

CHAPTER 135

DEPARTMENT OF PUBLIC HEALTH

[P]
Plumbing and mechanical systems board
within the department of public health;
see chapter 105

Table with 4 columns: Section Number, Section Description, Section Number, and Section Description. It lists various provisions under Division I (General Provisions), Division II (Miscellaneous Provisions), Division III (Morbidity and Mortality Study), and Division IV (Iowa Child Death Review Team).

- DIVISION VI
HEALTH FACILITIES COUNCIL
- 135.61 Definitions.
 - 135.62 Department to administer division — health facilities council established — appointments — powers and duties.
 - 135.63 Certificate of need required — exclusions.
 - 135.64 Criteria for evaluation of applications.
 - 135.65 Letter of intent to precede application — review and comment.
 - 135.66 Procedure upon receipt of application — public notification.
 - 135.67 Summary review procedure.
 - 135.68 Status reports on review in progress.
 - 135.69 Council to make final decision.
 - 135.70 Appeal of certificate of need decisions.
 - 135.71 Period for which certificate is valid — extension or revocation.
 - 135.72 Authority to adopt rules.
 - 135.73 Sanctions.
 - 135.74 Uniform financial reporting.
 - 135.75 Annual reports by hospitals, health care facilities.
 - 135.76 Analyses and studies by department.
 - 135.77 Repealed by 97 Acts, ch 203, §18.
 - 135.78 Data to be compiled.
 - 135.79 Civil penalty.
 - 135.80 Mental health professional shortage area program.
 - 135.81 Repealed by 83 Acts, ch 101, §129.
 - 135.82 Repealed by 91 Acts, ch 225, §15.
 - 135.83 Contracts for assistance with analyses, studies, and data.
 - 135.84 Repealed by 88 Acts, ch 1276, §46.
 - 135.85 through 135.89 Reserved.
- DIVISION VII
LICENSED HOSPICE PROGRAMS
- 135.90 through 135.96 Transferred to chapter 135J; 90 Acts, ch 1204, §66.
 - 135.97 through 135.99 Reserved.
- DIVISION VIII
LEAD ABATEMENT PROGRAM
- 135.100 Definitions.
 - 135.101 Childhood lead poisoning prevention program.
 - 135.102 Rules.
 - 135.103 Grant program.
 - 135.104 Requirements.
 - 135.105 Department duties.

- 135.105A Lead inspector, lead abater, and lead-safe renovator training and certification program established — civil penalty.
- 135.105B Voluntary guidelines — health and environmental measures — confirmed cases of lead poisoning.
- 135.105C Renovation, remodeling, and repainting — lead hazard notification process established.
- 135.105D Blood lead testing — provider education — payor of last resort.

DIVISION IX
HEALTHY FAMILIES PROGRAM

- 135.106 Healthy families programs — HOPES-HFI program.

DIVISION X
RURAL HEALTH AND PRIMARY CARE

- 135.107 Center for rural health and primary care established — duties.

DIVISION XI
DOMESTIC ABUSE DEATH REVIEW TEAM

- 135.108 Definitions.
- 135.109 Iowa domestic abuse death review team membership.
- 135.110 Iowa domestic abuse death review team powers and duties.
- 135.111 Confidentiality of domestic abuse death records.
- 135.112 Rulemaking.
- 135.113 through 135.117 Reserved.

DIVISION XII
CHILD PROTECTION — CHILD PROTECTION CENTER GRANTS — SHAKEN BABY SYNDROME PREVENTION

- 135.118 Child protection center grant program.
- 135.119 Shaken baby syndrome prevention program.

DIVISION XIII
TAXATION OF ORGANIZED DELIVERY SYSTEMS

- 135.120 Taxation of organized delivery systems.
- 135.121 through 135.129 Reserved.

DIVISION XIV
SUBSTANCE ABUSE TREATMENT FACILITY FOR PERSONS ON PROBATION

- 135.130 Substance abuse treatment facility for persons on probation.

	DIVISION XV		
	NEWBORN AND INFANT HEARING SCREENING		
135.131	Universal newborn and infant hearing screening.	135.156	Electronic health information — department duties — advisory council — executive committee.
			DIVISION XXII
	DIVISION XVI		MEDICAL HOME
	INTERAGENCY PHARMACEUTICALS BULK PURCHASING COUNCIL	135.157	Definitions.
135.132	Interagency pharmaceuticals bulk purchasing council.	135.158	Medical home purposes — characteristics.
135.133	through 135.139 Reserved.	135.159	Medical home system — advisory council — development and implementation.
			DIVISION XXIII
	DIVISION XVII		PREVENTION AND CHRONIC CARE MANAGEMENT
	DISASTER PREPAREDNESS		
135.140	Definitions.	135.160	Definitions.
135.141	Division of acute disease prevention and emergency response — establishment — duties of department.	135.161	Prevention and chronic care management initiative — advisory council.
135.142	Health care supplies.	135.162	Clinicians advisory panel.
135.143	Public health response teams.		DIVISION XXIV
135.144	Additional duties of the department related to a public health disaster.		HEALTH AND LONG-TERM CARE ACCESS
135.145	Information sharing.	135.163	Health and long-term care access.
135.146	First responder vaccination program.	135.164	Strategic plan.
135.147	Immunity for emergency aid — exceptions.		DIVISION XXV
135.148	and 135.149 Reserved.		HEALTH CARE TRANSPARENCY
	DIVISION XVIII	135.165	Health care transparency — reporting requirements — hospitals and nursing facilities.
	GAMBLING TREATMENT PROGRAM	135.166	Health care data — collection from hospitals.
135.150	Gambling treatment program — standards and licensing.	135.167	through 135.170 Reserved.
135.151	Reserved.		DIVISION XXVI
			ALZHEIMER'S DISEASE SERVICE NEEDS
	DIVISION XIX	135.171	Alzheimer's disease service needs.
	OBSTETRICAL AND NEWBORN INDIGENT PATIENT CARE PROGRAM	135.172	Reserved.
135.152	Statewide obstetrical and newborn indigent patient care program.		DIVISION XXVII
			EARLY CHILDHOOD IOWA COUNCIL
	DIVISION XX	135.173	Early childhood Iowa council. Repealed by 2010 Acts, ch 1031, §308.
	COLLABORATIVE SAFETY NET PROVIDER NETWORK	135.173A	Reserved.
135.153	Iowa collaborative safety net provider network established.	135.174	Lead agency and other state agencies. Repealed by 2010 Acts, ch 1031, §308.
135.153A	Safety net provider recruitment and retention initiatives program — repeal.		DIVISION XXVIII
			HEALTH CARE WORKFORCE SUPPORT INITIATIVE AND FUND
	DIVISION XXI	135.175	Health care workforce support initiative — workforce shortage fund — accounts — repeal.
	IOWA HEALTH INFORMATION TECHNOLOGY SYSTEM		
135.154	Definitions.		
135.155	Iowa electronic health — principles — goals.		

	DIVISION XXIX	135.177	Physician assistant mental health fellowship program — repeal.
	HEALTH CARE WORKFORCE SUPPORT	135.178	Nurse residency state matching grants program — repeal.
135.176	Medical residency training state matching grants program — repeal.		

DIVISION I
GENERAL PROVISIONS

135.1 Definitions.

For the purposes of chapter 155 and Title IV, subtitle 2, excluding chapter 146, unless otherwise defined:

1. “*Director*” shall mean the director of public health.
2. “*Health officer*” shall mean the physician who is the health officer of the local board of health.
3. “*Local board*” shall mean the local board of health.
4. “*Physician*” means a person licensed to practice medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatry, or optometry under the laws of this state; but a person licensed as a physician and surgeon shall be designated as a “physician” or “surgeon”, a person licensed as an osteopathic physician and surgeon shall be designated as an “osteopathic physician” or “osteopathic surgeon”, a person licensed as a chiropractor shall be designated as a “chiropractor”, a person licensed as a podiatrist shall be designated as a “podiatric physician”, and a person licensed as an optometrist shall be designated as an “optometrist”. A definition or designation contained in this subsection shall not be interpreted to expand the scope of practice of such licensees.
5. “*Rules*” shall include regulations and orders.
6. “*Sanitation officer*” shall mean the police officer who is the permanent sanitation and quarantine officer and who is subject to the direction of the local board of health in the execution of health and quarantine regulations.
7. “*State department*” or “*department*” shall mean the Iowa department of public health. [S13, §2583-b; C24, 27, 31, 35, 39, §2181; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.1] 86 Acts, ch 1245, §1101; 88 Acts, ch 1199, §1; 94 Acts, ch 1023, §10; 95 Acts, ch 108, §2; 96 Acts, ch 1036, §1; 96 Acts, ch 1212, §15; 2008 Acts, ch 1058, §14; 2008 Acts, ch 1084, §10; 2008 Acts, ch 1088, §141; 2009 Acts, ch 133, §30

135.2 Appointment of director and acting director.

1. *a.* The governor shall appoint the director of the department, subject to confirmation by the senate. The director shall serve at the pleasure of the governor. The director is exempt from the merit system provisions of chapter 8A, subchapter IV. The governor shall set the salary of the director within the range established by the general assembly.

b. The director shall possess education and experience in public health.

2. The director may appoint an employee of the department to be acting director, who shall have all the powers and duties possessed by the director. The director may appoint more than one acting director but only one acting director shall exercise the powers and duties of the director at any time.

[C97, S13, §2564; C24, 27, 31, 35, 39, §2182, 2184, 2185; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, §135.2, 135.4, 135.5; C81, §135.2]

86 Acts, ch 1245, §1102; 88 Acts, ch 1158, §32; 2003 Acts, ch 145, §186; 2006 Acts, ch 1184, §75

[P] Confirmation; §2.32

135.3 Disqualifications.

The director shall not hold any other lucrative office of this state, elective or appointive, during the director's term; provided, however, that the director may serve without compensation as an officer or member of the instructional staff of any of the state educational institutions if any such additional duties and responsibilities do not prohibit the director from performing the duties of the office of director.

[C97, S13, §2564; C24, 27, 31, 35, 39, §2183; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.3]

135.4 and 135.5 Repealed by 80 Acts, ch 1010, § 86.

135.6 Assistants and employees.

The director shall employ such assistants and employees as may be authorized by law, and the persons appointed shall perform duties as may be assigned to them by the director.

[C97, S13, §2564; C24, 27, 31, 35, 39, §2186; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.6]

86 Acts, ch 1245, §1103

135.7 Bonds.

The director shall require every employee who collects fees or handles funds belonging to the state to give an official bond, properly conditioned and signed by sufficient sureties, in a sum to be fixed by the director which bond shall be approved by the director and filed in the office of the secretary of state.

[C24, 27, 31, 35, 39, §2187; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.7]

135.8 Seal.

The department shall have an official seal and every commission, license, order, or other paper executed by the department may be attested with its seal.

[C24, 27, 31, 35, 39, §2188; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.8]

135.9 Expenses.

The director, field and office assistants, inspectors, and employees shall, in addition to salary, receive their necessary traveling expenses by the nearest traveled and practicable route and their necessary and incidental expenses when engaged in the performance of official business.

[C97, §2574; S13, §2564, 2574; C24, 27, 31, 35, 39, §2189; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.9]

135.10 Office.

The department shall be located at the seat of government.

[C97, §2564; S13, §2564; C24, 27, 31, 35, 39, §2190; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.10]

135.11 Duties of department.

The director of public health shall be the head of the "Iowa Department of Public Health", which shall:

1. Exercise general supervision over the public health, promote public hygiene and sanitation, prevent substance abuse and unless otherwise provided, enforce the laws relating to the same.
2. Conduct campaigns for the education of the people in hygiene and sanitation.
3. Issue monthly health bulletins containing fundamental health principles and other health data deemed of public interest.
4. Make investigations and surveys in respect to the causes of disease and epidemics, and the effect of locality, employment, and living conditions upon the public health. For this purpose the department may use the services of the experts connected with the state hygienic laboratory at the state university of Iowa.

5. Establish stations throughout the state for the distribution of antitoxins and vaccines to physicians, druggists, and other persons, at cost. All antitoxin and vaccine thus distributed shall be labeled "Iowa Department of Public Health".

6. Exercise general supervision over the administration and enforcement of the sexually transmitted diseases and infections law, chapter 139A, subchapter II.

7. Exercise sole jurisdiction over the disposal and transportation of the dead bodies of human beings and prescribe the methods to be used in preparing such bodies for disposal and transportation. However, the department may approve a request for an exception to the application of specific embalming and disposition rules adopted pursuant to this subsection if such rules would otherwise conflict with tenets and practices of a recognized religious denomination to which the deceased individual adhered or of which denomination the deceased individual was a member. The department shall inform the board of mortuary science of any such approved exception which may affect services provided by a funeral director licensed pursuant to chapter 156.

8. Establish, publish, and enforce rules which require companies, corporations, and other entities to obtain a permit from the department prior to scattering cremated human remains.

9. Exercise general supervision over the administration and enforcement of the vital statistics law, chapter 144.

10. Enforce the law relative to chapter 146 and "Health-related Professions", Title IV, subtitle 3, excluding chapter 155.

11. Establish and maintain divisions as are necessary for the proper enforcement of the laws administered by the department.

12. Establish, publish, and enforce rules not inconsistent with law for the enforcement of the provisions of chapters 125 and 155, and Title IV, subtitle 2, excluding chapter 146 and for the enforcement of the various laws, the administration and supervision of which are imposed upon the department.

13. Administer the statewide public health nursing, homemaker-home health aide, and senior health programs by approving grants of state funds to the local boards of health and the county boards of supervisors and by providing guidelines for the approval of the grants and allocation of the state funds. Program direction, evaluation requirements, and formula allocation procedures for each of the programs shall be established by the department by rule.

14. Administer chapters 125, 136A, 136C, 139A, 142, 142A, 144, and 147A.

15. Issue an annual report to the governor as provided in section 7E.3, subsection 4.

16. Consult with the office of statewide clinical education programs at the university of Iowa college of medicine and annually submit a report to the general assembly by January 15 verifying the number of physicians in active practice in Iowa by county who are engaged in providing obstetrical care. To the extent data are readily available, the report shall include information concerning the number of deliveries per year by specialty and county, the age of physicians performing deliveries, and the number of current year graduates of the university of Iowa college of medicine and the Des Moines university — osteopathic medical center entering into residency programs in obstetrics, gynecology, and family practice. The report may include additional data relating to access to obstetrical services that may be available.

17. Administer the statewide maternal and child health program and the program for children with disabilities by conducting mobile and regional child health specialty clinics and conducting other activities to improve the health of low-income women and children and to promote the welfare of children with actual or potential conditions which may cause disabilities and children with chronic illnesses in accordance with the requirements of Tit. V of the federal Social Security Act. The department shall provide technical assistance to encourage the coordination and collaboration of state agencies in developing outreach centers which provide publicly supported services for pregnant women, infants, and children. The department shall also, through cooperation and collaborative agreements with the department of human services and the mobile and regional child health specialty clinics, establish common intake proceedings for maternal and child health services. The department shall work in cooperation with the legislative services agency in monitoring

the effectiveness of the maternal and child health centers, including the provision of transportation for patient appointments and the keeping of scheduled appointments.

18. Establish, publish, and enforce rules requiring prompt reporting of methemoglobinemia, pesticide poisoning, and the reportable poisonings and illnesses established pursuant to section 139A.21.

19. Collect and maintain reports of pesticide poisonings and other poisonings, illnesses, or injuries caused by selected chemical or physical agents, including methemoglobinemia and pesticide and fertilizer hypersensitivity; and compile and publish, annually, a statewide and county-by-county profile based on the reports.

20. Adopt rules which require personnel of a licensed hospice, of a homemaker-home health aide provider agency which receives state homemaker-home health aide funds, or of an agency which provides respite care services and receives funds to complete a minimum of two hours of training concerning acquired immune deficiency syndrome-related conditions through a program approved by the department. The rules shall require that new employees complete the training within six months of initial employment and existing employees complete the training on or before January 1, 1989.

21. Adopt rules which require all emergency medical services personnel, firefighters, and law enforcement personnel to complete a minimum of two hours of training concerning acquired immune deficiency syndrome-related conditions and the prevention of human immunodeficiency virus infection.

22. Adopt rules which provide for the testing of a convicted or alleged offender for the human immunodeficiency virus pursuant to sections 915.40 through 915.43. The rules shall provide for the provision of counseling, health care, and support services to the victim.

23. Establish ad hoc and advisory committees to the director in areas where technical expertise is not otherwise readily available. Members may be compensated for their actual and necessary expenses incurred in the performance of their duties. To encourage health consumer participation, public members may also receive a per diem as specified in section 7E.6 if funds are available and the per diem is determined to be appropriate by the director. Expense moneys paid to the members shall be paid from funds appropriated to the department. A majority of the members of such a committee constitutes a quorum.

24. Establish an abuse education review panel for review and approval of mandatory reporter training curricula for those persons who work in a position classification that under law makes the persons mandatory reporters of child or dependent adult abuse and the position classification does not have a mandatory reporter training curriculum approved by a licensing or examining board.

25. Establish and administer a substance abuse treatment facility pursuant to section 135.130.

26. Administer annual grants to county boards of health for the purpose of conducting programs for the testing of private water supply wells, the closing of abandoned private water supply wells, and the renovation or rehabilitation of private water supply wells. Grants shall be funded through moneys transferred to the department from the agriculture management account of the groundwater protection fund pursuant to section 455E.11, subsection 2, paragraph "b", subparagraph (3), subparagraph division (b). The department shall adopt rules relating to the awarding of the grants.

27. Establish and administer, if sufficient funds are available to the department, a program to assess and forecast health workforce supply and demand in the state for the purpose of identifying current and projected workforce needs. The program may collect, analyze, and report data that furthers the purpose of the program. The program shall not release information that permits identification of individual respondents of program surveys.

28. In consultation with the advisory committee for perinatal guidelines, develop and maintain the statewide perinatal program based on the recommendations of the American academy of pediatrics and the American college of obstetricians and gynecologists contained in the most recent edition of the guidelines for perinatal care, and shall adopt rules in accordance with chapter 17A to implement those recommendations. Hospitals within the state shall determine whether to participate in the statewide perinatal program, and select the hospital's level of participation in the program. A hospital having determined

to participate in the program shall comply with the guidelines appropriate to the level of participation selected by the hospital. Perinatal program surveys and reports are privileged and confidential and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the affected hospital, and are not admissible in evidence in a judicial or administrative proceeding other than a proceeding involving verification of the participating hospital under this subsection.

29. In consultation with the department of corrections, the antibiotic resistance task force, and the American federation of state, county and municipal employees, develop educational programs to increase awareness and utilization of infection control practices in institutions listed in section 904.102.

30. Administer the Iowa youth survey, in collaboration with other state agencies, as appropriate, every two years to students in grades six, eight, and eleven in Iowa's public and nonpublic schools. Survey data shall be evaluated and reported, with aggregate data available online at the Iowa youth survey internet site.

1. [C97, §2565; C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.11(1)]

2, 3. [C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.11(2, 3)]

4. [C97, §2565; C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.11(4)]

5, 6. [C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, §135.11(8, 9); C73, 75, 77, 79, 81, §135.11(7, 8)]

7. [S13, §2572-a, -b, -c; C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, §135.11(11); C73, §135.11(10); C75, 77, 79, 81, §135.11(9)]

8. [C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, §135.11(12); C73, §135.11(11); C75, 77, 79, 81, §135.11(10)]

9. [S13, §2575-a42; C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, §135.11(13); C73, §135.11(12); C75, 77, 79, 81, §135.11(11)]

10. [C97, §2565; C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, §135.11(14); C73, §135.11(13); C75, 77, 79, 81, §135.11(12)]

11, 12. [C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, §135.11(15, 16); C73, §135.11(14, 15); C75, 77, 79, 81, §135.11(13, 14)]

13. [C97, §2565; C24, 27, 31, 35, 39, §2191; C46, 50, 54, 58, 62, 66, 71, §135.11(17); C73, §135.11(16); C75, 77, 79, 81, §135.11(15)]

14. [C75, 77, 79, 81, §135.11(16)]

15. [82 Acts, ch 1260, §55]

83 Acts, ch 27, §7; 86 Acts, ch 1245, §1104; 87 Acts, ch 8, §2; 87 Acts, ch 115, §22; 87 Acts, ch 225, §202; 88 Acts, ch 1224, §12; 89 Acts, ch 304, §103; 90 Acts, ch 1259, §10; 91 Acts, ch 258, §29; 93 Acts, ch 140, §4; 94 Acts, ch 1023, §11; 94 Acts, ch 1132, §9; 96 Acts, ch 1036, §2; 96 Acts, ch 1128, §1; 96 Acts, ch 1129, §23; 97 Acts, ch 23, §13; 97 Acts, ch 197, §1; 98 Acts, ch 1053, §1; 98 Acts, ch 1087, §1; 98 Acts, ch 1090, §60, 84; 98 Acts, ch 1221, §12; 99 Acts, ch 141, §2; 2000 Acts, ch 1058, §14; 2000 Acts, ch 1066, §37; 2000 Acts, ch 1223, §18; 2001 Acts, ch 58, §3; 2001 Acts, ch 122, §1; 2001 Acts, ch 184, §6; 2001 Acts, 2nd Ex, ch 1, §25, 28; 2002 Acts, ch 1108, §7; 2003 Acts, ch 33, §8, 11; 2003 Acts, ch 35, §45, 49; 2003 Acts, ch 44, §36; 2004 Acts, ch 1167, §1; 2005 Acts, ch 89, §2, 3; 2007 Acts, ch 10, §18; 2007 Acts, ch 159, §17; 2008 Acts, ch 1058, §1, 2, 15; 2008 Acts, ch 1084, §11; 2008 Acts, ch 1088, §83; 2008 Acts, ch 1180, §20; 2009 Acts, ch 41, §263; 2009 Acts, ch 151, §30; 2010 Acts, ch 1088, §4 – 6

[P] Laboratory tests, §263.7, 263.8

[SP] Establishment and funding of state poison control center; 2000 Acts, ch 1221, §1; 2001 Acts, ch 184, §1; 2002 Acts, ch 1174, §1; 2003 Acts, ch 183, §1; 2004 Acts, ch 1176, §1; 2005 Acts, ch 176, §1; 2006 Acts, ch 1181, §1; 2007 Acts, ch 208, §1; 2008 Acts, ch 1186, §1

[T] Subsection 13 stricken and former subsections 14 – 28 renumbered as 13 – 27

[T] Subsection 29 amended and renumbered as 28

[T] Subsection 30 renumbered as 29

[T] NEW subsection 30

135.11A Professional licensure division — other licensing boards — expenses — fees.

There shall be a professional licensure division within the department of public health. Each board under chapter 147 or under the administrative authority of the department, except the board of nursing, board of medicine, dental board, and board of pharmacy, shall receive

administrative and clerical support from the division and may not employ its own support staff for administrative and clerical duties.

The professional licensure division and the licensing boards may expend funds in addition to amounts budgeted, if those additional expenditures are directly the result of actual examination and exceed funds budgeted for examinations. Before the division or a licensing board expends or encumbers an amount in excess of the funds budgeted for examinations, the director of the department of management shall approve the expenditure or encumbrance. Before approval is given, the department of management shall determine that the examination expenses exceed the funds budgeted by the general assembly to the division or board and the division or board does not have other funds from which examination expenses can be paid. Upon approval of the department of management, the division or licensing board may expend and encumber funds for excess examination expenses. The amounts necessary to fund the excess examination expenses shall be collected as fees from additional examination applicants and shall be treated as repayment receipts as defined in section 8.2.

86 Acts, ch 1245, §1105; 91 Acts, ch 268, §306; 92 Acts, ch 1163, §34; 2007 Acts, ch 10, §19; 2007 Acts, ch 218, §192

135.12 Office of minority and multicultural health — established — duties.

1. The office of minority and multicultural health is established in the department. The purpose of the office is to improve the health of racial and ethnic minorities by bridging communication, delivery, and service requirements, and by providing customized services and practical approaches to problems and issues encountered by organizations and communities working to address the needs of these populations.

2. The office of minority and multicultural health shall be responsible for all of the following:

a. Serving as the liaison and advocate for the department on minority and multicultural health matters.

b. Assisting academic institutions, state agencies, community groups, and other entities in institutionalizing cultural competency within the health care workforce and delivery system through education, training, and practice to effectively address cross-cultural disparity and achieve health equity.

c. Promoting community strategic planning.

d. Reviewing the impact of programs, regulations, and health care resource policies on the delivery of and access to minority and multicultural health services.

2006 Acts, ch 1184, §76; 2010 Acts, ch 1192, §77

[T] Section stricken and rewritten

135.13 Transferred to § 135.107.

135.14 State public health dental director — duties.

1. The position of state public health dental director is established within the department.

2. The dental director shall perform all of the following duties:

a. Plan and direct all work activities of the statewide public health dental program.

b. Develop comprehensive dental initiatives for prevention activities.

c. Evaluate the effectiveness of the statewide public health dental program and of program personnel.

d. Manage the oral health bureau including direction, supervision, and fiscal management of bureau staff.

e. Other related work as required.

2007 Acts, ch 159, §13

135.15 Oral health bureau established — responsibilities.

An oral health bureau is established within the division of health promotion and chronic disease prevention of the department. The bureau shall be responsible for all of the following:

1. Providing population-based oral health services, including public health training,

improvement of dental support systems for families, technical assistance, awareness-building activities, and educational services, at the state and local level to assist Iowans in maintaining optimal oral health throughout all stages of life.

2. Performing infrastructure building and enabling services through the administration of state and federal grant programs targeting access improvement, prevention, and local oral health programs utilizing maternal and child health programs, Medicaid, and other new or existing programs.

3. Leveraging federal, state, and local resources for programs under the purview of the bureau.

4. Facilitating ongoing strategic planning and application of evidence-based research in oral health care policy development that improves oral health care access and the overall oral health of all Iowans.

5. Developing and implementing an ongoing oral health surveillance system for the evaluation and monitoring of the oral health status of children and other underserved populations.

2007 Acts, ch 159, §14

135.16 Special women, infants, and children supplemental food program — methamphetamine education.

As a component of the federal funding received by the department as the administering agency for the special women, infants, and children supplemental food program, from the United States department of agriculture, food and consumer service, the department shall incorporate a methamphetamine education program into its nutrition and health-related education services. The department shall be responsible for the development of the education program to be delivered, and for the selection of qualified contract agencies to deliver the instruction under the program.

99 Acts, ch 195, §8

135.17 Dental screening of children.

1. a. Except as provided in paragraphs “c” and “d”, the parent or guardian of a child enrolled in elementary school shall provide evidence to the school district or accredited nonpublic elementary school in which the child is enrolled of the child having, no earlier than three years of age but no later than four months after enrollment, at a minimum, a dental screening performed by a licensed physician, a licensed nurse, a licensed physician assistant, or a licensed dental hygienist or dentist. Except as provided in paragraphs “c” and “d”, the parent or guardian of a child enrolled in high school shall provide evidence to the school district or accredited nonpublic high school in which the child is enrolled of the child having, at a minimum, a dental screening performed no earlier than one year prior to enrollment and not later than four months after enrollment by a licensed dental hygienist or dentist. A school district or accredited nonpublic school shall provide access to a process to complete the screenings described in this paragraph as appropriate.

b. A person authorized to perform a dental screening required by this section shall record that the screening was completed, and such additional information required by the department, on uniform forms developed by the department in cooperation with the department of education. The form shall include a space for the person to summarize any condition that may indicate a need for special services.

c. The department shall specify the procedures that constitute a dental screening and authorize a waiver signed by a licensed physician, nurse, physician assistant, dental hygienist, or dentist for a person who is unduly burdened by the screening requirement.

d. The dental screening requirement shall not apply to a person who submits an affidavit signed by the person or, if the person is a minor, the person’s parent or legal guardian, stating that the dental screening conflicts with a genuine and sincere religious belief.

2. Each public and nonpublic school shall, in collaboration with the department, do the following:

a. Ensure that the parent or guardian of a student enrolled in the school has complied with the requirements of subsection 1.

b. Provide, if a student has not had a dental screening performed in accordance with subsection 1, the parent or guardian of the student with community dental screening referral resources, including contact information for the i-smile coordinator, department, or dental society.

3. By May 31 annually, each local board shall furnish the department with evidence that each student enrolled in any public or nonpublic school within the local board's jurisdiction has met the dental screening requirement in this section.

4. The department shall adopt rules to administer this section.

2007 Acts, ch 146, §1, 2; 2008 Acts, ch 1020, §1 – 3; 2009 Acts, ch 41, §39; 2009 Acts, ch 133, §31; 2010 Acts, ch 1088, §2, 3

[P] Dental clinics, see §280.7

[P] See also §135.105D, 139A.8, 299.4, 299.5, and 299.24

[T] Subsection 1, paragraphs a and b amended

[T] Subsection 3 amended

135.18 Conflicting statutes.

Provisions of this chapter in conflict with the state building code, as adopted pursuant to section 103A.7, shall not apply where the state building code has been adopted or when the state building code applies throughout the state.

[C73, 75, 77, 79, 81, §135.18]

2004 Acts, ch 1086, §33

135.19 Viral hepatitis program — awareness, vaccinations, and testing.

1. If sufficient funds are appropriated by the general assembly, the department shall establish and administer a viral hepatitis program. The goal of the program shall be to distribute information to citizens of this state who are at an increased risk for exposure to viral hepatitis regarding the higher incidence of hepatitis C exposure and infection among these populations, the dangers presented by the disease, and contacts for additional information and referrals. The program shall also make available hepatitis A and hepatitis B vaccinations, and hepatitis C testing.

2. The department shall establish by rule a list of individuals by category who are at increased risk for viral hepatitis exposure. The list shall be consistent with recommendations developed by the centers for disease control, and shall be developed in consultation with the Iowa viral hepatitis task force and the Iowa department of veterans affairs. The department shall also establish by rule what information is to be distributed and the form and manner of distribution. The rules shall also establish a vaccination and testing program, to be coordinated by the department through local health departments and clinics and other appropriate locations.

2006 Acts, ch 1045, §1; 2009 Acts, ch 182, §88

135.20 Hepatitis C awareness program — veterans — vaccinations. Repealed by 2009 Acts, ch 182, § 89.

135.21 Pay toilets.

No person shall make a charge or require any special device, key or slug for the use of a toilet located in a room provided for use of the public. Violation of this section is a simple misdemeanor.

[C24, 27, 31, 35, 39, §2839; C46, 50, 54, 58, 62, 66, 71, 73, 75, §170.34; C77, §732.25; C79, 81, §135.21]

135.22 Central registry for brain or spinal cord injuries.

1. As used in this section:

a. “*Brain injury*” means the occurrence of injury to the head not primarily related to a degenerative disease or aging process that is documented in a medical record with one or more of the following conditions attributed to the head injury:

(1) An observed or self-reported decreased level of consciousness.

(2) Amnesia.

- (3) A skull fracture.
- (4) An objective neurological or neuropsychological abnormality.
- (5) A diagnosed intracranial lesion.

b. “*Spinal cord injury*” means the occurrence of an acute traumatic lesion of neural elements in the spinal cord including the spinal cord and cauda equina, resulting in temporary or permanent sensory deficit, motor deficit, or bladder or bowel dysfunction.

2. The director shall establish and maintain a central registry of persons with brain or spinal cord injuries in order to facilitate prevention strategies and the provision of appropriate rehabilitative services to the persons by the department and other state agencies. Hospitals shall report patients who are admitted with a brain or spinal cord injury and their diagnoses to the director no later than forty-five days after the close of a quarter in which the patient was discharged. The report shall contain the name, age, and residence of the person, the date, type, and cause of the brain or spinal cord injury, and additional information as the director requires, except that where available, hospitals shall report the Glasgow coma scale. The director shall consult with health care providers concerning the availability of additional relevant information. The department shall maintain the confidentiality of all information which would identify any person named in a report. However, the identifying information may be released for bona fide research purposes if the confidentiality of the identifying information is maintained by the researchers, or the identifying information may be released by the person with the brain or spinal cord injury or by the person’s guardian or, if the person is a minor, by the person’s parent or guardian.

89 Acts, ch 320, §10; 92 Acts, ch 1237, §6; 94 Acts, ch 1068, §3; 99 Acts, ch 141, §3

135.22A Advisory council on brain injuries.

1. For purposes of this section, unless the context otherwise requires:
 - a. “*Brain injury*” means a brain injury as defined in section 135.22.
 - b. “*Council*” means the advisory council on brain injuries.
2. The advisory council on brain injuries is established. The following persons or their designees shall serve as ex officio, nonvoting members of the council:
 - a. The director of public health.
 - b. The director of human services and any division administrators of the department of human services so assigned by the director.
 - c. The director of the department of education.
 - d. The chief of the special education bureau of the department of education.
 - e. The administrator of the division of vocational rehabilitation services of the department of education.
 - f. The director of the department for the blind.
 - g. The commissioner of insurance.
3. The council shall be composed of a minimum of nine members appointed by the governor in addition to the ex officio members, and the governor may appoint additional members. Insofar as practicable, the council shall include persons with brain injuries; family members of persons with brain injuries; representatives of industry, labor, business, and agriculture; representatives of federal, state, and local government; and representatives of religious, charitable, fraternal, civic, educational, medical, legal, veteran, welfare, and other professional groups and organizations. Members shall be appointed representing every geographic and employment area of the state and shall include members of both sexes. A simple majority of the members appointed by the governor shall constitute a quorum.
4. Members of the council appointed by the governor shall be appointed for terms of two years. Vacancies on the council shall be filled for the remainder of the term of the original appointment. Members whose terms expire may be reappointed.
5. The voting members of the council shall appoint a chairperson and a vice chairperson and other officers as the council deems necessary. The officers shall serve until their successors are appointed and qualified. Members of the council shall receive actual expenses for their services. Members may also be eligible to receive compensation as provided in section 7E.6. The council shall adopt rules pursuant to chapter 17A.
6. The council shall do all of the following:

a. Promote meetings and programs for the discussion of methods to reduce the debilitating effects of brain injuries, and disseminate information in cooperation with any other department, agency, or entity on the prevention, evaluation, care, treatment, and rehabilitation of persons affected by brain injuries.

b. Study and review current prevention, evaluation, care, treatment, and rehabilitation technologies and recommend appropriate preparation, training, retraining, and distribution of personnel and resources in the provision of services to persons with brain injuries through private and public residential facilities, day programs, and other specialized services.

c. Participate in developing and disseminating criteria and standards which may be required for future funding or licensing of facilities, day programs, and other specialized services for persons with brain injuries in this state.

d. Make recommendations to the governor for developing and administering a state plan to provide services for persons with brain injuries.

e. Meet at least quarterly.

7. The department is designated as Iowa's lead agency for brain injury. For the purposes of this section, the designation of lead agency authorizes the department to perform or oversee the performance of those functions specified in subsection 6, paragraphs "a" through "c". The council is assigned to the department for administrative purposes. The director shall be responsible for budgeting, program coordination, and related management functions.

8. The council may receive gifts, grants, or donations made for any of the purposes of its programs and disburse and administer them in accordance with their terms and under the direction of the director.

92 Acts, ch 1237, §7; 94 Acts, ch 1068, §4; 94 Acts, ch 1109, §2; 97 Acts, ch 203, §13; 99 Acts, ch 141, §4; 2000 Acts, ch 1058, §15; 2005 Acts, ch 89, §4; 2006 Acts, ch 1184, §77

[P] For definition of "brain injury" for purposes of recognition as a disability, see also §225C.23

135.22B Brain injury services program.

1. *Definitions.* For the purposes of this section:

a. "*Brain injury services waiver*" means the state's medical assistance home and community-based services waiver for persons with brain injury implemented under chapter 249A.

b. "*Program administrator*" means the division of the department designated to administer the brain injury services program in accordance with subsection 2.

2. *Program created.*

a. A brain injury services program is created and shall be administered by a division of the Iowa department of public health in cooperation with counties and the department of human services.

b. The division of the department assigned to administer the advisory council on brain injuries under section 135.22A shall be the program administrator. The division duties shall include but are not limited to serving as the fiscal agent and contract administrator for the program and providing program oversight.

c. The division shall consult with the advisory council on brain injuries, established pursuant to section 135.22A, regarding the program and shall report to the council concerning the program at least quarterly. The council shall make recommendations to the department concerning the program's operation.

3. *Purpose.* The purpose of the brain injury services program is to provide services, service funding, or other support for persons with a brain injury under the cost-share program component or other components established pursuant to this section. Implementation of the cost-share component or any other component of the program is subject to the funding made available for the program.

4. *General requirements — cost-share component.* The cost-share component of the brain injury services program shall be directed to persons who have been determined to be ineligible for the brain injury services waiver or persons who are eligible for the waiver but funding was not authorized or available to provide waiver eligibility for the persons. The cost-share component is subject to general requirements which shall include but are not limited to all of the following:

a. Services offered are consistent with the services offered through the brain injury services waiver.

b. Each service consumer has a service plan developed prior to service implementation and the service plan is reviewed and updated at least quarterly.

c. All other funding sources for which the service consumer is eligible are utilized to the greatest extent possible. The funding sources potentially available include but are not limited to community resources and public and private benefit programs.

d. The maximum monthly cost of the services provided shall be based on the maximum monthly amount authorized for the brain injury services waiver.

e. Assistance under the cost-share component shall be made available to a designated number of service consumers who are eligible, as determined from the funding available for the cost-share component, on a first-come, first-served basis.

f. Nothing in this section shall be construed or is intended as, or shall imply, a grant of entitlement to services to persons who are eligible for participation in the cost-share component based upon the eligibility provisions adopted consistent with the requirements of this section. Any obligation to provide services pursuant to this section is limited to the extent of the funds appropriated or provided for the cost-share component.

5. *Cost-share component eligibility.* An individual must meet all of the following requirements in order to be eligible for the cost-share component of the brain injury services program:

a. The individual is age one month through sixty-four years.

b. The individual has a diagnosis of brain injury that meets the diagnosis eligibility criteria for the brain injury services waiver.

c. The individual is a resident of this state and either a United States citizen or a qualified alien as defined in 8 U.S.C. § 1641.

d. The individual meets the cost-share component's financial eligibility requirements and is willing to pay a cost-share for the cost-share component.

e. The individual does not receive services or funding under any type of medical assistance home and community-based services waiver.

6. *Cost-share requirements.*

a. The cost-share component's financial eligibility requirements shall be established in administrative rule. In establishing the requirements, the department shall consider the eligibility and cost-share requirements used for the hawk-i program under chapter 514I.

b. An individual's cost-share responsibility for services under the cost-share component shall be determined on a sliding scale based upon the individual's family income. An individual's cost-share shall be assessed as a copayment, which shall not exceed thirty percent of the cost payable for the service.

c. The service provider shall bill the department for the portion of the cost payable for the service that is not covered by the individual's copayment responsibility.

7. *Application process.*

a. The application materials for services under the cost-share component of the brain injury services program shall use the application form and other materials of the brain injury services waiver. In order to apply for the brain injury services program, the applicant must authorize the department of human services to provide the applicant's waiver application materials to the brain injury services program. The application materials provided shall include but are not limited to the waiver application and any denial letter, financial assessment, and functional assessment regarding the person.

b. If a functional assessment for the waiver has not been completed due to a person's financial ineligibility for the waiver, the brain injury services program may provide for a functional assessment to determine the person's needs by reimbursing the department of human services for the assessment.

c. The program administrator shall file copies of the individual's application and needs assessment with the program resource facilitator assigned to the individual's geographic area.

d. The department's program administrator shall make a final determination as to whether program funding will be authorized under the cost-share component.

8. *Service providers and reimbursement.* All of the following requirements apply

to service providers and reimbursement rates payable for services under the cost-share component:

a. A service provider must either be certified to provide services under the brain injury services waiver or have a contract with a county to provide services and will become certified to provide services under such waiver within a reasonable period of time specified in rule.

b. The reimbursement rate payable for the cost of a service provided under the cost-share component is the rate payable under the medical assistance program. However, if the service provided does not have a medical assistance program reimbursement rate, the rate shall be the amount payable under the county contract.

9. *Resource facilitation.* The program shall utilize resource facilitators to facilitate program services. The resource facilitator shall be available to provide ongoing support for individuals with brain injury in coping with the issues of living with a brain injury and in assisting such individuals in transitioning back to employment and living in the community. The resource facilitator is intended to provide a linkage to existing services and increase the capacity of the state's providers of services to persons with brain injury by doing all of the following:

a. Providing brain injury-specific information, support, and resources.

b. Enhancing the usage of support commonly available to an individual with brain injury from the community, family, and personal contacts and linking such individuals to appropriate services and community resources.

c. Training service providers to provide appropriate brain injury services.

d. Accessing, securing, and maximizing the private and public funding available to support an individual with a brain injury.

2006 Acts, ch 1114, §1; 2007 Acts, ch 126, §35; 2008 Acts, ch 1058, §3; 2008 Acts, ch 1187, §106 – 108

135.23 Repealed by 90 Acts, ch 1174, § 2.

135.24 Volunteer health care provider program established — immunity from civil liability.

1. The director shall establish within the department a program to provide to eligible hospitals, clinics, free clinics, field dental clinics, specialty health care provider offices, or other health care facilities, health care referral programs, or charitable organizations, free medical, dental, chiropractic, pharmaceutical, nursing, optometric, psychological, social work, behavioral science, podiatric, physical therapy, occupational therapy, respiratory therapy, and emergency medical care services given on a voluntary basis by health care providers. A participating health care provider shall register with the department and obtain from the department a list of eligible, participating hospitals, clinics, free clinics, field dental clinics, specialty health care provider offices, or other health care facilities, health care referral programs, or charitable organizations.

2. The department, in consultation with the department of human services, shall adopt rules to implement the volunteer health care provider program which shall include the following:

a. Procedures for registration of health care providers deemed qualified by the board of medicine, the board of physician assistants, the dental board, the board of nursing, the board of chiropractic, the board of psychology, the board of social work, the board of behavioral science, the board of pharmacy, the board of optometry, the board of podiatry, the board of physical and occupational therapy, the board of respiratory care, and the Iowa department of public health, as applicable.

b. Procedures for registration of free clinics, field dental clinics, and specialty health care provider offices.

c. Criteria for and identification of hospitals, clinics, free clinics, field dental clinics, specialty health care provider offices, or other health care facilities, health care referral programs, or charitable organizations, eligible to participate in the provision of free medical, dental, chiropractic, pharmaceutical, nursing, optometric, psychological, social work, behavioral science, podiatric, physical therapy, occupational therapy, respiratory therapy,

or emergency medical care services through the volunteer health care provider program. A free clinic, a field dental clinic, a specialty health care provider office, a health care facility, a health care referral program, a charitable organization, or a health care provider participating in the program shall not bill or charge a patient for any health care provider service provided under the volunteer health care provider program.

d. Identification of the services to be provided under the program. The services provided may include but shall not be limited to obstetrical and gynecological medical services, psychiatric services provided by a physician licensed under chapter 148, dental services provided under chapter 153, or other services provided under chapter 147A, 148A, 148B, 148C, 149, 151, 152, 152B, 152E, 154, 154B, 154C, 154D, 154F, or 155A.

3. A health care provider providing free care under this section shall be considered an employee of the state under chapter 669, shall be afforded protection as an employee of the state under section 669.21, and shall not be subject to payment of claims arising out of the free care provided under this section through the health care provider's own professional liability insurance coverage, provided that the health care provider has done all of the following:

a. Registered with the department pursuant to subsection 1.

b. Provided medical, dental, chiropractic, pharmaceutical, nursing, optometric, psychological, social work, behavioral science, podiatric, physical therapy, occupational therapy, respiratory therapy, or emergency medical care services through a hospital, clinic, free clinic, field dental clinic, specialty health care provider office, or other health care facility, health care referral program, or charitable organization listed as eligible and participating by the department pursuant to subsection 1.

4. A free clinic providing free care under this section shall be considered a state agency solely for the purposes of this section and chapter 669 and shall be afforded protection under chapter 669 as a state agency for all claims arising from the provision of free care by a health care provider registered under subsection 3 who is providing services at the free clinic in accordance with this section or from the provision of free care by a health care provider who is covered by adequate medical malpractice insurance as determined by the department, if the free clinic has registered with the department pursuant to subsection 1.

5. A field dental clinic providing free care under this section shall be considered a state agency solely for the purposes of this section and chapter 669 and shall be afforded protection under chapter 669 as a state agency for all claims arising from the provision of free care by a health care provider registered under subsection 3 who is providing services at the field dental clinic in accordance with this section or from the provision of free care by a health care provider who is covered by adequate medical malpractice insurance, as determined by the department, if the field dental clinic has registered with the department pursuant to subsection 1.

6. A specialty health care provider office providing free care under this section shall be considered a state agency solely for the purposes of this section and chapter 669 and shall be afforded protection under chapter 669 as a state agency for all claims arising from the provision of free care by a health care provider registered under subsection 3 who is providing services at the specialty health care provider office in accordance with this section or from the provision of free care by a health care provider who is covered by adequate medical malpractice insurance, as determined by the department, if the specialty health care provider office has registered with the department pursuant to subsection 1.

7. For the purposes of this section:

a. "*Charitable organization*" means a charitable organization within the meaning of section 501(c)(3) of the Internal Revenue Code.

b. "*Field dental clinic*" means a dental clinic temporarily or periodically erected at a location utilizing mobile dental equipment, instruments, or supplies, as necessary, to provide dental services.

c. "*Free clinic*" means a facility, other than a hospital or health care provider's office which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code and which has as its sole purpose the provision of health care services without charge to individuals who are otherwise unable to pay for the services.

d. "*Health care provider*" means a physician licensed under chapter 148, a chiropractor

licensed under chapter 151, a physical therapist licensed pursuant to chapter 148A, an occupational therapist licensed pursuant to chapter 148B, a podiatrist licensed pursuant to chapter 149, a physician assistant licensed and practicing under a supervising physician pursuant to chapter 148C, a licensed practical nurse, a registered nurse, or an advanced registered nurse practitioner licensed pursuant to chapter 152 or 152E, a respiratory therapist licensed pursuant to chapter 152B, a dentist, dental hygienist, or dental assistant registered or licensed to practice under chapter 153, an optometrist licensed pursuant to chapter 154, a psychologist licensed pursuant to chapter 154B, a social worker licensed pursuant to chapter 154C, a mental health counselor or a marital and family therapist licensed pursuant to chapter 154D, a speech pathologist or audiologist licensed pursuant to chapter 154F, a pharmacist licensed pursuant to chapter 155A, or an emergency medical care provider certified pursuant to chapter 147A.

e. “*Specialty health care provider office*” means the private office or clinic of an individual specialty health care provider or group of specialty health care providers as referred by the Iowa collaborative safety net provider network established in section 135.153, but does not include a field dental clinic, a free clinic, or a hospital.

93 Acts, ch 65, §1; 95 Acts, ch 121, §1; 98 Acts, ch 1027, §1 – 6; 2001 Acts, ch 176, §31; 2002 Acts, ch 1108, §8; 2003 Acts, ch 89, §1; 2005 Acts, ch 118, §1 – 6; 2007 Acts, ch 10, §20; 2007 Acts, ch 95, §1; 2007 Acts, ch 159, §18; 2007 Acts, ch 218, §101, 193; 2008 Acts, ch 1088, §84, 85; 2009 Acts, ch 118, §43; 2009 Acts, ch 133, §32

135.25 Emergency medical services fund.

An emergency medical services fund is created in the state treasury under the control of the department. The fund includes, but is not limited to, amounts appropriated by the general assembly, and other moneys available from federal or private sources which are to be used for purposes of this section. Funds remaining in the fund at the end of each fiscal year shall not revert to the general fund of the state but shall remain in the emergency medical services fund, notwithstanding section 8.33. The fund is established to assist counties by matching, on a dollar-for-dollar basis, moneys spent by a county for the acquisition of equipment for the provision of emergency medical services and by providing grants to counties for education and training in the delivery of emergency medical services, as provided in this section and section 422D.6. A county seeking matching funds under this section shall apply to the emergency medical services division of the department. The department shall adopt rules concerning the application and awarding process for the matching funds and the criteria for the allocation of moneys in the fund if the moneys are insufficient to meet the emergency medical services needs of the counties. Moneys allocated by the department to a county for emergency medical services purposes may be used for equipment or training and education as determined by the board of supervisors pursuant to section 422D.6.

93 Acts, ch 58, §1; 2000 Acts, ch 1043, §1

135.26 Automated external defibrillator grant program.

The department shall establish and implement an automated external defibrillator grant program which provides matching funds to local boards of health, community organizations, or cities for the program after standards and requirements for the utilization of automated external defibrillator equipment, and training on the use of such equipment, are developed at the local level. The objective of the program shall be to enhance the emergency response system in rural areas of the state where access to health care providers is often limited by providing increased access to automated external defibrillator equipment by rural emergency and community personnel. A local board of health, community organization, or city may submit an application to the department for review. The department shall establish criteria for the review and approval of grant applications by rule, and may accept gifts, grants, bequests, and other private contributions, as well as state or federal funds, for purposes of the program. The amount of a grant shall not exceed fifty percent of the cost of the automated external defibrillator equipment to be distributed to the applicant and the training program to be administered by the applicant at the local level. Each application shall include information demonstrating that the applicant will provide matching funds of fifty percent of the cost of

the program. Grant recipients shall submit an annual report to the department indicating automated external defibrillator equipment usage levels, patient outcomes, and number of individuals trained. For the purposes of this section, “rural” means a geographic area outside an urban or suburban setting with a population of less than fifty thousand persons.

2004 Acts, ch 1034, §1, 2; 2006 Acts, ch 1181, §7

135.27 Iowa healthy communities initiative — grant program.

1. *Program goals.* The department shall establish a grant program to energize local communities to transform the existing culture into a culture that promotes healthy lifestyles and leads collectively, community by community, to a healthier state. The grant program shall expand an existing healthy communities initiative to assist local boards of health, in collaboration with existing community resources, to build community capacity in addressing the prevention of chronic disease that results from risk factors including overweight and obesity conditions.

2. *Distribution of grants.* The department shall distribute the grants on a competitive basis and shall support the grantee communities in planning and developing wellness strategies and establishing methodologies to sustain the strategies. Grant criteria shall be consistent with the existing statewide initiative between the department and the department’s partners that promotes increased opportunities for physical activity and healthy eating for Iowans of all ages, or its successor, and the statewide comprehensive plan developed by the existing statewide initiative to increase physical activity, improve nutrition, and promote healthy behaviors. Grantees shall demonstrate an ability to maximize local, state, and federal resources effectively and efficiently.

3. *Departmental support.* The department shall provide support to grantees including capacity-building strategies, technical assistance, consultation, and ongoing evaluation.

4. *Eligibility.* Local boards of health representing a coalition of health care providers and community and private organizations are eligible to submit applications.

2006 Acts, ch 1006, §1, 2; 2008 Acts, ch 1188, §60

135.27A Governor’s council on physical fitness and nutrition.

1. A governor’s council on physical fitness and nutrition is established consisting of twelve members appointed by the governor who have expertise in physical activity, physical fitness, nutrition, and promoting healthy behaviors. At least one member shall be a representative of elementary and secondary physical education professionals, at least one member shall be a health care professional, at least one member shall be a registered dietician, at least one member shall be recommended by the department on aging, and at least one member shall be an active nutrition or fitness professional. In addition, at least one member shall be a member of a racial or ethnic minority. The governor shall select a chairperson for the council. Members shall serve terms of three years beginning and ending as provided in section 69.19. Appointments are subject to sections 69.16 and 69.16A. Members are entitled to receive reimbursement for actual expenses incurred while engaged in the performance of official duties. A member of the council may also be eligible to receive compensation as provided in section 7E.6.

2. The council shall assist in developing a strategy for implementation of the statewide comprehensive plan developed by the existing statewide initiative to increase physical activity, improve physical fitness, improve nutrition, and promote healthy behaviors. The strategy shall include specific components relating to specific populations and settings including early childhood, educational, local community, worksite wellness, health care, and older Iowans. The initial draft of the implementation plan shall be submitted to the governor and the general assembly by December 1, 2008.

3. The council shall assist the department in establishing and promoting a best practices internet site. The internet site shall provide examples of wellness best practices for individuals, communities, workplaces, and schools and shall include successful examples of both evidence-based and nonscientific programs as a resource.

4. The council shall provide oversight for the governor’s physical fitness challenge. The governor’s physical fitness challenge shall be administered by the department and shall

provide for the establishment of partnerships with communities or school districts to offer the physical fitness challenge curriculum to elementary and secondary school students. The council shall develop the curriculum, including benchmarks and rewards, for advancing the school wellness policy through the challenge.

2008 Acts, ch 1188, §61; 2009 Acts, ch 23, §8

135.28 State substitute medical decision-making board. Repealed by 2010 Acts, ch 1031, § 399.

135.29 Local substitute medical decision-making board.

1. Each county in this state may establish and fund a local substitute medical decision-making board. The local substitute medical decision-making board shall be comprised of medical professionals and lay persons appointed pursuant to the rules adopted by the department.

2. Pursuant to rules adopted by the department, the local substitute medical decision-making board may act as a substitute decision maker for patients incapable of making their own medical care decisions if no other substitute decision maker is available to act. The local substitute medical decision-making board may exercise decision-making authority in situations where there is sufficient time to review the patient's condition, and a reasonably prudent person would consider a decision to be medically necessary. Such medically necessary decisions shall constitute good cause for subsequently filing a petition in the district court for appointment of a guardian pursuant to chapter 633, but the local substitute medical decision-making board shall continue to act in the patient's best interests until a guardian is appointed. Notwithstanding any other provision to the contrary regarding confidentiality of medical records, the local substitute decision-making board may issue subpoenas relating to the production of medical records of a patient under the board's review. A person participating in good faith in releasing medical record information in response to a board subpoena is immune from any liability, civil or criminal, which might otherwise be incurred or imposed.

3. The local substitute medical decision-making board and its members shall not be held liable, jointly or severally, for any actions or omissions taken or made in the official discharge of their duties, except those acts or omissions constituting willful or wanton misconduct. A physician or other health care provider who acts on a decision or directive of the local substitute medical decision-making board shall not be held liable for any damages resulting from that act, unless such physician's or other health care provider's actions or omissions constitute negligence in the practice of the profession or occupation, or willful or wanton misconduct.

89 Acts, ch 178, §3; 90 Acts, ch 1026, §2; 93 Acts, ch 139, §3; 2010 Acts, ch 1031, §395

[T] Subsection 3 amended

DIVISION II

MISCELLANEOUS PROVISIONS

135.30 Protective eyeglasses — safety provisions. Repealed by 2009 Acts, ch 56, § 12.

135.30A Breast-feeding in public places.

Notwithstanding any other provision of law to the contrary, a woman may breast-feed the woman's own child in any public place where the woman's presence is otherwise authorized.

2000 Acts, ch 1140, §21

135.31 Location of boards — rulemaking.

The offices for the board of medicine, the board of pharmacy, the board of nursing, and the dental board shall be located within the department of public health. The individual boards shall have policymaking and rulemaking authority.

86 Acts, ch 1245, §1107; 2005 Acts, ch 3, §30; 2007 Acts, ch 10, §21; 2007 Acts, ch 218, §194

135.32 Publication and distribution.

The department shall publish from time to time a sufficient number of its rules to supply the needs of the several counties. The county auditor shall annually forward to the department a certified list of the names and addresses of the clerks of all the local boards of health in the auditor's county. Upon receipt of said list the department shall forward to the local boards sufficient copies for distribution in each county; and the clerk of the local board shall upon request furnish a copy of said rules to any resident, physician, or citizen.

[S13, §2571-b; C24, 27, 31, 35, 39, §2211; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.32]

135.33 Refusal of board to enforce rules.

If any local board shall fail to enforce the rules of the state department or carry out its lawful directions, the department may enforce the same within the territorial jurisdiction of such local board, and for that purpose it may exercise all of the powers given by statute to the local board, and may employ the necessary assistants to carry out its lawful directions.

[C97, §2572; S13, §2569-a, 2572; C24, 27, 31, 35, 39, §2212; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.33]

[P] Powers of local board, chapter 137

135.34 Expenses for enforcing rules.

All expenses incurred by the state department in determining whether its rules are enforced by a local board, and in enforcing the same when a local board has failed to do so, shall be paid in the same manner as the expenses of enforcing such rules when enforced by the local board.

[S13, §2572; C24, 27, 31, 35, 39, §2213; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.34]

135.35 Duty of peace officers.

All peace officers of the state when called upon by the department shall enforce its rules and execute the lawful orders of the department within their respective jurisdictions.

[C97, §2572; S13, §2572; C24, 27, 31, 35, 39, §2214; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.35]

135.36 Interference with health officer — penalties.

Any person resisting or interfering with the department, its employees, or authorized agents, in the discharge of any duty imposed by law shall be guilty of a simple misdemeanor.

[C24, 27, 31, 35, 39, §2215; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.36]

135.37 Tattooing — permit requirement — penalty.

1. A person shall not own, control and lease, act as an agent for, conduct, manage, or operate an establishment to practice the art of tattooing or engage in the practice of tattooing without first applying for and receiving a permit from the Iowa department of public health.

2. A minor shall not obtain a tattoo and a person shall not provide a tattoo to a minor. For the purposes of this section, "minor" means an unmarried person who is under the age of eighteen years.

3. A person who fails to meet the requirements of subsection 1 or a person providing a tattoo to a minor is guilty of a serious misdemeanor.

4. The Iowa department of public health shall:

a. Adopt rules pursuant to chapter 17A and establish and collect all fees necessary to administer this section. The provisions of chapter 17A, including licensing provisions, judicial review, and appeal, shall apply to this chapter.

b. Establish minimum safety and sanitation criteria for the operation of tattooing establishments.

5. If the Iowa department of public health determines that a provision of this section has been or is being violated, the department may order that a tattooing establishment not be operated until the necessary corrective action has been taken. If the establishment continues to be operated in violation of the order of the department, the department may request that the county attorney or the attorney general make an application in the name of the state to the district court of the county in which the violations have occurred for an order to enjoin the violations. This remedy is in addition to any other legal remedy available to the department.

6. As necessary to avoid duplication and promote coordination of public health inspection and enforcement activities, the department may enter into agreements with local boards of health to provide for inspection of tattooing establishments and enforcement activities in accordance with the rules and criteria implemented under this section.

89 Acts, ch 154, §1; 2008 Acts, ch 1058, §4; 2009 Acts, ch 133, §33

135.38 Penalty.

Any person who knowingly violates any provision of this chapter, or of the rules of the department, or any lawful order, written or oral, of the department or of its officers, or authorized agents, shall be guilty of a simple misdemeanor.

[C73, §419; C97, §2573; S13, §2575-a6; C24, 27, 31, 35, 39, §2217; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.38]

135.39 Federal aid.

The state department of public health is hereby authorized to accept financial aid from the government of the United States for the purpose of assisting in carrying on public health or substance abuse responsibility in the state of Iowa.

[C31, 35, §2217-c1; C39, §2217.1; C46, 50, 54, 58, 62, 66, 71, 73, 75, 77, 79, 81, §135.39]
86 Acts, ch 1245, §1108

135.39A Gifts and grants fund — appropriation.

The department is authorized to accept gifts, grants, or allotments of funds from any source to be used for programs authorized by this chapter or any other chapter which the department is responsible for administering. A public health gifts and grants fund is created as a separate fund in the state treasury under the control of the department. The fund shall consist of gift or grant moneys obtained from any source, including the federal government. The moneys collected under this section and deposited in the fund are appropriated to the department for the public health purposes specified in the gift or grant. Moneys in the fund shall not be subject to appropriation or expenditure for any other purpose. Notwithstanding section 8.33, moneys in the public health gifts and grants fund at the end of each fiscal year shall not revert to any other fund but shall remain in the public health gifts and grants fund for expenditure for subsequent fiscal years.

2004 Acts, ch 1168, §1

135.39B Early childhood immunizations — content.

1. Beginning January 1, 2006, early childhood immunizations administered in this state shall not contain more than trace amounts of mercury.

2. For the purposes of this section:

a. “*Early childhood immunizations*” means immunizations administered to children under eight years of age, unless otherwise provided in this section.

b. “*Trace amounts*” means trace amounts as defined by the United States food and drug administration.

3. The prohibition under this section shall not apply to early childhood immunizations for influenza or in times of emergency or epidemic as determined by the director of public health. If an emergency or epidemic is determined to exist by the director of public health under this

subsection, the director of public health shall notify the state board of health, the governor, and the legislative council, and shall notify the public upon request.

2004 Acts, ch 1159, §1

135.39C Elderly wellness services — payor of last resort.

The department shall implement elderly wellness services in a manner that ensures that the services provided are not payable by a third-party source.

2005 Acts, ch 175, §76

DIVISION III

MORBIDITY AND MORTALITY STUDY

135.40 Collection and distribution of information.

Any person, hospital, sanatorium, nursing or rest home, or other organization may provide information, interviews, reports, statements, memoranda, or other data relating to the condition and treatment of any person to the department, the Iowa medical society or any of its allied medical societies, the Iowa osteopathic medical association, any in-hospital staff committee, or the Iowa healthcare collaborative, to be used in the course of any study for the purpose of reducing morbidity or mortality, and no liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization that has acted reasonably and in good faith, by reason of having provided such information or material, or by reason of having released or published the findings and conclusions of such groups to advance medical research and medical education, or by reason of having released or published generally a summary of such studies.

For the purposes of this section, and section 135.41, the “*Iowa healthcare collaborative*” means an organization which is exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code and which is established to provide direction to promote quality, safety, and value improvement collaborative efforts by hospitals and physicians.

[C66, 71, 73, 75, 77, 79, 81, §135.40]

2006 Acts, ch 1128, §1

135.41 Publication.

The department, the Iowa medical society or any of its allied medical societies, the Iowa osteopathic medical association, any in-hospital staff committee, or the Iowa healthcare collaborative shall use or publish said material only for the purpose of advancing medical research or medical education in the interest of reducing morbidity or mortality, except that a summary of such studies may be released by any such group for general publication. In all events the identity of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances. A violation of this section shall constitute a simple misdemeanor.

[C66, 71, 73, 75, 77, 79, 81, §135.41]

2006 Acts, ch 1128, §2

135.42 Unlawful use.

All information, interviews, reports, statements, memoranda, or other data furnished in accordance with this division and any findings or conclusions resulting from such studies shall not be used or offered or received in evidence in any legal proceedings of any kind or character, but nothing contained herein shall be construed as affecting the admissibility as evidence of the primary medical or hospital records pertaining to the patient or of any other writing, record or reproduction thereof not contemplated by this division.

[C66, 71, 73, 75, 77, 79, 81, §135.42]

DIVISION IV

IOWA CHILD DEATH REVIEW TEAM

135.43 Iowa child death review team established — duties.

1. An Iowa child death review team is established as part of the office of the state medical examiner. The office of the state medical examiner shall provide staffing and administrative support to the team.

2. The membership of the review team is subject to the provisions of sections 69.16 and 69.16A, relating to political affiliation and gender balance. Review team members who are not designated by another appointing authority shall be appointed by the state medical examiner. Membership terms shall be for three years. A membership vacancy shall be filled in the same manner as the original appointment. The review team shall elect a chairperson and other officers as deemed necessary by the review team. The review team shall meet upon the call of the state medical examiner or as determined by the review team. The members of the team are eligible for reimbursement of actual and necessary expenses incurred in the performance of their official duties. The review team shall include the following:

- a. The state medical examiner or the state medical examiner's designee.
 - b. A certified or licensed professional who is knowledgeable concerning sudden infant death syndrome.
 - c. A pediatrician who is knowledgeable concerning deaths of children.
 - d. A family practice physician who is knowledgeable concerning deaths of children.
 - e. One mental health professional who is knowledgeable concerning deaths of children.
 - f. One social worker who is knowledgeable concerning deaths of children.
 - g. A certified or licensed professional who is knowledgeable concerning domestic violence.
 - h. A professional who is knowledgeable concerning substance abuse.
 - i. A local law enforcement official.
 - j. A county attorney.
 - k. An emergency room nurse who is knowledgeable concerning the deaths of children.
 - l. A perinatal expert.
 - m. A representative of the health insurance industry.
 - n. One other appointed at large.
3. The review team shall perform the following duties:

a. Collect, review, and analyze child death certificates and child death data, including patient records or other pertinent confidential information concerning the deaths of children under age eighteen, and other information as the review team deems appropriate for use in preparing an annual report to the governor and the general assembly concerning the causes and manner of child deaths. The report shall include analysis of factual information obtained through review and recommendations regarding prevention of child deaths.

b. Recommend to the governor and the general assembly interventions to prevent deaths of children based on an analysis of the cause and manner of such deaths.

c. Recommend to the agencies represented on the review team changes which may prevent child deaths.

d. Except as authorized by this section, maintain the confidentiality of any patient records or other confidential information reviewed.

e. Recommend to the department of human services, appropriate law enforcement agencies, and any other person involved with child protection, interventions that may prevent harm to a child who is related to or is living in the same home as a child whose case is reviewed by the team.

f. If the sharing of information is necessary to assist in or initiate a child death investigation or criminal prosecution and the office or agency receiving the information does not otherwise have access to the information, share information possessed by the review team with the office of the attorney general, a county attorney's office, or an appropriate law enforcement agency. The office or agency receiving the information shall maintain the

confidentiality of the information in accordance with this section. Unauthorized release or disclosure of the information received is subject to penalty as provided in this section.

g. In order to assist a division of the department in performing the division's duties, if the division does not otherwise have access to the information, share information possessed by the review team. The division receiving the information shall maintain the confidentiality of the information in accordance with this section. Unauthorized release or disclosure of the information received is subject to penalty as provided in this section.

4. The review team shall develop protocols for a child fatality review committee, to be appointed by the state medical examiner on an ad hoc basis, to immediately review the child abuse assessments which involve the fatality of a child under age eighteen. The state medical examiner shall appoint a medical examiner, a pediatrician, and a person involved with law enforcement to the committee.

a. The purpose of the review shall be to determine whether the department of human services and others involved with the case of child abuse responded appropriately. The protocols shall provide for the committee to consult with any multidisciplinary team, as defined in section 235A.13, that is operating in the area in which the fatality occurred.

b. The committee shall have access to patient records and other pertinent confidential information and, subject to the restrictions in this subsection, may disseminate the confidential information in the committee's report.

c. Upon completion of the review, the committee shall issue a report which shall include findings concerning the case and recommendations for changes to prevent child fatalities when similar circumstances exist. The report shall include but is not limited to the following information, subject to the restrictions listed in paragraph "d":

(1) The dates, outcomes, and results of any actions taken by the department of human services and others in regard to each report and allegation of child abuse involving the child who died.

(2) The results of any review of the case performed by a multidisciplinary team, or by any other public entity that reviewed the case.

(3) Confirmation of the department of human services receipt of any report of child abuse involving the child, including confirmation as to whether or not any assessment involving the child was performed in accordance with section 232.71B, the results of any assessment, a description of the most recent assessment and the services offered to the family, the services rendered to the family, and the basis for the department's decisions concerning the case.

d. Prior to issuing the report, the committee shall consult with the county attorney responsible for prosecution of the alleged perpetrator of the child fatality. The committee's report shall include child abuse information associated with the case and the child, but is subject to the restrictions applicable to the department of human services for release of information concerning a child fatality or near fatality in accordance with section 235A.15, subsection 9.

e. Following the completion of the trial of any alleged perpetrator of the child fatality and the appeal period for the granting of a new trial, the committee shall issue a supplemental report containing the information that was withheld, in accordance with paragraph "d", so as not to jeopardize the prosecution or the rights of the alleged perpetrator to a fair trial as described in section 235A.15, subsection 9, paragraphs "e" and "f".

f. The report and any supplemental report shall be submitted to the governor and general assembly.

g. If deemed appropriate by the committee, at any point in the review the committee may recommend to the department of human services, appropriate law enforcement agencies, and any other person involved with child protection, interventions that may prevent harm to a child who is related to or is living in the same home as a child whose case is reviewed by the committee.

5. a. The following individuals shall designate a liaison to assist the review team in fulfilling its responsibilities:

- (1) The director of public health.
- (2) The director of human services.
- (3) The commissioner of public safety.

- (4) The attorney general.
- (5) The director of transportation.
- (6) The director of the department of education.

b. In addition, the chairperson of the review team shall designate a liaison from the public at large to assist the review team in fulfilling its responsibilities.

6. The review team may establish subcommittees to which the team may delegate some or all of the team's responsibilities under subsection 3.

7. a. The state medical examiner, the Iowa department of public health, and the department of human services shall adopt rules providing for disclosure of information which is confidential under chapter 22 or any other provision of state law, to the review team for purposes of performing its child death and child abuse review responsibilities.

b. A person in possession or control of medical, investigative, assessment, or other information pertaining to a child death and child abuse review shall allow the inspection and reproduction of the information by the office of the state medical examiner upon the request of the office, to be used only in the administration and for the duties of the Iowa child death review team. Except as provided for a report on a child fatality by an ad hoc child fatality review committee under subsection 4, information and records produced under this section which are confidential under section 22.7 and chapter 235A, and information or records received from the confidential records, remain confidential under this section. A person does not incur legal liability by reason of releasing information to the department or the office of the state medical examiner as required under and in compliance with this section.

8. Review team members and their agents are immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of any act, omission, proceeding, decision, or determination undertaken or performed, or recommendation made as a review team member or agent provided that the review team members or agents acted in good faith and without malice in carrying out their official duties in their official capacity. The state medical examiner shall adopt rules pursuant to chapter 17A to administer this subsection. A complainant bears the burden of proof in establishing malice or lack of good faith in an action brought against review team members involving the performance of their duties and powers under this section.

9. A person who releases or discloses confidential data, records, or any other type of information in violation of this section is guilty of a serious misdemeanor.

95 Acts, ch 147, §2; 97 Acts, ch 159, §3, 4; 2000 Acts, ch 1051, §1; 2000 Acts, ch 1137, §1 – 3, 14; 2002 Acts, ch 1119, §129, 130; 2005 Acts, ch 6, §1 – 3; 2005 Acts, ch 179, §118; 2007 Acts, ch 159, §19, 20; 2009 Acts, ch 182, §108 – 111; 2010 Acts, ch 1069, §14

[P] Legislative findings and purpose; 95 Acts, ch 147, §1

[SP] Continuing effectiveness of rules adopted by department of public health until replacement rules are adopted by state medical examiner; 2009 Acts, ch 182, §113

[T] Subsection 7, paragraph b amended

135.44 Repealed by 88 Acts, ch 1158, § 102.

DIVISION V RENAL DISEASES

135.45 through 135.48 Repealed by 2005 Acts, ch 89, § 39.

135.49 through 135.60 Reserved.

DIVISION VI HEALTH FACILITIES COUNCIL

135.61 Definitions.

As used in this division, unless the context otherwise requires:

1. “*Affected persons*” means, with respect to an application for a certificate of need:
 - a. The person submitting the application.
 - b. Consumers who would be served by the new institutional health service proposed in the application.
 - c. Each institutional health facility or health maintenance organization which is located in the geographic area which would appropriately be served by the new institutional health service proposed in the application. The appropriate geographic service area of each institutional health facility or health maintenance organization shall be determined on a uniform basis in accordance with criteria established in rules adopted by the department.
 - d. Each institutional health facility or health maintenance organization which, prior to receipt of the application by the department, has formally indicated to the department pursuant to this division an intent to furnish in the future institutional health services similar to the new institutional health service proposed in the application.
 - e. Any other person designated as an affected person by rules of the department.
 - f. Any payer or third-party payer for health services.
2. “*Birth center*” means a facility or institution, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur following a normal, uncomplicated, low-risk pregnancy.
3. “*Consumer*” means any individual whose occupation is other than health services, who has no fiduciary obligation to an institutional health facility, health maintenance organization or other facility primarily engaged in delivery of services provided by persons in health service occupations, and who has no material financial interest in the providing of any health services.
4. “*Council*” means the state health facilities council established by this division.
5. “*Department*” means the Iowa department of public health.
6. “*Develop*”, when used in connection with health services, means to undertake those activities which on their completion will result in the offer of a new institutional health service or the incurring of a financial obligation in relation to the offering of such a service.
7. “*Director*” means the director of public health, or the director’s designee.
8. “*Financial reporting*” means reporting by which hospitals and health care facilities shall respectively record their revenues, expenses, other income, other outlays, assets and liabilities, and units of services.
9. “*Health care facility*” means health care facility as defined in section 135C.1.
10. “*Health care provider*” means a person licensed or certified under chapter 147, 148, 148A, 148C, 149, 151, 152, 153, 154, 154B, 154F, or 155A to provide in this state professional health care service to an individual during that individual’s medical care, treatment, or confinement.
11. “*Health maintenance organization*” means health maintenance organization as defined in section 514B.1, subsection 6.
12. “*Health services*” means clinically related diagnostic, curative, or rehabilitative services, and includes alcoholism, drug abuse, and mental health services.
13. “*Hospital*” means hospital as defined in section 135B.1, subsection 3.
14. “*Institutional health facility*” means any of the following, without regard to whether the facilities referred to are publicly or privately owned or are organized for profit or not or whether the facilities are part of or sponsored by a health maintenance organization:
 - a. A hospital.
 - b. A health care facility.
 - c. An organized outpatient health facility.
 - d. An outpatient surgical facility.
 - e. A community mental health facility.
 - f. A birth center.
15. “*Institutional health service*” means any health service furnished in or through institutional health facilities or health maintenance organizations, including mobile health services.
16. “*Mobile health service*” means equipment used to provide a health service that can be transported from one delivery site to another.

17. “*Modernization*” means the alteration, repair, remodeling, replacement or renovation of existing buildings or of the equipment previously installed therein, or both.

18. “*New institutional health service*” or “*changed institutional health service*” means any of the following:

a. The construction, development or other establishment of a new institutional health facility regardless of ownership.

b. Relocation of an institutional health facility.

c. Any capital expenditure, lease, or donation by or on behalf of an institutional health facility in excess of one million five hundred thousand dollars within a twelve-month period.

d. A permanent change in the bed capacity, as determined by the department, of an institutional health facility. For purposes of this paragraph, a change is permanent if it is intended to be effective for one year or more.

e. Any expenditure in excess of five hundred thousand dollars by or on behalf of an institutional health facility for health services which are or will be offered in or through an institutional health facility at a specific time but which were not offered on a regular basis in or through that institutional health facility within the twelve-month period prior to that time.

f. The deletion of one or more health services, previously offered on a regular basis by an institutional health facility or health maintenance organization or the relocation of one or more health services from one physical facility to another.

g. Any acquisition by or on behalf of a health care provider or a group of health care providers of any piece of replacement equipment with a value in excess of one million five hundred thousand dollars, whether acquired by purchase, lease, or donation.

h. Any acquisition by or on behalf of a health care provider or group of health care providers of any piece of equipment with a value in excess of one million five hundred thousand dollars, whether acquired by purchase, lease, or donation, which results in the offering or development of a health service not previously provided. A mobile service provided on a contract basis is not considered to have been previously provided by a health care provider or group of health care providers.

i. Any acquisition by or on behalf of an institutional health facility or a health maintenance organization of any piece of replacement equipment with a value in excess of one million five hundred thousand dollars, whether acquired by purchase, lease, or donation.

j. Any acquisition by or on behalf of an institutional health facility or health maintenance organization of any piece of equipment with a value in excess of one million five hundred thousand dollars, whether acquired by purchase, lease, or donation, which results in the offering or development of a health service not previously provided. A mobile service provided on a contract basis is not considered to have been previously provided by an institutional health facility.

k. Any air transportation service for transportation of patients or medical personnel offered through an institutional health facility at a specific time but which was not offered on a regular basis in or through that institutional health facility within the twelve-month period prior to the specific time.

l. Any mobile health service with a value in excess of one million five hundred thousand dollars.

m. Any of the following:

(1) Cardiac catheterization service.

(2) Open heart surgical service.

(3) Organ transplantation service.

(4) Radiation therapy service applying ionizing radiation for the treatment of malignant disease using megavoltage external beam equipment.

19. “*Offer*”, when used in connection with health services, means that an institutional health facility, health maintenance organization, health care provider, or group of health care providers holds itself out as capable of providing, or as having the means to provide, specified health services.

20. “*Organized outpatient health facility*” means a facility, not part of a hospital, organized and operated to provide health care to noninstitutionalized and nonhomebound persons on an

outpatient basis; it does not include private offices or clinics of individual physicians, dentists or other practitioners, or groups of practitioners, who are health care providers.

21. “*Outpatient surgical facility*” means a facility which as its primary function provides, through an organized medical staff and on an outpatient basis to patients who are generally ambulatory, surgical procedures not ordinarily performed in a private physician’s office, but not requiring twenty-four hour hospitalization, and which is neither a part of a hospital nor the private office of a health care provider who there engages in the lawful practice of surgery. “*Outpatient surgical facility*” includes a facility certified or seeking certification as an ambulatory surgical center, under the federal Medicare program or under the medical assistance program established pursuant to chapter 249A.

22. “*Technologically innovative equipment*” means equipment potentially useful for diagnostic or therapeutic purposes which introduces new technology in the diagnosis or treatment of disease, the usefulness of which is not well enough established to permit a specific plan of need to be developed for the state.

[C79, 81, §135.61; 82 Acts, ch 1194, §1, 2]

87 Acts, ch 215, §39; 91 Acts, ch 225, §1; 97 Acts, ch 93, §1, 2; 2002 Acts, ch 1162, §77; 2008 Acts, ch 1088, §86

135.62 Department to administer division — health facilities council established — appointments — powers and duties.

1. This division shall be administered by the department. The director shall employ or cause to be employed the necessary persons to discharge the duties imposed on the department by this division.

2. There is established a state health facilities council consisting of five persons appointed by the governor. The council shall be within the department for administrative and budgetary purposes.

a. *Qualifications.* The members of the council shall be chosen so that the council as a whole is broadly representative of various geographical areas of the state and no more than three of its members are affiliated with the same political party. Each council member shall be a person who has demonstrated by prior activities an informed concern for the planning and delivery of health services. A member of the council and any spouse of a member shall not, during the time that member is serving on the council, do either of the following:

(1) Be a health care provider nor be otherwise directly or indirectly engaged in the delivery of health care services nor have a material financial interest in the providing or delivery of health services.

(2) Serve as a member of any board or other policymaking or advisory body of an institutional health facility, a health maintenance organization, or any health or hospital insurer.

b. *Appointments.* Terms of council members shall be six years, beginning and ending as provided in section 69.19. A member shall be appointed in each odd-numbered year to succeed each member whose term expires in that year. Vacancies shall be filled by the governor for the balance of the unexpired term. Each appointment to the council is subject to confirmation by the senate. A council member is ineligible for appointment to a second consecutive term, unless first appointed to an unexpired term of three years or less.

c. *Chairperson.* The governor shall designate one of the council members as chairperson. That designation may be changed not later than July 1 of any odd-numbered year, effective on the date of the organizational meeting held in that year under paragraph “d”.

d. *Meetings.* The council shall hold an organizational meeting in July of each odd-numbered year, or as soon thereafter as the new appointee or appointees are confirmed and have qualified. Other meetings shall be held as necessary to enable the council to expeditiously discharge its duties. Meeting dates shall be set upon adjournment or by call of the chairperson upon five days’ notice to the other members.

e. *Compensation.* Each member of the council shall receive a per diem as specified in section 7E.6 and reimbursement for actual expenses while engaged in official duties.

f. *Duties.* The council shall do all of the following:

- (1) Make the final decision, as required by section 135.69, with respect to each application for a certificate of need accepted by the department.
- (2) Determine and adopt such policies as are authorized by law and are deemed necessary to the efficient discharge of its duties under this division.
- (3) Have authority to direct staff personnel of the department assigned to conduct formal or summary reviews of applications for certificates of need.
- (4) Advise and counsel with the director concerning the provisions of this division and the policies and procedures adopted by the department pursuant to this division.
- (5) Review and approve, prior to promulgation, all rules adopted by the department under this division.

[C79, 81, §135.62]

86 Acts, ch 1245, §1109; 88 Acts, ch 1277, §26; 90 Acts, ch 1256, §30; 91 Acts, ch 225, §2, 3; 97 Acts, ch 93, §3; 2009 Acts, ch 41, §40

[P] Confirmation, see §2.32

135.63 Certificate of need required — exclusions.

1. A new institutional health service or changed institutional health service shall not be offered or developed in this state without prior application to the department for and receipt of a certificate of need, pursuant to this division. The application shall be made upon forms furnished or prescribed by the department and shall contain such information as the department may require under this division. The application shall be accompanied by a fee equivalent to three-tenths of one percent of the anticipated cost of the project with a minimum fee of six hundred dollars and a maximum fee of twenty-one thousand dollars. The fee shall be remitted by the department to the treasurer of state, who shall place it in the general fund of the state. If an application is voluntarily withdrawn within thirty calendar days after submission, seventy-five percent of the application fee shall be refunded; if the application is voluntarily withdrawn more than thirty but within sixty days after submission, fifty percent of the application fee shall be refunded; if the application is withdrawn voluntarily more than sixty days after submission, twenty-five percent of the application fee shall be refunded. Notwithstanding the required payment of an application fee under this subsection, an applicant for a new institutional health service or a changed institutional health service offered or developed by an intermediate care facility for persons with mental retardation or an intermediate care facility for persons with mental illness as defined pursuant to section 135C.1 is exempt from payment of the application fee.

2. This division shall not be construed to augment, limit, contravene, or repeal in any manner any other statute of this state which may authorize or relate to licensure, regulation, supervision, or control of, nor to be applicable to:

a. Private offices and private clinics of an individual physician, dentist, or other practitioner or group of health care providers, except as provided by section 135.61, subsection 18, paragraphs “g”, “h”, and “m”, and subsections 20 and 21.

b. Dispensaries and first aid stations, located within schools, businesses, or industrial establishments, which are maintained solely for the use of students or employees of those establishments and which do not contain inpatient or resident beds that are customarily occupied by the same individual for more than twenty-four consecutive hours.

c. Establishments such as motels, hotels, and boarding houses which provide medical, nursing personnel, and other health related services as an incident to their primary business or function.

d. The remedial care or treatment of residents or patients in any home or institution conducted only for those who rely solely upon treatment by prayer or spiritual means in accordance with the creed or tenets of any recognized church or religious denomination.

e. A health maintenance organization or combination of health maintenance organizations or an institutional health facility controlled directly or indirectly by a health maintenance organization or combination of health maintenance organizations, except when the health maintenance organization or combination of health maintenance organizations does any of the following:

(1) Constructs, develops, renovates, relocates, or otherwise establishes an institutional health facility.

(2) Acquires major medical equipment as provided by section 135.61, subsection 18, paragraphs “i” and “j”.

f. A residential care facility, as defined in section 135C.1, including a residential care facility for persons with mental retardation, notwithstanding any provision in this division to the contrary.

g. (1) A reduction in bed capacity of an institutional health facility, notwithstanding any provision in this division to the contrary, if all of the following conditions exist:

(a) The institutional health facility reports to the department the number and type of beds reduced on a form prescribed by the department at least thirty days before the reduction. In the case of a health care facility, the new bed total must be consistent with the number of licensed beds at the facility. In the case of a hospital, the number of beds must be consistent with bed totals reported to the department of inspections and appeals for purposes of licensure and certification.

(b) The institutional health facility reports the new bed total on its next annual report to the department.

(2) If these conditions are not met, the institutional health facility is subject to review as a “*new institutional health service*” or “*changed institutional health service*” under section 135.61, subsection 18, paragraph “d”, and subject to sanctions under section 135.73. If the institutional health facility reestablishes the deleted beds at a later time, review as a “*new institutional health service*” or “*changed institutional health service*” is required pursuant to section 135.61, subsection 18, paragraph “d”.

h. (1) The deletion of one or more health services, previously offered on a regular basis by an institutional health facility or health maintenance organization, notwithstanding any provision of this division to the contrary, if all of the following conditions exist:

(a) The institutional health facility or health maintenance organization reports to the department the deletion of the service or services at least thirty days before the deletion on a form prescribed by the department.

(b) The institutional health facility or health maintenance organization reports the deletion of the service or services on its next annual report to the department.

(2) If these conditions are not met, the institutional health facility or health maintenance organization is subject to review as a “*new institutional health service*” or “*changed institutional health service*” under section 135.61, subsection 18, paragraph “f”, and subject to sanctions under section 135.73.

(3) If the institutional health facility or health maintenance organization reestablishes the deleted service or services at a later time, review as a “*new institutional health service*” or “*changed institutional health service*” may be required pursuant to section 135.61, subsection 18.

i. A residential program exempt from licensing as a health care facility under chapter 135C in accordance with section 135C.6, subsection 8.

j. The construction, modification, or replacement of nonpatient care services, including parking facilities, heating, ventilation and air conditioning systems, computers, telephone systems, medical office buildings, and other projects of a similar nature, notwithstanding any provision in this division to the contrary.

k. (1) The redistribution of beds by a hospital within the acute care category of bed usage, notwithstanding any provision in this division to the contrary, if all of the following conditions exist:

(a) The hospital reports to the department the number and type of beds to be redistributed on a form prescribed by the department at least thirty days before the redistribution.

(b) The hospital reports the new distribution of beds on its next annual report to the department.

(2) If these conditions are not met, the redistribution of beds by the hospital is subject to review as a new institutional health service or changed institutional health service pursuant to section 135.61, subsection 18, paragraph “d”, and is subject to sanctions under section 135.73.

l. The replacement or modernization of any institutional health facility if the replacement or modernization does not add new health services or additional bed capacity for existing health services, notwithstanding any provision in this division to the contrary. With respect to a nursing facility, “replacement” means establishing a new facility within the same county as the prior facility to be closed. With reference to a hospital, “replacement” means establishing a new hospital that demonstrates compliance with all of the following criteria through evidence submitted to the department:

- (1) Is designated as a critical access hospital pursuant to 42 U.S.C. § 1395i-4.
- (2) Serves at least seventy-five percent of the same service area that was served by the prior hospital to be closed and replaced by the new hospital.
- (3) Provides at least seventy-five percent of the same services that were provided by the prior hospital to be closed and replaced by the new hospital.
- (4) Is staffed by at least seventy-five percent of the same staff, including medical staff, contracted staff, and employees, as constituted the staff of the prior hospital to be closed and replaced by the new hospital.

m. Hemodialysis services provided by a hospital or freestanding facility, notwithstanding any provision in this division to the contrary.

n. Hospice services provided by a hospital, notwithstanding any provision in this division to the contrary.

o. The change in ownership, licensure, organizational structure, or designation of the type of institutional health facility if the health services offered by the successor institutional health facility are unchanged. This exclusion is applicable only if the institutional health facility consents to the change in ownership, licensure, organizational structure, or designation of the type of institutional health facility and ceases offering the health services simultaneously with the initiation of the offering of health services by the successor institutional health facility.

p. The conversion of an existing number of beds by an intermediate care facility for persons with mental retardation to a smaller facility environment, including but not limited to a community-based environment which does not result in an increased number of beds, notwithstanding any provision in this division to the contrary, including subsection 4, if all of the following conditions exist:

(1) The intermediate care facility for persons with mental retardation reports the number and type of beds to be converted on a form prescribed by the department at least thirty days before the conversion.

(2) The intermediate care facility for persons with mental retardation reports the conversion of beds on its next annual report to the department.

3. This division shall not be construed to be applicable to a health care facility operated by and for the exclusive use of members of a religious order, which does not admit more than two individuals to the facility from the general public, and which was in operation prior to July 1, 1986. However, this division is applicable to such a facility if the facility is involved in the offering or developing of a new or changed institutional health service on or after July 1, 1986.

4. A copy of the application shall be sent to the department of human services at the time the application is submitted to the Iowa department of public health. The department shall not process applications for and the council shall not consider a new or changed institutional health service for an intermediate care facility for persons with mental retardation unless both of the following conditions are met:

a. The new or changed beds shall not result in an increase in the total number of medical assistance certified intermediate care facility beds for persons with mental retardation in the state, exclusive of those beds at the state resource centers or other state institutions, beyond one thousand six hundred thirty-six beds.

b. A letter of support for the application is provided by the county board of supervisors, or the board’s designee, in the county in which the beds would be located.

[C79, 81, §135.63; 82 Acts, ch 1194, §3]

86 Acts, ch 1150, §1; 86 Acts, ch 1245, §1110; 91 Acts, ch 225, §4; 92 Acts, ch 1043, §1; 92 Acts, ch 1206, §1; 95 Acts, ch 120, §1; 96 Acts, ch 1129, §113; 97 Acts, ch 93, §4 – 8; 2002 Acts, ch 1120, §10; 2006 Acts, ch 1184, §78; 2008 Acts, ch 1191, §47; 2009 Acts, ch 184, §38

135.64 Criteria for evaluation of applications.

1. In determining whether a certificate of need shall be issued, the department and council shall consider the following:

a. The contribution of the proposed institutional health service in meeting the needs of the medically underserved, including persons in rural areas, low-income persons, racial and ethnic minorities, persons with disabilities, and the elderly, as well as the extent to which medically underserved residents in the applicant's service area are likely to have access to the proposed institutional health service.

b. The relationship of the proposed institutional health services to the long-range development plan, if any, of the person providing or proposing the services.

c. The need of the population served or to be served by the proposed institutional health services for those services.

d. The distance, convenience, cost of transportation, and accessibility to health services for persons who live outside metropolitan areas.

e. The availability of alternative, less costly, or more effective methods of providing the proposed institutional health services.

f. The immediate and long-term financial feasibility of the proposal presented in the application, as well as the probable impact of the proposal on the costs of and charges for providing health services by the person proposing the new institutional health service.

g. The relationship of the proposed institutional health services to the existing health care system of the area in which those services are proposed to be provided.

h. The appropriate and efficient use or prospective use of the proposed institutional health service, and of any existing similar services, including but not limited to a consideration of the capacity of the sponsor's facility to provide the proposed service, and possible sharing or cooperative arrangements among existing facilities and providers.

i. The availability of resources, including, but not limited to, health care providers, management personnel, and funds for capital and operating needs, to provide the proposed institutional health services and the possible alternative uses of those resources to provide other health services.

j. The appropriate and nondiscriminatory utilization of existing and available health care providers. Where both allopathic and osteopathic institutional health services exist, each application shall be considered in light of the availability and utilization of both allopathic and osteopathic facilities and services in order to protect the freedom of choice of consumers and health care providers.

k. The relationship, including the organizational relationship, of the proposed institutional health services to ancillary or support services.

l. Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the immediate geographic area in which the entities are located, which entities may include but are not limited to medical and other health professional schools, multidisciplinary clinics, and specialty centers.

m. The special needs and circumstances of health maintenance organizations.

n. The special needs and circumstances of biomedical and behavioral research projects designed to meet a national need and for which local conditions offer special advantages.

o. The impact of relocation of an institutional health facility or health maintenance organization on other institutional health facilities or health maintenance organizations and on the needs of the population to be served, or which was previously served, or both.

p. In the case of a construction project, the costs and methods of the proposed construction and the probable impact of the proposed construction project on total health care costs.

q. In the case of a proposal for the addition of beds to a health care facility, the consistency of the proposed addition with the plans of other agencies of this state responsible for provision and financing of long-term care services, including home health services.

r. The recommendations of staff personnel of the department assigned to the area of certificate of need, concerning the application, if requested by the council.

2. In addition to the findings required with respect to any of the criteria listed in subsection 1 of this section, the council shall grant a certificate of need for a new institutional health

service or changed institutional health service only if it finds in writing, on the basis of data submitted to it by the department, that:

a. Less costly, more efficient, or more appropriate alternatives to the proposed institutional health service are not available and the development of such alternatives is not practicable;

b. Any existing facilities providing institutional health services similar to those proposed are being used in an appropriate and efficient manner;

c. In the case of new construction, alternatives including but not limited to modernization or sharing arrangements have been considered and have been implemented to the maximum extent practicable;

d. Patients will experience serious problems in obtaining care of the type which will be furnished by the proposed new institutional health service or changed institutional health service, in the absence of that proposed new service.

3. In the evaluation of applications for certificates of need submitted by university hospital at Iowa City, the unique features of that institution relating to statewide tertiary health care, health science education, and clinical research shall be given due consideration. Further, in administering this division, the unique capacity of university hospitals for the evaluation of technologically innovative equipment and other new health services shall be utilized.

[C79, 81, §135.64]

91 Acts, ch 225, §5; 92 Acts, ch 1043, §2; 96 Acts, ch 1129, §113; 2002 Acts, ch 1120, §11

135.65 Letter of intent to precede application — review and comment.

1. Before applying for a certificate of need, the sponsor of a proposed new institutional health service or changed institutional health service shall submit to the department a letter of intent to offer or develop a service requiring a certificate of need. The letter shall be submitted as soon as possible after initiation of the applicant's planning process, and in any case not less than thirty days before applying for a certificate of need and before substantial expenditures to offer or develop the service are made. The letter shall include a brief description of the proposed new or changed service, its location, and its estimated cost.

2. Upon request of the sponsor of the proposed new or changed service, the department shall make a preliminary review of the letter for the purpose of informing the sponsor of the project of any factors which may appear likely to result in denial of a certificate of need, based on the criteria for evaluation of applications in section 135.64. A comment by the department under this section shall not constitute a final decision.

[C79, 81, §135.65]

91 Acts, ch 225, §6; 97 Acts, ch 93, §9

135.66 Procedure upon receipt of application — public notification.

1. Within fifteen business days after receipt of an application for a certificate of need, the department shall examine the application for form and completeness and accept or reject it. An application shall be rejected only if it fails to provide all information required by the department pursuant to section 135.63, subsection 1. The department shall promptly return to the applicant any rejected application, with an explanation of the reasons for its rejection.

2. Upon acceptance of an application for a certificate of need, the department shall promptly undertake to notify all affected persons in writing that formal review of the application has been initiated. Notification to those affected persons who are consumers or third-party payers or other payers for health services may be provided by distribution of the pertinent information to the news media.

3. Each application accepted by the department shall be formally reviewed for the purpose of furnishing to the council the information necessary to enable it to determine whether or not to grant the certificate of need. A formal review shall consist at a minimum of the following steps:

a. Evaluation of the application against the criteria specified in section 135.64.

b. A public hearing on the application, to be held prior to completion of the evaluation required by paragraph "a", shall be conducted by the council.

4. When a hearing is to be held pursuant to subsection 3, paragraph "b", the department

shall give at least ten days' notice of the time and place of the hearing. At the hearing, any affected person or that person's designated representative shall have the opportunity to present testimony.

[C79, 81, §135.66]
91 Acts, ch 225, §7

135.67 Summary review procedure.

1. The department may waive the letter of intent procedures prescribed by section 135.65 and substitute a summary review procedure, which shall be established by rules of the department, when it accepts an application for a certificate of need for a project which meets any of the criteria in paragraphs "a" through "e":

a. A project which is limited to repair or replacement of a facility or equipment damaged or destroyed by a disaster, and which will not expand the facility nor increase the services provided beyond the level existing prior to the disaster.

b. A project necessary to enable the facility or service to achieve or maintain compliance with federal, state, or other appropriate licensing, certification, or safety requirements.

c. A project which will not change the existing bed capacity of the applicant's facility or service, as determined by the department, by more than ten percent or ten beds, whichever is less, over a two-year period.

d. A project the total cost of which will not exceed one hundred fifty thousand dollars.

e. Any other project for which the applicant proposes and the department agrees to summary review.

2. The department's decision to disallow a summary review shall be binding upon the applicant.

[C79, 81, §135.67]
91 Acts, ch 225, §8 – 10; 2009 Acts, ch 41, §191

135.68 Status reports on review in progress.

While formal review of an application for a certificate of need is in progress, the department shall upon request inform any affected person of the status of the review, any findings which have been made in the course of the review, and any other appropriate information concerning the review.

[C79, 81, §135.68]

135.69 Council to make final decision.

The department shall complete its formal review of the application within ninety days after acceptance of the application, except as otherwise provided by section 135.72, subsection 4. Upon completion of the formal review, the council shall approve or deny the application. The council shall issue written findings stating the basis for its decision on the application, and the department shall send copies of the council's decision and the written findings supporting the decision to the applicant and to any other person who so requests.

Failure by the council to issue a written decision on an application for a certificate of need within the time required by this section shall constitute denial of and final administrative action on the application.

[C79, 81, §135.69]
91 Acts, ch 225, §11

135.70 Appeal of certificate of need decisions.

The council's decision on an application for certificate of need, when announced pursuant to section 135.69, is a final decision. Any dissatisfied party who is an affected person with respect to the application, and who participated or sought unsuccessfully to participate in the formal review procedure prescribed by section 135.66, may request a rehearing in accordance with chapter 17A and rules of the department. If a rehearing is not requested or an affected party remains dissatisfied after the request for rehearing, an appeal may be taken in the

manner provided by chapter 17A. Notwithstanding the Iowa administrative procedure Act, chapter 17A, a request for rehearing is not required, prior to appeal under section 17A.19.

[C79, 81, §135.70]

91 Acts, ch 225, §12

135.71 Period for which certificate is valid — extension or revocation.

A certificate of need shall be valid for a maximum of one year from the date of issuance. Upon the expiration of the certificate, or at any earlier time while the certificate is valid the holder thereof shall provide the department such information on the development of the project covered by the certificate as the department may request. The council shall determine at the end of the certification period whether sufficient progress is being made on the development of the project. The certificate of need may be extended by the council for additional periods of time as are reasonably necessary to expeditiously complete the project, but may be revoked by the council at the end of the first or any subsequent certification period for insufficient progress in developing the project.

Upon expiration of certificate of need, and prior to extension thereof, any affected person shall have the right to submit to the department information which may be relevant to the question of granting an extension. The department may call a public hearing for this purpose.

[C79, 81, §135.71]

97 Acts, ch 93, §10

135.72 Authority to adopt rules.

The department shall adopt, with approval of the council, such administrative rules as are necessary to enable it to implement this division. These rules shall include:

1. Additional procedures and criteria for review of applications for certificates of need.
2. Uniform procedures for variations in application of criteria specified by section 135.64 for use in formal review of applications for certificates of need, when such variations are appropriate to the purpose of a particular review or to the type of institutional health service proposed in the application being reviewed.
3. Uniform procedures for summary reviews conducted under section 135.67.
4. Criteria for determining when it is not feasible to complete formal review of an application for a certificate of need within the time limits specified in section 135.69. The rules adopted under this subsection shall include criteria for determining whether an application proposes introduction of technologically innovative equipment, and if so, procedures to be followed in reviewing the application. However, a rule adopted under this subsection shall not permit a deferral of more than sixty days beyond the time when a decision is required under section 135.69, unless both the applicant and the department agree to a longer deferment.

[C79, 81, §135.72]

91 Acts, ch 225, §13

135.73 Sanctions.

1. Any party constructing a new institutional health facility or an addition to or renovation of an existing institutional health facility without first obtaining a certificate of need or, in the case of a mobile health service, ascertaining that the mobile health service has received certificate of need approval, as required by this division, shall be denied licensure or change of licensure by the appropriate responsible licensing agency of this state.

2. A party violating this division shall be subject to penalties in accordance with this section. The department shall adopt rules setting forth the violations by classification, the criteria for the classification of any violation not listed, and procedures for implementing this subsection.

a. A class I violation is one in which a party offers a new institutional health service or changed institutional health service modernization or acquisition without review and approval by the council. A party in violation is subject to a penalty of three hundred dollars for each day of a class I violation. The department may seek injunctive relief which shall include restraining the commission or continuance of an act which would violate the

provisions of this paragraph. Notice and opportunity to be heard shall be provided to a party pursuant to rule of civil procedure 1.1507 and contested case procedures in accordance with chapter 17A. The department may reduce, alter, or waive a penalty upon the party showing good faith compliance with the department's request to immediately cease and desist from conduct in violation of this section.

b. A class II violation is one in which a party violates the terms or provisions of an approved application. The department may seek injunctive relief which shall include restraining the commission or continuance of or abating or eliminating an act which would violate the provisions of this subsection. Notice and opportunity to be heard shall be provided to a party pursuant to rule of civil procedure 1.1507 and contested case procedures in accordance with chapter 17A. The department may reduce, alter, or waive a penalty upon the party showing good faith compliance with the department's request to immediately cease and desist from conduct in violation of this section. A class II violation shall be abated or eliminated within a stated period of time determined by the department and specified by the department in writing. The period of time may be modified by the department for good cause shown. A party in violation may be subject to a penalty of five hundred dollars for each day of a class II violation.

3. Notwithstanding any other sanction imposed pursuant to this section, a party offering or developing any new institutional health service or changed institutional health service without first obtaining a certificate of need as required by this division may be temporarily or permanently restrained from doing so by any court of competent jurisdiction in any action brought by the state, any of its political subdivisions, or any other interested person.

4. The sanctions provided by this section are in addition to, and not in lieu of, any penalty prescribed by law for the acts against which these sanctions are invoked.

[C79, 81, §135.73]

91 Acts, ch 225, §14

135.74 Uniform financial reporting.

1. The department, after study and in consultation with any advisory committees which may be established pursuant to law, shall promulgate by rule pursuant to chapter 17A uniform methods of financial reporting, including such allocation methods as may be prescribed, by which hospitals and health care facilities shall respectively record their revenues, expenses, other income, other outlays, assets and liabilities, and units of service, according to functional activity center. These uniform methods of financial reporting shall not preclude a hospital or health care facility from using any accounting methods for its own purposes provided these accounting methods can be reconciled to the uniform methods of financial reporting prescribed by the department and can be audited for validity and completeness. Each hospital and each health care facility shall adopt the appropriate system for its fiscal year, effective upon such date as the department shall direct. In determining the effective date for reporting requirements, the department shall consider both the immediate need for uniform reporting of information to effectuate the purposes of this division and the administrative and economic difficulties which hospitals and health care facilities may encounter in complying with the uniform financial reporting requirement, but the effective date shall not be later than January 1, 1980.

2. In establishing uniform methods of financial reporting, the department shall consider:

a. The existing systems of accounting and reporting currently utilized by hospitals and health care facilities;

b. Differences among hospitals and health care facilities, respectively, according to size, financial structure, methods of payment for services, and scope, type and method of providing services; and

c. Other pertinent distinguishing factors.

3. The department shall, where appropriate, provide for modification, consistent with the purposes of this division, of reporting requirements to correctly reflect the differences among hospitals and among health care facilities referred to in subsection 2, and to avoid otherwise unduly burdensome costs in meeting the requirements of uniform methods of financial reporting.

4. The uniform financial reporting methods, where appropriate, shall be structured so as to establish and differentiate costs incurred for patient-related services rendered by hospitals and health care facilities, as distinguished from those incurred in the course of educational, research and other nonpatient-related activities including but not limited to charitable activities of these hospitals and health care facilities.

[C79, 81, §135.74]

135.75 Annual reports by hospitals, health care facilities.

1. Each hospital and each health care facility shall annually, after the close of its fiscal year, file with the department:

- a. A balance sheet detailing the assets, liabilities and net worth of the hospital or health care facility;
- b. A statement of its income and expenses; and
- c. Such other reports of the costs incurred in rendering services as the department may prescribe.

2. Where more than one licensed hospital or health care facility is operated by the reporting organization, the information required by this section shall be reported separately for each licensed hospital or health care facility. The department shall require preparation of specified financial reports by a certified public accountant, and may require attestation of responsible officials of the reporting hospital or health care facility that the reports submitted are to the best of their knowledge and belief prepared in accordance with the prescribed methods of reporting. The department shall have the right to inspect the books, audits and records of any hospital or health care facility as reasonably necessary to verify reports submitted pursuant to this division.

3. In obtaining the reports required by this section, the department and other state agencies shall coordinate their reporting requirements.

4. All reports filed under this section, except privileged medical information, shall be open to public inspection.

[C79, 81, §135.75]

135.76 Analyses and studies by department.

1. The department shall from time to time undertake analyses and studies relating to hospital and health care facility costs and to the financial status of hospitals or health care facilities, or both, which are subject to the provisions of this division. It shall further require the filing of information concerning the total financial needs of each individual hospital or health care facility and the resources currently or prospectively available to meet these needs, including the effect of proposals made by health systems agencies. The department shall also prepare and file such summaries and compilations or other supplementary reports based on the information filed with it as will, in its judgment, advance the purposes of this division.

2. The analyses and studies required by this section shall be conducted with the objective of providing a basis for determining whether or not regulation of hospital and health care facility rates and charges by the state of Iowa is necessary to protect the health or welfare of the people of the state.

3. In conducting its analyses and studies, the department should determine whether:

- a. The rates charged and costs incurred by hospitals and health care facilities are reasonably related to the services offered by those respective groups of institutions.
- b. Aggregate rates of hospitals and of health care facilities are reasonably related to the aggregate costs incurred by those respective groups of institutions.
- c. Rates are set equitably among all purchasers or classes of purchasers of hospital and of health care facility services.

d. The rates for particular services, supplies or materials established by hospitals and by health care facilities are reasonable. Determination of reasonableness of rates shall include consideration of a fair rate of return to proprietary hospitals and health care facilities.

4. All data gathered and compiled and all reports prepared under this section, except privileged medical information, shall be open to public inspection.

[C79, 81, §135.76]

135.77 Repealed by 97 Acts, ch 203, § 18.

135.78 Data to be compiled.

The department shall compile all relevant financial and utilization data in order to have available the statistical information necessary to properly monitor hospital and health care facility charges and costs. Such data shall include necessary operating expenses, appropriate expenses incurred for rendering services to patients who cannot or do not pay, all properly incurred interest charges, and reasonable depreciation expenses based on the expected useful life of the property and equipment involved. The department shall also obtain from each hospital and health care facility a current rate schedule as well as any subsequent amendments or modifications of that schedule as it may require. In collection of the data required by this section and sections 135.74 through 135.76, the department and other state agencies shall coordinate their reporting requirements.

[C79, 81, §135.78]

2002 Acts, ch 1119, §14; 2003 Acts, ch 108, §34

135.79 Civil penalty.

Any hospital or health care facility which fails to file with the department the financial reports required by sections 135.74 to 135.78 is subject to a civil penalty of not to exceed five hundred dollars for each offense.

[C79, 81, §135.79]

135.80 Mental health professional shortage area program.

1. For the purposes of this section, “*mental health professional shortage areas*” means geographic areas in this state that have been designated by the United States department of health and human services, health resources and services administration, bureau of health professionals, as having a shortage of mental health professionals.

2. The department shall establish and administer a mental health professional shortage area program in accordance with this section. Implementation of the program shall be limited to the extent of the funding appropriated or otherwise made available for the program.

3. The program shall provide stipends to support psychiatrist positions with an emphasis on securing and retaining medical directors at community mental health centers, providers of mental health services to county residents pursuant to a waiver approved under section 225C.7, subsection 3, and hospital psychiatric units that are located in mental health professional shortage areas.

4. The department shall apply the rules in determining the number and amounts of stipends within the amount of funding available for the program for a fiscal year.

5. For each fiscal year in which funding is allocated by the program, the department shall report to the governor and general assembly summarizing the program’s activities and the impact made to address the shortage of mental health professionals.

2007 Acts, ch 218, §102

[SP] Allocation of funds; 2007 Acts, ch 218, §97; 2008 Acts, ch 1187, §62; 2009 Acts, ch 182, §60

135.81 Repealed by 83 Acts, ch 101, § 129.

135.82 Repealed by 91 Acts, ch 225, § 15.

135.83 Contracts for assistance with analyses, studies, and data.

In furtherance of the department’s responsibilities under sections 135.76 and 135.78, the director may contract with the Iowa hospital association and third-party payers, the Iowa health care facilities association and third-party payers, or the Iowa association of homes for the aging and third-party payers for the establishment of pilot programs dealing with prospective rate review in hospitals or health care facilities, or both. Such contract shall be subject to the approval of the executive council and shall provide for an equitable representation of health care providers, third-party payers, and health care consumers in the determination of criteria for rate review. No third-party payer shall be excluded from positive

financial incentives based upon volume of gross patient revenues. No state or federal funds appropriated or available to the department shall be used for any such pilot program.

[C79, 81, §135.83]

98 Acts, ch 1100, §13; 2001 Acts, ch 74, §2; 2002 Acts, ch 1050, §16

135.84 Repealed by 88 Acts, ch 1276, § 46.

135.85 through 135.89 Reserved.

DIVISION VII

LICENSED HOSPICE PROGRAMS

135.90 through 135.96 Transferred to chapter 135J; 90 Acts, ch 1204, § 66.

135.97 through 135.99 Reserved.

DIVISION VIII

LEAD ABATEMENT PROGRAM

135.100 Definitions.

For the purposes of this division, unless the context otherwise requires:

1. “*Department*” means the Iowa department of public health.
2. “*Local board*” means the local board of health.

87 Acts, ch 55, §1

135.101 Childhood lead poisoning prevention program.

There is established a childhood lead poisoning prevention program within the Iowa department of public health. The department shall implement and review programs necessary to eliminate potentially dangerous toxic lead levels in children in Iowa in a year for which funds are appropriated to the department for this purpose.

87 Acts, ch 55, §2; 99 Acts, ch 141, §5

135.102 Rules.

The department shall adopt rules, pursuant to chapter 17A, regarding the:

1. Implementation of the grant program pursuant to section 135.103.
2. Maintenance of laboratory facilities for the childhood lead poisoning prevention program.
3. Maximum blood lead levels in children living in targeted rental dwelling units.
4. Standards and program requirements of the grant program pursuant to section 135.103.
5. Prioritization of proposed childhood lead poisoning prevention programs, based on the geographic areas known with children identified with elevated blood lead level resulting from surveys completed by the department.
6. Model regulations for lead hazard remediation to be used in instances in which a child is confirmed as lead poisoned. The department shall make the model regulations available to local boards of health and shall promote the adoption of the regulations at the local level, in cities and counties implementing lead hazard remediation programs. Nothing in this subsection shall be construed as requiring the adoption of the model regulations.
7. Implementation of a requirement that children receive a blood lead test prior to the age of six and before enrolling in any elementary school in Iowa in accordance with section 135.105D.

87 Acts, ch 55, §3; 99 Acts, ch 141, §6; 2001 Acts, ch 182, §9; 2007 Acts, ch 79, §1

135.103 Grant program.

The department shall implement a childhood lead poisoning prevention grant program which provides federal, state, or other funds to local boards of health or cities for the program after standards and requirements for the local program are developed. The department may also use federal, state, or other funds provided for the childhood lead poisoning prevention grant program to purchase environmental and blood testing services from a public health laboratory.

87 Acts, ch 55, §4; 91 Acts, ch 268, §307; 99 Acts, ch 141, §7; 2004 Acts, ch 1168, §2

135.104 Requirements.

The program by a local board of health or city receiving funding for an approved childhood lead poisoning prevention grant program shall include:

1. A public education program about lead poisoning and dangers of lead poisoning to children.
2. An effective outreach effort to ensure availability of services in the predicted geographic area.
3. A screening program for children, with emphasis on children less than six years of age.
4. Access to laboratory services for lead analysis.
5. A program of referral of identified children for assessment and treatment.
6. An environmental assessment of suspect dwelling units.
7. Surveillance to ensure correction of the identified hazardous settings.
8. A plan of intent to continue the program on a maintenance basis after the grant is discontinued.

87 Acts, ch 55, §5; 99 Acts, ch 141, §8, 9; 2002 Acts, ch 1108, §9; 2004 Acts, ch 1168, §3

135.105 Department duties.

The department shall:

1. Coordinate the childhood lead poisoning prevention program with the department of natural resources, the university of Iowa poison control program, the mobile and regional child health speciality clinics, and any agency or program known for a direct interest in lead levels in the environment.
2. Survey geographic areas not included in the grant program pursuant to section 135.103 periodically to determine prioritization of such areas for future grant programs.

87 Acts, ch 55, §6; 99 Acts, ch 141, §10

135.105A Lead inspector, lead abater, and lead-safe renovator training and certification program established — civil penalty.

1. The department shall establish a program for the training and certification of lead inspectors, lead abaters, and lead-safe renovators. The department shall maintain a listing, available to the public and to city and county health departments, of lead inspector, lead abater, and lead-safe renovator training programs that have been approved by the department, and of lead inspectors, lead abaters, and lead-safe renovators who have successfully completed the training program and have been certified by the department. A person may be certified as a lead inspector, a lead abater, or a lead-safe renovator, or may be certified to provide two or more of such services. However, a person who holds more than one such certification shall not provide inspection service and also provide abatement service or renovation service at the same site unless a written consent or waiver, following full disclosure by the person, is obtained from the owner or manager of the site.

2. A person who owns real property which includes a residential dwelling and who performs lead inspection, lead abatement, or renovation of the residential dwelling is not required to obtain certification to perform these measures, unless the residential dwelling is occupied by a person other than the owner or a member of the owner's immediate family while the measures are being performed. However, the department shall encourage property owners who are not required to be certified to complete the applicable training course to ensure the use of appropriate and safe lead inspection, lead abatement, or lead-safe renovation procedures.

3. Except as otherwise provided in this section, a person shall not perform lead abatement or lead inspections, and shall not perform renovations on target housing or a child-occupied facility, unless the person has completed a training program approved by the department and has obtained certification pursuant to this section. All lead abatement and lead inspections; and lead inspector, lead abater, and lead-safe renovation training programs; and renovations on target housing or a child-occupied facility, shall be performed and conducted in accordance with work practice standards established by the department. A person shall not conduct a training program for lead inspectors, lead abaters, or lead-safe renovators unless the program has been submitted to and approved by the department.

4. A person who violates this section is subject to a civil penalty not to exceed five thousand dollars for each offense.

5. The department shall adopt rules regarding minimum requirements for lead inspector, lead abater, and lead-safe renovator training programs, certification, work practice standards, and suspension and revocation requirements, and shall implement the training and certification programs. The department shall seek federal funding and shall establish fees in amounts sufficient to defray the cost of the programs. The fees shall be used for any of the department's duties under this division, including but not limited to the costs of full-time equivalent positions for program services and investigations. Fees received shall be considered repayment receipts as defined in section 8.2.

96 Acts, ch 1161, §1, 4; 97 Acts, ch 159, §5; 98 Acts, ch 1100, §14; 2004 Acts, ch 1167, §2; 2009 Acts, ch 37, §1; 2010 Acts, ch 1192, §49, 73

[SP] For definitions, see §135.105C(2)

[SP] 2010 amendment to subsection 5 applies to any fees collected pursuant to this section during or after the fiscal year beginning July 1, 2009; 2010 Acts, ch 1192, §73

[T] Subsection 5 amended

135.105B Voluntary guidelines — health and environmental measures — confirmed cases of lead poisoning.

1. The department may develop voluntary guidelines which may be used to develop and administer local programs to address the health and environmental needs of children who are confirmed as lead poisoned.

2. The voluntary guidelines may be based upon existing local ordinances that address the medical case management of children's health needs and the mitigation of the environmental factors which contributed to the lead poisoning.

3. Following development of the voluntary guidelines, cities or counties may elect to utilize the guidelines in developing and administering local programs through city or county health departments on a city, county, or multicounty basis or may request that the state develop and administer the local program. However, cities and counties are not required to develop and administer local programs based upon the guidelines.

96 Acts, ch 1161, §2, 4

135.105C Renovation, remodeling, and repainting — lead hazard notification process established.

1. *a.* A person who performs renovation, remodeling, or repainting services for target housing or a child-occupied facility for compensation shall provide an approved lead hazard information pamphlet to the owner and occupant of the housing or facility prior to commencing the services. The department shall adopt rules to implement the renovation, remodeling, and repainting lead hazard notification process under this section.

b. The rules shall include but are not limited to an authorization that the lead hazard notification to parents or guardians of the children attending a child-occupied facility may be completed by posting an informational sign and a copy of the approved lead hazard information pamphlet. The rules shall also address requirements for notification of parents or guardians of the children visiting a child-occupied facility when the facility is vacant for an extended period of time.

2. For the purpose of this section and section 135.105A, unless the context otherwise requires:

a. (1) “*Child-occupied facility*” means a building, or portion of a building, constructed prior to 1978, that is described by all of the following:

(a) The building is visited on a regular basis by the same child, who is less than six years of age, on at least two different days within any week. For purposes of this paragraph “a”, a week is a Sunday through Saturday period.

(b) Each day’s visit by the child lasts at least three hours, and the combined annual visits total at least sixty hours.

(2) A child-occupied facility may include but is not limited to a child care center, preschool, or kindergarten classroom. A child-occupied facility also includes common areas that are routinely used by children who are less than six years of age, such as restrooms and cafeterias, and the exterior walls and adjoining space of the building that are immediately adjacent to the child-occupied facility or the common areas routinely used by children under the age of six years.

b. “*Target housing*” means housing constructed prior to 1978 with the exception of housing for the elderly or for persons with disabilities and housing that does not contain a bedroom, unless at least one child, under six years of age, resides or is expected to reside in the housing.

3. A person who violates this section is subject to a civil penalty not to exceed five thousand dollars for each offense.

97 Acts, ch 159, §6, 24; 2000 Acts, ch 1140, §22; 2001 Acts, ch 58, §4; 2009 Acts, ch 37, §2

135.105D Blood lead testing — provider education — payor of last resort.

1. For purposes of this section:

a. “*Blood lead testing*” means taking a capillary or venous sample of blood and sending it to a laboratory to determine the level of lead in the blood.

b. “*Capillary*” means a blood sample taken from the finger or heel for lead analysis.

c. “*Health care provider*” means a physician who is licensed under chapter 148, or a person who is licensed as a physician assistant under chapter 148C or as an advanced registered nurse practitioner.

d. “*Venous*” means a blood sample taken from a vein in the arm for lead analysis.

2. a. A parent or guardian of a child under the age of two is strongly encouraged to have the child tested for elevated blood lead levels by the age of two. Except as provided in paragraph “b” and subsection 4, a parent or guardian shall provide evidence to the school district elementary attendance center or the accredited nonpublic elementary school in which the parent’s or guardian’s child is enrolled that the child was tested for elevated blood lead levels by the age of six according to recommendations provided by the department.

b. The board of directors of each school district and the authorities in charge of each nonpublic school shall, in collaboration with the department, do the following:

(1) Ensure that the parent or guardian of a student enrolled in the school has complied with the requirements of paragraph “a”.

(2) Provide, if the parent or guardian cannot provide evidence that the child received a blood lead test in accordance with paragraph “a”, the parent or guardian with community blood lead testing program information, including contact information for the department.

c. Notwithstanding any other provision to the contrary, nothing in this section shall subject a parent, guardian, or legal custodian of a child of compulsory attendance age to any penalties under chapter 299.

3. The board of directors of each school district and the authorities in charge of each nonpublic school shall furnish the department, in the format specified by the department, within sixty days after the start of the school calendar, a list of the children enrolled in kindergarten. The department shall notify the school districts and nonpublic schools of the children who have not met the blood lead testing requirements set forth in this section and shall work with the school districts, nonpublic schools, and the local childhood lead poisoning prevention programs to assure that these children are tested as required by this section.

4. The department may waive the requirements of subsection 2 if the department determines that a child is of very low risk for elevated blood lead levels, or if the child’s

parent or legal guardian submits an affidavit, signed by the parent or legal guardian, stating that the blood lead testing conflicts with a genuine and sincere religious belief.

5. The department shall provide rules adopted pursuant to section 135.102, subsection 7, to local school boards and the authorities in charge of nonpublic schools.

6. The department shall work with health care provider associations to educate health care providers regarding requirements for testing children who are enrolled in certain federally funded programs and regarding department recommendations for testing other children for lead poisoning.

7. The department shall implement blood lead testing for children under six years of age who are not eligible for the testing services to be paid by a third-party source. The department shall contract with one or more public health laboratories to provide blood lead analysis for such children. The department shall establish by rule the procedures for health care providers to submit samples to the contracted public health laboratories for analysis. The department shall also establish by rule a method to reimburse health care providers for drawing blood samples from such children and the dollar amount that the department will reimburse health care providers for the service. The department shall also establish by rule a method to reimburse health care providers for analyzing blood lead samples using a portable blood lead testing instrument and the dollar amount that the department will reimburse health care providers for the service. Payment for blood lead analysis and drawing blood samples shall be limited to the amount appropriated for the program in a fiscal year.

2006 Acts, ch 1184, §79; 2007 Acts, ch 79, §2, 3; 2007 Acts, ch 215, §88; 2008 Acts, ch 1020, §4 – 6; 2008 Acts, ch 1088, §87

[P] Nurse licensure, see chapter 152

[P] See also §135.17, 139A.8, 299.4, 299.5, and 299.24

DIVISION IX

HEALTHY FAMILIES PROGRAM

135.106 Healthy families programs — HOPES-HFI program.

1. The Iowa department of public health shall establish a healthy opportunities for parents to experience success (HOPES) – healthy families Iowa (HFI) program to provide services to families and children during the prenatal through preschool years. The program shall be designed to do all of the following:

- a. Promote optimal child health and development.
- b. Improve family coping skills and functioning.
- c. Promote positive parenting skills and intrafamilial interaction.
- d. Prevent child abuse and neglect and infant mortality and morbidity.

2. The HOPES-HFI program shall be developed by the Iowa department of public health, and may be implemented, in whole or in part, by contracting with a nonprofit child abuse prevention organization, local nonprofit certified home health program or other local nonprofit organizations, and shall include, but is not limited to, all of the following components:

a. Identification of barriers to positive birth outcomes, encouragement of collaboration and cooperation among providers of health care, social and human services, and other services to pregnant women and infants, and encouragement of pregnant women and women of childbearing age to seek health care and other services which promote positive birth outcomes.

b. Provision of community-based home-visiting family support to pregnant women and new parents who are identified through a standardized screening process to be at high risk for problems with successfully parenting their child.

c. Provision by family support workers of individual guidance, information, and access to health care and other services through care coordination and community outreach, including transportation.

d. Provision of systematic screening, prenatally or upon the birth of a child, to identify high-risk families.

e. Interviewing by a HOPES-HFI program worker or hospital social worker of families identified as high risk and encouragement of acceptance of family support services.

f. Provision of services including, but not limited to, home visits, support services, and instruction in child care and development.

g. Individualization of the intensity and scope of services based upon the family's needs, goals, and level of risk.

h. Assistance by a family support worker to participating families in creating a link to a "medical home" in order to promote preventive health care.

i. Evaluation and reporting on the program, including an evaluation of the program's success in reducing participants' risk factors and provision of services and recommendations for changes in or expansion of the program.

j. Provision of continuous follow-up contact with a family served by the program until identified children reach age three or age four in cases of continued high need or until the family attains its individualized goals for health, functioning, and self-sufficiency.

k. Provision or employment of family support workers who have experience as a parent, knowledge of health care services, social and human services, or related community services and have participated in a structured training program.

l. Provision of a training program that meets established standards for the education of family support workers. The structured training program shall include at a minimum the fundamentals of child health and development, dynamics of child abuse and neglect, and principles of effective parenting and parenting education.

m. Provision of crisis child care through utilization of existing child care services to participants in the program.

n. Program criteria shall include a required match of one dollar provided by the organization contracting to deliver services for each two dollars provided by the state grant. This requirement shall not restrict the department from providing unmatched grant funds to communities to plan new or expanded programs for HOPES-HFI. The department shall establish a limit on the amount of administrative costs that can be supported with state funds.

o. Involvement with the community assessment and planning process in the community served by HOPES-HFI programs to enhance collaboration and integration of family support programs.

p. Collaboration, to the greatest extent possible, with other family support programs funded or operated by the state.

q. Utilization of private party, third party, and medical assistance for reimbursement to defray the costs of services provided by the program to the extent possible.

3. It is the intent of the general assembly to provide communities with the discretion and authority to redesign existing local programs and services targeted at and assisting families expecting babies and families with children who are newborn through five years of age. The Iowa department of public health, department of human services, department of education, and other state agencies and programs, as appropriate, shall provide technical assistance and support to communities desiring to redesign their local programs and shall facilitate the consolidation of existing state funding appropriated and made available to the community for family support services. Funds which are consolidated in accordance with this subsection shall be used to support the redesigned service delivery system. In redesigning services, communities are encouraged to implement a single uniform family risk assessment mechanism and shall demonstrate the potential for improved outcomes for children and families. Requests by local communities for the redesigning of services shall be submitted to the Iowa department of public health, department of human services, and department of education, and are subject to the approval of the early childhood Iowa state board in consultation with the departments, based on the practices utilized with early childhood Iowa areas under chapter 256I.

92 Acts, 2nd Ex, ch 1001, §419; 97 Acts, ch 138, §1; 98 Acts, ch 1206, §10; 2004 Acts, ch 1086, §35; 2006 Acts, ch 1157, §15; 2010 Acts, ch 1031, §290

[T] Subsection 3 amended

DIVISION X

RURAL HEALTH AND PRIMARY CARE

135.107 Center for rural health and primary care established — duties.

1. The center for rural health and primary care is established within the department.
2. The center for rural health and primary care shall do all of the following:
 - a. Provide technical planning assistance to rural communities and counties exploring innovative means of delivering rural health services through community health services assessment, planning, and implementation, including but not limited to hospital conversions, cooperative agreements among hospitals, physician and health practitioner support, recruitment and retention of primary health care providers, public health services, emergency medical services, medical assistance facilities, rural health care clinics, and alternative means which may be included in the long-term community health services assessment and developmental plan. The center for rural health and primary care shall encourage collaborative efforts of the local boards of health, hospital governing boards, and other public and private entities located in rural communities to adopt a long-term community health services assessment and developmental plan pursuant to rules adopted by the department and perform the duties required of the Iowa department of public health in section 135B.33.
 - b. Provide technical assistance to assist rural communities in improving Medicare reimbursements through the establishment of rural health clinics, defined pursuant to 42 U.S.C. § 1395x, and distinct part skilled nursing facility beds.
 - c. Coordinate services to provide research for the following items:
 - (1) Examination of the prevalence of rural occupational health injuries in the state.
 - (2) Assessment of training and continuing education available through local hospitals and others relating to diagnosis and treatment of diseases associated with rural occupational health hazards.
 - (3) Determination of continuing education support necessary for rural health practitioners to diagnose and treat illnesses caused by exposure to rural occupational health hazards.
 - (4) Determination of the types of actions that can help prevent agricultural accidents.
 - (5) Surveillance and reporting of disabilities suffered by persons engaged in agriculture resulting from diseases or injuries, including identifying the amount and severity of agricultural-related injuries and diseases in the state, identifying causal factors associated with agricultural-related injuries and diseases, and indicating the effectiveness of intervention programs designed to reduce injuries and diseases.
 - d. Cooperate with the center for agricultural health and safety established under section 262.78, the center for health effects of environmental contamination established under section 263.17, and the department of agriculture and land stewardship. The agencies shall coordinate programs to the extent practicable.
 - e. Administer grants for farm safety education efforts directed to rural families for the purpose of preventing farm-related injuries to children.
3. The center for rural health and primary care shall establish a primary care provider recruitment and retention endeavor, to be known as PRIMECARRE. The endeavor shall include a community grant program, a primary care provider loan repayment program, and a primary care provider community scholarship program. The endeavor shall be developed and implemented in a manner to promote and accommodate local creativity in efforts to recruit and retain health care professionals to provide services in the locality. The focus of the endeavor shall be to promote and assist local efforts in developing health care provider recruitment and retention programs.
 - a. *Community grant program.*
 - (1) The center for rural health and primary care shall adopt rules establishing an application process to be used by the center to establish a grant assistance program as provided in this paragraph, and establishing the criteria to be used in evaluating the

applications. Selection criteria shall include a method for prioritizing grant applications based on illustrated efforts to meet the health care provider needs of the locality and surrounding area. Such assistance may be in the form of a forgivable loan, grant, or other nonfinancial assistance as deemed appropriate by the center. An application submitted shall contain a commitment of at least a dollar-for-dollar match of the grant assistance. Application may be made for assistance by a single community or group of communities.

(2) Grants awarded under the program shall be subject to the following limitations:

(a) Ten thousand dollars for a single community or region with a population of ten thousand or less. An award shall not be made under this program to a community with a population of more than ten thousand.

(b) An amount not to exceed one dollar per capita for a region in which the population exceeds ten thousand. For purposes of determining the amount of a grant for a region, the population of the region shall not include the population of any community with a population of more than ten thousand located in the region.

b. *Primary care provider loan repayment program.*

(1) A primary care provider loan repayment program is established to increase the number of health professionals practicing primary care in federally designated health professional shortage areas of the state. Under the program, loan repayment may be made to a recipient for educational expenses incurred while completing an accredited health education program directly related to obtaining credentials necessary to practice the recipient's health profession.

(2) The center for rural health and primary care shall adopt rules relating to the establishment and administration of the primary care provider loan repayment program. Rules adopted pursuant to this paragraph shall provide, at a minimum, for all of the following:

(a) Determination of eligibility requirements and qualifications of an applicant to receive loan repayment under the program, including but not limited to years of obligated service, clinical practice requirements, and residency requirements. One year of obligated service shall be provided by the applicant in exchange for each year of loan repayment, unless federal requirements otherwise require. Loan repayment under the program shall not be approved for a health provider whose license or certification is restricted by a medical regulatory authority of any jurisdiction of the United States, other nations, or territories.

(b) Identification of federally designated health professional shortage areas of the state and prioritization of such areas according to need.

(c) Determination of the amount and duration of the loan repayment an applicant may receive, giving consideration to the availability of funds under the program, and the applicant's outstanding educational loans and professional credentials.

(d) Determination of the conditions of loan repayment applicable to an applicant.

(e) Enforcement of the state's rights under a loan repayment program contract, including the commencement of any court action.

(f) Cancellation of a loan repayment program contract for reasonable cause.

(g) Participation in federal programs supporting repayment of loans of health care providers and acceptance of gifts, grants, and other aid or amounts from any person, association, foundation, trust, corporation, governmental agency, or other entity for the purposes of the program.

(h) Upon availability of state funds, determination of eligibility criteria and qualifications for participating communities and applicants not located in federally designated shortage areas.

(i) Other rules as necessary.

(3) The center for rural health and primary care may enter into an agreement under chapter 28E with the college student aid commission for the administration of this program.

c. *Primary care provider community scholarship program.*

(1) A primary care provider community scholarship program is established to recruit and to provide scholarships to train primary health care practitioners in federally designated health professional shortage areas of the state. Under the program, scholarships may be awarded to a recipient for educational expenses incurred while completing an accredited

health education program directly related to obtaining the credentials necessary to practice the recipient's health profession.

(2) The department shall adopt rules relating to the establishment and administration of the primary care provider community scholarship program. Rules adopted pursuant to this paragraph shall provide, at a minimum, for all of the following:

(a) Determination of eligibility requirements and qualifications of an applicant to receive scholarships under the program, including but not limited to years of obligated service, clinical practice requirements, and residency requirements. One year of obligated service shall be provided by the applicant in exchange for each year of scholarship receipt, unless federal requirements otherwise require.

(b) Identification of federally designated health professional shortage areas of the state and prioritization of such areas according to need.

(c) Determination of the amount of the scholarship an applicant may receive.

(d) Determination of the conditions of scholarship to be awarded to an applicant.

(e) Enforcement of the state's rights under a scholarship contract, including the commencement of any court action.

(f) Cancellation of a scholarship contract for reasonable cause.

(g) Participation in federal programs supporting scholarships for health care providers and acceptance of gifts, grants, and other aid or amounts from any person, association, foundation, trust, corporation, governmental agency, or other entity for the purposes of the program.

(h) Upon availability of state funds, determination of eligibility criteria and qualifications for participating communities and applicants not located in federally designated shortage areas.

(i) Other rules as necessary.

(3) The center for rural health and primary care may enter into an agreement under chapter 28E with the college student aid commission for the administration of this program.

4. a. Eligibility under any of the programs established under the primary care provider recruitment and retention endeavor shall be based upon a community health services assessment completed under subsection 2, paragraph "a". A community or region, as applicable, shall submit a letter of intent to conduct a community health services assessment and to apply for assistance under this subsection. The letter shall be in a form and contain information as determined by the center. A letter of intent shall be submitted to the center by January 1 preceding the fiscal year for which an application for assistance is to be made.

b. Assistance under this subsection shall not be granted until such time as the community or region making application has completed the community health services assessment and adopted a long-term community health services assessment and developmental plan. In addition to any other requirements, a developmental plan shall include a clear commitment to informing high school students of the health care opportunities which may be available to such students.

c. The center for rural health and primary care shall seek additional assistance and resources from other state departments and agencies, federal agencies and grant programs, private organizations, and any other person, as appropriate. The center is authorized and directed to accept on behalf of the state any grant or contribution, federal or otherwise, made to assist in meeting the cost of carrying out the purpose of this subsection. All federal grants to and the federal receipts of the center are appropriated for the purpose set forth in such federal grants or receipts. Funds appropriated by the general assembly to the center for implementation of this subsection shall first be used for securing any available federal funds requiring a state match, with remaining funds being used for the community grant program.

d. The center for rural health and primary care may, to further the purposes of this subsection, provide financial assistance in the form of grants to support the effort of a community which is clearly part of the community's long-term community health services assessment and developmental plan. Efforts for which such grants may be awarded include but are not limited to the procurement of clinical equipment, clinical facilities, and telecommunications facilities, and the support of locum tenens arrangements and primary care provider mentor programs.

5. a. There is established an advisory committee to the center for rural health and primary care consisting of one representative, approved by the respective agency, of each of the following agencies: the department of agriculture and land stewardship, the Iowa department of public health, the department of inspections and appeals, the national institute for rural health policy, the rural health resource center, the institute of agricultural medicine and occupational health, and the Iowa state association of counties. The governor shall appoint two representatives of consumer groups active in rural health issues and a representative of each of two farm organizations active within the state, a representative of an agricultural business in the state, a representative of a critical needs hospital, a practicing rural family physician, a practicing rural physician assistant, a practicing rural advanced registered nurse practitioner, and a rural health practitioner who is not a physician, physician assistant, or advanced registered nurse practitioner, as members of the advisory committee. The advisory committee shall also include as members two state representatives, one appointed by the speaker of the house of representatives and one by the minority leader of the house, and two state senators, one appointed by the majority leader of the senate and one by the minority leader of the senate.

b. The advisory committee shall regularly meet with the administrative head of the center as well as the director of the center for agricultural health and safety established under section 262.78. The head of the center and the director of the center for agricultural health and safety shall consult with the advisory committee and provide the committee with relevant information regarding their agencies.

c. A simple majority of the membership of the advisory committee shall constitute a quorum. Action may be taken by the affirmative vote of a majority of the advisory committee membership.

89 Acts, ch 304, §702; 90 Acts, ch 1207, §1, 2; 90 Acts, ch 1223, §18

C93, §135.13

94 Acts, ch 1168, §2

C95, §135.107

95 Acts, ch 67, §10; 96 Acts, ch 1128, §2, 3; 97 Acts, ch 23, §14; 97 Acts, ch 203, §14; 98 Acts, ch 1100, §15; 2000 Acts, ch 1058, §16, 17; 2000 Acts, ch 1140, §23 – 25; 2000 Acts, ch 1223, §20, 21; 2005 Acts, ch 89, §5; 2009 Acts, ch 41, §41; 2010 Acts, ch 1031, §396; 2010 Acts, ch 1061, §26

[P] Legislative findings; 94 Acts, ch 1168, §1

[T] Subsection 3, paragraph b, subparagraph (2), subparagraph division (h) amended

[T] Subsection 5, paragraph a amended

DIVISION XI

DOMESTIC ABUSE DEATH REVIEW TEAM

135.108 Definitions.

As used in this division, unless the context otherwise requires:

1. “*Department*” means the Iowa department of public health.
2. “*Director*” means the director of public health.
3. “*Domestic abuse death*” means a homicide or suicide that involves or is a result of an assault as defined in section 708.1 and to which any of the following circumstances apply to the parties involved:
 - a. The alleged or convicted perpetrator is related to the decedent as spouse, separated spouse, or former spouse.
 - b. The alleged or convicted perpetrator resided with the decedent at the time of the assault that resulted in the homicide or suicide.
 - c. The alleged or convicted perpetrator and the decedent resided together in the past but did not reside together at the time of the assault that resulted in the homicide or suicide.
 - d. The alleged or convicted perpetrator and decedent are parents of the same minor child, whether they were married or lived together at any time.

e. The alleged or convicted perpetrator was in an ongoing personal relationship with the decedent.

f. The alleged or convicted perpetrator was arrested for or convicted of stalking or harassing the decedent, or an order or court-approved agreement was entered against the perpetrator under chapter 232, 236, 598, or 915 to restrict contact by the perpetrator with the decedent.

g. The decedent was related by blood or affinity to an individual who lived in the same household with or was in the workplace or proximity of the decedent, and that individual was threatened with assault by the perpetrator.

4. “*Team*” means the domestic abuse death review team established in section 135.109. 2000 Acts, ch 1136, §1

135.109 Iowa domestic abuse death review team membership.

1. An Iowa domestic abuse death review team is established as an independent agency of state government.

2. The department shall provide staffing and administrative support to the team.

3. The team shall include the following members:

a. The state medical examiner or the state medical examiner’s designee.

b. A licensed physician or nurse who is knowledgeable concerning domestic abuse injuries and deaths, including suicides.

c. A licensed mental health professional who is knowledgeable concerning domestic abuse.

d. A representative or designee of the Iowa coalition against domestic violence.

e. A certified or licensed professional who is knowledgeable concerning substance abuse.

f. A law enforcement official who is knowledgeable concerning domestic abuse.

g. A law enforcement investigator experienced in domestic abuse investigation.

h. An attorney experienced in prosecuting domestic abuse cases.

i. A judicial officer appointed by the chief justice of the supreme court.

j. A clerk of the district court appointed by the chief justice of the supreme court.

k. An employee or subcontractor of the department of corrections who is a trained batterers’ education program facilitator.

l. An attorney licensed in this state who provides criminal defense assistance or child custody representation, and who has experience in dissolution of marriage proceedings.

m. Both a female and a male victim of domestic abuse.

n. A family member of a decedent whose death resulted from domestic abuse.

4. The following individuals shall each designate a liaison to assist the team in fulfilling the team’s duties:

a. The attorney general.

b. The director of the Iowa department of corrections.

c. The director of public health.

d. The director of human services.

e. The commissioner of public safety.

f. The administrator of the bureau of vital records of the Iowa department of public health.

g. The director of the department of education.

h. The state court administrator.

i. The director of the department of human rights.

j. The director of the state law enforcement academy.

5. a. The director of public health, in consultation with the attorney general, shall appoint review team members who are not designated by another appointing authority.

b. A membership vacancy shall be filled in the same manner as the original appointment.

c. The membership of the review team is subject to the provisions of sections 69.16 and 69.16A, relating to political affiliation and gender balance.

d. A member of the team may be reappointed to serve additional terms on the team, subject to the provisions of chapter 69.

6. Membership terms shall be three-year staggered terms.

7. Members of the team are eligible for reimbursement of actual and necessary expenses incurred in the performance of their official duties.

8. Team members and their agents are immune from any liability, civil or criminal, which might otherwise be incurred or imposed as a result of any act, omission, proceeding, decision, or determination undertaken or performed, or recommendation made as a team member or agent provided that the team members or agents acted reasonably and in good faith and without malice in carrying out their official duties in their official capacity. A complainant bears the burden of proof in establishing malice or unreasonableness or lack of good faith in an action brought against team members involving the performance of their duties and powers.

2000 Acts, ch 1136, §2; 2006 Acts, ch 1184, §80, 81

135.110 Iowa domestic abuse death review team powers and duties.

1. The review team shall perform the following duties:

a. Prepare a biennial report for the governor, supreme court, attorney general, and the general assembly concerning the following subjects:

(1) The causes and manner of domestic abuse deaths, including an analysis of factual information obtained through review of domestic abuse death certificates and domestic abuse death data, including patient records and other pertinent confidential and public information concerning domestic abuse deaths.

(2) The contributing factors of domestic abuse deaths.

(3) Recommendations regarding the prevention of future domestic abuse deaths, including actions to be taken by communities, based on an analysis of these contributing factors.

b. Advise and consult the agencies represented on the team and other state agencies regarding program and regulatory changes that may prevent domestic abuse deaths.

c. Develop protocols for domestic abuse death investigations and team review.

2. In performing duties pursuant to subsection 1, the review team shall review the relationship between the decedent victim and the alleged or convicted perpetrator from the point where the abuse allegedly began, until the domestic abuse death occurred, and shall review all relevant documents pertaining to the relationship between the parties, including but not limited to protective orders and dissolution, custody, and support agreements and related court records, in order to ascertain whether a correlation exists between certain events in the relationship and any escalation of abuse, and whether patterns can be established regarding such events in relation to domestic abuse deaths in general. The review team shall consider such conclusions in making recommendations pursuant to subsection 1.

3. The team shall meet upon the call of the chairperson, upon the request of a state agency, or as determined by a majority of the team.

4. The team shall annually elect a chairperson and other officers as deemed necessary by the team.

5. The team may establish committees or panels to whom the team may assign some or all of the team's responsibilities.

6. Members of the team who are currently practicing attorneys or current employees of the judicial branch of state government shall not participate in the following:

a. An investigation by the team that involves a case in which the team member is presently involved in the member's professional capacity.

b. Development of protocols by the team for domestic abuse death investigations and team review.

c. Development of regulatory changes related to domestic abuse deaths.

2000 Acts, ch 1136, §3; 2000 Acts, ch 1232, §48; 2002 Acts, ch 1119, §131; 2006 Acts, ch 1184, §82

135.111 Confidentiality of domestic abuse death records.

1. A person in possession or control of medical, investigative, or other information pertaining to a domestic abuse death and related incidents and events preceding the

domestic abuse death, shall allow for the inspection and review of written or photographic information related to the death, whether the information is confidential or public in nature, by the department upon the request of the department and the team, to be used only in the administration and for the official duties of the team. Information and records produced under this section that are confidential under the law of this state or under federal law, or because of any legally recognized privilege, and information or records received from the confidential records, remain confidential under this section.

2. A person does not incur legal liability by reason of releasing information to the department as required under and in compliance with this section.

3. A person who releases or discloses confidential data, records, or any other type of information in violation of this section is guilty of a serious misdemeanor.

2000 Acts, ch 1136, §4

135.112 Rulemaking.

The department shall adopt rules pursuant to chapter 17A relating to the administration of the domestic abuse death review team and sections 135.108 through 135.111.

2000 Acts, ch 1136, §5

135.113 through 135.117 Reserved.

DIVISION XII

CHILD PROTECTION — CHILD PROTECTION CENTER GRANTS — SHAKEN BABY SYNDROME PREVENTION

135.118 Child protection center grant program.

1. A child protection center grant program is established in the Iowa department of public health in accordance with this section. The director of public health shall establish requirements for the grant program and shall award grants. A grant may be used for establishment of a new center or for support of an existing center.

2. The eligibility requirements for a child protection center grant shall include but are not limited to all of the following:

a. A grantee must meet or be in the process of meeting the standards established by the national children's alliance for children's advocacy centers.

b. A grantee must have in place an interagency memorandum of understanding regarding participation in the operation of the center and for coordinating the activities of the government entities that respond to cases of child abuse in order to facilitate the appropriate disposition of child abuse cases through the juvenile and criminal justice systems. Agencies participating under the memorandum must include the following that are operating in the area served by the grantee:

(1) Department of human services county offices assigned to child protection.

(2) County and municipal law enforcement agencies.

(3) Office of the county attorney.

(4) Other government agencies involved with child abuse assessments or service provision.

c. The interagency memorandum must provide for a cooperative team approach to responding to child abuse, reducing the number of interviews required of a victim of child abuse, and establishing an approach that emphasizes the best interest of the child and that provides investigation, assessment, and rehabilitative services.

d. As necessary to address serious cases of child abuse such as those involving sexual abuse, serious physical abuse, and substance abuse, a grantee must be able to involve or consult with persons from various professional disciplines who have training and expertise in addressing special types of child abuse. These persons may include but are not limited to physicians and other health care professionals, mental health professionals, social workers,

child protection workers, attorneys, juvenile court officers, public health workers, child development experts, child educators, and child advocates.

3. The director shall create a committee to consider grant proposals and to make grant recommendations to the director. The committee membership may include but is not limited to representatives of the following: departments of human services, justice, and public health, Iowa medical society, Iowa hospital association, Iowa nurses association, and an association representing social workers.

4. Implementation of the grant program is subject to the availability of funding for the grant program.

2001 Acts, ch 166, §1

135.119 Shaken baby syndrome prevention program.

1. For the purposes of this section:

a. “*Birth center*” and “*birthing hospital*” mean the same as defined in section 135.131.

b. “*Child care provider*” means the same as a child care facility, as defined in section 237A.1, that is providing child care to a child who is newborn through age three.

c. “*Family support program*” means a program offering instruction and support for families in which home visitation is the primary service delivery mechanism.

d. “*Parent*” means the same as “*custodian*”, “*guardian*”, or “*parent*”, as defined in section 232.2, of a child who is newborn through age three.

e. “*Person responsible for the care of a child*” means the same as defined in section 232.68, except that it is limited to persons responsible for the care of a child who is newborn through age three.

f. “*Shaken baby syndrome*” means the collection of signs and symptoms resulting from the vigorous shaking of a child who is three years of age or younger. Shaken baby syndrome may result in bleeding inside the child’s head and may cause one or more of the following conditions: irreversible brain damage; blindness, retinal hemorrhage, or eye damage; cerebral palsy; hearing loss; spinal cord injury, including paralysis; seizures; learning disability; central nervous system injury; closed head injury; rib fracture; subdural hematoma; or death. Shaken baby syndrome also includes the symptoms included in the diagnosis code for shaken infant syndrome utilized by Iowa hospitals.

2. a. The department shall establish a statewide shaken baby syndrome prevention program to educate parents and persons responsible for the care of a child about the dangers to children three years of age or younger caused by shaken baby syndrome and to discuss ways to reduce the syndrome’s risks. The program plan shall allow for voluntary participation by parents and persons responsible for the care of a child.

b. The program plan shall describe strategies for preventing shaken baby syndrome by providing education and support to parents and persons responsible for the care of a child and shall identify multimedia resources, written materials, and other resources that can assist in providing the education and support.

c. The department shall consult with experts with experience in child abuse prevention, child health, and parent education in developing the program plan.

d. The program plan shall incorporate a multiyear, collaborative approach for implementation of the plan. The plan shall address how to involve those who regularly work with parents and persons responsible for the care of a child, including but not limited to child abuse prevention programs, child care resource and referral programs, child care providers, family support programs, programs receiving funding through the early childhood Iowa initiative, public and private schools, health care providers, local health departments, birth centers, and birthing hospitals.

e. The program plan shall identify the methodology to be used for improving the tracking of shaken baby syndrome incidents and for evaluating the effectiveness of the plan’s education and support efforts.

f. The program plan shall describe how program results will be reported.

g. The program plan may provide for implementation of the program through a contract with a private agency or organization experienced in furnishing the services set forth in the program plan.

3. The department shall implement the program plan to the extent of the amount appropriated or made available for the program for a fiscal year.

2009 Acts, ch 7, §1; 2010 Acts, ch 1031, §291

[T] Subsection 2, paragraph d amended

DIVISION XIII

TAXATION OF ORGANIZED DELIVERY SYSTEMS

135.120 Taxation of organized delivery systems.

Payments received by an organized delivery system licensed by the director for health care services, insurance, indemnity, or other benefits to which an enrollee is entitled through an organized delivery system authorized under 1993 Iowa Acts, ch. 158, and payments by an organized delivery system licensed by the director to providers for health care services, to insurers, or corporations authorized under chapter 514 for insurance, indemnity, or other service benefits authorized under 1993 Iowa Acts, ch. 158, are not premiums received and taxable under the provisions of section 432.1 for the first five years of the existence of the organized delivery system, its successors or assigns, or the first five years after July 1, 1996, whichever is the later. After the first five years, the payments received shall be considered premiums received and shall be taxable under the provisions of section 432.1, subsection 1. However, payments made by the United States secretary of health and human services under contracts issued under section 1833 or 1876 of the federal Social Security Act, section 4015 of the federal Omnibus Budget Reconciliation Act of 1987, or chapter 249A for enrolled members shall not be considered premiums received and shall not be taxable under section 432.1.

96 Acts, ch 1146, §1; 2002 Acts, ch 1158, §1

135.121 through 135.129 Reserved.

DIVISION XIV

SUBSTANCE ABUSE TREATMENT FACILITY FOR PERSONS ON PROBATION

135.130 Substance abuse treatment facility for persons on probation.

1. The director shall establish and operate a facility for the purpose of providing a structured treatment program for persons with a substance abuse problem who are on probation and under the supervision of a judicial district department of correctional services. The department shall enter into an agreement pursuant to chapter 28E with the department of corrections for assistance in establishing security for the facility. The department, in consultation with the department of corrections, shall adopt rules pursuant to chapter 17A to administer this section. The rules adopted shall include rules related to the treatment requirements of the program.

2. A substance abuse treatment facility advisory council is established within the department to advise and make recommendations to the director regarding the establishment and operation of a facility for persons with a substance abuse problem who are on probation and to assist with the implementation of treatment programs that are proven to be effective for offenders. The substance abuse treatment facility advisory council shall consist of the directors of the eight judicial district departments of correctional services and one representative each from the judicial branch, the Iowa department of public health, the department of corrections, and the governor's office of drug control policy.

3. The department, in consultation with the department of corrections and the advisory council, shall adopt rules pursuant to chapter 17A to establish and operate the facility.

2001 Acts, ch 184, §7

DIVISION XV
NEWBORN AND INFANT
HEARING SCREENING

135.131 Universal newborn and infant hearing screening.

1. For the purposes of this section, unless the context otherwise requires:
 - a. “*Birth center*” means birth center as defined in section 135.61.
 - b. “*Birthing hospital*” means a private or public hospital licensed pursuant to chapter 135B that has a licensed obstetric unit or is licensed to provide obstetric services.
2. All newborns and infants born in this state shall be screened for hearing loss in accordance with this section. The person required to perform the screening shall use at least one of the following procedures:
 - a. Automated or diagnostic auditory brainstem response.
 - b. Otoacoustic emissions.
 - c. Any other technology approved by the department.
3.
 - a. A birthing hospital shall screen every newborn delivered in the hospital for hearing loss prior to discharge of the newborn from the birthing hospital. A birthing hospital that transfers a newborn for acute care prior to completion of the hearing screening shall notify the receiving facility of the status of the hearing screening. The receiving facility shall be responsible for completion of the newborn hearing screening.
 - b. The birthing hospital or other facility completing the hearing screening under this subsection shall report the results of the screening to the parent or guardian of the newborn and to the department in a manner prescribed by rule of the department. The birthing hospital or other facility shall also report the results of the hearing screening to the primary care provider of the newborn or infant upon discharge from the birthing hospital or other facility. If the newborn or infant was not tested prior to discharge, the birthing hospital or other facility shall report the status of the hearing screening to the primary care provider of the newborn or infant.
4. A birth center shall refer the newborn to a licensed audiologist, physician, or hospital for screening for hearing loss prior to discharge of the newborn from the birth center. The hearing screening shall be completed within thirty days following discharge of the newborn. The person completing the hearing screening shall report the results of the screening to the parent or guardian of the newborn and to the department in a manner prescribed by rule of the department. Such person shall also report the results of the screening to the primary care provider of the newborn.
5. If a newborn is delivered in a location other than a birthing hospital or a birth center, the physician or other health care professional who undertakes the pediatric care of the newborn or infant shall ensure that the hearing screening is performed within three months of the date of the newborn’s or infant’s birth. The physician or other health care professional shall report the results of the hearing screening to the parent or guardian of the newborn or infant, to the primary care provider of the newborn or infant, and to the department in a manner prescribed by rule of the department.
6. A birthing hospital, birth center, physician, or other health care professional required to report information under subsection 3, 4, or 5 shall report all of the following information to the department relating to a newborn’s or infant’s hearing screening, as applicable:
 - a. The name, address, and telephone number, if available, of the mother of the newborn or infant.
 - b. The primary care provider at the time of the newborn’s or infant’s discharge from the birthing hospital or birth center.
 - c. The results of the hearing screening.
 - d. Any rescreenings and the diagnostic audiological assessment procedures used.
 - e. Any known risk indicators for hearing loss of the newborn or infant.
 - f. Other information specified in rules adopted by the department.
7. The department may share information with agencies and persons involved with

newborn and infant hearing screenings, follow-up, and intervention services, including the local birth-to-three coordinator or similar agency, the local area education agency, and local health care providers. The department shall adopt rules to protect the confidentiality of the individuals involved.

8. An audiologist who provides services addressed by this section shall conduct diagnostic audiological assessments of newborns and infants in accordance with standards specified in rules adopted by the department. The audiologist shall report all of the following information to the department relating to a newborn's or infant's hearing, follow-up, diagnostic audiological assessment, and intervention services, as applicable:

a. The name, address, and telephone number, if available, of the mother of the newborn or infant.

b. The results of the hearing screening and any rescreenings, including the diagnostic audiological assessment procedures used.

c. The nature of any follow-up or other intervention services provided to the newborn or infant.

d. Any known risk indicators for hearing loss of the newborn or infant.

e. Other information specified in rules adopted by the department.

9. This section shall not apply if the parent objects to the screening. If a parent objects to the screening, the birthing hospital, birth center, physician, or other health care professional required to report information under subsection 3, 4, or 5 to the department shall obtain a written refusal from the parent, shall document the refusal in the newborn's or infant's medical record, and shall report the refusal to the department in the manner prescribed by rule of the department.

10. A person who acts in good faith in complying with this section shall not be civilly or criminally liable for reporting the information required to be reported by this section.

2003 Acts, ch 102, §1; 2009 Acts, ch 37, §3

DIVISION XVI

INTERAGENCY PHARMACEUTICALS BULK PURCHASING COUNCIL

135.132 Interagency pharmaceuticals bulk purchasing council.

1. For the purposes of this section, "*interagency pharmaceuticals bulk purchasing council*" or "*council*" means the interagency pharmaceuticals bulk purchasing council created in this section.

2. An interagency pharmaceuticals bulk purchasing council is created within the Iowa department of public health. The department shall provide staff support to the council and the department of pharmaceutical care of the university of Iowa hospitals and clinics shall act in an advisory capacity to the council. The council shall be composed of all of the following members:

a. The director of public health, or the director's designee.

b. The director of human services, or the director's designee.

c. The director of the department of administrative services, or the director's designee.

d. A representative of the state board of regents.

e. The director of the department of corrections, or the director's designee.

f. The director, or the director's designee, of any other agency that purchases pharmaceuticals designated to be included as a member by the director of public health.

3. The council shall select a chairperson annually from its membership. A majority of the members of the council shall constitute a quorum.

4. The council shall do all of the following:

a. Develop procedures that member agencies must follow in purchasing pharmaceuticals. However, a member agency may elect not to follow the council's procedures if the agency is able to purchase the pharmaceuticals for a lower price than the price available through

the council. An agency that does not follow the council's procedures shall report all of the following to the council:

- (1) The purchase price for the pharmaceuticals.
- (2) The name of the wholesaler, retailer, or manufacturer selling the pharmaceuticals.
- b. Designate a member agency as the central purchasing agency for purchasing of pharmaceuticals.
- c. Use existing distribution networks, including wholesale and retail distributors, to distribute the pharmaceuticals.
- d. Investigate options that maximize purchasing power, including expanding purchasing under the medical assistance program, qualifying for participation in purchasing programs under 42 U.S.C. § 256b, as amended, and utilizing rebate programs, hospital disproportionate share purchasing, multistate purchasing alliances, and health department and federally qualified health center purchasing.
- e. In collaboration with the department of pharmaceutical care of the university of Iowa hospitals and clinics, make recommendations to member agencies regarding drug utilization review, prior authorization, the use of restrictive formularies, the use of mail order programs, and copayment structures. This paragraph shall not apply to the medical assistance program but only to the operations of the member agencies.
5. The central purchasing agency may enter into agreements with a local governmental entity to purchase pharmaceuticals for the local governmental entity.
6. The council shall develop procedures under which the council may disclose information relating to the prices manufacturers or wholesalers charge for pharmaceuticals by category of pharmaceutical. The procedure shall prohibit the council from disclosing information that identifies a specific manufacturer or wholesaler or the prices charged by a specific manufacturer or wholesaler for a specific pharmaceutical.

2003 Acts, ch 112, §1; 2003 Acts, ch 145, §286

135.133 through 135.139 Reserved.

DIVISION XVII

DISASTER PREPAREDNESS

135.140 Definitions.

As used in this division, unless the context otherwise requires:

1. "*Bioterrorism*" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism.
2. "*Department*" means the Iowa department of public health.
3. "*Director*" means the director of public health or the director's designee.
4. "*Disaster*" means disaster as defined in section 29C.2.
5. "*Division*" means the division of acute disease prevention and emergency response of the department.
6. "*Public health disaster*" means a state of disaster emergency proclaimed by the governor in consultation with the department pursuant to section 29C.6 for a disaster which specifically involves an imminent threat of an illness or health condition that meets any of the following conditions of paragraphs "a" and "b":
 - a. Is reasonably believed to be caused by any of the following:
 - (1) Bioterrorism or other act of terrorism.
 - (2) The appearance of a novel or previously controlled or eradicated infectious agent or biological toxin.
 - (3) A chemical attack or accidental release.
 - (4) An intentional or accidental release of radioactive material.

- (5) A nuclear or radiological attack or accident.
- (6) A natural occurrence or incident, including but not limited to fire, flood, storm, drought, earthquake, tornado, or windstorm.
- (7) A man-made occurrence or incident, including but not limited to an attack, spill, or explosion.
 - b. Poses a high probability of any of the following:
 - (1) A large number of deaths in the affected population.
 - (2) A large number of serious or long-term disabilities in the affected population.
 - (3) Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of the affected population.
 - (4) Short-term or long-term physical or behavioral health consequences to a large number of the affected population.

7. “*Public health response team*” means a team of professionals, including licensed health care providers, nonmedical professionals skilled and trained in disaster or emergency response, and public health practitioners, which is sponsored by a hospital or other entity and approved by the department to provide disaster assistance in the event of a disaster or threatened disaster.

2003 Acts, ch 33, §1, 11; 2003 Acts, ch 179, §64; 2005 Acts, ch 89, §6, 7; 2006 Acts, ch 1184, §83; 2009 Acts, ch 37, §4, 5

135.141 Division of acute disease prevention and emergency response — establishment — duties of department.

1. A division of acute disease prevention and emergency response is established within the department. The division shall coordinate the administration of this division of this chapter with other administrative divisions of the department and with federal, state, and local agencies and officials.

- 2. The department shall do all of the following:
 - a. Coordinate with the homeland security and emergency management division of the department of public defense the administration of emergency planning matters which involve the public health, including development, administration, and execution of the public health components of the comprehensive plan and emergency management program pursuant to section 29C.8.
 - b. Coordinate with federal, state, and local agencies and officials, and private agencies, organizations, companies, and persons, the administration of emergency planning, response, and recovery matters that involve the public health.
 - c. Conduct and maintain a statewide risk assessment of any present or potential danger to the public health from biological agents.
 - d. If a public health disaster exists, or if there is reasonable cause to believe that a public health disaster is imminent, conduct a risk assessment of any present or potential danger to the public health from chemical, radiological, or other potentially dangerous agents.
 - e. For the purpose of paragraphs “c” and “d”, an employee or agent of the department may enter into and examine any premises containing potentially dangerous agents with the consent of the owner or person in charge of the premises or, if the owner or person in charge of the premises refuses admittance, with an administrative search warrant obtained under section 808.14. Based on findings of the risk assessment and examination of the premises, the director may order reasonable safeguards or take any other action reasonably necessary to protect the public health pursuant to rules adopted to administer this subsection.
 - f. Coordinate the location, procurement, storage, transportation, maintenance, and distribution of medical supplies, drugs, antidotes, and vaccines to prepare for or in response to a public health disaster, including receiving, distributing, and administering items from the strategic national stockpile program of the centers for disease control and prevention of the United States department of health and human services.
 - g. Conduct or coordinate public information activities regarding emergency and disaster planning, response, and recovery matters that involve the public health.
 - h. Apply for and accept grants, gifts, or other funds to be used for programs authorized by this division of this chapter.

i. Establish and coordinate other programs or activities as necessary for the prevention, detection, management, and containment of public health disasters, and for the recovery from such disasters.

j. Adopt rules pursuant to chapter 17A for the administration of this division of this chapter including rules adopted in cooperation with the Iowa pharmacy association and the Iowa hospital association for the development of a surveillance system to monitor supplies of drugs, antidotes, and vaccines to assist in detecting a potential public health disaster. Prior to adoption, the rules shall be approved by the state board of health and the administrator of the homeland security and emergency management division of the department of public defense.

2003 Acts, ch 33, §2, 11; 2003 Acts, ch 179, §157; 2005 Acts, ch 89, §8; 2009 Acts, ch 37, §6; 2009 Acts, ch 41, §42

135.142 Health care supplies.

1. The department may purchase and distribute antitoxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies as deemed advisable in the interest of preparing for or controlling a public health disaster.

2. If a public health disaster exists or there is reasonable cause to believe that a public health disaster is imminent and if the public health disaster or belief that a public health disaster is imminent results in a statewide or regional shortage or threatened shortage of any product described under subsection 1, whether or not such product has been purchased by the department, the department may control, restrict, and regulate by rationing and using quotas, prohibitions on shipments, allocation, or other means, the use, sale, dispensing, distribution, or transportation of the relevant product necessary to protect the public health, safety, and welfare of the people of this state. The department shall collaborate with persons who have control of the products when reasonably possible.

3. In making rationing or other supply and distribution decisions, the department shall give preference to health care providers, disaster response personnel, and mortuary staff.

4. During a public health disaster, the department may procure, store, or distribute any antitoxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies located within the state as may be reasonable and necessary to respond to the public health disaster, and may take immediate possession of these pharmaceutical agents and supplies. If a public health disaster affects more than one state, this section shall not be construed to allow the department to obtain antitoxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents or medical supplies for the primary purpose of hoarding such items or preventing the fair and equitable distribution of these pharmaceutical and medical supplies among affected states. The department shall collaborate with affected states and persons when reasonably possible.

5. The state shall pay just compensation to the owner of any product lawfully taken or appropriated by the department for the department's temporary or permanent use in accordance with this section. The amount of compensation shall be limited to the costs incurred by the owner to procure the item.

2003 Acts, ch 33, §3, 11; 2004 Acts, ch 1086, §34

135.143 Public health response teams.

1. The department shall approve public health response teams to supplement and support disrupted or overburdened local medical and public health personnel, hospitals, and resources. Assistance shall be rendered under the following circumstances:

a. At or near the site of a disaster or threatened disaster by providing direct medical care to victims or providing other support services.

b. If local medical or public health personnel or hospitals request the assistance of a public health response team to provide direct medical care to victims or to provide other support services in relation to any of the following incidents:

(1) During an incident resulting from a novel or previously controlled or eradicated infectious agent, disease, or biological toxin.

(2) After a chemical attack or accidental chemical release.

- (3) After an intentional or accidental release of radioactive material.
- (4) In response to a nuclear or radiological attack or accident.
- (5) Where an incident poses a high probability of a large number of deaths or long-term disabilities in the affected population.
- (6) During or after a natural occurrence or incident, including but not limited to fire, flood, storm, drought, earthquake, tornado, or windstorm.
- (7) During or after a man-made occurrence or incident, including but not limited to an attack, spill, or explosion.

2. The department shall provide by rule a process for registration and approval of public health response team members and sponsor entities and shall authorize specific public health response teams, which may include but are not limited to disaster assistance teams and environmental health response teams. The department may expedite the registration and approval process during a disaster, threatened disaster, or other incident described in subsection 1.

3. A member of a public health response team acting pursuant to this division of this chapter shall be considered an employee of the state under section 29C.21 and chapter 669, shall be afforded protection as an employee of the state under section 669.21, and shall be considered an employee of the state for purposes of workers' compensation, disability, and death benefits, provided that the member has done all of the following:

- a. Registered with and received approval to serve on a public health response team from the department.
- b. Provided direct medical care or other support services during a disaster, threatened disaster, or other incident described in subsection 1; or participated in a training exercise to prepare for a disaster or other incident described in subsection 1.

4. The department shall provide the department of administrative services with a list of individuals who have registered with and received approval from the department to serve on a public health response team. The department shall update the list on a quarterly basis, or as necessary for the department of administrative services to determine eligibility for coverage.

5. Upon notification of a compensable loss, the department of administrative services shall seek funding from the executive council for those costs associated with covered workers' compensation benefits.

2003 Acts, ch 33, §4, 11; 2003 Acts, ch 145, §286; 2005 Acts, ch 89, §9; 2009 Acts, ch 37, §7, 8

135.144 Additional duties of the department related to a public health disaster.

If a public health disaster exists, the department, in conjunction with the governor, may do any of the following:

1. Decontaminate or cause to be decontaminated, to the extent reasonable and necessary to address the public health disaster, any facility or material if there is cause to believe the contaminated facility or material may endanger the public health.

2. Adopt and enforce measures to provide for the identification and safe disposal of human remains, including performance of postmortem examinations, transportation, embalming, burial, cremation, interment, disinterment, and other disposal of human remains. To the extent possible, religious, cultural, family, and individual beliefs of the deceased person or the deceased person's family shall be considered when disposing of any human remains.

3. Take reasonable measures as necessary to prevent the transmission of infectious disease and to ensure that all cases of communicable disease are properly identified, controlled, and treated.

4. Take reasonable measures as necessary to ensure that all cases of chemical, biological, and radiological contamination are properly identified, controlled, and treated.

5. Order physical examinations and tests and collect specimens as necessary for the diagnosis or treatment of individuals, to be performed by any qualified person authorized to do so by the department. An examination or test shall not be performed or ordered if the examination or test is reasonably likely to lead to serious harm to the affected individual. The department may isolate or quarantine, pursuant to chapter 139A and the rules implementing chapter 139A and this division of this chapter, any individual whose refusal of medical

examination or testing results in uncertainty regarding whether the individual has been exposed to or is infected with a communicable or potentially communicable disease or otherwise poses a danger to public health.

6. Vaccinate or order that individuals be vaccinated against an infectious disease and to prevent the spread of communicable or potentially communicable disease. Vaccinations shall be administered by any qualified person authorized to do so by the department. The vaccination shall not be provided or ordered if it is reasonably likely to lead to serious harm to the affected individual. To prevent the spread of communicable or potentially communicable disease, the department may isolate or quarantine, pursuant to chapter 139A and the rules implementing chapter 139A and this division of this chapter, any person who is unable or unwilling to undergo vaccination pursuant to this subsection.

7. Treat or order that individuals exposed to or infected with disease receive treatment or prophylaxis. Treatment or prophylaxis shall be administered by any qualified person authorized to do so by the department. Treatment or prophylaxis shall not be provided or ordered if the treatment or prophylaxis is reasonably likely to lead to serious harm to the affected individual. To prevent the spread of communicable or potentially communicable disease, the department may isolate or quarantine, pursuant to chapter 139A and the rules implementing chapter 139A and this division of this chapter, any individual who is unable or unwilling to undergo treatment or prophylaxis pursuant to this section.

8. Isolate or quarantine individuals or groups of individuals pursuant to chapter 139A and the rules implementing chapter 139A and this division of this chapter.

9. Inform the public when a public health disaster has been declared or terminated, about protective measures to take during the disaster, and about actions being taken to control the disaster.

10. Accept grants and loans from the federal government pursuant to section 29C.6 or available provisions of federal law.

11. If a public health disaster or other public health emergency situation exists which poses an imminent threat to the public health, safety, and welfare, the department, in conjunction with the governor, may provide financial assistance, from funds appropriated to the department that are not otherwise encumbered, to political subdivisions as needed to alleviate the disaster or the emergency. If the department does not have sufficient unencumbered funds, the governor may request that the executive council, pursuant to the authority of section 7D.29, commit sufficient funds, up to one million dollars, that are not otherwise encumbered from the general fund, as needed and available, for the disaster or the emergency. If additional financial assistance is required in excess of one million dollars, approval by the legislative council is also required.

12. Temporarily reassign department employees for purposes of response and recovery efforts, to the extent such employees consent to the reassignments.

13. Order, in conjunction with the department of education, temporary closure of any public school or nonpublic school, as defined in section 280.2, to prevent or control the transmission of a communicable disease as defined in section 139A.2.

2003 Acts, ch 33, §5, 11; 2003 Acts, ch 179, §65; 2004 Acts, ch 1097, §1; 2005 Acts, ch 19, §32; 2009 Acts, ch 37, §9; 2010 Acts, ch 1088, §1

[T] NEW subsection 13

135.145 Information sharing.

1. When the department of public safety or other federal, state, or local law enforcement agency learns of a case of a disease or health condition, unusual cluster, or a suspicious event that may be the cause of a public health disaster, the department or agency shall immediately notify the department, the administrator of the homeland security and emergency management division of the department of public defense, the department of agriculture and land stewardship, and the department of natural resources as appropriate.

2. When the department learns of a case of a disease or health condition, an unusual cluster, or a suspicious event that may be the cause of a public health disaster, the department shall immediately notify the department of public safety, the homeland security and

emergency management division of the department of public defense, and other appropriate federal, state, and local agencies and officials.

3. Sharing of information on diseases, health conditions, unusual clusters, or suspicious events between the department and public safety authorities and other governmental agencies shall be restricted to sharing of only the information necessary for the prevention, control, and investigation of a public health disaster.

4. Release of information pursuant to this section shall be consistent with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

2003 Acts, ch 33, §6, 11; 2003 Acts, ch 179, §157; 2006 Acts, ch 1079, §1

[P] Communicable and infectious diseases and poisonings, see chapter 139A

135.146 First responder vaccination program.

1. In the event that federal funding is received for administering vaccinations for first responders, the department shall offer a vaccination program for first responders who may be exposed to infectious diseases when deployed to disaster locations. For purposes of this section, “*first responder*” means state and local law enforcement personnel, fire department personnel, and emergency medical personnel who will be deployed to sites of bioterrorism attacks, terrorist attacks, catastrophic or natural disasters, and other disasters. The vaccinations shall include, but not be limited to, vaccinations for hepatitis B, diphtheria, tetanus, influenza, and other vaccinations when recommended by the United States public health service and in accordance with federal emergency management agency policy. Immune globulin will be made available when necessary.

2. Participation in the vaccination program shall be voluntary, except for first responders who are classified as having occupational exposure to blood-borne pathogens as defined by the occupational safety and health administration standard contained in 29 C.F.R. § 1910.1030. First responders who are so classified shall be required to receive the vaccinations as described in subsection 1. A first responder shall be exempt from this requirement, however, when a written statement from a licensed physician is presented indicating that a vaccine is medically contraindicated for that person or the first responder signs a written statement that the administration of a vaccination conflicts with religious tenets.

3. The department shall establish first responder notification procedures regarding the existence of the program by rule, and shall develop, and distribute to first responders, educational materials on methods of preventing exposure to infectious diseases. In administering the program, the department may contract with county and local health departments, not-for-profit home health care agencies, hospitals, physicians, and military unit clinics.

2004 Acts, ch 1012, §1, 2; 2005 Acts, ch 3, §31

135.147 Immunity for emergency aid — exceptions.

1. A person, corporation, or other legal entity, or an employee or agent of such person, corporation, or entity, who, during a public health disaster, in good faith and at the request of or under the direction of the department or the department of public defense renders emergency care or assistance to a victim of the public health disaster shall not be liable for civil damages for causing the death of or injury to a person, or for damage to property, unless such acts or omissions constitute recklessness.

2. The immunities provided in this section shall not apply to any person, corporation, or other legal entity, or an employee or agent of such person, corporation, or entity, whose act or omission caused in whole or in part the public health disaster and who would otherwise be liable therefor.

2007 Acts, ch 159, §21

135.148 and 135.149 Reserved.

DIVISION XVIII
GAMBLING TREATMENT PROGRAM

135.150 Gambling treatment program — standards and licensing.

1. *a.* The department shall operate a gambling treatment program to provide programs which may include but are not limited to outpatient and follow-up treatment for persons affected by problem gambling, rehabilitation and residential treatment programs, information and referral services, crisis call access, education and preventive services, and financial management and credit counseling services.

b. A person shall not maintain or conduct a gambling treatment program funded through the department unless the person has obtained a license for the program from the department. The department shall adopt rules to establish standards for the licensing and operation of gambling treatment programs under this section. The rules shall specify, but are not limited to specifying, the qualifications for persons providing gambling treatment services, standards for the organization and administration of gambling treatment programs, and a mechanism to monitor compliance with this section and the rules adopted under this section.

2. The department shall report semiannually to the general assembly's standing committees on government oversight regarding the operation of the gambling treatment program. The report shall include but is not limited to information on the moneys expended and grants awarded for operation of the gambling treatment program.

2004 Acts, ch 1136, §55; 2005 Acts, ch 175, §77; 2009 Acts, ch 182, §106; 2010 Acts, ch 1069, §15

[SP] Moneys in former gambling treatment fund that remain unencumbered or unobligated at the close of FY 2008-2009 transferred to general fund; 2009 Acts, ch 182, §107

[SP] Department of public health to continue to implement a process for creation of a system for uniform delivery of gambling and substance abuse treatment services; 2008 Acts, ch 1187, §3; 2009 Acts, ch 182, §2; 2010 Acts, ch 1192, §2

[T] Subsection 2 amended

135.151 Reserved.

DIVISION XIX
OBSTETRICAL AND NEWBORN
INDIGENT PATIENT
CARE PROGRAM

135.152 Statewide obstetrical and newborn indigent patient care program.

1. The department shall establish a statewide obstetrical and newborn indigent patient care program to provide obstetrical and newborn care to medically indigent residents of this state at the appropriate and necessary level, at a licensed hospital or health care facility closest and most available to the residence of the indigent individual.

2. The department shall administer the program, and appropriations by the general assembly for the program shall be allocated to the obstetrical and newborn patient care fund within the department to be utilized for the obstetrical and newborn indigent patient care program.

3. The department shall adopt administrative rules pursuant to chapter 17A to administer the program.

4. The department shall establish a patient quota formula for determining the maximum number of obstetrical and newborn patients eligible for the program, annually, from each county. The formula used shall be based upon the annual appropriation for the program, the average number of live births in each county for the most recent three-year period, and the per capita income for each county for the most recent year. The formula shall also provide for reassignment of an unused county quota allotment on April 1 of each year.

5. *a.* The department, in collaboration with the department of human services and the Iowa state association of counties, shall adopt rules pursuant to chapter 17A to establish

minimum standards for eligibility for obstetrical and newborn care, including physician examinations, medical testing, ambulance services, and inpatient transportation services under the program. The minimum standards shall provide that the individual is not otherwise eligible for assistance under the medical assistance program or for assistance under the medically needy program without a spend-down requirement pursuant to chapter 249A, or for expansion population benefits pursuant to chapter 249J. If the individual is eligible for assistance pursuant to chapter 249A or 249J, or if the individual is eligible for maternal and child health care services covered by a maternal and child health program, the obstetrical and newborn indigent patient care program shall not provide the assistance, care, or covered services provided under the other program.

b. The minimum standards for eligibility shall provide eligibility for persons with family incomes at or below one hundred eighty-five percent of the federal poverty level as defined by the most recently revised poverty income guidelines published by the United States department of health and human services, and shall provide, but shall not be limited to providing, eligibility for uninsured and underinsured persons financially unable to pay for necessary obstetrical and newborn care. The minimum standards may include a spend-down provision. The resource standards shall be set at or above the resource standards under the federal supplemental security income program. The resource exclusions allowed under the federal supplemental security income program shall be allowed and shall include resources necessary for self-employment.

c. The department in cooperation with the department of human services, shall develop a standardized application form for the program and shall coordinate the determination of eligibility for the medical assistance and medically needy programs under chapter 249A, the medical assistance expansion under chapter 249J, and the obstetrical and newborn indigent patient care program.

6. The department shall establish application procedures and procedures for certification of an individual for obstetrical and newborn care under this section.

7. An individual certified for obstetrical and newborn care under this division may choose to receive the appropriate level of care at any licensed hospital or health care facility.

8. The obstetrical and newborn care costs of an individual certified for such care under this division at a licensed hospital or health care facility or from licensed physicians shall be paid by the department from the obstetrical and newborn patient care fund.

9. All providers of services to obstetrical and newborn patients under this division shall agree to accept as full payment the reimbursements allowable under the medical assistance program established pursuant to chapter 249A, adjusted for intensity of care.

10. The department shall establish procedures for payment for providers of services to obstetrical and newborn patients under this division from the obstetrical and newborn patient care fund. All billings from such providers shall be submitted directly to the department. However, payment shall not be made unless the requirements for application and certification for care pursuant to this division and rules adopted by the department are met.

11. Moneys encumbered prior to June 30 of a fiscal year for a certified eligible pregnant woman scheduled to deliver in the next fiscal year shall not revert from the obstetrical and newborn patient care fund to the general fund of the state. Moneys allocated to the obstetrical and newborn patient care fund shall not be transferred nor voluntarily reverted from the fund within a given fiscal year.

2005 Acts, ch 167, §43, 66

DIVISION XX

COLLABORATIVE SAFETY NET PROVIDER NETWORK

135.153 Iowa collaborative safety net provider network established.

1. The department shall establish an Iowa collaborative safety net provider network that includes community health centers, rural health clinics, free clinics, maternal and child health

centers, the expansion population provider network as described in chapter 249J, local boards of health that provide direct services, Iowa family planning network agencies, child health specialty clinics, and other safety net providers. The network shall be a continuation of the network established pursuant to 2005 Iowa Acts, ch. 175, section 2, subsection 12. The network shall include all of the following:

a. An Iowa safety net provider advisory group consisting of representatives of community health centers, rural health clinics, free clinics, maternal and child health centers, the expansion population provider network as described in chapter 249J, local boards of health that provide direct services, Iowa family planning network agencies, child health specialty clinics, other safety net providers, patients, and other interested parties.

b. A planning process to logically and systematically implement the Iowa collaborative safety net provider network.

c. A database of all community health centers, rural health clinics, free clinics, maternal and child health centers, the expansion population provider network as described in chapter 249J, local boards of health that provide direct services, Iowa family planning network agencies, child health specialty clinics, and other safety net providers. The data collected shall include the demographics and needs of the vulnerable populations served, current provider capacity, and the resources and needs of the participating safety net providers.

d. Network initiatives to, at a minimum, improve quality, improve efficiency, reduce errors, and provide clinical communication between providers. The network initiatives shall include but are not limited to activities that address all of the following:

- (1) Training.
- (2) Information technology.
- (3) Financial resource development.
- (4) A referral system for ambulatory care.
- (5) A referral system for specialty care.
- (6) Pharmaceuticals.
- (7) Recruitment of health professionals.

2. The network shall form a governing group which includes two individuals each representing community health centers, rural health clinics, free clinics, maternal and child health centers, the expansion population provider network as described in chapter 249J, local boards of health that provide direct services, the state board of health, Iowa family planning network agencies, child health specialty clinics, and other safety net providers.

3. The department shall provide for evaluation of the network and its impact on the medically underserved.

2007 Acts, ch 218, §103

[SP] Development and continuation of pharmaceutical infrastructure for safety net providers and implementation of specialty care initiative in two communities; 2007 Acts, ch 218, §97, 108, 109; 2008 Acts, ch 1187, §62; 2009 Acts, ch 182, §60; 2010 Acts, ch 1192, §2

[SP] Development of plan for coordination of care for individuals with diabetes who receive care from safety net providers; 2010 Acts, ch 1134, §4

135.153A Safety net provider recruitment and retention initiatives program — repeal.

The department, in accordance with efforts pursuant to sections 135.163 and 135.164 and in cooperation with the Iowa collaborative safety net provider network governing group as described in section 135.153, shall establish and administer a safety net provider recruitment and retention initiatives program to address the health care workforce shortage relative to safety net providers. Funding for the program may be provided through the health care workforce shortage fund or the safety net provider network workforce shortage account created in section 135.175. The department, in cooperation with the governing group, shall adopt rules pursuant to chapter 17A to implement and administer such program. This section is repealed June 30, 2014.

2009 Acts, ch 118, §44, 54

[SP] Implementation of section conditioned upon availability of funding; 2009 Acts, ch 118, §54

DIVISION XXI
IOWA HEALTH INFORMATION
TECHNOLOGY SYSTEM

135.154 Definitions.

As used in this division, unless the context otherwise requires:

1. “*Board*” means the state board of health created pursuant to section 136.1.
2. “*Department*” means the department of public health.
3. “*Health care professional*” means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.
4. “*Health information technology*” means the application of information processing, involving both computer hardware and software, that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication, decision making, quality, safety, and efficiency of clinical practice, and may include but is not limited to:
 - a. An electronic health record that electronically compiles and maintains health information that may be derived from multiple sources about the health status of an individual and may include a core subset of each care delivery organization’s electronic medical record such as a continuity of care record or a continuity of care document, computerized physician order entry, electronic prescribing, or clinical decision support.
 - b. A personal health record through which an individual and any other person authorized by the individual can maintain and manage the individual’s health information.
 - c. An electronic medical record that is used by health care professionals to electronically document, monitor, and manage health care delivery within a care delivery organization, is the legal record of the patient’s encounter with the care delivery organization, and is owned by the care delivery organization.
 - d. A computerized provider order entry function that permits the electronic ordering of diagnostic and treatment services, including prescription drugs.
 - e. A decision support function to assist physicians and other health care providers in making clinical decisions by providing electronic alerts and reminders to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments.
 - f. Tools to allow for the collection, analysis, and reporting of information or data on adverse events, the quality and efficiency of care, patient satisfaction, and other health care-related performance measures.
5. “*Interoperability*” means the ability of two or more systems or components to exchange information or data in an accurate, effective, secure, and consistent manner and to use the information or data that has been exchanged and includes but is not limited to:
 - a. The capacity to connect to a network for the purpose of exchanging information or data with other users.
 - b. The ability of a connected, authenticated user to demonstrate appropriate permissions to participate in the instant transaction over the network.
 - c. The capacity of a connected, authenticated user to access, transmit, receive, and exchange usable information with other users.
6. “*Recognized interoperability standard*” means interoperability standards recognized by the office of the national coordinator for health information technology of the United States department of health and human services.

2008 Acts, ch 1188, §23

135.155 Iowa electronic health — principles — goals.

1. Health information technology is rapidly evolving so that it can contribute to the goals of improving access to and quality of health care, enhancing efficiency, and reducing costs.

2. To be effective, the health information technology system shall comply with all of the following principles:

- a. Be patient-centered and market-driven.
 - b. Be based on approved standards developed with input from all stakeholders.
 - c. Protect the privacy of consumers and the security and confidentiality of all health information.
 - d. Promote interoperability.
 - e. Ensure the accuracy, completeness, and uniformity of data.
3. Widespread adoption of health information technology is critical to a successful health information technology system and is best achieved when all of the following occur:
- a. The market provides a variety of certified products from which to choose in order to best fit the needs of the user.
 - b. The system provides incentives for health care professionals to utilize the health information technology and provides rewards for any improvement in quality and efficiency resulting from such utilization.
 - c. The system provides protocols to address critical problems.
 - d. The system is financed by all who benefit from the improved quality, efficiency, savings, and other benefits that result from use of health information technology.

2008 Acts, ch 1188, §24

135.156 Electronic health information — department duties — advisory council — executive committee.

1. a. The department shall direct a public and private collaborative effort to promote the adoption and use of health information technology in this state in order to improve health care quality, increase patient safety, reduce health care costs, enhance public health, and empower individuals and health care professionals with comprehensive, real-time medical information to provide continuity of care and make the best health care decisions. The department shall provide coordination for the development and implementation of an interoperable electronic health records system, telehealth expansion efforts, the health information technology infrastructure, and other health information technology initiatives in this state. The department shall be guided by the principles and goals specified in section 135.155.

b. All health information technology efforts shall endeavor to represent the interests and meet the needs of consumers and the health care sector, protect the privacy of individuals and the confidentiality of individuals' information, promote physician best practices, and make information easily accessible to the appropriate parties. The system developed shall be consumer-driven, flexible, and expandable.

2. a. An electronic health information advisory council is established which shall consist of the representatives of entities involved in the electronic health records system task force established pursuant to section 217.41A, Code 2007,* a pharmacist, a licensed practicing physician, a consumer who is a member of the state board of health, a representative of the state's Medicare quality improvement organization, the executive director of the Iowa communications network, a representative of the private telecommunications industry, a representative of the Iowa collaborative safety net provider network created in section 135.153, a nurse informaticist from the university of Iowa, and any other members the department or executive committee of the advisory council determines necessary and appoints to assist the department or executive committee at various stages of development of the electronic health information system. Executive branch agencies shall also be included as necessary to assist in the duties of the department and the executive committee. Public members of the advisory council shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent. Any legislative members shall be paid the per diem and expenses specified in section 2.10.

b. An executive committee of the electronic health information advisory council is established. Members of the executive committee of the advisory council shall receive reimbursement for actual expenses incurred while serving in their official capacity only

if they are not eligible for reimbursement by the organization that they represent. The executive committee shall consist of the following members:

(1) Three members, each of whom is the chief information officer of one of the three largest private health care systems in the state.

(2) One member who is the chief information officer of the university of Iowa hospitals and clinics, or the chief information officer's designee, selected by the director of the university of Iowa hospitals and clinics.

(3) One member who is a representative of a rural hospital which is a member of the Iowa hospital association, selected by the Iowa hospital association.

(4) One member who is a consumer member of the state board of health, selected by the state board of health.

(5) One member who is a licensed practicing physician, selected by the Iowa medical society.

(6) One member who is licensed to practice nursing, selected by the Iowa nurses association.

(7) One representative of an insurance carrier, selected by the federation of Iowa insurers.

3. The executive committee, with the technical assistance of the advisory council and the support of the department, shall do all of the following:

a. Develop a statewide health information technology plan by July 1, 2009. In developing the plan, the executive committee shall seek the input of providers, payers, and consumers. Standards and policies developed for the plan shall promote and be consistent with national standards developed by the office of the national coordinator for health information technology of the United States department of health and human services and shall address or provide for all of the following:

(1) The effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvement. The executive committee shall recommend requirements for interoperable electronic health records in this state including a recognized interoperability standard.

(2) Education of the public and health care sector about the value of health information technology in improving patient care, and methods to promote increased support and collaboration of state and local public health agencies, health care professionals, and consumers in health information technology initiatives.

(3) Standards for the exchange of health care information.

(4) Policies relating to the protection of privacy of patients and the security and confidentiality of patient information.

(5) Policies relating to information ownership.

(6) Policies relating to governance of the various facets of the health information technology system.

(7) A single patient identifier or alternative mechanism to share secure patient information. If no alternative mechanism is acceptable to the executive committee, all health care professionals shall utilize the mechanism selected by the executive committee by July 1, 2010.

(8) A standard continuity of care record and other issues related to the content of electronic transmissions. All health care professionals shall utilize the standard continuity of care record by July 1, 2010.

(9) Requirements for electronic prescribing.

(10) Economic incentives and support to facilitate participation in an interoperable system by health care professionals.

b. Identify existing and potential health information technology efforts in this state, regionally, and nationally, and integrate existing efforts to avoid incompatibility between efforts and avoid duplication.

c. Coordinate public and private efforts to provide the network backbone infrastructure for the health information technology system. In coordinating these efforts, the executive committee shall do all of the following:

(1) Develop policies to effectuate the logical cost-effective usage of and access to the state-owned network, and support of telecommunication carrier products, where applicable.

(2) Consult with the Iowa communications network, private fiberoptic networks, and any other communications entity to seek collaboration, avoid duplication, and leverage opportunities in developing a network backbone.

(3) Establish protocols to ensure compliance with any applicable federal standards.

(4) Determine costs for accessing the network at a level that provides sufficient funding for the network.

d. Promote the use of telemedicine.

(1) Examine existing barriers to the use of telemedicine and make recommendations for eliminating these barriers.

(2) Examine the most efficient and effective systems of technology for use and make recommendations based on the findings.

e. Address the workforce needs generated by increased use of health information technology.

f. Recommend rules to be adopted in accordance with chapter 17A to implement all aspects of the statewide health information technology plan and the network.

g. Coordinate, monitor, and evaluate the adoption, use, interoperability, and efficiencies of the various facets of health information technology in this state.

h. Seek and apply for any federal or private funding to assist in the implementation and support of the health information technology system and make recommendations for funding mechanisms for the ongoing development and maintenance costs of the health information technology system.

i. Identify state laws and rules that present barriers to the development of the health information technology system and recommend any changes to the governor and the general assembly.

4. Recommendations and other activities resulting from the work of the department or the executive committee shall be presented to the board for action or implementation.

2008 Acts, ch 1188, §25

DIVISION XXII

MEDICAL HOME

135.157 Definitions.

As used in this division, unless the context otherwise requires:

1. “*Board*” means the state board of health created pursuant to section 136.1.

2. “*Department*” means the department of public health.

3. “*Health care professional*” means a person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

4. “*Medical home*” means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, and other health care professionals, and where appropriate, the patient’s family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient’s family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in section 135.158.

5. “*National committee for quality assurance*” means the nationally recognized, independent nonprofit organization that measures the quality and performance of health care and health care plans in the United States; provides accreditation, certification, and recognition programs for health care plans and programs; and is recognized in Iowa as an accrediting organization for commercial and Medicaid-managed care organizations.

6. “*Personal provider*” means the patient’s first point of contact in the health care system with a primary care provider who identifies the patient’s health needs and, working with a team of health care professionals, provides for and coordinates appropriate care to address the health needs identified.

7. “Primary care” means health care which emphasizes providing for a patient’s general health needs and utilizes collaboration with other health care professionals and consultation or referral as appropriate to meet the needs identified.

8. “Primary care provider” means any of the following who provide primary care and meet certification standards:

- a. A physician who is a family or general practitioner, a pediatrician, an internist, an obstetrician, or a gynecologist.
- b. An advanced registered nurse practitioner.
- c. A physician assistant.
- d. A chiropractor licensed pursuant to chapter 151. 2008 Acts, ch 1188, §44; 2009 Acts, ch 41, §43

135.158 Medical home purposes — characteristics.

1. The purposes of a medical home are the following:
 - a. To reduce disparities in health care access, delivery, and health care outcomes.
 - b. To improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage and to provide for the sustainability of the health care system.
 - c. To provide a tangible method to document if each Iowan has access to health care.
2. A medical home has all of the following characteristics:
 - a. A personal provider. Each patient has an ongoing relationship with a personal provider trained to provide first contact and continuous and comprehensive care.
 - b. A provider-directed medical practice. The personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing health care of patients.
 - c. Whole person orientation. The personal provider is responsible for providing for all of a patient’s health care needs or taking responsibility for appropriately arranging health care by other qualified health care professionals. This responsibility includes health care at all stages of life including provision of acute care, chronic care, preventive services, and end-of-life care.
 - d. Coordination and integration of care. Care is coordinated and integrated across all elements of the complex health care system and the patient’s community. Care is facilitated by registries, information technology, health information exchanges, and other means to assure that patients receive the indicated care when and where they need and want the care in a culturally and linguistically appropriate manner.
 - e. Quality and safety. The following are quality and safety components of the medical home:
 - (1) Provider-directed medical practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between providers, the patient, and the patient’s family.
 - (2) Evidence-based medicine and clinical decision-support tools guide decision making.
 - (3) Providers in the medical practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
 - (4) Patients actively participate in decision making and feedback is sought to ensure that the patients’ expectations are being met.
 - (5) Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
 - (6) Practices participate in a voluntary recognition process conducted by an appropriate nongovernmental entity to demonstrate that the practice has the capabilities to provide patient-centered services consistent with the medical home model.
 - (7) Patients and families participate in quality improvement activities at the practice level.
 - f. Enhanced access to health care. Enhanced access to health care is available through systems such as open scheduling, expanded hours, and new options for communication between the patient, the patient’s personal provider, and practice staff.
 - g. Payment. The payment system appropriately recognizes the added value provided to

patients who have a patient-centered medical home. The payment structure framework of the medical home provides all of the following:

- (1) Reflects the value of provider and nonprovider staff and patient-centered care management work that is in addition to the face-to-face visit.
- (2) Pays for services associated with coordination of health care both within a given practice and between consultants, ancillary providers, and community resources.
- (3) Supports adoption and use of health information technology for quality improvement.
- (4) Supports provision of enhanced communication access such as secure electronic mail and telephone consultation.
- (5) Recognizes the value of provider work associated with remote monitoring of clinical data using technology.
- (6) Allows for separate fee-for-service payments for face-to-face visits. Payments for health care management services that are in addition to the face-to-face visit do not result in a reduction in the payments for face-to-face visits.
- (7) Recognizes case mix differences in the patient population being treated within the practice.
- (8) Allows providers to share in savings from reduced hospitalizations associated with provider-guided health care management in the office setting.
- (9) Allows for additional payments for achieving measurable and continuous quality improvements.

2008 Acts, ch 1188, §45

135.159 Medical home system — advisory council — development and implementation.

1. The department shall administer the medical home system. The department shall adopt rules pursuant to chapter 17A necessary to administer the medical home system.

2. *a.* The department shall establish an advisory council which shall include but is not limited to all of the following members, selected by their respective organizations, and any other members the department determines necessary to assist in the department's duties at various stages of development of the medical home system:

- (1) The director of human services, or the director's designee.
- (2) The commissioner of insurance, or the commissioner's designee.
- (3) A representative of the federation of Iowa insurers.
- (4) A representative of the Iowa dental association.
- (5) A representative of the Iowa nurses association.
- (6) A physician and an osteopathic physician licensed pursuant to chapter 148 who are family physicians and members of the Iowa academy of family physicians.
- (7) A health care consumer.
- (8) A representative of the Iowa collaborative safety net provider network established pursuant to section 135.153.
- (9) A representative of the governor's developmental disabilities council.
- (10) A representative of the Iowa chapter of the American academy of pediatrics.
- (11) A representative of the child and family policy center.
- (12) A representative of the Iowa pharmacy association.
- (13) A representative of the Iowa chiropractic society.
- (14) A representative of the university of Iowa college of public health.

b. Public members of the advisory council shall receive reimbursement for actual expenses incurred while serving in their official capacity only if they are not eligible for reimbursement by the organization that they represent.

3. The department shall develop a plan for implementation of a statewide medical home system. The department, in collaboration with parents, schools, communities, health plans, and providers, shall endeavor to increase healthy outcomes for children and adults by linking the children and adults with a medical home, identifying health improvement goals for children and adults, and linking reimbursement strategies to increasing healthy outcomes for children and adults. The plan shall provide that the medical home system shall do all of the following:

- a.* Coordinate and provide access to evidence-based health care services, emphasizing

convenient, comprehensive primary care and including preventive, screening, and well-child health services.

- b. Provide access to appropriate specialty care and inpatient services.
- c. Provide quality-driven and cost-effective health care.
- d. Provide access to pharmacist-delivered medication reconciliation and medication therapy management services, where appropriate.
- e. Promote strong and effective medical management including but not limited to planning treatment strategies, monitoring health outcomes and resource use, sharing information, and organizing care to avoid duplication of service. The plan shall provide that in sharing information, the priority shall be the protection of the privacy of individuals and the security and confidentiality of the individual's information. Any sharing of information required by the medical home system shall comply and be consistent with all existing state and federal laws and regulations relating to the confidentiality of health care information and shall be subject to written consent of the patient.
- f. Emphasize patient and provider accountability.
- g. Prioritize local access to the continuum of health care services in the most appropriate setting.
- h. Establish a baseline for medical home goals and establish performance measures that indicate a child or adult has an established and effective medical home. For children, these goals and performance measures may include but are not limited to childhood immunization rates, well-child care utilization rates, care management for children with chronic illnesses, emergency room utilization, and oral health service utilization.
- i. For children, coordinate with and integrate guidelines, data, and information from existing newborn and child health programs and entities, including but not limited to the healthy opportunities for parents to experience success – healthy families Iowa program, the early childhood Iowa initiative, the center for congenital and inherited disorders screening and health care programs, standards of care for pediatric health guidelines, the office of multicultural health* established in section 135.12, the oral health bureau established in section 135.15, and other similar programs and services.

4. The department shall develop an organizational structure for the medical home system in this state. The organizational structure plan shall integrate existing resources, provide a strategy to coordinate health care services, provide for monitoring and data collection on medical homes, provide for training and education to health care professionals and families, and provide for transition of children to the adult medical care system. The organizational structure may be based on collaborative teams of stakeholders throughout the state such as local public health agencies, the collaborative safety net provider network established in section 135.153, or a combination of statewide organizations. Care coordination may be provided through regional offices or through individual provider practices. The organizational structure may also include the use of telemedicine resources, and may provide for partnering with pediatric and family practice residency programs to improve access to preventive care for children. The organizational structure shall also address the need to organize and provide health care to increase accessibility for patients including using venues more accessible to patients and having hours of operation that are conducive to the population served.

5. The department shall adopt standards and a process to certify medical homes based on the national committee for quality assurance standards. The certification process and standards shall provide mechanisms to monitor performance and to evaluate, promote, and improve the quality of health of and health care delivered to patients through a medical home. The mechanism shall require participating providers to monitor clinical progress and performance in meeting applicable standards and to provide information in a form and manner specified by the department. The evaluation mechanism shall be developed with input from consumers, providers, and payers. At a minimum the evaluation shall determine any increased quality in health care provided and any decrease in cost resulting from the medical home system compared with other health care delivery systems. The standards and process shall also include a mechanism for other ancillary service providers to become affiliated with a certified medical home.

6. The department shall adopt education and training standards for health care professionals participating in the medical home system.

7. The department shall provide for system simplification through the use of universal referral forms, internet-based tools for providers, and a central medical home internet site for providers.

8. The department shall recommend a reimbursement methodology and incentives for participation in the medical home system to ensure that providers enter and remain participating in the system. In developing the recommendations for incentives, the department shall consider, at a minimum, providing incentives to promote wellness, prevention, chronic care management, immunizations, health care management, and the use of electronic health records. In developing the recommendations for the reimbursement system, the department shall analyze, at a minimum, the feasibility of all of the following:

a. Reimbursement under the medical assistance program to promote wellness and prevention, provide care coordination, and provide chronic care management.

b. Increasing reimbursement to Medicare levels for certain wellness and prevention services, chronic care management, and immunizations.

c. Providing reimbursement for primary care services by addressing the disparities between reimbursement for specialty services and primary care services.

d. Increased funding for efforts to transform medical practices into certified medical homes, including emphasizing the implementation of the use of electronic health records.

e. Targeted reimbursement to providers linked to health care quality improvement measures established by the department.

f. Reimbursement for specified ancillary support services such as transportation for medical appointments and other such services.

g. Providing reimbursement for medication reconciliation and medication therapy management service, where appropriate.

9. The department shall coordinate the requirements and activities of the medical home system with the requirements and activities of the dental home for children as described in section 249J.14, and shall recommend financial incentives for dentists and nondental providers to promote oral health care coordination through preventive dental intervention, early identification of oral disease risk, health care coordination and data tracking, treatment, chronic care management, education and training, parental guidance, and oral health promotions for children.

10. The department shall integrate the recommendations and policies developed by the prevention and chronic care management advisory council into the medical home system.

11. *Implementation phases.*

a. Initial implementation shall require participation in the medical home system of children who are recipients of full benefits under the medical assistance program. The department shall work with the department of human services and shall recommend to the general assembly a reimbursement methodology to compensate providers participating under the medical assistance program for participation in the medical home system.

b. The department shall work with the department of human services to expand the medical home system to adults who are recipients of full benefits under the medical assistance program and the expansion population under the IowaCare program. The department shall work with the centers for Medicare and Medicaid services of the United States department of health and human services to allow Medicare recipients to utilize the medical home system.

c. The department shall work with the department of administrative services to allow state employees to utilize the medical home system.

d. The department shall work with insurers and self-insured companies, if requested, to make the medical home system available to individuals with private health care coverage.

12. The department shall provide oversight for all certified medical homes. The department shall review the progress of the medical home system and recommend improvements to the system, as necessary.

13. The department shall annually evaluate the medical home system and make

recommendations to the governor and the general assembly regarding improvements to and continuation of the system.

14. Recommendations and other activities resulting from the duties authorized for the department under this section shall require approval by the board prior to any subsequent action or implementation.

2008 Acts, ch 1188, §46; 2009 Acts, ch 41, §44; 2009 Acts, ch 133, §34; 2010 Acts, ch 1031, §292; 2010 Acts, ch 1141, §23

[SP] “Office of minority and multicultural health” probably intended; corrective legislation is pending

[T] Subsection 3, paragraph i amended

[T] Subsection 9 amended

DIVISION XXIII PREVENTION AND CHRONIC CARE MANAGEMENT

135.160 Definitions.

For the purpose of this division, unless the context otherwise requires:

1. “*Board*” means the state board of health created pursuant to section 136.1.
2. “*Chronic care*” means health care services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the chronic condition, and prevent complications related to the chronic condition.
3. “*Chronic care information system*” means approved information technology to enhance the development and communication of information to be used in providing chronic care, including clinical, social, and economic outcomes of chronic care.
4. “*Chronic care management*” means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the health care professional and patient relationship, and a chronic care plan emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.
5. “*Chronic care plan*” means a plan of care between an individual and the individual’s principal health care professional that emphasizes prevention of complications through patient empowerment including but not limited to providing incentives to engage the patient in the patient’s own care and in clinical, social, or other interventions designed to minimize the negative effects of the chronic condition.
6. “*Chronic care resources*” means health care professionals, advocacy groups, health departments, schools of public health and medicine, health plans, and others with expertise in public health, health care delivery, health care financing, and health care research.
7. “*Chronic condition*” means an established clinical condition that is expected to last a year or more and that requires ongoing clinical management.
8. “*Department*” means the department of public health.
9. “*Director*” means the director of public health.
10. “*Eligible individual*” means a resident of this state who has been diagnosed with a chronic condition or is at an elevated risk for a chronic condition and who is a recipient of medical assistance, is a member of the expansion population pursuant to chapter 249J, or is an inmate of a correctional institution in this state.
11. “*Health care professional*” means health care professional as defined in section 135.157.
12. “*Health risk assessment*” means screening by a health care professional for the purpose of assessing an individual’s health, including tests or physical examinations and a survey or other tool used to gather information about an individual’s health, medical history, and health risk factors during a health screening.

2008 Acts, ch 1188, §50

135.161 Prevention and chronic care management initiative — advisory council.

1. The director, in collaboration with the prevention and chronic care management advisory council, shall develop a state initiative for prevention and chronic care management. The state initiative consists of the state's plan for developing a chronic care organizational structure for prevention and chronic care management, including coordinating the efforts of health care professionals and chronic care resources to promote the health of residents and the prevention and management of chronic conditions, developing and implementing arrangements for delivering prevention services and chronic care management, developing significant patient self-care efforts, providing systemic support for the health care professional-patient relationship and options for channeling chronic care resources and support to health care professionals, providing for community development and outreach and education efforts, and coordinating information technology initiatives with the chronic care information system.

2. The director may accept grants and donations and shall apply for any federal, state, or private grants available to fund the initiative. Any grants or donations received shall be placed in a separate fund in the state treasury and used exclusively for the initiative or as federal law directs.

3. *a.* The director shall establish and convene an advisory council to provide technical assistance to the director in developing a state initiative that integrates evidence-based prevention and chronic care management strategies into the public and private health care systems, including the medical home system. Public members of the advisory council shall receive their actual and necessary expenses incurred in the performance of their duties and may be eligible to receive compensation as provided in section 7E.6.

b. The advisory council shall elicit input from a variety of health care professionals, health care professional organizations, community and nonprofit groups, insurers, consumers, businesses, school districts, and state and local governments in developing the advisory council's recommendations.

c. The advisory council shall submit initial recommendations to the director for the state initiative for prevention and chronic care management no later than July 1, 2009. The recommendations shall address all of the following:

(1) The recommended organizational structure for integrating prevention and chronic care management into the private and public health care systems. The organizational structure recommended shall align with the organizational structure established for the medical home system developed pursuant to division XXII. The advisory council shall also review existing prevention and chronic care management strategies used in the health insurance market and in private and public programs and recommend ways to expand the use of such strategies throughout the health insurance market and in the private and public health care systems.

(2) A process for identifying leading health care professionals and existing prevention and chronic care management programs in the state, and coordinating care among these health care professionals and programs.

(3) A prioritization of the chronic conditions for which prevention and chronic care management services should be provided, taking into consideration the prevalence of specific chronic conditions and the factors that may lead to the development of chronic conditions; the fiscal impact to state health care programs of providing care for the chronic conditions of eligible individuals; the availability of workable, evidence-based approaches to chronic care for the chronic condition; and public input into the selection process. The advisory council shall initially develop consensus guidelines to address the two chronic conditions identified as having the highest priority and shall also specify a timeline for inclusion of additional specific chronic conditions in the initiative.

(4) A method to involve health care professionals in identifying eligible patients for prevention and chronic care management services, which includes but is not limited to the use of a health risk assessment.

(5) The methods for increasing communication between health care professionals and patients, including patient education, patient self-management, and patient follow-up plans.

(6) The educational, wellness, and clinical management protocols and tools to be used by health care professionals, including management guideline materials for health care delivery.

(7) The use and development of process and outcome measures and benchmarks, aligned to the greatest extent possible with existing measures and benchmarks such as the “best in class” estimates utilized in the national healthcare quality report of the agency for health care research and quality of the United States department of health and human services, to provide performance feedback for health care professionals and information on the quality of health care, including patient satisfaction and health status outcomes.

(8) Payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to utilize prevention services, establish management systems for chronic conditions, improve health outcomes, and improve the quality of health care, including case management fees, payment for technical support and data entry associated with patient registries, and the cost of staff coordination within a medical practice.

(9) Methods to involve public and private groups, health care professionals, insurers, third-party administrators, associations, community and consumer groups, and other entities to facilitate and sustain the initiative.

(10) Alignment of any chronic care information system or other information technology needs with other health care information technology initiatives.

(11) Involvement of appropriate health resources and public health and outcomes researchers to develop and implement a sound basis for collecting data and evaluating the clinical, social, and economic impact of the initiative, including a determination of the impact on expenditures and prevalence and control of chronic conditions.

(12) Elements of a marketing campaign that provides for public outreach and consumer education in promoting prevention and chronic care management strategies among health care professionals, health insurers, and the public.

(13) A method to periodically determine the percentage of health care professionals who are participating, the success of the empowerment-of-patients approach, and any results of health outcomes of the patients participating.

(14) A means of collaborating with the health professional licensing boards pursuant to chapter 147 to review prevention and chronic care management education provided to licensees, as appropriate, and recommendations regarding education resources and curricula for integration into existing and new education and training programs.

4. Following submission of initial recommendations to the director for the state initiative for prevention and chronic care management by the advisory council, the director shall submit the state initiative to the board for approval. Subject to approval of the state initiative by the board, the department shall initially implement the state initiative among the population of eligible individuals. Following initial implementation, the director shall work with the department of human services, insurers, health care professional organizations, and consumers in implementing the initiative beyond the population of eligible individuals as an integral part of the health care delivery system in the state. The advisory council shall continue to review and make recommendations to the director regarding improvements to the initiative. Any recommendations are subject to approval by the board.

5. Following the initial submission of recommendations pursuant to subsection 3, the council shall recommend, no later than December 15, 2011, strategies to collect and provide statistically accurate data concerning chronic disease in multicultural groups of racial and ethnic diversity in the state. Following implementation of the strategies and collection of data, the council shall also make evidence-based recommendations to the director to address and reduce identified disparities.

2008 Acts, ch 1188, §51; 2010 Acts, ch 1088, §7

[T] NEW subsection 5

135.162 Clinicians advisory panel.

1. The director shall convene a clinicians advisory panel to advise and recommend to the department clinically appropriate, evidence-based best practices regarding the implementation of the medical home as defined in section 135.157 and the prevention and

chronic care management initiative pursuant to section 135.161. The director shall act as chairperson of the advisory panel.

2. The clinicians advisory panel shall consist of nine members representing licensed medical health care providers selected by their respective professional organizations. Terms of members shall begin and end as provided in section 69.19. Any vacancy shall be filled in the same manner as regular appointments are made for the unexpired portion of the regular term. Members shall serve terms of three years. A member is eligible for reappointment for three successive terms.

3. The clinicians advisory panel shall meet on a quarterly basis to receive updates from the director regarding strategic planning and implementation progress on the medical home and the prevention and chronic care management initiative and shall provide clinical consultation to the department regarding the medical home and the initiative.

2008 Acts, ch 1188, §52

DIVISION XXIV
HEALTH AND LONG-TERM
CARE ACCESS

135.163 Health and long-term care access.

The department shall coordinate public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, diverse, and sustainable health care workforce in this state. The health care delivery infrastructure and the health care workforce shall address the broad spectrum of health care needs of Iowans throughout their lifespan including long-term care needs. The department shall, at a minimum, do all of the following:

1. Develop a strategic plan for health care delivery infrastructure and health care workforce resources in this state.

2. Provide for the continuous collection of data to provide a basis for health care strategic planning and health care policymaking.

3. Make recommendations regarding the health care delivery infrastructure and the health care workforce that assist in monitoring current needs, predicting future trends, and informing policymaking.

2008 Acts, ch 1188, §57

135.164 Strategic plan.

1. The strategic plan for health care delivery infrastructure and health care workforce resources shall describe the existing health care system, describe and provide a rationale for the desired health care system, provide an action plan for implementation, and provide methods to evaluate the system. The plan shall incorporate expenditure control methods and integrate criteria for evidence-based health care. The department shall do all of the following in developing the strategic plan for health care delivery infrastructure and health care workforce resources:

a. Conduct strategic health planning activities related to preparation of the strategic plan.

b. Develop a computerized system for accessing, analyzing, and disseminating data relevant to strategic health planning. The department may enter into data sharing agreements and contractual arrangements necessary to obtain or disseminate relevant data.

c. Conduct research and analysis or arrange for research and analysis projects to be conducted by public or private organizations to further the development of the strategic plan.

d. Establish a technical advisory committee to assist in the development of the strategic plan. The members of the committee may include but are not limited to health economists, representatives of the university of Iowa college of public health, health planners, representatives of health care purchasers, representatives of state and local agencies that regulate entities involved in health care, representatives of health care providers and health care facilities, and consumers.

2. The strategic plan shall include statewide health planning policies and goals related to the availability of health care facilities and services, the quality of care, and the cost of care. The policies and goals shall be based on the following principles:

a. That a strategic health planning process, responsive to changing health and social needs and conditions, is essential to the health, safety, and welfare of Iowans. The process shall be reviewed and updated as necessary to ensure that the strategic plan addresses all of the following:

- (1) Promoting and maintaining the health of all Iowans.
- (2) Providing accessible health care services through the maintenance of an adequate supply of health facilities and an adequate workforce.
- (3) Controlling excessive increases in costs.
- (4) Applying specific quality criteria and population health indicators.
- (5) Recognizing prevention and wellness as priorities in health care programs to improve quality and reduce costs.
- (6) Addressing periodic priority issues including disaster planning, public health threats, and public safety dilemmas.

(7) Coordinating health care delivery and resource development efforts among state agencies including those tasked with facility, services, and professional provider licensure; state and federal reimbursement; health service utilization data systems; and others.

(8) Recognizing long-term care as an integral component of the health care delivery infrastructure and as an essential service provided by the health care workforce.

b. That both consumers and providers throughout the state must be involved in the health planning process, outcomes of which shall be clearly articulated and available for public review and use.

c. That the supply of a health care service has a substantial impact on utilization of the service, independent of the effectiveness, medical necessity, or appropriateness of the particular health care service for a particular individual.

d. That given that health care resources are not unlimited, the impact of any new health care service or facility on overall health expenditures in this state must be considered.

e. That excess capacity of health care services and facilities places an increased economic burden on the public.

f. That the likelihood that a requested new health care facility, service, or equipment will improve health care quality and outcomes must be considered.

g. That development and ongoing maintenance of current and accurate health care information and statistics related to cost and quality of health care and projections of the need for health care facilities and services are necessary to developing an effective health care planning strategy.

h. That the certificate of need program as a component of the health care planning regulatory process must balance considerations of access to quality care at a reasonable cost for all Iowans, optimal use of existing health care resources, fostering of expenditure control, and elimination of unnecessary duplication of health care facilities and services, while supporting improved health care outcomes.

i. That strategic health care planning must be concerned with the stability of the health care system, encompassing health care financing, quality, and the availability of information and services for all residents.

3. The health care delivery infrastructure and health care workforce resources strategic plan developed by the department shall include all of the following:

a. A health care system assessment and objectives component that does all of the following:

(1) Describes state and regional population demographics, health status indicators, and trends in health status and health care needs.

(2) Identifies key policy objectives for the state health care system related to access to care, health care outcomes, quality, and cost-effectiveness.

b. A health care facilities and services plan that assesses the demand for health care facilities and services to inform state health care planning efforts and direct certificate of

need determinations for those facilities and services subject to certificate of need. The plan shall include all of the following:

- (1) An inventory of each geographic region's existing health care facilities and services.
- (2) Projections of the need for each category of health care facility and service, including those subject to certificate of need.
- (3) Policies to guide the addition of new or expanded health care facilities and services to promote the use of quality, evidence-based, cost-effective health care delivery options, including any recommendations for criteria, standards, and methods relevant to the certificate of need review process.

(4) An assessment of the availability of health care providers, public health resources, transportation infrastructure, and other considerations necessary to support the needed health care facilities and services in each region.

c. A health care data resources plan that identifies data elements necessary to properly conduct planning activities and to review certificate of need applications, including data related to inpatient and outpatient utilization and outcomes information, and financial and utilization information related to charity care, quality, and cost. The plan shall provide all of the following:

(1) An inventory of existing data resources, both public and private, that store and disclose information relevant to the health care planning process, including information necessary to conduct certificate of need activities. The plan shall identify any deficiencies in the inventory of existing data resources and the data necessary to conduct comprehensive health care planning activities. The plan may recommend that the department be authorized to access existing data sources and conduct appropriate analyses of such data or that other agencies expand their data collection activities as statutory authority permits. The plan may identify any computing infrastructure deficiencies that impede the proper storage, transmission, and analysis of health care planning data.

(2) Recommendations for increasing the availability of data related to health care planning to provide greater community involvement in the health care planning process and consistency in data used for certificate of need applications and determinations. The plan shall also integrate the requirements for annual reports by hospitals and health care facilities pursuant to section 135.75, the provisions relating to analyses and studies by the department pursuant to section 135.76, the data compilation provisions of section 135.78, and the provisions for contracts for assistance with analyses, studies, and data pursuant to section 135.83.

d. An assessment of emerging trends in health care delivery and technology as they relate to access to health care facilities and services, quality of care, and costs of care. The assessment shall recommend any changes to the scope of health care facilities and services covered by the certificate of need program that may be warranted by these emerging trends. In addition, the assessment may recommend any changes to criteria used by the department to review certificate of need applications, as necessary.

e. A rural health care resources plan to assess the availability of health resources in rural areas of the state, assess the unmet needs of these communities, and evaluate how federal and state reimbursement policies can be modified, if necessary, to more efficiently and effectively meet the health care needs of rural communities. The plan shall consider the unique health care needs of rural communities, the adequacy of the rural health care workforce, and transportation needs for accessing appropriate care.

f. A health care workforce resources plan to assure a competent, diverse, and sustainable health care workforce in Iowa and to improve access to health care in underserved areas and among underserved populations. The plan shall include the establishment of an advisory council to inform and advise the department and policymakers regarding issues relevant to the health care workforce in Iowa. The health care workforce resources plan shall recognize long-term care as an essential service provided by the health care workforce.

4. The department shall submit the initial statewide health care delivery infrastructure and resources strategic plan to the governor and the general assembly by January 1, 2010,

and shall submit an updated strategic plan to the governor and the general assembly every two years thereafter.

2008 Acts, ch 1188, §58

DIVISION XXV

HEALTH CARE TRANSPARENCY

135.165 Health care transparency — reporting requirements — hospitals and nursing facilities.

Each hospital and nursing facility in this state that is recognized by the Internal Revenue Code as a nonprofit organization or entity shall submit to the department of public health and the legislative services agency, annually, a copy of the hospital's internal revenue service form 990, including but not limited to schedule J or any successor schedule that provides compensation information for certain officers, directors, trustees, and key employees, information about the highest compensated employees, and information regarding revenues, expenses, excess or surplus revenues, and reserves within ninety days following the due date for filing the hospital's or nursing facility's return for the taxable year.

2008 Acts, ch 1188, §65

135.166 Health care data — collection from hospitals.

1. The department of public health shall enter into a memorandum of understanding to utilize the Iowa hospital association to act as the department's intermediary in collecting, maintaining, and disseminating hospital inpatient, outpatient, and ambulatory information, as initially authorized in 1996 Iowa Acts, ch. 1212, section 5, subsection 1, paragraph "a", subparagraph (4) and 641 IAC 177.3.

2. The memorandum of understanding shall include but is not limited to provisions that address the duties of the department and the Iowa hospital association regarding the collection, reporting, disclosure, storage, and confidentiality of the data.

2009 Acts, ch 118, §57

135.167 through 135.170 Reserved.

DIVISION XXVI

ALZHEIMER'S DISEASE SERVICE NEEDS

135.171 Alzheimer's disease service needs.

1. The department shall regularly analyze Iowa's population by county and age to determine the existing service utilization and future service needs of persons with Alzheimer's disease and similar forms of irreversible dementia. The analysis shall also address the availability of existing caregiver services for such needs and the appropriate service level for the future.

2. The department shall modify its community needs assessment activities to include questions to identify and quantify the numbers of persons with Alzheimer's disease and similar forms of irreversible dementia at the community level.

3. The department shall collect data on the numbers of persons demonstrating combative behavior related to Alzheimer's disease and similar forms of irreversible dementia. The department shall also collect data on the number of physicians and geropsychiatric units available in the state to provide treatment and services to such persons. Health care facilities that serve such persons shall provide information to the department for the purposes of the data collection required by this subsection.

4. The department's implementation of the requirements of this section shall be limited to the extent of the funding appropriated or otherwise made available for the requirements.

2008 Acts, ch 1140, §1

[P] See also §231.62

135.172 Reserved.

DIVISION XXVII
EARLY CHILDHOOD IOWA
COUNCIL

135.173 Early childhood Iowa council. Repealed by 2010 Acts, ch 1031, § 308.

135.173A Reserved.

[SP] For future text of this section, effective July 1, 2011, see 2010 Acts, ch 1031, §354, 361; 2010 Acts, ch 1192, §84

135.174 Lead agency and other state agencies. Repealed by 2010 Acts, ch 1031, § 308.

DIVISION XXVIII
HEALTH CARE WORKFORCE SUPPORT
INITIATIVE AND FUND

135.175 Health care workforce support initiative — workforce shortage fund — accounts — repeal.

1. *a.* A health care workforce support initiative is established to provide for the coordination and support of various efforts to address the health care workforce shortage in this state. This initiative shall include the medical residency training state matching grants program created in section 135.176, the nurse residency state matching grants program created in section 135.178, the health care professional and Iowa needs nurses now initiative created in sections 261.128 and 261.129, the safety net provider recruitment and retention initiatives program created in section 135.153A, health care workforce shortage national initiatives, and the physician assistant mental health fellowship program created in section 135.177.

b. A health care workforce shortage fund is created in the state treasury as a separate fund under the control of the department, in cooperation with the entities identified in this section as having control over the accounts within the fund. The fund and the accounts within the fund shall be controlled and managed in a manner consistent with the principles specified and the strategic plan developed pursuant to sections 135.163 and 135.164.

2. The fund and the accounts within the fund shall consist of moneys appropriated from the general fund of the state for the purposes of the fund or the accounts within the fund; moneys received from the federal government for the purposes of addressing the health care workforce shortage; contributions, grants, and other moneys from communities and health care employers; and moneys from any other public or private source available.

3. The department and any entity identified in this section as having control over any of the accounts within the fund, may receive contributions, grants, and in-kind contributions to support the purposes of the fund and the accounts within the fund. Not more than five percent of the moneys allocated to any account within the fund may be used for administrative costs.

4. The fund and the accounts within the fund shall be separate from the general fund of the state and shall not be considered part of the general fund of the state. The moneys in the fund and the accounts within the fund shall not be considered revenue of the state, but rather shall be moneys of the fund or the accounts. The moneys in the fund and the accounts within the fund are not subject to section 8.33 and shall not be transferred, used, obligated,

appropriated, or otherwise encumbered, except to provide for the purposes of this section. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys deposited in the fund shall be credited to the fund and the accounts within the fund.

5. The fund shall consist of the following accounts:

a. The medical residency training account. The medical residency training account shall be under the control of the department and the moneys in the account shall be used for the purposes of the medical residency training state matching grants program as specified in section 135.176. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to the medical residency training state matching grants program or account for the purposes of such account.

b. The health care professional and Iowa needs nurses now initiative account. The health care professional and Iowa needs nurses now initiative account shall be under the control of the college student aid commission created in section 261.1 and the moneys in the account shall be used for the purposes of the health care professional incentive payment program and the Iowa needs nurses now initiative as specified in sections 261.128 and 261.129. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to the health care professional and Iowa needs nurses now initiative or the account for the purposes of the account.

c. The safety net provider network workforce shortage account. The safety net provider network workforce shortage account shall be under the control of the governing group of the Iowa collaborative safety net provider network created in section 135.153 and the moneys in the account shall be used for the purposes of the safety net provider recruitment and retention initiatives program as specified in section 135.153A. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to the safety net provider recruitment and retention initiatives program or the account for the purposes of the account.

d. The health care workforce shortage national initiatives account. The health care workforce shortage national initiatives account shall be under the control of the state entity identified for receipt of the federal funds by the federal government entity through which the federal funding is available for a specified health care workforce shortage initiative. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to health care workforce shortage national initiatives or the account and for a specified health care workforce shortage initiative.

e. The physician assistant mental health fellowship program account. The physician assistant mental health fellowship program account shall be under the control of the department and the moneys in the account shall be used for the purposes of the physician assistant mental health fellowship program as specified in section 135.177. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to the physician assistant mental health fellowship program or the account for the purposes of the account.

f. The Iowa needs nurses now infrastructure account. The Iowa needs nurses now infrastructure account shall be under the control of the department and the moneys in the account shall be used to award grants in accordance with rules adopted by the department, in consultation with the board of nursing, the department of education, and a statewide association that represents nurses specified by the director, pursuant to chapter 17A, for clinical simulators, laboratory facilities, health information technology, and other infrastructure to improve the training of nurses and nurse educators in the state and to enhance the clinical experience for nurses. Grants awarded shall authorize the use of a reasonable portion of the grant moneys for training in the use of the infrastructure purchased with the grant moneys. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to the Iowa needs nurses now infrastructure account for the purposes of the account.

g. The nurse residency state matching grants program account. The nurse residency state matching grants program account shall be under the control of the department and the moneys in the account shall be used for the purposes of the nurse residency state matching

grants program as specified in section 135.178. Moneys in the account shall consist of moneys appropriated or allocated for deposit in or received by the fund or the account and specifically dedicated to the nurse residency state matching grants program account for the purposes of such account.

6. a. Moneys in the fund and the accounts in the fund shall only be appropriated in a manner consistent with the principles specified and the strategic plan developed pursuant to sections 135.163 and 135.164 to support the medical residency training state matching grants program, the nurse residency state matching grants program, the health care professional incentive payment program, the Iowa needs nurses now initiative, the safety net recruitment and retention initiatives program, for national health care workforce shortage initiatives, for the physician assistant mental health fellowship program, for the purposes of the Iowa needs nurses now infrastructure account, and to provide funding for state health care workforce shortage programs as provided in this section.

b. State programs that may receive funding from the fund and the accounts in the fund, if specifically designated for the purpose of drawing down federal funding, are the primary care recruitment and retention endeavor (PRIMECARRE), the Iowa affiliate of the national rural recruitment and retention network, the primary care office shortage designation program, the state office of rural health, and the Iowa health workforce center, administered through the bureau of health care access of the department of public health; the area health education centers programs at Des Moines university — osteopathic medical center and the university of Iowa; the Iowa collaborative safety net provider network established pursuant to section 135.153; any entity identified by the federal government entity through which federal funding for a specified health care workforce shortage initiative is received; and a program developed in accordance with the strategic plan developed by the department of public health in accordance with sections 135.163 and 135.164.

c. State appropriations to the fund shall be allocated in equal amounts to each of the accounts within the fund, unless otherwise specified in the appropriation or allocation. Any federal funding received for the purposes of addressing state health care workforce shortages shall be deposited in the health care workforce shortage national initiatives account, unless otherwise specified by the source of the funds, and shall be used as required by the source of the funds. If use of the federal funding is not designated, twenty-five percent of such funding shall be deposited in the safety net provider network workforce shortage account to be used for the purposes of the account and the remainder of the funds shall be used in accordance with the strategic plan developed by the department of public health in accordance with sections 135.163 and 135.164, or to address workforce shortages as otherwise designated by the department of public health. Other sources of funding shall be deposited in the fund or account and used as specified by the source of the funding.

7. No more than five percent of the moneys in any of the accounts within the fund, not to exceed one hundred thousand dollars in each account, shall be used for administrative purposes, unless otherwise provided by the appropriation, allocation, or source of the funds.

8. The department, in cooperation with the entities identified in this section as having control over any of the accounts within the fund, shall submit an annual report to the governor and the general assembly regarding the status of the health care workforce support initiative, including the balance remaining in and appropriations from the health care workforce shortage fund and the accounts within the fund.

9. This section is repealed June 30, 2014.

2009 Acts, ch 118, §45, 54; 2010 Acts, ch 1147, §2 – 6, 13

[SP] Implementation of section conditioned upon availability of funding; 2009 Acts, ch 118, §54

[SP] Implementation of 2010 amendments conditioned upon availability of funding; 2010 Acts, ch 1147, §13

[T] Subsection 1, paragraph a amended

[T] Subsection 3 amended

[T] Subsection 5, paragraph b amended

[T] Subsection 5, NEW paragraphs f and g

[T] Subsection 6, paragraph a amended

DIVISION XXIX
HEALTH CARE WORKFORCE SUPPORT

135.176 Medical residency training state matching grants program — repeal.

1. The department shall establish a medical residency training state matching grants program to provide matching state funding to sponsors of accredited graduate medical education residency programs in this state to establish, expand, or support medical residency training programs. Funding for the program may be provided through the health care workforce shortage fund or the medical residency training account created in section 135.175. For the purposes of this section, unless the context otherwise requires, “*accredited*” means a graduate medical education program approved by the accreditation council for graduate medical education or the American osteopathic association. The grant funds may be used to support medical residency programs through any of the following:

a. The establishment of new or alternative campus accredited medical residency training programs. For the purposes of this paragraph, “*new or alternative campus accredited medical residency training program*” means a program that is accredited by a recognized entity approved for such purpose by the accreditation council for graduate medical education or the American osteopathic association with the exception that a new medical residency training program that, by reason of an insufficient period of operation is not eligible for accreditation on or before the date of submission of an application for a grant, may be deemed accredited if the accreditation council for graduate medical education or the American osteopathic association finds, after consultation with the appropriate accreditation entity, that there is reasonable assurance that the program will meet the accreditation standards of the entity prior to the date of graduation of the initial class in the program.

b. The provision of new residency positions within existing accredited medical residency or fellowship training programs.

c. The funding of residency positions which are in excess of the federal residency cap. For the purposes of this paragraph, “*in excess of the federal residency cap*” means a residency position for which no federal Medicare funding is available because the residency position is a position beyond the cap for residency positions established by the federal Balanced Budget Act of 1997, Pub. L. No. 105-33.

2. The department shall adopt rules pursuant to chapter 17A to provide for all of the following:

a. Eligibility requirements for and qualifications of a sponsor of an accredited graduate medical education residency program to receive a grant. The requirements and qualifications shall include but are not limited to all of the following:

(1) Only a sponsor that establishes a dedicated fund to support a residency program that meets the specifications of this section shall be eligible to receive a matching grant. A sponsor funding residency positions in excess of the federal residency cap, as defined in subsection 1, paragraph “c”, exclusive of funds provided under the medical residency training state matching grants program established in this section, is deemed to have satisfied this requirement and shall be eligible for a matching grant equal to the amount of funds expended for such residency positions, subject to the limitation on the maximum award of grant funds specified in paragraph “e”.

(2) A sponsor shall demonstrate, through documented financial information as prescribed by rule of the department, that funds have been reserved and will be expended by the sponsor in the amount required to provide matching funds for each residency proposed in the request for state matching funds.

(3) A sponsor shall demonstrate, through objective evidence as prescribed by rule of the department, a need for such residency program in the state.

b. The application process for the grant.

c. Criteria for preference in awarding of the grants, including preference in the residency specialty.

d. Determination of the amount of a grant. The total amount of a grant awarded to a

sponsor shall be limited to no more than twenty-five percent of the amount that the sponsor has demonstrated through documented financial information has been reserved and will be expended by the sponsor for each residency sponsored for the purpose of the residency program.

e. The maximum award of grant funds to a particular individual sponsor per year. An individual sponsor shall not receive more than twenty-five percent of the state matching funds available each year to support the program. However, if less than ninety-five percent of the available funds has been awarded in a given year, a sponsor may receive more than twenty-five percent of the state matching funds available if total funds awarded do not exceed ninety-five percent of the available funds. If more than one sponsor meets the requirements of this section and has established, expanded, or supported a graduate medical residency training program, as specified in subsection 1, in excess of the sponsor's twenty-five percent maximum share of state matching funds, the state matching funds shall be divided proportionately among such sponsors.

f. Use of the funds awarded. Funds may be used to pay the costs of establishing, expanding, or supporting an accredited graduate medical education program as specified in this section, including but not limited to the costs associated with residency stipends and physician faculty stipends.

3. This section is repealed June 30, 2014.

2009 Acts, ch 118, §46, 54

[SP] Implementation of section conditioned upon availability of funding; 2009 Acts, ch 118, §54

135.177 Physician assistant mental health fellowship program — repeal.

1. The department, in cooperation with the college student aid commission, shall establish a physician assistant mental health fellowship program in accordance with this section. Funding for the program may be provided through the health care workforce shortage fund or the physician assistant mental health fellowship program account created in section 135.175. The purpose of the program is to determine the effect of specialized training and support for physician assistants in providing mental health services on addressing Iowa's shortage of mental health professionals.

2. The program shall provide for all of the following:

a. Collaboration with a hospital serving a thirteen-county area in central Iowa that provides a clinic at the Iowa veterans home, a private nonprofit agency headquartered in a city with a population of more than one hundred ninety thousand that operates a freestanding psychiatric medical institution for children, a private university with a medical school educating osteopathic physicians located in a city with a population of more than one hundred ninety thousand, the Iowa veterans home, and any other clinical partner designated for the program. Population figures used in this paragraph refer to the most recent certified federal census. The clinical partners shall provide supervision, clinical experience, training, and other support for the program and physician assistant students participating in the program.

b. Elderly, youth, and general population clinical experiences.

c. A fellowship of twelve months for three physician assistant students, annually.

d. Supervision of students participating in the program provided by the university and the other clinical partners participating in the program.

e. A student participating in the program shall be eligible for a stipend of not more than fifty thousand dollars for the twelve months of the fellowship plus related fringe benefits. In addition, a student who completes the program and practices in Iowa in a mental health professional shortage area, as defined in section 135.80, shall be eligible for up to twenty thousand dollars in loan forgiveness. The stipend and loan forgiveness provisions shall be determined by the department and the college student aid commission, in consultation with the clinical partners.

f. The state and private entity clinical partners shall regularly evaluate and document their experiences with the approaches utilized and outcomes achieved by the program to identify an optimal model for operating the program. The evaluation process shall include but is not limited to identifying ways the program's clinical and training components could be modified

to facilitate other student and practicing physician assistants specializing as mental health professionals.

3. This section is repealed June 30, 2014.

2009 Acts, ch 118, §47, 54

[SP] Implementation of section conditioned upon availability of funding; 2009 Acts, ch 118, §54

135.178 Nurse residency state matching grants program — repeal.

1. The department shall establish a nurse residency state matching grants program to provide matching state funding to sponsors of nurse residency programs in this state to establish, expand, or support nurse residency programs that meet standards adopted by rule of the department. Funding for the program may be provided through the health care workforce shortage fund or the nurse residency state matching grants program account created in section 135.175. The department, in cooperation with the Iowa board of nursing, the department of education, Iowa institutions of higher education with board of nursing-approved programs to educate nurses, and the Iowa nurses association, shall adopt rules pursuant to chapter 17A to establish minimum standards for nurse residency programs to be eligible for a matching grant that address all of the following:

a. Eligibility requirements for and qualifications of a sponsor of a nurse residency program to receive a grant, including that the program includes both rural and urban components.

b. The application process for the grant.

c. Criteria for preference in awarding of the grants.

d. Determination of the amount of a grant.

e. Use of the funds awarded. Funds may be used to pay the costs of establishing, expanding, or supporting a nurse residency program as specified in this section, including but not limited to the costs associated with residency stipends and nursing faculty stipends.

2. This section is repealed June 30, 2014.

2010 Acts, ch 1147, §7, 13

[SP] Implementation of section conditioned upon availability of funding; 2010 Acts, ch 1147, §13

[T] NEW section