterns

Shelley Moreland, LPN is the part-time program coordinator.

Goals for last fiscal year were:

Encourage program participants to spread the word about the program to help utilize all allocated slots.
Met

Increase community outreach activities to encourage program participation to help utilize all three funding sources.
Met

Obligate 2/3 of CFY's allocated slots by December 31, 2015 and use all slots by the end of the program year.
Met

Goals for next fiscal year are:

Provide outreach, educational/promotional material at the Crawford County Breast Cancer Awareness Walk held annually in October.

Obligate 2/3 of CFY's allocated slots by December 31, 2015 and use all slots by the end of the program year.

Child Health

Program Description

The Child Health program assists children ages 0-21 to obtain a physical examination. The program provides a voucher to pay for services and coordinates well-child care with the child's primary medical provider. Contracts were established with CCMH Physicians Clinic, Crawford County Clinic, and Boys Town Pediatrics. For those children without insurance coverage, assistance with Medicaid or ***hawk-i*** will be provided. For those children that do not qualify for either of those programs, grant funds can be utilized to pay for the well-child examinations (vouchers).

For those children with no pay source for medical or dental care, indirect services may also include a dental screening, fluoride varnish, oral health education, referral to a dentist and provision of voucher to pay for services, and developmental screening to age six. If needed, a referral to the WIC dietitian for nutrition assessment and/or counseling can also be arranged. Children needing vaccines and lead screens are referred to their local public health agency for these services.

Program Update

In 2015-2016, a total of 81 unduplicated clients were served, which is a decrease of 12 clients from the previous year. There are 127 active clients in the Child Health program with 98% indicating Hispanic/Latino ethnicity.

Service	2014-2015	2015-2016
Clients Served (unduplicated)	93	81
Well-child Vouchers Issued	59	51
Dental Vouchers Issued	66	68

Staffing Patterns

Rocio Fernandez is the coordinator of the Child Health program. She also provides bilingual support. Deb Birks, BSN RN provides nursing services and Jen Macke, RDH provides oral health services for Child Health clients.

HCCMS Family Health Services

Child Health Services Questionnaire
37 Questionnaires Answered

1. **Is this your first time using these services?** Yes-4 No-31

   If yes, how long did it take for you to get an appointment?

   Within the next month-3 2 months-0 3 months-0 Longer-0

2. **How did you hear about these services?** WIC-3 Friend-20 Doctor's Office-3 DHS-4 Family-1 School-1

3. **Did you/your child receive a variety of services that are important to good health?**

   Yes-31 No-2

4. **Are these same services available at your doctor's office?**

   Yes-23 No-8

5. **Will you continue coming here for these services?** Yes-37 No-0

   If No, why not? NA

6. **Compared to your doctor's office, was your waiting time for the services provided here:**

   About Right-26 Too Long-1 Not enough time-0

7. **Would you recommend these services to others?** Yes-37 No-0

   If No, why not? NA

8. **If these services were no longer available, where would you go for similar services?**

   Doctor-10 Hospital-11 Nowhere-4 Another Clinic-8

9. **Did you understand the information that was given to you today?**

   Yes-32 No-0 If No, why not? NA

10. **Did you know that if your child does not have Medicaid or other insurance, the Child Health Program offers assistance with Dental and Doctor visits if funds are available?**

    Yes-27 No-3

    If yes, have you ever utilized these services?

    Yes-25 No-5 Not Applicable-0

11. **Which of the following things prevents you from going to the doctor or dentist?**
    No transportation-0 Cost-17 Office hours-0 Provider doesn't accept insurance-0
    Fear-0 Unpaid bill-1 Nothing-17 Other-0

Communicable Disease

Program Description

Public Health coordinates the follow-up of all communicable diseases reported in Crawford County. Public Health's goal is control and prevention of disease. When a communicable disease is considered probable, a clinical case or confirmed, a case investigation is started. Case investigation involves determining possible sources of the person's infection, assessing the likelihood of the individual transmitting the infection to others, establishing prevention strategies and education for the infected person and the contacts. Prevention efforts may slow or help eliminate the disease. Diseases are reported by individuals, physicians, nurses, local health departments, and laboratories. The Iowa Disease Surveillance System (IDSS) is a statewide tracking system for communicable diseases. The Iowa Department of Public Health (IDPH), local hospitals and local Public Health agencies are able to utilize this system to share information regarding these communicable disease clients.

Program Update

Confirmed & Probable Diseases:

In 2015-2016 there were 22 confirmed and probable cases of disease in Crawford County: 6 Campylobacteriosis, 3 Cryptosporidiosis, 7 Shigatoxin producing E. coli, 2 Giardia, 1 Hepatitis A, 1 Hepatitis B chronic, and 2 Salmonella. There were also 78 confirmed sexually transmitted diseases which were followed up by IDPH staff.

The following cases (16) were reported and followed up by agency staff: 3 Cryptosporidiosis, 7 Shigatoxin producing E. coli, 1 Hepatitis A, 1 Hepatitis B chronic, 1 Malaria, 1 Pertussis, and 2 Salmonella.

The differences in the lists above occur when staff follows up on a case but it ultimately does not meet national case definition. Diseases like Giardia and Campylobacteriosis are followed up by IDPH staff versus local public health staff.

Tuberculosis (TB):

IDPH collaborates with medical providers and local public health agencies to minimize the spread of TB in Iowa by promoting effective diagnosis and treatment for persons with TB infection or disease. This is accomplished by:

- Collecting, analyzing, and reporting data
- Developing effective TB control policies
- Providing consultation and technical assistance to public health agencies and clinicians
- Providing case management oversight of active TB disease cases to ensure appropriate treatment completion and thorough contact investigations of infectious cases of TB disease

- Providing TB medications and approved treatment regimens for all persons afflicted with TB infection or disease
- Coordinating services for refugees and immigrants who enter Iowa with a history of TB infection or disease to ensure they receive clinically appropriate treatment

Persons who are infected but who do not have TB disease are asymptomatic and not infectious; such persons usually have a positive reaction to the tuberculin skin test (PPD) with a negative chest x-ray. Only 10% of infected persons will develop TB disease at some time in their lives, but the risk is considerably higher for persons who are immunosuppressed, especially those with HIV infection. For these people, public health facilitates medication administration for people with either latent TB infection or active TB disease. In 2015-2016, there were 2 clients coming to the agency monthly for assessment and medication refill for latent TB infection.

Active TB disease is when a person has a positive skin test and an abnormal chest X-ray. The person may have some or all the following symptoms: coughing, loss of appetite, weight loss, fever, fatigue, night sweats and/or bloody sputum. The person is usually contagious for approximately 4-5 weeks after initiation of antibiotics. Active disease is curable with antibiotics and isolation. Untreated active TB disease can lead to death.

For people with active TB disease, IDPH provides antibiotics at no cost for the client. The role of public health is to provide Direct Observation Therapy (DOT), which usually lasts six to nine months. DOT requires that a public health nurse directly observe the client taking the antibiotics. DOT visits are completed outside at the client's home, with the nurse standing upwind from the client to avoid exposure. TB skin testing of immediate contacts is also completed and DOT administration of medications is provided for those who have active TB disease. DOT administration of antibiotics is provided routinely for a child under the age of four even if testing is negative. In 2015-2016 there was 1 active TB case in Crawford County.

In 2015-2016 there were 59 TB skin tests given, an increase of 15 from 2014-2015.

TB tests are provided to community members as well as local fire departments, employees at childcare centers/assisted living facilities/pharmacies, nursing students, city and county employees, and those who had possible contact with an infected individual.

Staffing Patterns

Amy Hartwig, BSN RN was the coordinator for this program until her resignation in March 2016. In the interim, investigations and TB medications/testing were provided by various agency nurses. In May 2016, Mary Schwery, RN was hired to fill the public health nurse position and took over these duties.

Community Equipment Loan Program

Program Description

The Community Equipment Loan Program (CELP) lends out health equipment to community members to be used following hospitalization, surgery, illness and disabilities. Originally the equipment was donated to Crawford County Home Health, Hospice & Public Health by the Vail VFW in 1999. The equipment is to be used on a short term basis; it is not loaned out with the intentions of it being used for years. Anyone can use the equipment in the Crawford County area regardless of income or age. There is no cost to the individual for the use of the equipment. Items offered include: wheelchairs, walkers, bath benches, stool risers, canes, etc. Due to lack of other funding sources, we have been forced to absorb this program expense in order to maintain safe equipment and update equipment, as needed.

Program Update

In 2015-2016 there were 58 pieces of equipment loaned to individuals in need of this assistance.

Staffing Pattern

Kay Blunk, HCA is the coordinator of the Community Equipment Loan Program and is assisted by Bill Greteman, HCA and Susan Boettger, HCA.

Crawford County Drug, Alcohol & Tobacco Coalition (Dr AlTo)

Program Description

Crawford County's Drug/Alcohol/Tobacco (Dr AlTo) Coalition was established in 2005 after the completion of a survey for the Community Health Needs Assessment and Health Improvement Plan. The results of the health related survey showed drugs, alcohol and tobacco used to be the 2nd highest concern for those citizens of Crawford County that responded to the survey (child abuse and domestic violence ranked first, which could also be a result of drug and alcohol use). Dr AlTo's mission is to help reduce the use of drugs, alcohol and tobacco through public education and awareness initiatives. The Coalition is made up of community organizations and other interested individuals.

Dr AlTo has a resource library on prevention and abuse relating to drugs, alcohol and tobacco issues that can be used in educating others on these topics. Dr AlTo also provides information at health fairs and other community events such as parent teacher conferences in efforts to help with public education and awareness initiatives regarding drugs, alcohol and tobacco prevention.

Dr AlTo is working towards increasing the awareness of the effects and consequences of the use and abuse of drugs, alcohol and tobacco. Dr AlTo's motto is "Healthy Choices Makes Healthy Kids!" The Coalition's goal is to increase the accessibility of resources to the schools and community organizations working with the youth in Crawford County. Ultimately, Dr AlTo wants to coordinate and collaborate with community partners to educate the youth in Crawford County and is attempting to bring people and resources together to better serve the community.

Program Update

CCHHH&PH is the fiscal agent for this coalition. Grants are obtained to provide community awareness activities. The Dr. AlTo Coalition is made up of community organizations and other interested individuals. Members include: Crawford County Home Health, Hospice & Public Health; Crawford County Memorial Hospital; Iowa State University Extension; Crawford County Community Partnership in Tobacco Control; Jackson Recovery Center; Crawford County Juvenile Court Services; Plains Area Mental Health Center; Denison Community Schools; Job Corps Center; Lutheran Services in Iowa; Department of Human Services; Family Crisis Center; Centers Against Abuse & Sexual Assault; Crawford County Early Childhood Iowa; Crawford County Decategorization; Chamber & Development Council of Crawford County; Crawford County Board of Health; Crawford County Board of Supervisors; and other interested individuals.

Activities that Dr AlTo has participated in include: PSAs to county newspapers, Denison Homecoming parade, co-sponsor Health Fairs, 7th grade Ag Days at the Crawford County fairgrounds, freshman orientation and sponsored speakers at county schools.

This year, Dr. AlTo provided bags with educational and promotional materials for adolescents entering 9th grade at Denison Community Schools, Charter Oak Ute, Ar We Va, and IKM-Manning. Community Partners for Protecting Children (CPPC) funded this activity provided by Dr AlTo.

Staffing Patterns

Laura Beeck, BSN RN was the facilitator of this coalition until her resignation, at which time Kim Fineran, BSN RN took over those duties. The agency administrative assistant provides clerical support.

EPSDT

Program Description

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, also called *Care for Kids,* provides comprehensive child health care for Medicaid eligible children under the age of 21. The two components of the EPSDT program are: (1) assuring the availability and accessibility of required health care resources (Informing); and (2) helping Medicaid recipients and their parents or guardians effectively use these resources (Care Coordination). EPSDT is provided as part of the HCCMS Child Health program.

Families with children who are newly eligible for Medicaid coverage do not always know about all the services available to their children. Through the informing process, they are told about the health care services covered under the program. During this process, emphasis is placed on the importance of preventive medical and oral health care for all the children in the family.

Care coordination is the process of linking the client to the health care system. The care coordinator works with the family to assure that overall health is improved through preventive exams, early diagnosis, and appropriate treatment. Care coordination helps families to become independent health consumers; develop healthy beliefs, attitudes, and behaviors; make informed health care choices for their children; establish and maintain medical and dental homes; and improve the health and physical well-being of their children. With the addition of Managed Care Organizations (MCOs) overseeing Medicaid as of April 2016, our focus turned to dental care coordination, although we touch on all aspects of overall well-being.

EPSDT emphasizes preventive care and the importance of providing children with regular and early health visits from birth until age 21. *Care for Kids* services include regular medical and dental checkups, vision and hearing tests, information about growth and development, immunizations, lab testing, nutrition education, and referrals.

Program Update

As a result of the switch to MCOs and the loss of care coordination services, HCCMS was forced to amend its contract with Harrison County Home & Public Health. In March 2016, HCCMS staff began providing ESPDT services for the residents of Harrison County in addition to the residents of the other four counties the project serves.

Staffing Patterns

Deb Birks, BSN RN is the part time EPSDT Program Coordinator. Shelley Moreland, LPN, Gayle Chapman, RN, and Rocio Fernandez, all part time employees, provide EPSDT services (informing and care coordination). Bilingual staff and interpreter lines are utilized as needed for families with limited English proficiency.

Family Planning

Program Description

The Family Planning program assists individuals (men, women, and adolescents) by providing reproductive health examinations, birth control supplies, testing and treatment for sexually transmitted infections (STI), pap smears, breast examinations, tests for high blood pressure and anemia, pregnancy tests, infertility examinations, counseling, referrals, and health education.

Costs for services at Family Planning clinics are based on ability to pay and are often less than at other health centers. Services are free for people whose income is below the federal poverty guidelines. Medicaid and private insurance can also be billed for services as applicable.

Program Update

There were 24 Family Planning Clinics held in Denison in 2015-2016 which resulted in 487 services being provided to 212 clients (unduplicated). The number of tests and services provided are shown in the following table:

Family Planning Program	2014-2015	2015-2016
Initial Exam (Provider Visit)	14	54
Annual Exam (Provider Visit)	56	81
Other Provider Visit	74	39
Office Visit (Nurse Visit)	328	310
Pap Test	38	33
Chlamydia Test	72	58
Chlamydia Treatment	6	8
Gonorrhea Test	75	59
Gonorrhea Treatment	1	0
Pregnancy Tests	97	91
Positive Pregnancy Tests	2	9
Contraceptive Refill	376	315
DepoProvera Injections	140	160
Emergency Contraceptive Pills	24	22
Hormone Implant (Nexplanon) Insertions	19	7
Hormone Implant (Nexplanon) Removals	10	9
IUD (Paragard/Mirena) Insertions	3	4
IUD (Paragard/Mirena) Removals	3	2
Gardisal Injections	2	0
Male Clients (Unduplicated)	10	7
Female Clients (Unduplicated)	204	205
New Clients (Unduplicated)	81	84
Returning Clients (Unduplicated)	133	128

Staffing Patterns

Amy Hartwig, BSN RN was the coordinator for Family Planning program until her resignation in March 2016. Kim Fineran, BSN RN coordinated contracted nursing services with Cass County until Mary Schwery, RN was hired in May 2016. Kelly Weltz is the clerical support for family planning with interpreter support during both walk-in and practitioner clinics.

Jennifer Muff, ARNP is the medical provider for the Family Planning program. Dr. Roger Davidson is the medical director for the program.

Goals for last fiscal year were:

Family Planning log, inventory log, and education/outreach log will be completed and submitted in a timely manner.
Met

Community Education and Outreach efforts will increase with a focus on adolescent and minority populations.
Met

CVR, EHR, and log errors will decrease.
Not met

Goals for next fiscal year are:

Implement new electronic medical record (Ahlers/Practice Suites).

Provide at least 2 community education and outreach activities with a focus on the adolescent population.

Increase adolescent (through age 24) use of the family planning program by five percent (15-16 usage: 86; goal for 16-17 usage: 90).

Family STEPS

Program Description

Family STEPS (Support To Experience Parenting Success) continues to be a successful program that started in 2001. Funding is provided through Early Childhood Iowa (ECI) and Prevent Child Abuse Iowa. The Family STEPS program earned the Iowa Family Support Credential in January 2012.

Family STEPS offers support and education for families expecting a child or with a child ages 0-5, who live in Crawford County and meet the program requirements. Home visits are provided to the families using the Partners for a Healthy Baby and/or the Healthy Babies Healthy Families curriculum. These curriculums provide guidance and support in parenting and many other aspects including development of the child/children, discipline and prenatal education for expecting parents. Family STEPS is part of a three county (Crawford, Sac and Buena Vista) Early Childhood Iowa program.

Program Update

At the end of this fiscal year, we had 70 families participating in the Family STEPS program, with 28 new admissions and 33 discharges. The main reasons for the discharges were families moving out of the area, children exceeding age criteria for the program, goals being met, and/or not meeting credentialing criteria. At the end of June, there were 36 clients participating in the Family STEPS program including 20 Hispanic, 9 Caucasian, 1 Black and 6 Asian families. 15 of the Hispanic families need the use of an interpreter. Due to the high level of need for this program there typically is a waiting list. As of June 30, 2016 there were 4 families waiting to be enrolled. While on the waiting list, they receive information about community resources and outreach clinics that may be available to them prior to admission. Referrals continue to come from multiple community partners including, but not limited to; pyhsicians' offices, hospitals, Family Planning, Maternal Health, Child Health, 1st Five, WIC, One-Time Mom/Baby, DHS, and Promise Jobs. A total of 635 visits were completed this fiscal year.

Staffing Patterns

Jennifer Chapman, BSN RN and Amy Trucke, LPN provide the in-home family support visits to the families in Crawford County. A Spanish Interpreter is utilized for Hispanic families that do not speak English. There are monthly peer to peer supervision and administrator meetings, as well as quarterly staff meetings with the staff from Sac and Buena Vista counties and the Early Childhood Iowa Coordinator.

Goals for this fiscal year were:

Continue to obtain the most up to date information for prenatal care, infant and child care through age five.

Ongoing

Ensure that local doctors and other community affiliates are aware and have a clear understanding of the Family STEPS program.

Ongoing

Assist clients in accessing available community services.

Ongoing

Continue to offer parenting education classes at the Denison Job Corps campus and within the community with a six week session to meet Promise Job requirements.

Ongoing

Facilitate/invite families to participate in two group parent get-togethers with the purpose of increasing social supports.

Met

Ensure that the FY2015 ICAPP: Parent Development Surveys are completed and submitted on time to the Prevent Child Abuse Organization.

Met

Continue to utilize the REDCap Family Support Database which is a web based data system to aid in the process of data collection for ECI and IDPH.

Met

Continue the preparation for the recertification process for the Iowa Family Support Credentialing.

Met

Maintain a family case weight, minimum case weight 20, and maximum case weight 30 to determine the Family STEPS workers caseload.

Revised

Goals for the next fiscal year are:

Obtain the most up to date information for prenatal care, infant and child care through age five.

Ensure that local medical providers and other community affiliates are aware of and have a clear understanding of the Family STEPS program.

Assist clients in accessing available community services.

Offer parenting education classes at the Denison Job Corps campus and within the community as needed to meet Promise Job requirements.

Ensure that the FY2016 ICAPP: Parent Development Surveys are completed and submitted on time to the Prevent Child Abuse Organization.

Initiate Daisey, the new web-based data system that is being used to collect data for ECI and IDPH.

Complete the program recertification and Peer Review process for the Iowa Family Support Credential.

Maintain a family case weight, minimum case weight 20, and maximum case weight 25 to determine the Family STEPS workers caseload.

hawk-i

Program Description

hawk-i is low-cost or free insurance for children who meet the following criteria: Children must be under the age of 19 years, have no other health insurance (including Medicaid), must be a citizen of the United States or a qualified alien, and meet income guidelines. There are two options for families to choose from: coverage for both medical and dental services and a dental-only option for families with medical coverage but no dental coverage.

Beginning September 2010, Iowa implemented a service called presumptive eligibility for children. The program offers families the option to complete an application and be given temporary coverage immediately. This coverage extends throughout the period while the formal determination for Medicaid eligibility is completed. Presumptive eligibility covers all services covered by Medicaid.

The ***hawk-i*** contact person within the agency answers questions regarding both the ***hawk-i*** program and presumptive eligibility assists with completing the applications, and follows up for a client if needed. The agency supplies area medical providers, dentists, hospitals, pharmacies, chiropractors, orthodontists, optometrists, banks, and other appropriate locations with informational brochures and posters. This information is also made available for Kindergarten Round-Up, preschools, and school registrations.

Staffing Patterns

Kim Fineran, BSN RN was the contact person for the agency.

Health Maintenance

Program Description

At the direction of Diane K. Anderson, our Public Health Regional Consultant, the agency began a Health Maintenance program as an addition to the Public Health programs. This program is intended to serve clients who have unskilled nursing needs, have no pay source (are private pay or county pay only) and need a visit on an infrequent basis. The program was started in early 2016 with the Home Health nurses providing the nursing visits. Most of the clients are seen for things such as medication set-up, monthly lab draws, or a general assessment.

Program Update

There were 10 clients admitted to the Health Maintenance in the Fiscal Year and 0 discharges. 73 nursing visits were made. The nurses use a non-skilled "non-OASIS" form for admission and recertification and a regular nursing visit note for other visits. Clients need physician orders and a Plan of Care for the program.

Staffing Patterns

Kim Fineran, BSN RN oversees the program. Kim Feser, RN; Kara Bral, MSN RN; Janet Schroeder-Brus, RN; and Alyssa Willenborg, RN provide nursing visits with assistance as needed by Christina Woerdehoff, BSN RN.

Goals for last fiscal year:

Not applicable-new program

Goals for next fiscal year:

Continue to admit applicable clients

Assist low-income health maintenance clients to access Medicaid.

Develop policies and procedures for the program.

Adult Hepatitis B

Program Description

The Hepatitis B vaccine is provided for adults through Public Health. OSHA has a mandatory requirement for employers to vaccinate staff if high-risk exposure to Hepatitis B is possible. To be adequately protected, a person needs a series of three shots over a period of six months. Crawford County Home Health, Hospice & Public Health has been supplying and administering the vaccine as requested by service organizations or health care students.

Program Update

In 2015-2016, there was a total of 4 injections given. This is a decrease from 19 injections given in 2014-2015. The table below shows the breakdown of individuals who started or completed the Hepatitis series this fiscal year. Hepatitis B vaccine is also provided children and adolescents during VFC Immunization clinics and not included in these statistics.

WESCO	1
Agency	3
Total	4

Staffing Patterns

Amy Hartwig, BSN RN was the coordinator for this program until her resignation in March 2016. In the interim, the injections were provided by various agency nurses. In May 2016, Mary Schwery, RN was hired to fill the public health nurse position and took over these duties.

Immunization

Program Description

The Immunization program provides vaccinations for children from birth through 18 years. All the vaccine is supplied through a federal program, Vaccines for Children (VFC). Only children who meet the following criteria are eligible to receive the vaccine: Medicaid recipient, uninsured, underinsured where health insurance does not cover immunizations, or Native Americans. Children not meeting these criteria are referred back to a family medical provider. Two clinics are held per month. One clinic is held in the afternoon and one is in the morning to cover different times of the day. The clients are taken on a first-come first-served basis. An additional clinic was held each month in August, October, and November to focus on school vaccinations and flu shots. Walk-in immunizations are provided to transfer students per school request. IRIS is a statewide computer program used to maintain immunization records. All vaccinations for children through the age of 18 are entered into this system by Public Health. The four medical provider's offices in Denison enter the vaccinations into IRIS.

In addition to staffing the clinics, the immunization coordinator is responsible for auditing the county's school records to assure all children/youth comply with the state's minimum immunization requirements. This is done in the fall every year. The results of last year's audit shows that the area schools are 94.89% in compliance and childcare centers are at 90%.

IRIS is a secure and confidential web-based computer system that contains immunization information for individuals of all ages residing in the State of Iowa. The system offers several benefits, including the capability to instantly assess immunization status, future interface with other state information systems, enhanced reporting and recall systems, and consolidation of immunization records as children move or change healthcare providers.

Program Update

Information is distributed at schools, area health fairs, preschools, and childcare centers. Updated information is also provided to the provider offices and school nurses. Agency information and brochures are offered in Spanish to better serve the Hispanic population in Crawford County.

In fiscal year 2015-2016, 1,167 immunizations were given to 506 children as compared to 1,375 immunizations given to 552 children in 2014-2015. There were 46 less children served and 208 less vaccines given this fiscal year.

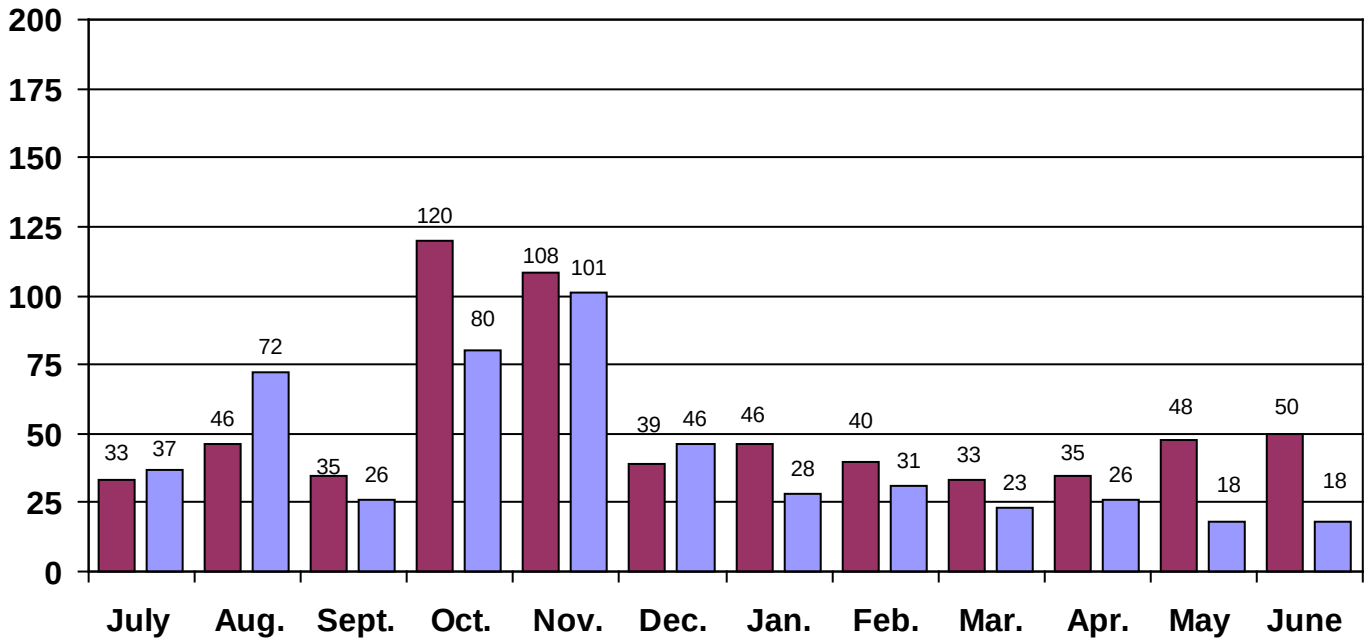
The following chart compares the vaccines given in the past 2 years.

Vaccines	**2014-2015**	**2015-2016**
DTaP (Infanrix)	21	27
DT	0	3
DTaP/IPV/Hep B (Pediarix)	73	74
Dtap/IPV (Kinrix)	23	19
HIB (Pedvax)	85	64
HIB (ActHIB)	0	3
Hep B, Adol. Hep B	38	34
Hep A (Vaqta)	223	171
Hep A (Havrix)	0	8
MMR	13	14
MMR/Varicella (Proquad)	68	56
Polio (IPV)	45	23
Tdap	92	68
Varicella	16	22
Meningococcal (Menactra)	91	61
HPV (Gardasil)	169	148
Prevnar	104	92
Rotavirus (Rotarix)	45	33
Influenza –Pediatric	122	60
Flumist	149	187
Totals	**1375**	**1167**

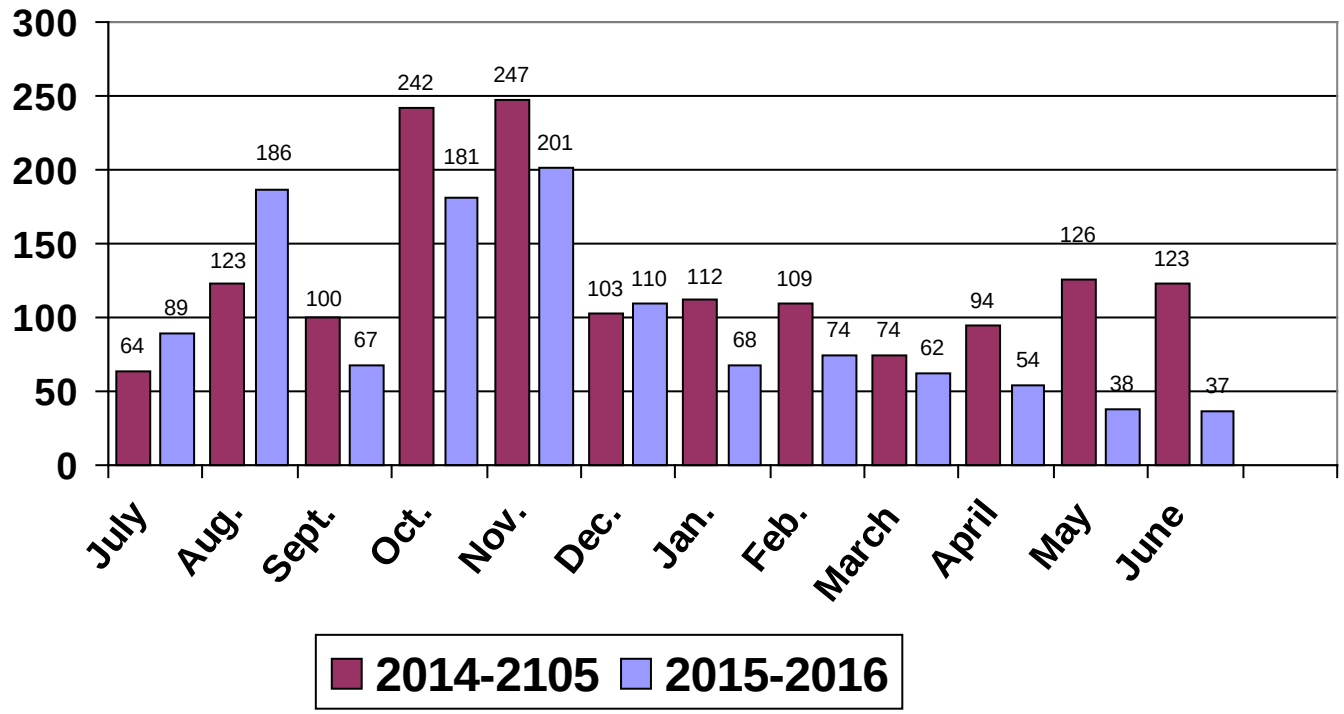
Staffing Patterns

Amy Hartwig, BSN RN was the immunization program coordinator until her resignation in March 2016, at which time Deb Birks, BSN RN took over the program. The clinics are staffed with one RN, one LPN, two clerical staff (one being bilingual) and one interpreter. Shelley Moreland, LPN is the assistant during clinic and Kelly Weltz is the primary clerical staff for the program.

Number of Children/Adolescents Immunized Per Month



Number of Vaccines given per month



The top chart reflects the number of children who received immunizations, and the bottom chart reflects how many vaccinations were given to those children per month.

Goals for last fiscal year were:
The immunization rate for children 24 months of age served by the agency will meet the national goal of 90% for 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella, 4 Pneumococcal Conjugate Vaccine Series (4-3-1-3-3-1-4). Baseline measure is 63% (2014 benchmark report). Current measure (2015 benchmark report) is 75%.
Not met-ongoing

The immunization rate of adolescents (13-15 years of age) served by the agency will increase by 5%. Fully immunized includes 1 Td/Tdap, 3 Hepatitis B, 2 MMR, 2 Varicella, and 1 Meningococcal vaccine. Baseline measure is 51% (2014 benchmark report). Current measure is 74% (2015 benchmark report).
Met

The immunization rate of adolescent females (13-15 years of age) served by the agency who receive 3 doses of HPV vaccine will increase by 5%. Baseline measure is 34% (2014 benchmark report). Current measure is 48% (2015 benchmark).
Met

Goals for last fiscal year were:
The immunization rate for children 24 months of age served by the agency will meet the national goal of 90% for 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 Varicella, 4 Pneumococcal Conjugate Vaccine Series (4-3-1-3-3-1-4).

The immunization rate of adolescents (13-15 years of age) served by the agency will increase by 5%. Fully immunized includes 1 Td/Tdap, 3 Hepatitis B, 2 MMR, 2 Varicella, and 1 Meningococcal vaccine.

The immunization rate of adolescent females (13-15 years of age) served by the agency who receive 3 doses of HPV vaccine will increase by 5%.

Evaluation Questionnaire for Immunization Clinic

168 surveys returned

1. How did you hear about the Clinic?
   Friend/family-88 Doctor-31 DHS-19 Radio-0
   Other-26

2. Were the clinic hours convenient for you? Yes-163 No-3
   If no, what hours would be more convenient? 2p-5p_____

3. Compared to your doctor's office, was your waiting time for services in our clinic
   About right for the services received-160 Too Long-1

4. Were personnel at the Clinic courteous?
   Yes-165 No-2 If no, please explain_____

5. Before your child received their shots, did you feel well informed about the vaccines, their side effects and the use of over the counter pain medications to control fever?
   Yes -162 No-0 If no, please explain_____

6. Did you understand the information given to you at clinic?
   Yes-165 No-0 If no, please explain _____

7. Were you given information about when you should return for the child's next immunization clinic? Yes-163 No-0

8. Would you recommend the Clinic to others?
   Yes-165 No-0 If no, please explain_____

9. Will you continue to bring your child to this Immunization clinic?
   Yes-165 No-0 If no, please explain

10. Please add any additional comments:
    Great service. Thanks for the clinic and for helping us and the personnel. The clinic is very good. Thank you for the attention. Good job. I like having them vaccinate my son. Staff is willing to help- thanks! I like the clinic because they help me. I will continue to bring my children. It is very good. Thank you for your help. Everything was good. Thank you for services received. The people that work at the clinic are very kind.

Influenza

Program Description

Crawford County Home Health, Hospice & Public Health provides influenza vaccinations to the residents of Crawford County. The purpose for administering the vaccine is to reduce the potential for influenza relating to the high incidence of respiratory illness and complications associated with it.

Program Update

There were 16 clinics held around the county, this is an increase of 4 from the number of clinics held the previous year. In addition to the community clinics, several walk-in clinics were held at Public Health throughout influenza season. Vaccine was also provided to volunteers, clients, and county employees. There were 308 influenza vaccinations given to adults and 5 given to children that did not qualify for the state funded Vaccines for Children (VFC) program in 2014-2015 compared with 384 in 2014-2015.

Staffing Patterns

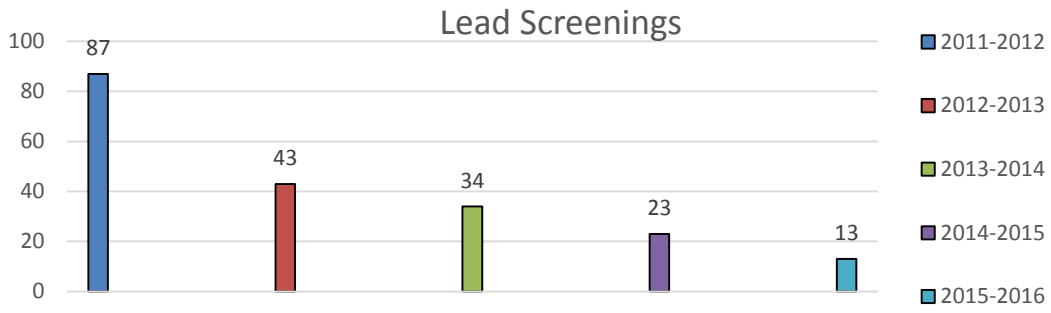
Amy Hartwig, BSN RN coordinated the Influenza program with Terra Sell and Jody Utech providing clerical support. Other Public Health nurses and clerical staff assist with this service as needed. Home Health nurses administer vaccinations to clients on their caseloads.

Lead

Program Description

Lead screenings are completed on children ages 12 months to 6 years of age. Public Health screens children through Immunization clinics. Finger sticks are performed with the blood specimen being sent to State Hygienic Laboratory (SHL). The results are sent back to Public Health for follow-up as needed. If the results are greater than 10µg/dl, the level is rechecked in 3 months. If the reading is greater than 15µg/dl a venous blood draw is done. Further follow-up and interventions are completed depending on the venous result. Interventions may include education, nutrition consultation, environmental assessment, medical examination, AEA referral, and treatment with medication.

There were 13 children screened for lead poisoning in 2015-2016 compared to 23 children screened in 2014-2015. In 2015-2016, no children were found to have levels greater than15µg/dl, which would have required confirmatory venipunctures and close follow-up. Children with elevated levels are followed until the lead levels return to normal limits, which are 2 lead level readings below 10 or 3 below 15. The need for blood lead screening has been identified because Iowa has a high percentage of older homes. Lead based paint, the most common source of lead poisoning, is often found in homes built before 1960.



Staffing Patterns

Amy Hartwig, BSN RN was the coordinator of the Lead program until her resignation in March 2016, at which time Kim Fineran, BSN RN coordinated services. In May 2016, Mary Schwery, RN was hired and took over as program coordinator. Jennifer Chapman, BSN RN and Amy Trucke, LPN provide testing during immunization clinics. Kelly Weltz is the clerical staff that works with the Lead program.

Maternal Health

Program Description

The Maternal Health program provides care coordination (including the Medicaid prenatal risk Assessment and presumptive eligibility determination), education, oral health services, and postpartum home visits. Enhanced services include more intense care coordination, health education, nutrition, and psychosocial services. All pregnant women are eligible to enroll in the program, regardless of pay source. The clients are seen throughout the pregnancy for services through visits in the office, client's home, or school. Each client also receives a postpartum home visit. Enrolled women may also receive prenatal vitamins through this program. Nutritional counseling is offered by the WIC nutritionist on two occasions during the pregnancy and again post-partum. A social worker completes psychosocial services as needed. The agency interpreter is available at appointment times to assist with the increasing number of Hispanic clients. This helps considerably with the ability to effectively educate clients. Referrals are received by the program from WIC, Family STEPS, Family Planning, school nurses, and some inquiries about the program are received by a pregnant individual, due to word of mouth.

Program Update

The Maternal Health visits are provided by appointment in the office, client's home, or at school. In 2015-2016, 27 clients were served, which is 11 more than 2014-2015. Oral health screenings, fluoride varnish, care coordination, health education, home visits, risk-assessments, and presumptive Medicaid eligibility determination were provided this year. The Maternal Health program continues to see a large percentage of Hispanic clients, many with advanced pregnancies and no medical care. Names of medical providers are provided so that the pregnant woman can try to obtain care and Public Health then follows-up within the month to verify care has started.

Staffing Patterns

Amy Hartwig, BSN RN was the coordinator of the Maternal Health program until her resignation in March 2016. Deb Birks, BSN RN filled in during Amy's resignation. Mary Schwery, RN was hired in May 2016 and took over coordination of the program.

Goals for this fiscal year were:

Increase the number of clients who receive 2 or more education visits. Baseline measure is zero; current measure is five.
Met

Increase the total number of Maternal Health visits by at least 10%. Baseline measure is 20 visits; current measure is 44 visits, increase of 120%.
Met

Goals for next fiscal year are:

Increase the number of clients who receive 2 or more education visits.

Obtain client satisfaction surveys from at least 75% of clients who received a service. Baseline measure is 2 out of 21 clients or 10%.

HCCMS Family Health Services

Maternal and Child Health Services Questionnaire

1. **Which county do you live in?** 2 questionnaires returned for Crawford County
2. **Is this your first time using these services?** Yes-1 No-1

   If yes, how long did it take for you to get an appointment? No answer-0

   Within the next month-1 2 months-0 3 months-0 Longer-0
3. **Which service are you using?** Maternal Health-6 Child Health
4. **How did you hear about these services?** WIC-0 Friend-1 Doctor's Office-0 DHS-1

   Other (please specify): 0
5. **Did you/your child receive a variety of services that are important to good health?**

   Yes-2 No-0 No answer-0
6. **Are these same services available at your doctor's office?** Yes-0 No-2
7. **Will you continue coming here for these services?** Yes-2 No-0

   If No, why not? _____
8. **Compared to your doctor's office, was your waiting time for the services provided here:**

   About Right-2 Too Long-0 Not enough time-0 No answer-0
9. **Would you recommend these services to others?** Yes-2 No-0

   If No, why not? _____
10. **If these services were no longer available, where would you go for similar services?**

    Doctor-0 Hospital-0 No Where-1 Another Clinic-1 Other (please specify): 0
11. **Did you understand the information that was given to you today?** Yes-2 No-0

    If No, why not?_____
12. **Did you know that if your child does not have Medicaid or other insurance, the Child Health Program offers assistance with Dental and Doctor visits if funds are available?**

    Yes-2 No-0 No answer-0

    If yes, have you ever utilized these services? Yes-1 No-1 Not Applicable-0 No answer-0

One Time Mom/Baby Visits

Program Description

Public Health offers a one-time postpartum visit for mothers and newborns that live in Crawford County. A nurse tries to provide a home visit within five days post hospitalization or as ordered by the physician. This visit provides assessment of mother/baby and support/education to the parents. This is a complimentary service provided by Public Health.

Program Update

Public Health continues to work with the hospital and doctors to provide a post-partum visit to newborns and mothers in Crawford County. There were no visits provided this fiscal year. This program is being combined with the Maternal Health program next fiscal year.

Staffing Patterns

Amy Hartwig, BSN RN was the coordinator for this program until her resignation in March 2016. Deb Birks, BSN RN filled in after her resignation until Mary Schwery, RN was hired in May 2016. Interpreters are utilized for the Spanish speaking clientele.

Public Health Preparedness

Program Description

Following September 11, 2001 the country became more aware that terrorism is a very real threat. Centers for Disease Control (CDC) & Health Resources and Services Administration (HRSA) felt Biopreparedness was where public health departments and hospitals would play a large role in planning to be prepared for such tragedies. Starting in September 2002, IDPH received grant funding from the CDC for public health preparedness and funding from HRSA for hospital readiness efforts. Building infrastructure has been a very important part of these efforts especially in public health. Coalitions were developed a couple years ago. Crawford counties coalition includes: Crawford County Memorial Hospital, Crawford County Emergency Management, Crawford County Environmental Health, and Crawford County Public Health. Strategic planning continues to occur related to individual county coalitions joining together to meet the needs of the grant requirements, as well as community needs.

Program Update

Public Health Emergency Preparedness grant dollars have been used to build infrastructure, mass vaccination plans, epidemiology and pandemic influenza planning. Scenarios, tabletop drills, functional and full-scale exercises are all part of these planning efforts. These drills have been statewide, regional, and specific to a county. By exercising these plans the respective participants are able to see what works and what doesn't work and gives everyone experience in the event of a real emergency. These planning efforts are not just for bioterrorism activities, but can be used for other real world emergency situations such as food-borne or communicable disease outbreaks such as H1N1. Having regular communication and interaction with local partners is important so in the event of a real emergency there is better understanding of everyone's roles and this leads to a better team approach due to the trust that has been developed over the years of collaboration.

Staffing Patterns

Laura Beeck, BSN RN, coordinated these planning efforts until her resignation from the Administrator position in October 2015, at which time Kim Fineran, BSN RN took over these duties. The entire staff, many volunteers and other county organizations are also needed to implement these plans in the event of an emergency situation. Agency staff will fill the following Incident Command roles in the event of an incident/emergency: Incident Commander, Liaison Officer, Planning Chief, PIO, Logistics Chief, Safety Officer, Operations Chief, Finance Chief, and Volunteer Coordinator. Staff members who will fill these roles in the event of an incident include: Laura Beeck, Lynette Ludwig, Kim

Fineran, Al Schramm, Kay Blunk, Amy Trucke and Mary Schwery. Continued training is needed to educate staff on the various roles during an event.

Goals for last fiscal year were:

Continue to update all plans and checklists for public health emergency response events.
Ongoing

Incident command staff will receive refreshers or additional training as needed.
Ongoing

Continue working to develop coalition and plans specific to the coalition needs.
Ongoing

Participate in exercises or drills with county and regional partners as indicated.
Ongoing

Work with coalition members and other county partners for planning activities related to county needs.
Ongoing

Continue strategic planning to expand coalition to include additional members or other counties to meet requirements and needs.
Ongoing

Goals for next fiscal year are:

Continue to update all plans and checklists for public health emergency response events.

Incident command staff will receive refreshers or additional training as needed.

Continue working to develop coalition and plans specific to the coalition needs.

Participate in exercises or drills with county and regional partners as indicated.

Work with coalition members and other county partners for planning activities related to county needs.

Continue strategic planning to expand coalition to include additional members or other counties to meet requirements and needs.

Vision Screening

Program Description

The Vision Screening program involves a Public Health nurse testing the vision of children in the county schools that do not have a nurse on staff or have not contracted with one. These schools provide a pre-screen of all students, and then notify Public Health of all students that have a vision test of 20/40 or worse. The Public Health nurse then goes to the school and re-screens those children during immunization audits. When the re-screening indicates vision impairment, a letter is sent to the parents regarding the impairment and recommends that the child see a vision care provider.

Program Update

In the past year, there were no schools that needed vision screens. The numbers of students needing re-screened has decreased tremendously since the implementation of recommended vision screenings and screening cards signed off by physicians prior to school registration.

Staffing Patterns

Amy Hartwig, BSN RN was the coordinator of this program until her resignation in March 2016, at which time Deb Birks, BSN RN took over the program.

HCCMS Program

Five County Maternal/Child Health & Family Planning Project

2015

2016

HCCMS Maternal Child Health & Family Planning

Program Description

HCCMS is a five county Maternal/Child Health (MCH) and Family Planning (FP) project, funded by the Iowa Department of Public Health. The five counties included in the project are **H**arrison, **C**rawford, **C**ass, **M**onona, and **S**helby. The program is in its nineteenth year and continues to serve the maternal health, child health, and family planning needs in each of the five counties.

Maternal Health (MH) services include education, care coordination, oral health, and postpartum services. In addition, enhanced services including more in-depth education and care coordination, nutrition and diabetes management, and psychosocial services are provided to women with high-risk pregnancies. RN and Social Worker services are provided in a manner that is convenient to the client. Home visits are completed for those whom transportation is a problem. Referrals are made to WIC for nutrition counseling. During the MH visit, health information is obtained and parenting education is provided, with appropriate referrals as needed. The nurse also completes a dental screen, fluoride varnish, and provides oral health educational materials.

Child Health clinical services are provided using an indirect service model through the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) program. These services involve case management, assisting the families to access medical and dental care for well-child and dental examinations. For those children without insurance coverage, assistance with Medicaid or ***hawk-i*** will be provided. If the child does not qualify for either of those programs, grant funds may be used to pay for the preventive examinations.

Presumptive eligibility (PE) provides Medicaid coverage for a limited time while a formal eligibility determination is being processed by the Department of Human Services. The goal of this process is to provide immediate healthcare coverage for families who are likely to be eligible for Medicaid. Families complete the application, the application is entered into the DHS web-based system, and a decision is generated immediately. If approved, the family member(s) are assigned an identification number. HCCMS provides this service for children (ages 0 through 18 years) and pregnant women who enroll in the Maternal Health program.

Family Planning services and clinics are provided in all five counties. Services include contraceptive services to help women and men plan and space births, prevent unintended pregnancies, and reduce the number of abortions; pregnancy testing and counseling; helping clients who want to conceive; basic infertility services; preconception health services to improve infant and maternal outcomes and improve women's and men's health; and providing sexually transmitted disease screening and treatment services to prevent tubal infertility and improve the health of women, men, and infants.

Program Updates

HCCMS Indirect Child Health program served 81 unduplicated clients this fiscal year. 7,413 child and adolescent clients were served through other child health programs. The table below shows the service type and the number of services provided.

Services	2015-2016
Informing and Care Coordination	9,304
Oral Health	2,810
Health Screening (Development Screen and Interpreter)	256

HCCMS Maternal Health Program served 72 unduplicated clients this fiscal year.

Services	2015-2016
Oral Health	51
Care Coordination	69
Nursing visits (education, assessment, home visits)	119
Medicaid Prenatal Risk Assessment	38
Presumptive Eligibility Determination	18
Interpreter	25

The HCCMS Family Planning program served 541 unduplicated clients that received a total of 7,766 services this fiscal year. 98.56% of these clients were at 250% of poverty or below (84.56% at 100% or below).

Services	2014-2015	2015-2016
Initial Exam (Provider Visit)	77	106
Annual Exam (Provider Visit)	213	242
Other Provider Visit	222	112
Office Visit (Nurse Visit)	961	783
Pap Test	118	101
Chlamydia Test	315	250
Chlamydia Treatment	51	27
Gonorrhea Test	318	249
Gonorrhea Treatment	9	6
Pregnancy Tests	214	191
Positive Pregnancy Tests	5	15
Contraceptive Refill	994	804
DepoProvera Injections	353	377
Emergency Contraceptive Pills	46	37
Hormone Implant (Nexplanon) Insertions	56	37
Hormone Implant (Nexplanon) Removals	40	36
IUD (Paragard/Mirena) Insertions	4	9
IUD (Paragard/Mirena) Removals	9	6
Gardisal Injections	21	3
Male Clients (Unduplicated)	31	23
Female Clients (Unduplicated)	642	518
New Clients (Unduplicated)	260	200
Returning Clients (Unduplicated)	413	341

Staffing Patterns

Laura Beeck, BSN RN was the Executive Director until her resignation from the agency. Kim Fineran, BSN RN took over these duties in February 2016. Kim Fineran is also the Project Director, Maternal/Child/Family Planning Coordinator. Monica Neumann is the Fiscal Officer for the project and provides billing services for all programs. Ashley Eggers, BA also provides billing services. Deb Birks, BSN RN is the EPSDT Coordinator.

Goals for this fiscal year:

Increase the total number of Maternal Health clients receiving a health education service by at least 10%.
Met

Expand indirect child health services to include contracts with providers in communities surrounding Denison.
Ongoing

Update the format of the Maternal Child Health and Family Planning policies and procedures manuals to reflect that of the IDPH manuals to allow for ease of policy review and audits.
Ongoing

Goals for next fiscal year are:

Expand indirect child health services to include contracts with providers in communities surrounding Denison.

Update the format of the Maternal Child Health and Family Planning policies and procedures manuals to reflect that of the IDPH manuals to allow for ease of policy review and audits.

Implement a one-nurse model of services for Family Planning services; beginning with Crawford and Shelby Counties in 16-17 and expand to other counties as nursing staff changes occur.

HCCMS Family Health Services

Maternal and Child Health Services Questionnaire

1. **Which county do you live in?** Maternal Health—Harrison-3/Crawford-2/Cass-0/Monona-4/Shelby-3
   Child Health—Harrison-0/Crawford-35/Cass-0/Monona-0/Shelby-2
2. **Is this your first time using these services?** Maternal Health—Yes-9 / No-3
   Child Health—Yes-4 / No-31

   If yes, how long did it take for you to get an appointment?

   Maternal Health—Within the next month-8 / 2 months-0 / 3 months-0 / Longer-0
   Child Health—Within the next month-3 / 2 months-0 / 3 months-0 / Longer-0
3. **Which service are you using?** Maternal Health-12 Child Health-37
4. **How did you hear about these services?**
   Maternal Health—WIC-4 / Friend-2 / Doctor's Office-4 / DHS-2
   Child Health—WIC-3 / Friend-20 / Doctor's Office-3 / DHS-4 / Family-1
5. **Did you/your child receive a variety of services that are important to good health?**
   Maternal Health—Yes-12 / No-0 Child Health—Yes-31 / No-2
6. **Are these same services available at your doctor's office?**
   Maternal Health—Yes-8 /No-4 Child Health—Yes-23 / No-8
7. **Will you continue coming here for these services?**
   Maternal Health—Yes-12 / No-0 Child Health—Yes-37 / No-0
8. **Compared to your doctor's office, was your waiting time for the services provided here:**
   Maternal Health—About Right-12 / Too Long-0 / Not enough time-0
   Child Health—About Right-26 / Too Long-1 / Not enough time-0
9. **Would you recommend these services to others?**
   Maternal Health—Yes-12 / No-0 Child Health— Yes-37 / No-0
10. **If these services were no longer available, where would you go for similar services?**
    Maternal Health—Doctor-9 / Hospital-1 / Nowhere-1 / Another Clinic-1
    Child Health—Doctor-10 / Hospital-11 / Nowhere-4 / Another Clinic-8
11. **Did you understand the information that was given to you today?**
    Maternal Health—Yes-12 / No-0 Child Health—Yes-32 / No-0
12. **Did you know that if your child does not have Medicaid or other insurance, the Child Health Program offers assistance with Dental and Doctor visits if funds are available?**
    Maternal Health—Yes-7 / No-4 Child Health—Yes-27 / No-3

    If yes, have you ever utilized these services?

    Maternal Health—Yes-4 / No-4 / Not applicable-4
    Child Health—Yes-25 / No-5 / Not applicable-0
13. **Which of the following things prevents you from going to the doctor or dentist?**

    Maternal Health—No transportation-1 / Cost-1 / Office hours-0 / Provider won't take my insurance-0 / Fear-0
    Unpaid bill-0 / Nothing-8 / Other-0

    Child Health— No transportation-0 / Cost-17 / Office hours-0 / Provider won't take my insurance-0 / Fear-0
    Unpaid bill-1 / Nothing-7 / Other-0

1. What services are you here for today?

10	First time examination here	3	Repeat PAP smear	1	Male exam
8	Receiving Depo Provera injection(shot)	22	Yearly examination	17	Other
12	Concern with birth control method	3	STI testing and or treatment	3	No Answer

2. How long did it take to get an appointment?

31	Less than 1 week	11	1 week	0	No answer
16	2 weeks	4	Longer		

3. Why did you choose this clinic?

27	Location	8	Hours	12	IFPN
25	Prices	16	Confidentiality	5	Other
21	Preference for a female practitioner	19	Clinic Staff	0	No answer

4. How did you hear about us?

22	Friend	8	Relative	4	Other
4	Doctor	3	Public Health	12	No Answer
2	Nurse	3	School	0	Google Search
1	Hospital	4	Been here before	1	Walk-in
4	Another clinic	0	Coworker		

5. Were you given the opportunity to ask questions today?

53 Yes 0 No 8 No Answer

If yes, were those questions answered to your satisfaction?

45 Yes 0 No 16 No answer

6. How do you feel about the length of time that was spent with you at each part of your visit?

	Too much time	About right	Not enough	Does not apply	No answer
Check-in/paperwork	5	45	1	1	9
Pre-exam consultation	3	44	2	1	11
Examination	3	43	3	1	11
Check-out/pay bill/get supplies	3	42	2	2	12

7. What is the best time for you to come to the clinic?

29	Weekday mornings	16	Weekday evenings
31	Weekday afternoons	8	Saturday
3	No answer		

8. Would you recommend this Family Planning clinic to others?

58 Yes 0 No 3 No answer

HCCMS Family Health Services
Family Planning Survey Comments

Question: What was the best part of your visit?

HARRISON
The kindness showed to me / I was treated very well / All of it / Good / Getting all of my questions answered / Friendly staff / I got my questions answered

CASS
It was all good / Compassion and attention / Everything was okay / Felt welcome / Quick and friendly / Granddaughter getting birth control / All of it

CRAWFORD
The attention / All of it / I didn't have to wait too long/ My questions got answered / Removing Nexplanon / Getting the correct medication to fix my issue / All of it / Attention / It was all good / I liked it all, the staff and the friendliness and dedication shown to the patients

MONONA
They were very friendly/ The kindness / Attention / All of it / Okay / Them asking and answering questions being friendly I got my questions answered / Everything

SHELBY
Seeing all you lovely ladies again / You're great / Everyone was friendly / Nice staff / Friendliness of the staff / The people / They answered every question, polite, and thorough / Got my questions answered / Having one on one contact with a practitioner / When the pain was over / Finding out I can try a method to reset my period / That I did not feel it / Meeting a new lady / Calla's concerns / Being able to ask questions and getting answered right away / Implanon is out and chatting with the ladies as amazing too

HCCMS
Child Care Nurse Consultant

Program Description

The Iowa Department of Human Services (DHS) and the Iowa Department of Public Health (IDPH) support Healthy Child Care Iowa (HCCI) to improve the health and safety of children attending childcare, as well as to assist families in accessing community-based resources including medical homes. The title, Child Care Nurse Consultant (CCNC), is emerging as a subspecialty in a variety of disciplines. Iowa is using the term Child Care Nurse Consultant to note a specialty within the pediatric public health nursing professional practice. Registered nurses (RNs) practicing in public health have long been called upon by childcare providers to assist the provider in responding to issues of childhood communicable disease, child development, safety and injury prevention, nutrition and family health. Public health nurses with pediatric expertise have gradually built the subspecialty.

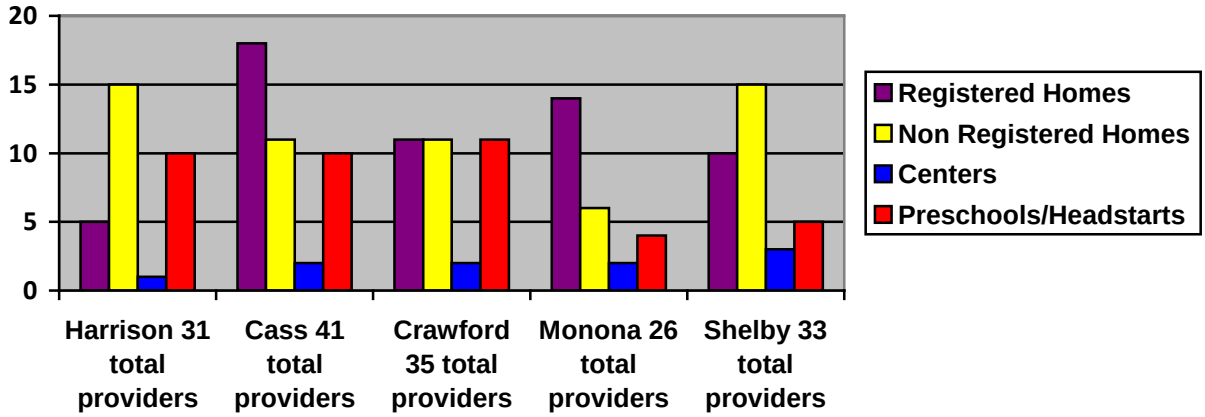
Program Update

In today's society, families are faced with the challenge of balancing home, work, education and recreation. More children between the ages of birth to 12 years are spending considerable time in out-of-home care arrangements. Children may have several childcare providers during the day to meet the needs of the family. Families depend on childcare providers to attend to the child's needs, anticipate problems or concerns and to direct or refer families to needed resources. The CCNC is one of the resources available to support childcare providers in meeting the health and safety needs of the children in out-of-home childcare.

The CCNC provides guidance, training, coordination and support to community-based childcare businesses to promote safe and healthy childcare environments for all children including children with special health or developmental needs. Upon request or based upon identified needs, the CCNC conducts on-site consultation to address and resolve health and safety issues, assists with policy development, provides trainings based on individual needs, and promotes involvement with Iowa's Quality Rating System (QRS).

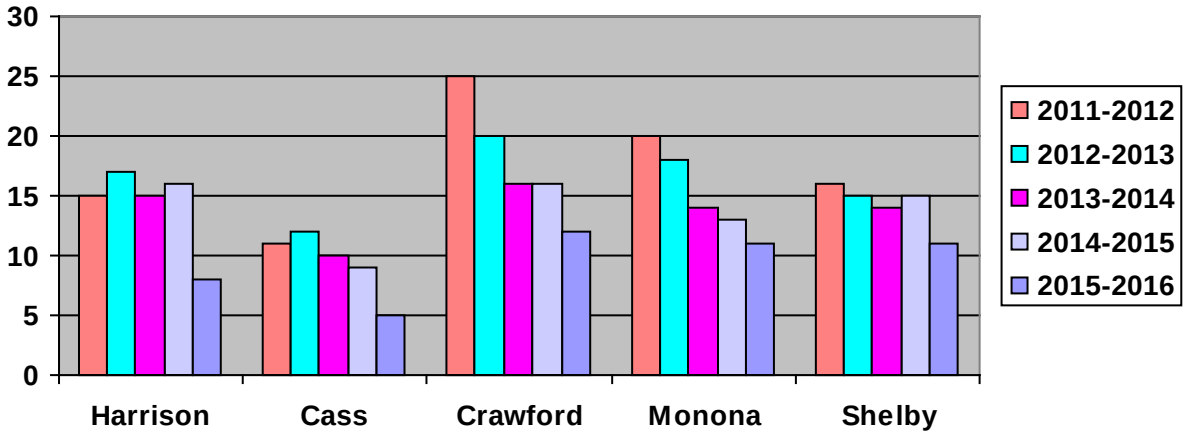
HCCMS and the CCNC have worked closely with Early Childhood Iowa (ECI) to secure funding for this position. The five counties have three Early Childhood Iowa areas. In Fiscal year 15-16, HCCMS Family Health Services received a funding from Boost4Families for Cass County; BVCS Early Childhood Iowa for Crawford County; and HMS Early Childhood Iowa for Harrison, Monona, and Shelby counties.

Number of Child Care Providers by Type as of June 30, 2016

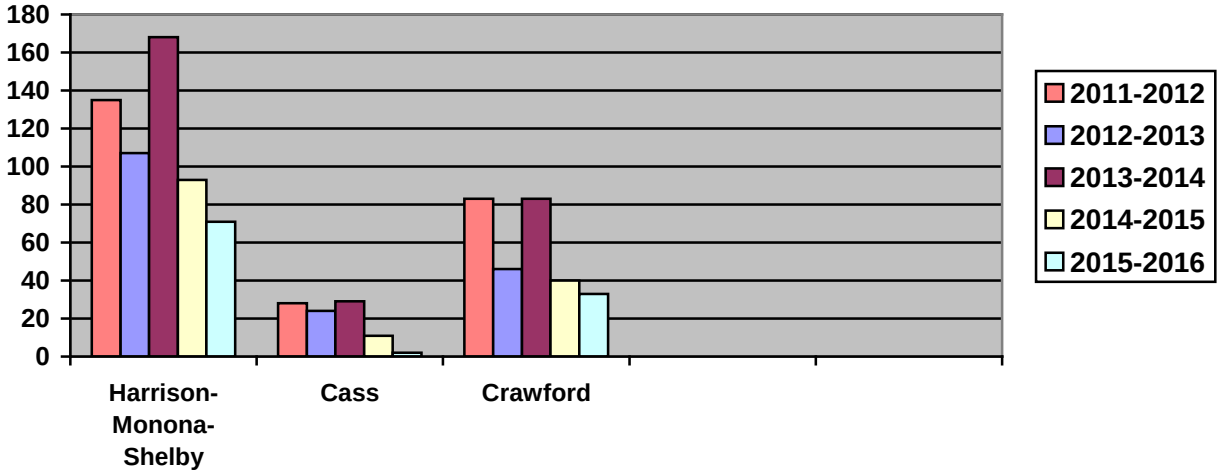


Active Business Partnership Agreements (BPA)*

*BPA's are valid for 2 years from date of signatures



Number of Provider Visits per Early Childhood Iowa Area



Staffing Patterns

Whitney Urich, RN was the full-time CCNC until her resignation in December 2015. The position has been offered and Chris Lee, RN will begin August 1, 2016.

Goals for this fiscal year were:

Fill the vacant CCNC position.
Met

Newly hired CCNC will complete the required training by IDPH.
Met

Newly hired CCNC will complete the Child Care Resource & Referral credentialing process and begin providing trainings.
Met

Goals for next fiscal year are:

Provide a minimum of one training opportunity for child care providers in each Early Childhood Iowa service area.

Contact child care providers whose Business Partnership Agreement is expired or about to expire to encourage renewal.

Children at Home Program

Program Description

The Children at Home program is a contracted service administered by the Iowa Department of Human Services. The program assists families by helping them locate formal and informal assistance, helping connect parents with other parents, advocating for families and children at the local and state level, and collaborating with other local agencies that provide assistance to families and children.

Children at Home is designed to assist families of children with a disability (defined as an individual who is less than 22 years of age and meets the definition of developmental disability) in securing the services and supports they identify as necessary in helping their child to remain at home. Financial assistance is intended to enable them to obtain those services and supports that are not met by other programs.

Program Update

In 2014-2015, a total of 12 children from 8 families received funding for supports and services. Funds were provided for many varied items such as medical supplies not covered by insurance, mileage for physician visits, sensory items for autistic children, camp registration, and handicap home modifications.

Beginning July 1, administration of this program has moved from DHS to IDPH and has been contracted to Visiting Nurse Services (VNS). With this transition, CAH program services will be available statewide through the Iowa Support Network.

Staffing Patterns

Marty Bornhoft, RN was the program coordinator until his resignation in March 2015. After his resignation, Kim Fineran, BSN RN provided program coordination.

Goals for this fiscal year were:

Increase visibility and participation in the program by providing community outreach activities.
Met

Increase the number of families served. Baseline measure is 8. Current measure is 9 families
Met

Goals for next fiscal year are:

Not applicable-program ended June 30, 2016

Dental Wellness Plan Outreach

Program Description

Delta Dental of Iowa, the largest and most experienced provider of dental benefits in the state, is a member of the Delta Dental Plans Association, a national organization of not-for-profit Delta Dental member companies. Delta Dental of Iowa is a provider of dental benefits to over 900,000 members and holds a leading market position in the employer-sponsored dental plan market in Iowa. As a not-for-profit, Delta Dental of Iowa supports a number of community and public benefit programs that improve the oral health of Iowans.

The Iowa Dental Wellness Plan (DWP) began May 1, 2014 and provides dental benefits to adults 19-64 years of age who are enrolled in the Iowa Health and Wellness Plan. Delta Dental of Iowa, in partnership with the Department of Human Services, is administering the dental benefits. The DWP aims to improve member awareness about the importance of good oral health, establishing a dental home, and completing treatment plans.

In November 2014, Delta Dental released the Iowa Dental Wellness Plan Community Collaboration Request for Proposal (RFP). The intent of the RFP is to develop a coordinated approach for educating members, providers, and community partners on the program design and streamline a process for members to access needed dental care. This RFP was open to Title V Maternal Child Health Contractor to apply. HCCMS submitted a proposal and was awarded funding to run from January 30, 2015 through June 30, 2016. A renewal option for additional funding through June 30, 2017 will be available later this fall.

After the initial proposal cycle, HCCMS was approached by Delta Dental to provide services in neighboring counties that were not awarded. Funding for Montgomery and Taylor counties was also awarded to HCCMS at that time.

Staffing Patterns

Jennifer Macke, RDH provides oversight for the program. Sara Duncklee was the part-time Outreach Coordinator until her resignation in August 2015. Nikki Ahart was hired in November 2015 as the Outreach Coordinator. In January 2016, Nikki moved to the 1st Five Program as the Site Coordinator. The DWP Outreach position remained vacant, with various staff members assisting with the program until June 2016, at which time Renae Schneider, RDA was hired to provide services.

Goals for this fiscal year were:

Collaborate with the I-Smile Coordinator to assure a referral system is established for DWP members. **Ongoing**

Educate community stakeholders on DWP plan design and the population it serves. **Ongoing**

Promote oral health through outreach to new enrollees, follow-up with members who received emergency or stabilization services, and assist members with support, education, referrals, and reminders. **Ongoing**

Goals for next fiscal year are:

Collaborate with Emergency Department staff in all counties to reduce the number of patients going to the Emergency Room for tooth related problems.

Educate members of the importance of prevention through regular dental checks.

HCCMS 1st Five Healthy Mental Development Initiative

Program Description

1st Five is a public-private partnership bridging primary care and public health services in Iowa. The 1st Five model supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children birth to 5 and coordinates referrals, interventions and follow-up.

Iowa's 1st Five Healthy Mental Development Initiative builds partnerships between physician practices and public service providers to enhance high quality well-child care. 1st Five promotes the use of developmental tools that support healthy mental development for young children during the first five years. By using a tool for all children that includes social-emotional development and family risk factors, providers are able to identify children at risk for developmental concerns that, if left untreated, would play out later in life.

The foundations of mental health are set in the first five years of life. During these years, children rapidly develop social and emotional capacities that prepare them to be self-confident, trusting, empathetic, intellectually inquisitive, competent in using language to communicate and capable of relating well to others. These emotional skills form the foundation of a child's "healthy mental development" - to develop the ability to regulate and express emotions, form close personal relationships with other children and adults, and explore and learn from their environment. This social-emotional foundation also plays a key role in determining a child's school readiness.

Program Update

Two educational opportunities for primary care providers and community partners were held this program year. The first educational opportunity was provided on May 1, 2016 (25 attendees) and included the topics Trauma Informed Care, Vicarious Trauma and Self-Care, and Cultural Competence Applications in a Clinical Setting. The presentation, which was held on May 16, 2016 (12 attendees), was Lemonade for Life which included both Adverse Childhood Experiences (ACEs) and how you help clients cope with trauma.

In 2015-2016, 175 partnership building contacts, 324 consultation contacts, and 10 trainings were provided. 66 referrals were received which resulted in 359 additional resource referrals being provided to families. With the addition of Medicaid's Managed Care Organizations in April 2016, the program transitioned from billing Medicaid for some of the services we provided to a system in which our care coordination minutes come almost solely out of grant funds.

One of the cornerstones of the 1st Five program is building relationships with physicians. This year, we added Atlantic, Anita, Griswold, and Massena Medical Centers in Cass County to the 1st Five Program. We have now engaged all major medical clinics in each of our five counties.

Staffing Patterns

Lori Hoch, RN was the coordinator of the program until her resignation in December 2015. Nikki Ahart, who was the care coordinator for the program, took over the program coordinator role in January 2016. Marcy Melby was hired in May 2016 to provide care coordination for families participating in the program.

Goals for this fiscal year were:

Increase the number of primary care providers that begin screening children using a standardized tool by 5%.
Met

Facilitate at least one training opportunity for primary care providers and community with a focus on topics such as ACEs, Trauma Informed Care, Perinatal and Postpartum Depression, Developmental Surveillance and Screening, social determinants of health, and other topics that educate and promote children's healthy mental development.
Met

Goals for next fiscal year are:

Increase the number of primary care providers that begin screening children using a standardized tool by 5%.

Facilitate at least three training opportunities for primary care providers and community partners in our service area with the focus being on "Paper Tigers" which is a documentary based on ACEs, Trauma Informed Care, social determinants of health, and other topics that educate and promote children's healthy mental development.

HCCMS I-Smile

Program Description

In 2005, the Iowa legislature passed a Medicaid reform initiative that included a mandate stating all children twelve years of age or younger who receive medical assistance shall have a designated dental home and shall be provided with dental screenings and preventive care as identified in the oral health standards of the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT). In response, the I-Smile Dental Home Project was created.

The goal of creating a dental home is to ensure that children receive age-appropriate comprehensive dental care. The American Academy of Pediatric Dentistry's (AAPD) definition of a dental home is the conceptual framework for the I-smile project. AAPD recommends that children be referred for preventive and routine oral health care as early as 6 months of age and no later than 12 months of age.

A dental home provides acute care, preventive services, assessment of oral disease, individualized preventive care based on risk assessment, anticipatory guidance, information about caring for teeth and gums, dietary counseling, and referral to dental specialists as needed.

IDPH envisions a conceptual dental home, allowing a team approach to manage oral disease. Primary prevention and care coordination are the focus of the I-Smile project. Through referrals, dentists serve as the providers of treatment and definitive evaluation. Additional health professionals, such as dental hygienists and registered nurses, are an integral part of a network providing oral screenings, education, and preventive services as needed to assure that all children receive care.

Program Update

In fiscal year 2015-2016 a total of 4,818 oral health services were provided throughout HCCMS service delivery area. Services consisted of oral health screenings, fluoride varnish, sealant application, care coordination, and education. Oral health services are provided in the preschool setting through a partnership with Early Childhood Iowa (ECI). Through grants, ECI provides funding for the dental hygienist to provide services in licensed preschool and Head Start settings. Services are also provided at WIC clinics periodically throughout the year.

Staffing Patterns

Jennifer Macke, RDH is the part-time I-Smile Coordinator. Sharon Davidson, RDH assists with oral health services at preschools and Head Start.

Goals for this fiscal year were:

I-Smile Coordinator will attend a Board of Health meeting in each county to provide information about the I-Smile program and services.
Met

I-Smile Coordinator will visit each medical office in the service area to promote the I-Smile program, promote referrals for dental examinations by age 1, and request referrals for families needing assistance locating oral health care.
Met

I-Smile Coordinator will visit each dental office in the service area to promote the I-Smile program, Dental Wellness Plan, establish/maintain contracts to accept dental vouchers for children with no insurance coverage, promote dental examinations by age 1, provide school screening requirement updates, encourage provision of services for Medicaid-eligible children, and request referrals for families denied services due to lack of financial resources and/or no insurance coverage.
Met

Goals for next fiscal year are:

I-Smile Coordinator will attend a Board of Health meeting in each county to provide information about the I-Smile program services, Dental Wellness program, Dentist by one Campaign and inform them of the current status of each county's community water fluoridation.

The I-Smile Coordinator will educate the communities that are not currently receiving the optimal amount of fluoride in their community water systems. Assist in sustaining/initiating community water fluoridation in communities in need.

The I-Smile Coordinator will ensure each Head Start in the service area will receive screenings/fluoride varnishes 3 times per school year (increasing from 2 times per school year).

HCCMS I-Smile @ School

Program Description

School-based dental sealant programs are an important and effective public health approach in promoting the oral health of children and adolescents. Eighty to ninety percent of dental decay in children ages 5 - 17 occurs in the pits and fissures of teeth, mostly on the chewing surfaces. Placing dental sealants on molar teeth significantly lowers the probability that decay in those teeth will occur.

The cost of preventing tooth decay by placing dental sealants in children is much less than the cost of treating tooth decay, and the savings realized over a lifetime can be substantial. If untreated decay progresses, it may be necessary to perform root canals and other extensive and expensive procedures. According to the Surgeon General Report, there is strong evidence supporting dental sealants and community sealant programs for the prevention of dental decay, particularly for high-risk children.

School-based sealant programs improve communication between parents and oral health professionals, helping parents make informed decisions about the benefits dental sealants provide. In addition, these programs help families who lack insurance or who don't have access to preventive services due to transportation or other barriers to care. Most importantly, the coordination of these programs has also been linked to helping families establish dental homes.

Program Update

This year, school-based services were provided in 7 schools: Crawford County-Denison Elementary; Cass County-CAM North Elementary, CAM South Elementary, Washington Elementary, Lewis Elementary, Elliott Elementary; and Monona County-Maple Valley Elementary School.

Screening and fluoride varnish services were provided to 78 children in Crawford County. Sealants were provided to 47 children on 163 teeth. In Cass County, 182 children received screenings and fluoride varnish and 139 children received sealants on 449 teeth. In Monona County, 17 children received screenings and fluoride varnish with 9 children receiving sealants on 40 teeth.

Staffing Patterns

Jennifer Macke, RDH is the I-Smile Coordinator. She provided program oversight and direct services. Peggy Mortensen, RDH and Amy Paulsen, RDH are contracted hygienists that assist with screenings, fluoride varnish, and sealants.

Goals for this fiscal year were:

Provide sealant services at Washington Elementary, Lewis Elementary, Elliott Elementary, Mapleton Elementary, and Denison Elementary.
Met

Goals for next fiscal year are:

Continue to provide sealant services at the following locations: Cass County-Washington, Elliott, and Lewis Elementary Schools; Crawford County-Denison Elementary; Monona County-Mapleton Elementary. Add the following new locations: Cass County-Iowa Connections Academy; Harrison County-Missouri Valley Elementary; Monona County-Whiting Elementary School; and Shelby County-Irwin Elementary School.