

CHAPTER 135

DEPARTMENT OF PUBLIC HEALTH

Referred to in §7E.5, 135B.5, 135H.6, 136.3, 147A.3, 163.3A, 225C.6A

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

	DIVISION I	135.26	Automated external defibrillator grant program. Repealed by 2017 Acts, ch 148, §24.
	GENERAL PROVISIONS		
135.1	Definitions.	135.27	Iowa healthy communities initiative — grant program.
135.2	Appointment of director and acting director.	135.27A	Governor’s council on physical fitness and nutrition. Repealed by 2011 Acts, ch 129, §94, 156.
135.3	Disqualifications.		
135.4	and 135.5 Reserved.	135.28	State substitute medical decision-making board. Repealed by 2010 Acts, ch 1031, §399.
135.6	Assistants and employees.		
135.7	Bonds.	135.29	Local substitute medical decision-making board. Repealed by 2017 Acts, ch 148, §24.
135.8	Seal.		
135.9	Expenses.		
135.10	Office.		
135.11	Duties of department.		
135.11A	Professional licensure division — other licensing boards — expenses — fees.		
135.12	Office of minority and multicultural health — established — duties. Repealed by 2017 Acts, ch 174, §99.		
135.13	Reserved.		
135.14	State public health dental director — duties.		
135.15	Oral and health delivery system bureau established — responsibilities.		
135.16	Special women, infants, and children supplemental food program — methamphetamine education.		
135.16A	Vendors participating in federal food program — egg sales.		
135.17	Dental screening of children.		
135.18	Conflicting statutes.		
135.19	Viral hepatitis program — awareness, vaccinations, and testing.		
135.20	Hepatitis C awareness program — veterans — vaccinations. Repealed by 2009 Acts, ch 182, §89.		
135.21	Pay toilets.		
135.22	Central registry for brain or spinal cord injuries.		
135.22A	Advisory council on brain injuries.		
135.22B	Brain injury services program.		
135.23	Repealed by 90 Acts, ch 1174, §2.		
135.24	Volunteer health care provider program established — immunity from civil liability.		
135.24A	Free clinics — volunteer record check.		
135.25	Emergency medical services fund.		
			DIVISION II
			MISCELLANEOUS PROVISIONS
		135.30	Protective eyeglasses — safety provisions. Repealed by 2009 Acts, ch 56, §12.
		135.30A	Breast-feeding in public places.
		135.31	Location of boards — rulemaking.
		135.32	Publication and distribution. Repealed by 2012 Acts, ch 1113, §19.
		135.33	Refusal of board to enforce rules.
		135.34	Expenses for enforcing rules.
		135.35	Duty of peace officers.
		135.36	Interference with health officer — penalties.
		135.37	Tattooing — permit requirement — penalty.
		135.37A	Natural hair braiding.
		135.38	Penalty.
		135.39	Federal aid.
		135.39A	Gifts and grants fund — appropriation.
		135.39B	Early childhood immunizations — content.
		135.39C	Elderly wellness services — payor of last resort.
		135.39D	Vision screening.
			DIVISION III
			MORBIDITY AND MORTALITY STUDY
		135.40	Collection and distribution of information.
		135.41	Publication.
		135.42	Unlawful use.

	DIVISION IV		DIVISION VIII
	IOWA CHILD DEATH REVIEW TEAM		LEAD ABATEMENT PROGRAM
135.43	Iowa child death review team established — duties.	135.100	Definitions.
135.44	Reserved.	135.101	Childhood lead poisoning prevention program.
	DIVISION V	135.102	Rules.
	RENAL DISEASES	135.103	Grant program.
135.45	through 135.48 Repealed by 2005 Acts, ch 89, §39.	135.104	Requirements.
135.49	through 135.60 Reserved.	135.105	Department duties.
	DIVISION VI	135.105A	Lead inspector, lead abater, and lead-safe renovator training and certification program established — civil penalty.
	HEALTH FACILITIES COUNCIL	135.105B	Voluntary guidelines — health and environmental measures — confirmed cases of lead poisoning.
135.61	Definitions.	135.105C	Renovation, remodeling, and repainting — lead hazard notification process established.
135.62	Department to administer division — health facilities council established — appointments — powers and duties.	135.105D	Blood lead testing — provider education — payor of last resort.
135.63	Certificate of need required — exclusions.		
135.64	Criteria for evaluation of applications.		DIVISION IX
135.65	Letter of intent to precede application — review and comment.		HEALTHY FAMILIES PROGRAM
135.66	Procedure upon receipt of application — public notification.	135.106	Healthy families programs — HOPES-HFI program.
135.67	Summary review procedure.		
135.68	Status reports on review in progress.		DIVISION X
135.69	Council to make final decision.		RURAL HEALTH AND PRIMARY CARE
135.70	Appeal of certificate of need decisions.	135.107	Center for rural health and primary care established — duties.
135.71	Period for which certificate is valid — extension or revocation.		
135.72	Authority to adopt rules.		DIVISION XI
135.73	Sanctions.		DOMESTIC ABUSE DEATH REVIEW TEAM
135.74	Uniform financial reporting.	135.108	Definitions.
135.75	Annual reports by hospitals, health care facilities.	135.109	Iowa domestic abuse death review team membership.
135.76	Analyses and studies by department.	135.110	Iowa domestic abuse death review team powers and duties.
135.77	Report to governor and legislature. Repealed by 97 Acts, ch 203, §18.	135.111	Confidentiality of domestic abuse death records.
135.78	Data to be compiled.	135.112	Rulemaking.
135.79	Civil penalty.	135.113	through 135.117 Reserved.
135.80	and 135.81 Reserved.		
135.82	Review forms. Repealed by 91 Acts, ch 225, §15.		DIVISION XII
135.83	Contracts for assistance with analyses, studies, and data.		CHILD PROTECTION — CHILD PROTECTION CENTER GRANTS — SHAKEN BABY SYNDROME PREVENTION
135.84	through 135.89 Reserved.	135.118	Child protection center grant program.
	DIVISION VII	135.119	Shaken baby syndrome prevention program.
	RESERVED		
135.90	through 135.99 Reserved.		

DIVISION XIII		DIVISION XIX	
TAXATION OF ORGANIZED DELIVERY SYSTEMS		OBSTETRICAL AND NEWBORN INDIGENT PATIENT CARE PROGRAM	
135.120	Taxation of organized delivery systems. Repealed by 2017 Acts, ch 148, §101.	135.152	Statewide obstetrical and newborn indigent patient care program. Repealed by 2017 Acts, ch 148, §24.
135.121	through 135.129 Reserved.		
DIVISION XIV		DIVISION XX	
SUBSTANCE ABUSE TREATMENT FACILITY FOR PERSONS ON PROBATION		COLLABORATIVE SAFETY NET PROVIDER NETWORK	
135.130	Substance abuse treatment facility for persons on probation. Repealed by 2017 Acts, ch 148, §24.	135.153	Iowa collaborative safety net provider network established.
		135.153A	Safety net provider recruitment and retention initiatives program — repeal. Repealed by its own terms; 2015 Acts, ch 30, §211.
DIVISION XV		DIVISION XXI	
NEWBORN AND INFANT HEARING SCREENING		IOWA HEALTH INFORMATION NETWORK	
135.131	Universal newborn and infant hearing screening.	135.154	through 135.156F Repealed by 2015 Acts, ch 73, §8, 9.
DIVISION XVI		DIVISION XXII	
INTERAGENCY PHARMACEUTICALS BULK PURCHASING COUNCIL		PATIENT-CENTERED HEALTH	
135.132	Interagency pharmaceuticals bulk purchasing council. Repealed by 2017 Acts, ch 148, §26.	135.157	Definitions. Repealed by 2017 Acts, ch 148, §11.
135.133	through 135.139 Reserved.	135.158	Medical home purposes — characteristics. Repealed by 2017 Acts, ch 148, §11.
		135.159	Patient-centered health advisory council.
DIVISION XVII		DIVISION XXIII	
DISASTER PREPAREDNESS		PREVENTION AND CHRONIC CARE MANAGEMENT	
135.140	Definitions.	135.160	Definitions. Repealed by 2012 Acts, ch 1021, §120.
135.141	Division of acute disease prevention and emergency response — establishment — duties of department.	135.161	Prevention and chronic care management initiative — advisory council. Repealed by 2011 Acts, ch 129, §81, 82.
135.142	Health care supplies.	135.162	Clinicians advisory panel. Repealed by 2011 Acts, ch 63, §35.
135.143	Public health response teams.		
135.144	Additional duties of the department related to a public health disaster.		
135.145	Information sharing.		
135.146	First responder vaccination program.		
135.147	Immunity for emergency aid — exceptions.	135.163	Health care access.
135.148	and 135.149 Reserved.	135.164	Strategic plan. Repealed by 2017 Acts, ch 148, §19.
DIVISION XVIII		DIVISION XXV	
GAMBLING TREATMENT PROGRAM		HEALTH DATA	
135.150	Gambling treatment program — standards and licensing.	135.165	Health care transparency — reporting requirements — hospitals and nursing facilities. Repealed by 2012 Acts, ch 1113, §24.
135.151	Reserved.		

135.166	Health data — collection and use — collection from hospitals.	135.179	Fulfilling Iowa’s need for dentists.
135.167	through 135.170 Reserved.		
	DIVISION XXVI		DIVISION XXX
	ALZHEIMER’S DISEASE SERVICE NEEDS		MENTAL HEALTH PROFESSIONAL SHORTAGE AREA PROGRAM
135.171	Alzheimer’s disease service needs.	135.180	Mental health professional shortage area program. Repealed by 2017 Acts, ch 148, §19.
135.172	Reserved.		
	DIVISION XXVII		DIVISION XXXI
	STATE CHILD CARE ADVISORY COMMITTEE		BEHAVIOR ANALYST AND ASSISTANT BEHAVIOR ANALYST GRANTS PROGRAM
135.173	Early childhood Iowa council. Repealed by 2010 Acts, ch 1031, §308.	135.181	Board-certified behavior analyst and board-certified assistant behavior analyst grants program — fund.
135.173A	Child care advisory committee.	135.182	through 135.184 Reserved.
135.174	Lead agency and other state agencies. Repealed by 2010 Acts, ch 1031, §308.		
	DIVISION XXVIII		DIVISION XXXII
	HEALTH CARE WORKFORCE SUPPORT INITIATIVE AND FUND		EPINEPHRINE AUTO-INJECTOR SUPPLY
135.175	Health care workforce support initiative — workforce shortage fund — accounts.	135.185	Epinephrine auto-injector supply.
		135.186	through 135.189 Reserved.
	DIVISION XXIX		DIVISION XXXIII
	HEALTH CARE WORKFORCE SUPPORT		POSSESSION AND ADMINISTRATION OF OPIOID ANTAGONISTS
135.176	Medical residency training state matching grants program.	135.190	Possession and administration of opioid antagonists — immunity.
135.177	Physician assistant mental health fellowship program — repeal. Repealed by its own terms; 2015 Acts, ch 30, §214.		DIVISION XXXIV
135.178	Nurse residency state matching grants program.	135.191	STROKE CARE — REPORTING AND DATABASE Stroke care — continuous quality improvement.

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. “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; 2012 Acts, ch 1113, §16](#)

Referred to in [§135C.1, 144.26, 514.21](#)

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](#)

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 Reserved.

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 healthy aging and essential public health services by approving grants of state funds to the local boards of health for the purposes of promoting healthy aging throughout the lifespan and enhancing health promotion and disease prevention services, and by providing guidelines for the approval of the grants and allocation of the state funds.

Guidelines, evaluation requirements and formula allocation procedures for the services 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 training concerning blood-borne pathogens, including human immunodeficiency virus and viral hepatitis, consistent with standards from the federal occupational safety and health administration.

21. Adopt rules which require all emergency medical services personnel, fire fighters, and law enforcement personnel to complete training concerning blood-borne pathogens, including human immunodeficiency virus and viral hepatitis, consistent with standards from the federal occupational safety and health administration.

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. Review and approve 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. 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.

26. 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.

27. 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](#).

28. 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](#).

29. 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; 2011 Acts, ch 63, §33; 2012 Acts, ch 1113, §22; 2013 Acts, ch 129, §49; 2014 Acts, ch 1106, §1; 2017 Acts, ch 148, §2, 20; 2018 Acts, ch 1041, §127

Referred to in §231B.4, 232.69, 235B.16, 237.3, 455E.11

Laboratory tests, §263.7, 263.8

Requirement for department to collaborate with Iowa Medicaid enterprise and child health speciality clinics to integrate initiative for first five years of a child's life with various integrated care models; 2013 Acts, ch 138, §3, 133; 2014 Acts, ch 1140, §3; 2015 Acts, ch 137, §3, 123; 2016 Acts, ch 1139, §3; 2017 Acts, ch 174, §3, 42; 2018 Acts, ch 1165, §6

Code editor directive applied

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

1. 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.

2. 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; 2018 Acts, ch 1041, §127

Code editor directive applied

135.12 Office of minority and multicultural health — established — duties. Repealed by 2017 Acts, ch 174, §99.

135.13 Reserved.

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:

- Plan and direct all work activities of the statewide public health dental program.
- Develop comprehensive dental initiatives for prevention activities.
- 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 and health delivery system bureau established — responsibilities.

An oral and health delivery system 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.

6. Facilitating the provision of oral health services through dental homes. For the purposes of [this section](#), “dental home” means a network of individualized care based on risk assessment, which includes oral health education, dental screenings, preventive services, diagnostic services, treatment services, and emergency services.

2007 Acts, ch 159, §14; 2017 Acts, ch 148, §4; 2018 Acts, ch 1165, §110

Section amended

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

135.16A Vendors participating in federal food program — egg sales.

1. As used in [this section](#), unless the context otherwise requires:

a. “Conventional eggs” means eggs other than specialty eggs.

b. “Eggs” means shell eggs that are graded as “AA”, “A”, or “B” pursuant to [7 C.F.R. pt. 56, subpt. A](#), and that are sold at retail in commercial markets.

c. “Federal food program” means the special supplemental food program for women, infants, and children as provided in 42 U.S.C. §1786, et seq.

d. “Grocery store” means a food establishment as defined in [section 137F.1](#) licensed by the department of inspections and appeals pursuant to [section 137F.4](#), to sell food or food products to customers intended for preparation or consumption off premises.

e. “Specialty eggs” means eggs produced by domesticated chickens, and sold at retail in commercial markets if the chickens producing such eggs are advertised as being housed in any of the following environments:

- (1) Cage-free.
- (2) Free-range.
- (3) Enriched colony cage.

2. a. The department of inspections and appeals shall assist the Iowa department of public health in adopting rules necessary to implement and administer [this section](#).

b. If necessary to implement, administer, and enforce [this section](#), the Iowa department of public health, in cooperation with the department of agriculture and land stewardship, shall submit a request to the United States department of agriculture for a waiver or other exception from regulations as deemed feasible by the Iowa department of public health. The Iowa department of public health shall regularly report the status of such request to the legislative services agency.

3. A grocery store that is a vendor participating in a federal food program and offering specialty eggs for retail sale shall maintain an inventory of conventional eggs for retail sale sufficient to meet federal and state requirements for participation in the federal food program.

4. [This section](#) does not require a grocery store to do any of the following:

- a. Stock or sell specialty eggs.
- b. Stock or sell eggs, if the grocery store elects not to stock or sell conventional eggs for retail sale as part of its normal business.
- c. Comply with the provisions of [this section](#), if the grocery store's inventory of eggs for retail sale was limited to specialty eggs prior to January 1, 2018.

5. A violation of [subsection 3](#) by a grocery store shall not be construed to disqualify a grocery store from participating in a federal food program unless otherwise authorized by the United States department of agriculture.

[2018 Acts, ch 1025, §1; 2018 Acts, ch 1172, §19](#)

NEW section

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](#)

Dental clinics, see §280.7

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 clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions, or tumor of the brain, not primarily related to a degenerative disease or aging process, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions, and is diagnosed by a physician. The diagnoses of clinically evident damage to the brain used for a diagnosis of brain injury shall be the same as specified by rule for eligibility for the home and community-based services waiver for persons with brain injury under the medical assistance program.

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](#); [2012 Acts, ch 1120, §66](#)

Referred to in [§135.22A](#), [225C.23](#), [335.25](#), [414.22](#)

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.
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; 2013 Acts, ch 124, §2

Referred to in [§135.22B](#)

Recognition of "brain injury" as a disability, §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 polysomnography, 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, marital and family therapist, behavior analyst, or assistant behavior analyst 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; 2015 Acts, ch 70, §1; 2018 Acts, ch 1106, §1, 14

Referred to in [§135.24A](#), [135M.2](#)

2018 amendment to subsection 7, paragraph d takes effect January 1, 2019; 2018 Acts, ch 1106, §14

Subsection 7, paragraph d amended

135.24A Free clinics — volunteer record check.

1. For purposes of [this section](#), “*free clinic*” means a free clinic as defined in [section 135.24](#) that is also a network of free clinics in this state that offers operational and collaborative opportunities to free clinics.

2. Persons who are potential volunteers or volunteers in a free clinic in a position having direct individual contact with patients of the free clinic shall be subject to criminal history and child and dependent adult abuse record checks in accordance with [this section](#). The free clinic shall request that the department of public safety perform the criminal history check and the department of human services perform child and dependent adult abuse record checks of the person in this state and may request these checks in other states.

3. A free clinic subject to [this section](#) shall establish an evaluation process to determine whether a crime of founded child or dependent adult abuse warrants prohibition of the person’s participation as a volunteer in the free clinic. The evaluation process shall not be less stringent than the evaluation process performed by the department of human services and shall be approved by the department of human services.

2018 Acts, ch 1104, §1, 5

Referred to in [§235A.15](#), [235B.6](#)

NEW section

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](#)

Referred to in [§144.45A](#), [147A.6](#), [147A.23](#), [321.34](#)

135.26 Automated external defibrillator grant program. Repealed by 2017 Acts, ch 148, §24.

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. Repealed by 2011 Acts, ch 129, §94, 156.

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

135.29 Local substitute medical decision-making board. Repealed by 2017 Acts, ch 148, §24.

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. Repealed by 2012 Acts, ch 1113, §19.

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]

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](#)

Referred to in [§157.3A](#)

135.37A Natural hair braiding.

A person shall register with the department in order to perform a commercial service involving natural hair braiding. For purposes of [this section](#), “*natural hair braiding*” means a method of natural hair care consisting of braiding, locking, twisting, weaving, cornrowing, or otherwise physically manipulating hair without the use of chemicals to alter the hair’s physical characteristics that incorporates both traditional and modern styling techniques.

[2016 Acts, ch 1138, §12](#)

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

135.39D Vision screening.

1. The parent or guardian of a child to be enrolled in a public or accredited nonpublic elementary school shall ensure that the child is screened for vision impairment at least once before enrollment in kindergarten and again before enrollment in grade three. The parent or guardian of the child shall ensure that evidence of the vision screening is provided to the school district or accredited nonpublic school in which the child is enrolled. Evidence of the vision screening may be provided either directly from the parent or guardian or from a vision screening provider referred to in [subsection 2](#), and may be provided in either written or electronic form.

2. The requirement for vision screening may be satisfied by any of the following:

a. A vision screening or comprehensive eye examination by a licensed ophthalmologist or licensed optometrist.

b. A vision screening conducted at a pediatrician's or family practice physician's office, a free clinic, a child care center, a local public health department, a public or accredited nonpublic school, or a community-based organization, or by an advanced registered nurse practitioner or physician assistant.

c. An online vision screening, which may be conducted by a child's parent or guardian.

d. A photoscreening vision screening, including a vision screening by Iowa kidsight.

3. All vision screening methods pursuant to [subsection 2](#), including emerging vision screening technologies, shall be age-appropriate and shall be approved by the department in consultation with leading vision organizations in the state, licensed ophthalmologists, and licensed optometrists.

4. A person who performs a vision screening required pursuant to [this section](#) shall report the results of the vision screening to the department. The department may collect and maintain such reports through the statewide immunization registry or a private contractor.

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

a. Provide the parents or guardians of students with vision screening referral resources.

b. Arrange for evidence of vision screenings provided pursuant to [subsection 1](#) to be forwarded to the department.

6. A child shall not be prohibited from attending school based upon the failure of a parent or guardian to ensure that the child has received the vision screening required by [this section](#).

7. If a vision screening required pursuant to [this section](#) identifies potential vision impairment in a child, the person who performed the vision screening shall, if the person is not a licensed ophthalmologist or licensed optometrist, refer the child to a licensed ophthalmologist or licensed optometrist for a comprehensive eye examination.

8. The department shall establish procedures to contact parents or guardians of children identified as having potential vision impairment based on the results of a vision screening required pursuant to [subsection 1](#) or a comprehensive eye examination required pursuant to [subsection 7](#) in order to provide information on obtaining necessary vision correction.

9. The department may share information with licensed health care providers, agencies, and other persons involved with vision screenings, eye examinations, follow-up services, and intervention services as necessary to administer [this section](#). The department shall adopt rules to protect the confidentiality of the individuals involved.

10. The vision screening requirement shall not apply if the vision screening conflicts with a parent's or guardian's genuine and sincere religious belief.

11. 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](#).

12. The department shall adopt rules necessary to administer [this section](#).

[2013 Acts, ch 76, §1](#)

See also §280.7A

DIVISION III

MORBIDITY AND MORTALITY STUDY

135.40 Collection and distribution of information.

1. 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.

2. 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](#)

Referred to in [§135.40](#)

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

Referred to in §216A.133A, 691.6
Legislative findings and purpose; 95 Acts, ch 147, §1

135.44 Reserved.

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

Referred to in §249K.2

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

Referred to in §135.63, 135.131, 135P1, 505.27, 708.3A

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](#)

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 an intellectual disability 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 [section 135.61, 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 an intellectual disability, 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 an intellectual disability 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 an intellectual disability 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 an intellectual disability 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 an intellectual disability 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 an intellectual disability 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; 2012 Acts, ch 1019, §7 – 10

Referred to in §135.66, 135B.5A, 135C.2, 231C.3

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 the university of Iowa hospitals and clinics, 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](#); [2014 Acts, ch 1026, §29](#)

Referred to in [§135.65](#), [135.66](#), [135.72](#)

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](#)

Referred to in [§135.67](#)

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](#)

Referred to in [§135.70](#)

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](#)

Referred to in [§135.72](#)

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.

1. 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.

2. 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; 2018 Acts, ch 1041, §127](#)

Referred to in [§135.62, 135.70, 135.72](#)

Code editor directive applied

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.

1. 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.

2. 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](#); [2018 Acts, ch 1041, §127](#)

Code editor directive applied

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 deferral.

[C79, 81, §135.72]

[91 Acts, ch 225, §13](#)

Referred to in [§135.69](#)

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](#)

Referred to in [§135.63](#)

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 all of the following:

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.

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]

[2013 Acts, ch 30, §27](#)

Referred to in [§135.78](#), [135.79](#)

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 all of the following 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.

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]

[2013 Acts, ch 30, §28](#)

Referred to in [§135.78](#), [135.79](#)

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]

Referred to in [§135.78](#), [135.79](#), [135.83](#)

135.77 Report to governor and legislature. 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](#)

Referred to in [§135.79](#), [135.83](#)

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 and 135.81 Reserved.

135.82 Review forms. 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 leading age Iowa 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; 2013 Acts, ch 30, §29](#)

135.84 through 135.89 Reserved.

DIVISION VII
RESERVED

135.90 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](#)

Referred to in [§135.105D](#)

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](#)

Referred to in [§135.102, 135.105](#)

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 specialty 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](#); [2012 Acts, ch 1023, §24](#)

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

Referred to in [§135.105C](#)

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

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

Referred to in §135.102, 299.4

Nurse licensure, see chapter 152

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](#).

4. It is the intent of the general assembly that priority for family support funding be given to approaches using evidence-based or promising models for family support.

[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; 2011 Acts, ch 129, §84, 156; 2016 Acts, ch 1113, §1](#)

Referred to in [§232.69, 256I.13](#)

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 health care workforce and community support grant program and a primary care provider loan repayment 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. The center for rural health and primary care may enter into an agreement with the college student aid commission for the administration of the center's grant and loan repayment programs.

a. *Health care workforce and community support grant program.*

(1) The center for rural health and primary care shall adopt rules establishing flexible application processes based upon the department's strategic plan to be used by the center to establish a grant assistance program as provided in this paragraph "a", 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 may contain a commitment of matching funds for the grant assistance. Application may be made for assistance by a single community or group of communities or in response to programs recommended in the strategic plan to address health workforce shortages.

(2) Grants awarded under the program shall be awarded to rural, underserved areas

or special populations as identified by the department's strategic plan or evidence-based documentation.

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 unless federal requirements otherwise require.

(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.

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". Participation in a community health services assessment process shall be documented by the community or region.

b. Assistance under [this subsection](#) shall not be granted until such time as the community or region making application has completed a community health services assessment and adopted a long-term community health services assessment and developmental plan. In addition to any other requirements, an applicant's plan shall include, to the extent possible, 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 health care workforce and community support 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 department of public health, the department of inspections and appeals, a national or regional institute for rural health policy, 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; 2017 Acts, ch 148, §13 – 15](#)

Referred to in [§262.78, 263.17](#)

Legislative findings; [94 Acts, ch 1168, §1](#)

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](#)
Referred to in [§135.112](#)

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](#)

Referred to in [§135.108, 135.112, 216A.133A](#)

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

Referred to in §135.112

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

Referred to in §135.112

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

DIVISION XIII

TAXATION OF ORGANIZED DELIVERY SYSTEMS

135.120 Taxation of organized delivery systems. Repealed by 2017 Acts, ch 148, §101.

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. Repealed by 2017 Acts, ch 148, §24.

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. a. If the results of the newborn hearing screening performed under [this section](#) demonstrate that the newborn has hearing loss, the birthing hospital, birth center, physician, or other health care professional required to ensure that the hearing screening is performed on the newborn under [this section](#), shall do all of the following:

(1) Test the newborn or ensure that the newborn is tested for congenital cytomegalovirus before the newborn is twenty-one days of age.

(2) Provide information to the parent of the newborn including information regarding the birth defects caused by congenital cytomegalovirus and early intervention and treatment resources and services available for children diagnosed with congenital cytomegalovirus.

b. **This subsection** shall not apply if the parent objects to the testing. If a parent objects to the testing, the birthing hospital, birth center, physician, or other health care professional required to test or to ensure that the newborn is tested for congenital cytomegalovirus under **this subsection** 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. **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.

11. 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; 2017 Acts, ch 77, §2

Referred to in §135.119, 135B.18A

DIVISION XVI

INTERAGENCY PHARMACEUTICALS BULK PURCHASING COUNCIL

135.132 Interagency pharmaceuticals bulk purchasing council. Repealed by 2017 Acts, ch 148, §26.

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

Referred to in §29C.6, 135M.1, 135M.3, 135M.4, 137.116, 139A.2

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 department of homeland security and emergency management the administration of emergency planning matters which involve the public health, including development, administration, and execution of the public health components of the comprehensive emergency 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. 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.

d. For the purpose of paragraph “c”, 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](#).

e. 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.

f. Conduct or coordinate public information activities regarding emergency and disaster planning, response, and recovery matters that involve the public health.

g. Apply for and accept grants, gifts, or other funds to be used for programs authorized by [this division](#) of [this chapter](#).

h. 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.

i. 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 director of the department of homeland security and emergency management.

[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](#); [2012 Acts, ch 1021, §45](#); [2013 Acts, ch 29, §45](#); [2017 Acts, ch 148, §21, 22](#)

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 authorization from the executive council to pay as an expense from the appropriations addressed in [section 7D.29](#) 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](#); [2011 Acts, ch 131, §25, 158](#)

Referred to in [§29C.20](#)

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 the executive council to authorize the payment of up to one million dollars as an expense from the appropriations addressed in [section 7D.29](#) to alleviate 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](#); [2011 Acts, ch 131, §26, 158](#)

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 director of the department of homeland security and emergency management, 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 department of homeland security and emergency management, 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; 2013 Acts, ch 29, §46](#)

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 annually 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; 2017 Acts, ch 148, §3](#)

135.151 Reserved.

DIVISION XIX
OBSTETRICAL AND NEWBORN
INDIGENT PATIENT
CARE PROGRAM

135.152 Statewide obstetrical and newborn indigent patient care program. Repealed by 2017 Acts, ch 148, §24.

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, 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, §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, 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, 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, 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](#); [2013 Acts, ch 138, §117 – 119, 127](#); [2014 Acts, ch 1026, §143](#)

Referred to in [§135.24](#), [135.159](#)

135.153A Safety net provider recruitment and retention initiatives program — repeal. Repealed by its own terms; [2015 Acts, ch 30, §211](#).

DIVISION XXI

IOWA HEALTH INFORMATION NETWORK

135.154 through 135.156F Repealed by 2015 Acts, ch 73, §8, 9. See chapter 135D.

DIVISION XXII

PATIENT-CENTERED HEALTH

135.157 Definitions. Repealed by 2017 Acts, ch 148, §11.

135.158 Medical home purposes — characteristics. Repealed by 2017 Acts, ch 148, §11.

135.159 Patient-centered health advisory council.

1. The department shall establish a patient-centered health 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:

- a. The director of human services, or the director's designee.
- b. The commissioner of insurance, or the commissioner's designee.
- c. A representative of the federation of Iowa insurers.
- d. A representative of the Iowa dental association.
- e. A representative of the Iowa nurses association.
- f. A physician and an osteopathic physician licensed pursuant to [chapter 148](#) who are family physicians and members of the Iowa academy of family physicians.
- g. A health care consumer.
- h. A representative of the Iowa collaborative safety net provider network established pursuant to [section 135.153](#).

- i. A representative of the Iowa developmental disabilities council.
 - j. A representative of the Iowa chapter of the American academy of pediatrics.
 - k. A representative of the child and family policy center.
 - l. A representative of the Iowa pharmacy association.
 - m. A representative of the Iowa chiropractic society.
 - n. A representative of the university of Iowa college of public health.
 - o. A certified palliative care physician.
2. The patient-centered health advisory council may utilize the assistance of other relevant public health and health care expertise when necessary to carry out the council's purposes and responsibilities.
3. A public member of the patient-centered health advisory council shall receive reimbursement for actual expenses incurred while serving in the member's official capacity only if the member is not eligible for reimbursement by the organization the member represents.
4. The purposes of the patient-centered health advisory council shall include all of the following:
- a. To serve as a resource on emerging health care transformation initiatives in Iowa.
 - b. To convene stakeholders in Iowa to streamline efforts that support state-level and community-level integration and focus on reducing fragmentation of the health care system.
 - c. To encourage partnerships and synergy between community health care partners in the state who are working on new system-level models to provide better health care at lower costs by focusing on shifting from volume-based to value-based health care.
 - d. To lead discussions on the transformation of the health care system to a patient-centered infrastructure that integrates and coordinates services and supports to address social determinants of health and to meet population health goals.
 - e. To provide a venue for education and information gathering for stakeholders and interested parties to learn about emerging health care initiatives across the state.
 - f. To develop recommendations for submission to the department related to health care transformation issues.

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; 2011 Acts, ch 25, §16; 2011 Acts, ch 129, §78, 82; 2012 Acts, ch 1023, §25; 2013 Acts, ch 138, §176, 187; 2015 Acts, ch 137, §38 – 41, 162, 163; 2017 Acts, ch 148, §5; 2017 Acts, ch 174, §98

DIVISION XXIII

PREVENTION AND CHRONIC CARE MANAGEMENT

135.160 Definitions. Repealed by 2012 Acts, ch 1021, §120.

135.161 Prevention and chronic care management initiative — advisory council. Repealed by 2011 Acts, ch 129, §81, 82.

135.162 Clinicians advisory panel. Repealed by 2011 Acts, ch 63, §35.

DIVISION XXIV

HEALTH CARE ACCESS

135.163 Health 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. 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; 2017 Acts, ch 148, §16

Referred to in §84A.11, 135.175

135.164 Strategic plan. Repealed by 2017 Acts, ch 148, §19.

DIVISION XXV

HEALTH DATA

135.165 Health care transparency — reporting requirements — hospitals and nursing facilities. Repealed by 2012 Acts, ch 1113, §24.

135.166 Health data — collection and use — collection from hospitals.

1. *a.* 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 data, as initially authorized in 1996 Iowa Acts, ch. 1212, §5, subsection 1, paragraph "a", subparagraph (4), and 641 IAC 177.3.

b. 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.

2. Unless otherwise authorized or required by state or federal law, data collected under this section shall not include the social security number of the individual subject of the data.

2009 Acts, ch 118, §57; 2014 Acts, ch 1026, §143; 2017 Acts, ch 148, §104

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](#)

See also §231.62

135.172 Reserved.

DIVISION XXVII

STATE CHILD CARE ADVISORY COMMITTEE

135.173 Early childhood Iowa council. Repealed by 2010 Acts, ch 1031, §308.

135.173A Child care advisory committee.

1. The early childhood stakeholders alliance shall establish a state child care advisory committee as part of the stakeholders alliance. The advisory committee shall advise and make recommendations to the governor, general assembly, department of human services, and other state agencies concerning child care.

2. The membership of the advisory committee shall consist of a broad spectrum of parents and other persons from across the state with an interest in or involvement with child care.

3. Except as otherwise provided, the voting members of the advisory committee shall be appointed by the stakeholders alliance from a list of names submitted by a nominating committee to consist of one member of the advisory committee, one member of the department of human services' child care staff, three consumers of child care, and one member of a professional child care organization. Two names shall be submitted for each appointment. The voting members shall be appointed for terms of three years.

4. The voting membership of the advisory committee shall be appointed in a manner so as to provide equitable representation of persons with an interest in child care and shall include all of the following:

- a. Two parents of children served by a registered child development home.
- b. Two parents of children served by a licensed center.
- c. Two not-for-profit child care providers.
- d. Two for-profit child care providers.
- e. One child care home provider.
- f. Three child development home providers.
- g. One child care resource and referral service grantee.
- h. One nongovernmental child advocacy group representative.
- i. One designee of the department of human services.
- j. One designee of the Iowa department of public health.
- k. One designee of the department of education.
- l. One head start program provider.
- m. One person who is a business owner or executive officer from nominees submitted by the Iowa chamber of commerce executives.
- n. One designee of the early childhood office of the department of management.
- o. One person who is a member of the Iowa afterschool alliance.
- p. One person who is part of a local program implementing the statewide preschool program for four-year-old children under [chapter 256C](#).
- q. One person who represents the early childhood stakeholders alliance.

5. In addition to the voting members of the advisory committee, the membership shall include four legislators as ex officio, nonvoting members. The four legislators shall be appointed one each by the majority leader of the senate, the minority leader of the senate, the speaker of the house of representatives, and the minority leader of the house of representatives for terms as provided in [section 69.16B](#).

6. In fulfilling the advisory committee's role, the committee shall do all of the following:

a. Consult with the department of human services and make recommendations concerning policy issues relating to child care.

b. Advise the department of human services concerning services relating to child care, including but not limited to any of the following:

- (1) Resource and referral services.
- (2) Provider training.
- (3) Quality improvement.
- (4) Public-private partnerships.
- (5) Standards review and development.

(6) The federal child care and development block grant, state funding, grants, and other funding sources for child care.

c. Assist the department of human services in developing an implementation plan to provide seamless service to recipients of public assistance, which includes child care services. For the purposes of [this subsection](#), “seamless service” means coordination, where possible, of the federal and state requirements which apply to child care.

d. Advise and provide technical services to the director of the department of education or the director’s designee relating to prekindergarten, kindergarten, and before and after school programming and facilities.

e. Make recommendations concerning child care expansion programs that meet the needs of children attending a core education program by providing child care before and after the core program hours and during times when the core program does not operate.

f. Make recommendations for improving collaborations between the child care programs involving the department of human services and programs supporting the education and development of young children including but not limited to the federal head start program; the statewide preschool program for four-year-old children; and the early childhood, at-risk, and other early education programs administered by the department of education.

g. Make recommendations for eliminating duplication and otherwise improving the eligibility determination processes used for the state child care assistance program and other programs supporting low-income families, including but not limited to the federal head start, early head start, and even start programs; the early childhood, at-risk, and preschool programs administered by the department of education; the family and self-sufficiency grant program; and the family investment program.

h. Make recommendations as to the most effective and efficient means of managing the state and federal funding available for the state child care assistance program.

i. Review program data from the department of human services and other departments concerning child care as deemed to be necessary by the advisory committee, although a department shall not provide personally identifiable data or information.

j. Advise and assist the early childhood stakeholders alliance in developing the strategic plan required pursuant to [section 256I.4, subsection 4](#).

7. The department of human services shall provide information to the advisory committee semiannually on all of the following:

a. Federal, state, local, and private revenues and expenditures for child care including but not limited to updates on the current and future status of the revenues and expenditures.

b. Financial information and data relating to regulation of child care by the department of human services and the usage of the state child care assistance program.

c. Utilization and availability data relating to child care regulation, quantity, and quality from consumer and provider perspectives.

d. Statistical and demographic data regarding child care providers and the families utilizing child care.

e. Statistical data regarding the processing time for issuing notices of decision to state child care assistance applicants and for issuing payments to child care providers.

8. The advisory committee shall coordinate with the early childhood stakeholders alliance its reporting annually in December to the governor and general assembly concerning the status of child care in the state, providing findings, and making recommendations. The

annual report may be personally presented to the general assembly's standing committees on human resources by a representative of the advisory committee.

[2010 Acts, ch 1031, §354, 361](#); [2015 Acts, ch 30, §55 – 57](#)

Referred to in [§237A.1, 256.9](#)

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.

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](#), and the fulfilling Iowa's need for dentists matching grant program created in [section 135.179](#).

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 [section 135.163](#).

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 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.

c. 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.

d. The fulfilling Iowa's need for dentists matching grant program account. The fulfilling Iowa's need for dentists matching grant program account shall be under the control of the department and the moneys in the account shall be used for the purposes of the fulfilling Iowa's need for dentists matching grant program as specified in [section 135.179](#). Moneys in the account shall consist of moneys appropriated or allocated for deposit in the account or received by the fund or the account and specifically dedicated to the fulfilling Iowa's need for dentists matching grant 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 [section 135.163](#) to support the medical residency training state matching grants program, the nurse residency state matching grants program, the fulfilling Iowa's need for dentists matching grant program, 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 oral and health delivery systems bureau of the department, the primary care office and shortage designation program, and the state office of rural health, administered through the oral and health delivery systems bureau of the department of public health; 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 [section 135.163](#).

c. 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, the funds shall be used in accordance with the strategic plan developed by the department of public health in accordance with [section 135.163](#), 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 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.

[2015 Acts, ch 30, §212, 218, 219; 2016 Acts, ch 1073, §55, 56, 187, 189; 2017 Acts, ch 148, §17, 18; 2018 Acts, ch 1165, §111 – 113](#)

Referred to in [§135.176, 135.178, 135.179, 249M.4](#)

Subsection 1, paragraph a amended

Subsection 5, NEW paragraph b

Subsection 6, paragraph a amended

DIVISION XXIX
HEALTH CARE WORKFORCE SUPPORT

135.176 Medical residency training state matching grants program.

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) A sponsor shall demonstrate that funds have been budgeted and will be expended by the sponsor in the amount required to provide matching funds for each residency position proposed in the request for state matching funds.

(2) 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 proposing the establishment of a new or alternative campus accredited medical residency training program as defined in subsection 1, paragraph “a”, shall be limited to no more than one hundred percent of the amount the sponsor has budgeted as demonstrated under paragraph “a”. The total amount of a grant awarded to a sponsor proposing the provision of a new residency position within an existing accredited medical residency or fellowship training program as specified in subsection 1, paragraph “b”, or the funding of residency positions which are in excess of the federal residency cap as defined in subsection 1, paragraph “c”, shall be limited to no more than twenty-five percent of the amount that the sponsor has budgeted for each residency position 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 that establishes a new or alternative campus accredited medical residency training program as defined in subsection 1, paragraph “a”, shall not receive more than fifty percent of the state matching funds available each year to support the program. An individual sponsor proposing the provision of a new residency position within an existing accredited medical residency or fellowship training program as specified in subsection 1, paragraph “b”, or the funding of residency positions which are in excess of the federal residency cap as defined in subsection 1, paragraph “c”, shall not receive more than twenty-five percent of the state matching funds available each year to support the program.

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.

[2015 Acts, ch 30, §213, 218, 219; 2015 Acts, ch 57, §18 – 21; 2016 Acts, ch 1073, §57](#)

Referred to in [§135.175](#)

135.177 Physician assistant mental health fellowship program — repeal. Repealed by its own terms; [2015 Acts, ch 30, §214](#).

135.178 Nurse residency state matching grants program.

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:

1. 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.

2. The application process for the grant.

3. Criteria for preference in awarding of the grants.

4. Determination of the amount of a grant.

5. 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.

[2015 Acts, ch 30, §215, 218, 219; 2016 Acts, ch 1139, §76, 78, 79](#)

Referred to in [§135.175](#)

2016 amendment takes effect May 27, 2016, and applies retroactively to June 30, 2016; 2016 Acts, ch 1139, §78, 79

135.179 Fulfilling Iowa’s need for dentists.

1. The department, in cooperation with a dental nonprofit health service corporation, shall create the fulfilling Iowa’s need for dentists matching grant program.

2. Funding for the program may be provided through the health care workforce shortage fund or the fulfilling Iowa’s need for dentists matching grant program account created in [section 135.175](#). The purpose of the program is to establish, expand, or support the placement of dentists in dental or rural shortage areas across the state by providing education loan repayments.

3. The department shall contract with a dental nonprofit health service corporation to implement and administer the program. The dental nonprofit health service corporation shall provide loan repayments to dentists who practice in a dental or rural shortage area as defined by the department.

[2014 Acts, ch 1106, §10](#)

Referred to in [§135.175](#)

DIVISION XXX

MENTAL HEALTH PROFESSIONAL SHORTAGE AREA PROGRAM

135.180 Mental health professional shortage area program. Repealed by 2017 Acts, ch 148, §19.

DIVISION XXXI

BEHAVIOR ANALYST AND ASSISTANT BEHAVIOR ANALYST GRANTS PROGRAM

135.181 Board-certified behavior analyst and board-certified assistant behavior analyst grants program — fund.

1. The department shall establish a board-certified behavior analyst and board-certified assistant behavior analyst grants program to provide grants to Iowa resident and nonresident applicants who have been accepted for admission or are attending a university, community college, or an accredited private institution, within or outside the state of Iowa, are enrolled in a program that is accredited and meets coursework requirements to prepare the applicant to be eligible for board certification as a behavior analyst or assistant behavior analyst, and demonstrate financial need.

2. The department, in cooperation with the department of education, shall adopt rules pursuant to [chapter 17A](#) to establish minimum standards for applicants to be eligible for a grant that address all of the following:

a. Eligibility requirements for and qualifications of an applicant to receive a grant. The applicant shall agree to practice in the state of Iowa for a period of time, not to exceed four years, as specified in the contract entered into between the applicant and the department at the time the grant is awarded. In addition, the applicant shall agree, as specified in the contract, that during the contract period, the applicant will assist in supervising an individual working toward board certification as a behavior analyst or assistant behavior analyst or to consult with schools and service providers that provide services and supports to individuals with autism.

b. The application process for the grant.

c. Criteria for preference in awarding of the grants. Priority in the awarding of a grant shall be given to applicants who are residents of Iowa.

d. Determination of the amount of a grant. The amount of funding awarded to each applicant shall be based on the applicant's enrollment status, the number of applicants, and the total amount of available funds. The total amount of funds awarded to an individual applicant shall not exceed fifty percent of the total costs attributable to program tuition and fees, annually.

e. Use of the funds awarded. Funds awarded may be used to offset the costs attributable to tuition and fees for the accredited behavior analyst or assistant behavior analyst program.

3. a. A board-certified behavior analyst and board-certified assistant behavior analyst grants program fund is created in the state treasury as a separate fund under the control of the department. The fund shall consist of moneys appropriated from the general fund of the state for the purposes of the fund and moneys from any other public or private source available.

b. The department may receive contributions, grants, and in-kind contributions to support the purposes of the fund. Not more than five percent of the moneys in the fund may be used annually for administrative costs.

c. 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 shall not be considered revenue of the state, but rather shall be moneys of the fund. Moneys 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.

d. The moneys in the fund are appropriated to the department and shall be used to provide grants to individuals who meet the criteria established under [this section](#).

4. The department shall submit a report to the governor and the general assembly no later than January 1, annually, that includes but is not limited to all of the following:

a. The number of applications received for the immediately preceding fiscal year.

b. The number of applications approved and the total amount of funding awarded in grants in the immediately preceding fiscal year.

c. The cost of administering the program in the immediately preceding fiscal year.

d. Recommendations for any changes to the program.

[2015 Acts, ch 137, §68, 162, 163; 2016 Acts, ch 1139, §57, 58](#)

135.182 through 135.184 Reserved.

DIVISION XXXII

EPINEPHRINE AUTO-INJECTOR SUPPLY

135.185 Epinephrine auto-injector supply.

1. For purposes of [this section](#), unless the context otherwise requires:

a. “*Epinephrine auto-injector*” means the same as provided in [section 280.16](#).

b. “*Facility*” means a food establishment as defined in [section 137F.1](#), a carnival as defined in [section 88A.1](#), a recreational camp, a youth sports facility, or a sports arena.

c. “*Licensed health care professional*” means the same as provided in [section 280.16](#).

d. “*Personnel authorized to administer epinephrine*” means an employee or agent of a facility who is trained and authorized to administer an epinephrine auto-injector.

2. Notwithstanding any other provision of law to the contrary, a licensed health care professional may prescribe epinephrine auto-injectors in the name of a facility to be maintained for use as provided in [this section](#).

3. A facility may obtain a prescription for epinephrine auto-injectors and maintain a supply of such auto-injectors in a secure location at each location where a member of the public may be present for use as provided in [this section](#). A facility that obtains such a prescription shall replace epinephrine auto-injectors in the supply upon use or expiration. Personnel authorized to administer epinephrine may possess and administer epinephrine auto-injectors from the supply as provided in [this section](#).

4. Personnel authorized to administer epinephrine may provide or administer an epinephrine auto-injector from the facility’s supply to an individual present at the facility if such personnel reasonably and in good faith believe the individual is having an anaphylactic reaction.

5. The following persons, provided they have acted reasonably and in good faith, shall not be liable for any injury arising from the provision, administration, or assistance in the administration of an epinephrine auto-injector as provided in [this section](#):

a. Any personnel authorized to administer epinephrine who provide, administer, or assist in the administration of an epinephrine auto-injector to an individual present at the facility who such personnel believe to be having an anaphylactic reaction.

b. The owner or operator of the facility.

c. The prescriber of the epinephrine auto-injector.

6. The department of public health, the board of medicine, the board of nursing, and the board of pharmacy shall adopt rules pursuant to [chapter 17A](#) to implement and administer [this section](#), including but not limited to standards and procedures for the prescription, distribution, storage, replacement, and administration of epinephrine auto-injectors, and for training and authorization to be required for personnel authorized to administer epinephrine.

[2015 Acts, ch 68, §1; 2016 Acts, ch 1073, §58](#)

Referred to in [§155A.27](#)

135.186 through 135.189 Reserved.

DIVISION XXXIII

POSSESSION AND ADMINISTRATION OF OPIOID ANTAGONISTS

135.190 Possession and administration of opioid antagonists — immunity.

1. For purposes of [this section](#), unless the context otherwise requires:
 - a. “*Licensed health care professional*” means the same as defined in [section 280.16](#).
 - b. “*Opioid antagonist*” means the same as defined in [section 147A.1](#).
 - c. “*Opioid-related overdose*” means the same as defined in [section 147A.1](#).
 - d. “*Person in a position to assist*” means a family member, friend, caregiver, health care provider, employee of a substance abuse treatment facility, or other person who may be in a place to render aid to a person at risk of experiencing an opioid-related overdose.
2. a. Notwithstanding any other provision of law to the contrary, a licensed health care professional may prescribe an opioid antagonist to a person in a position to assist.
 - b. (1) Notwithstanding any other provision of law to the contrary, a pharmacist licensed under [chapter 155A](#) may, by standing order or through collaborative agreement, dispense, furnish, or otherwise provide an opioid antagonist to a person in a position to assist.
 - (2) A pharmacist who dispenses, furnishes, or otherwise provides an opioid antagonist pursuant to a valid prescription, standing order, or collaborative agreement shall provide instruction to the recipient in accordance with any protocols and instructions developed by the department under [this section](#).
3. A person in a position to assist may possess and provide or administer an opioid antagonist to an individual if the person in a position to assist reasonably and in good faith believes that such individual is experiencing an opioid-related overdose.
4. A person in a position to assist or a prescriber of an opioid antagonist who has acted reasonably and in good faith shall not be liable for any injury arising from the provision, administration, or assistance in the administration of an opioid antagonist as provided in [this section](#).
5. The department may adopt rules pursuant to [chapter 17A](#) to implement and administer [this section](#).

[2016 Acts, ch 1061, §1](#); [2016 Acts, ch 1139, §68 – 70, 72 – 75](#)

Referred to in [§155A.27](#)

DIVISION XXXIV

STROKE CARE — REPORTING AND DATABASE

135.191 Stroke care — continuous quality improvement.

1. A nationally certified comprehensive stroke center or a nationally certified primary stroke center operating in the state shall report to the statewide stroke database data consistent with nationally recognized guidelines on the treatment of individuals with confirmed cases of stroke within the state. If a nationally certified comprehensive stroke center or nationally certified primary stroke center does not comply with [this subsection](#) by reporting data consistent with nationally recognized guidelines, the department may request a review of the certification of the comprehensive stroke center or the primary stroke center by the certifying entity.
2. The department, in partnership with the university of Iowa college of public health, department of epidemiology, shall do all of the following:
 - a. Maintain or utilize a statewide stroke database that compiles information and statistics on stroke care which aligns with nationally recognized stroke consensus metrics.
 - b. Utilize the get with the guidelines-stroke data set platform or a data tool with equivalent data measures and with confidentiality standards consistent with federal and state

law and other health information and data collection, storage, and sharing requirements of the department.

c. Partner with national voluntary health organizations and stroke advocacy organizations that plan for achieving stroke care quality improvement to avoid duplication and redundancy.

d. Encourage nationally certified acute stroke-ready hospitals and emergency medical services agencies to report data consistent with nationally recognized guidelines on the treatment of individuals with confirmed cases of stroke within the state.

[2017 Acts, ch 26, §1](#)

Implementation of section contingent upon utilization of existing resources by the department of public health and shall not require appropriation of additional funding; 2017 Acts, ch 26, §2