Maternal Health Logic Model

IMPACT:
Improved childbirth outcomes

Planned Work			Intended Results	
Inputs ➡ "What resources will be invested?"	**Outputs** ➡ "What do you plan to do?"		**Performance Measures** ➡ "How will progress be measured?	**Outcomes** "What are the planned results?"
Staff: • MCH Project Director • MH Project Coordinator • WHIS Administrator • Physician to oversee program • Register Nurse • Social Worker or related bachelors • Licensed dietician or (MOU with WIC dietician) • Other service providers • Office staff (management, intake, billing) • Data entry staff Facility: • Office space Supplies: • Computer/Internet • email • Phone • Printer • Software • Copier • Other Community Partners: • Board of Health • WIC • Local Public Health • Early Childhood Iowa	Services: Infrastructure building: • Development / review of Maternal Health protocols • Development of community linkages • Outreach/ marketing • Work with local medical /dental providers to inform them of the program • Work with local medical providers to enhance care coordination services • Linkage with local boards of health • Promote quality assurance initiatives including client satisfaction surveys, internal/external chart audit & WHIS Reviews (documentation review), record retention, billing practices, and	Activities: Applicants will describe the methodologies that will be undertaken to implement the MH program on the MH Activity Worksheet.	**Required NPM#18 Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.** **Percent of women served who report a medical home** Optional : National Performance Measure (NPM) #8 The rate of birth (per 1,000) for teenagers aged 15-17 years. NPM # 11 The percentage of mothers who breast feed their infants at 6 months NPM #15 Percent of women who smoke in the last three months of pregnancy	**Increase the percent of pregnant women receive care in the first trimester (WHIS data)** **Increase the percent of women served who report a medical home (WHIS data)** Decrease the number of teen pregnancies (Vital Statistics Data) Increase the number of women who breastfeed their infants for at least 6 months (PedNSS data) Decrease the number of women of childbearing age who use tobacco products. (Vital Statistics)

• Medical/dental providers • Family Planning Providers • CH agencies • Local birthing hospitals • Local Mental Health Professionals • Other Funding: • Title V MH funds • IDPH fee-for-service reimbursements • Medicaid fee-for-service reimbursements • In-kind • Other grants / resources	other local initiatives • Other Population based: • Public education • Health promotion activities • Population-based screenings Enabling: Provide high quality services within Maternal Health/Medicaid guidelines • Assess health insurance needs assist with Presumptive Eligibility determination • Care coordination for Medicaid and non- Medicaid clients Direct Care: Provide high quality services within Child Health/ Medicaid guidelines • Health Education • Social assessment and guidance • Health screening for depression, tobacco/substance abuse and domestic violence • Oral health screening and prevention • Immunizations		SPM #4 Percent of women who are counseled about developing a reproductive life plan SPM#6 Percent of Medicaid enrolled women receiving preventive dental health services during pregnancy	Decrease in the number of unintended pregnancies (Barriers survey) Increase number of dental services to women served (WHIS) Increase the number of pregnant women who receive preventive dental services

	• Nutrition counseling (may be provided by WIC staff) • Nursing assessment/ evaluation • Home visit for nursing • Social work home visit • Evaluation & management • Pregnancy testing • Preventive medicine counseling (when screening for chlamydia and gonorrhea) • Local (in town transportation) • Interpretation • Other			

IMPACT:
Improved health outcomes for children

Child Health Logic Model

(not including ***hawk-i*** Outreach or Oral Health)

Planned Work			Intended Results	
Inputs → "What resources will be invested?"	**Outputs** → "What do you plan to do?"		**Performance Measures** → "How will progress be measured?	**Outcomes** "What are the planned results?"
Staff: • MCH Project Director • CH Project Coordinator • EPSDT Coordinator • CAReS Administrator • Early ACCESS Service Coordinator(s) • RN • CCNC • Social Worker • Licensed dietician • Interpreters • Other service providers • Office staff (management, intake, billing) • Data entry staff Facility: • Office space Travel capacity Supplies: • Computer/Internet • email • Phone • Printer • Software • Copier • Other Community Partners:	Services: Infrastructure building: • Development / review of Child Health protocols • Development of community linkages • Outreach /marketing • Advocacy • Work with local medical providers to inform them of the program • Work with local medical providers to enhance care coordination services • Linkage with local boards of health • Promote quality assurance initiatives including client satisfaction surveys, internal/external chart audit & CAReS Reviews (documentation review), record retention, billing practices, and other local initiatives	Activities: Applicants will describe the methodologies that will be undertaken to implement the CH program (excluding I-Smile™ and ***hawk-i*** Outreach) on the CH Activity Worksheet.	**Required:** Percent of inform completions achieved CMS 416 Participation Rate (The percent of Medicaid enrolled children in each county receiving at least one preventive health screen in a given year) Percent of children served who report a medical home National Performance Measure #7: Percent of children fully immunized by 24 months Percent of children ages 9-35 months receiving a blood lead test	Increase the % of families fully informed of the EPSDT program Increase the % of children receiving well child screens Increase the % of children having a medical home (regular source of medical care) Increase the % children fully immunized Increase the % children receiving a blood lead test at an early age

• Board of Health • WIC • Local Public Health • Empowerment • Local medical providers • Immunization Providers (i-4) • Local Childhood Lead Poisoning Prevention Programs • CCR & R • Child care businesses • ISU Extension • AEA • Local DHS • Child and Adult Care Food Program (CACFP) • Other Funding: • Title V CH funds • IDPH fee-for-service reimbursements • Medicaid fee-for-service reimbursements • In-kind • Other grants / resources	• Professional development (staff and community partners) • Community development to improve health and safety in child care and other settings • Other Population based: • Public education • Health promotion activities • Population-based screenings • Assessment of injury hazards of facility, equipment, supplies, and practices in child care settings • Assessment of health and safety policy and practice within child care settings • Child record review in child care businesses • Information and referral relating to out of home child care • Technical assistance for children with special needs to assure inclusion in child care • Other Enabling: Provide high quality services within Child Health/Medicaid guidelines • Informing/re-		Number of children age 0 to 3 receiving a developmental test from the child health agency that results in a referral to the AEA Number of children age 0 to 3 found not eligible for Early ACCESS by the AEA and referred to the Child Health agency for developmental monitoring The number of child care businesses receiving on-site CCNC services. **Optional:** State Performance Measure #8: Rate of hospitalizations due to unintentional injury among children ages 0-14 National Performance Measure #10: The rate of deaths to children ages 14	Increase in the number of referrals to the AEA by the child health agency for children with developmental testing scores indicating need Increase in the number of children receiving developmental monitoring by the child health agency due to referral from the AEA when not eligible for Early ACCESS Increase the number of child care businesses receiving on-site services from the CCNC Reduction in the rate of children experiencing unintentional injuries Reduction in the rate of child deaths resulting

	informing for newly Medicaid eligibles • Care coordination for Medicaid and non- Medicaid clients Direct Care: Provide high quality services within Child Health/ Medicaid guidelines • Well child exams (initial/periodic) • Immunization administration • Immunization administration with counseling • Blood draw • Blood lead analysis w/blood draw • Developmental testing • Nutrition counseling (initial /reassessment) • Nursing assessment/ evaluation • Home visit for nursing • Social work home visit • Evaluation & management • Preventive medicine counseling (when screening for chlamydia and gonorrhea) • Hemoglobin / hematocrit • Visual acuity • Instrument-based ocular screening		years and younger caused by motor vehicle crashes National Performance Measure #14: The percent of children ages 2-5 years receiving WIC services with a BMI at or above the 85th percentile National Performance Measure #16: The rate of suicide deaths among youths 15 – 19 years	from motor vehicle crashes Reduction in the % of children who are overweight or obese Reduction in the rate of suicide among adolescents

	• Speech audiometry • Local (in town transportation) • Interpretation • Depression screening (adolescent or caregiver) • Domestic violence screening (adolescent or caregiver) • Annual alcohol screening (adolescent or caregiver) • Alcohol and/or drug screening (adolescent or caregiver) • Alcohol and/or drug screening w/ brief intervention (SBIRT) (adolescent or caregiver)			

IMPACT:
Children with health insurance coverage

hawk-i Outreach Logic Model

Planned Work			Intended Results	
Inputs "What resources will be invested?"	**Outputs** "What do you plan to do?"		**Performance Measures** "How will progress be measured?"	**Outcomes** "What are the planned results?"
Staff: • ***hawk-i*** Outreach Coordinator • MCH Project Director • CH Project Director • EPSDT Coordinator • I-Smile™ Coordinator (Dental hygienist(s)) • Nurse(s) • Administrative staff (fiscal, management, intake, billing) Facility: • Office space Supplies: • Computer with internet, email • Printer • Software • Copier • Phone	Services: Infrastructure Building: • Development of community partnerships ***hawk-i*** outreach to families • ***hawk-i*** outreach to medical and health care providers • ***hawk-i*** outreach to schools • ***hawk-i*** outreach to faith-based organizations • ***hawk-i*** outreach to special populations (including but not limited to Native Americans, Hispanics, and African-Americans) • Development of ***hawk-i*** outreach strategies that build on existing community linkages Population-based: • Public education (presentations, articles, interviews)	Activities: Applicants will describe the methodologies that will be undertaken to implement the ***hawk-i*** Outreach components of the CH program on the ***hawk-i*** Outreach Activity Worksheet.	Projected number of uninsured children who would become enrolled in ***hawk-i*** or Medicaid by September 30, 2016. Data Source: Iowa SCHIP Enrollment by County Report	Increase in the number of children enrolled in ***hawk-i*** or Medicaid as a result of community-based outreach

Funding: • ***hawk-i*** Title V CH • Medicaid reimburse-ment • In-Kind • Other sources (e.g. grants)	• Outreach Events/Exhibits (back to school campaigns, health fairs, county fairs) Enabling: • Presumptive eligibility for children • Care coordination services			

IMPACT:
Children with good oral health

CH - Oral Health Logic Model (I-Smile™ and CH-Dental)

Planned Work			Intended Results	
Inputs ➡ "What resources will be invested?"	**Outputs** ➡ "What do you plan to do?"		**Performance Measures** ➡ "How will progress be measured?"	**Outcomes** "What are the planned results?"
Staff: • I-Smile™ Coordinator (dental hygienist) • MCH Project Director • EPSDT Coordinator • CAReS Administrator • Dental hygienist(s) • Nurse(s) • Administrative staff (fiscal, management, intake, billing) • Data entry staff Facility: • Office space Travel capacity Supplies: • Computer with internet, email • Printer • Software • Copier • Phone	Services: Infrastructure Building: • Linkage with local boards of health • Oral health planning and needs assessments • Development of partnerships • Establishment of referral networks • Outreach to health care providers • Coordination of school screening and audit process • Outreach to families • Training and oversight of staff involved with oral health services • Development of oral health protocols • Oral health advocacy • Professional development for staff and community partners • Participate in quality assurance initiatives	Activities: Applicants will describe the methodologies that will be undertaken to implement the oral health components of the CH program (I-Smile™ and CH-Dental) on the OH Activity Worksheet.	**Required:** The percent of Medicaid-enrolled children ages 0-14 in each county who receive a dental service (CMS 416) State Performance Measure #7 : The percent of Medicaid-enrolled children ages 0-5 in each county who receive a dental service (CMS 416) Number of dentists accepting Medicaid referrals Number of dentists accepting Title V referrals Number of general and pediatric dentists in service area Number of personal visits made to dental practices by I-Smile™ Coordinator	Increase in the % of Medicaid-enrolled children receiving a dental service (ages 0-14) Increase in the % of Medicaid-enrolled children receiving a dental service (ages 0-5) Increase in the % of children having a dental home (receiving care based on risk assessment, including education, screenings, preventive, diagnostic, treatment, and emergency services) Decrease in rate of tooth decay for children Decrease in rate of children with no payment source for dental care

Community Partners Funding: • I-Smile™ • Title V CH • Title V CH-Dental • Medicaid reimbursement • In-Kind • Other sources (e.g. grants)	Population-based: • Public education (presentations, articles) • Oral health promotion • Oral screenings for population groups • Education and training for health care professionals Enabling: • Dental care coordination services • Referrals to dentists for regular and restorative dental care Direct Care: • Gap-filling preventive dental services (fluoride varnish application, sealant application, prophylaxis, radiographs, tobacco counseling, nutrition counseling, oral hygiene instruction) • Oral screenings and risk assessments		Number of phone/mail outreach contacts made to dental practices by I-Smile™ Coordinator Number of personal visits made to medical practices by I-Smile™ Coordinator Number of phone/mail outreach contacts made to medical practices by I-Smile™ Coordinator Number of medical practices receiving training from I-Smile™ Coordinator **Optional:** National Performance Measure #9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth	

Family Planning Logic Model

IMPACT:
Increase percentage of pregnancies in Iowa that are intended (Barriers data)

Planned Work			Intended Results	
Inputs ➡ "What resources will be invested?"	**Outputs** "What do you plan to do?" ➡		**Performance Measures** ➡ "How will progress be measured?"	**Outcomes** "What are the planned results?"
Staff: • Project coordinator • Medical Director • Physicians • NPs, PAs, • RN, LPN, CMA • Interpreter • Lab personnel • Other service providers • Office staff , (registration, billing, scheduling, data entry) • Outreach and education staff Community partners: • Board of Health • Local Public Health • Local health care providers • Schools	Required Services: • **Provision of high quality family planning services in compliance with Title X Program Guidelines (1)(5)** • **Support national priorities, key issues and legislative mandates of the DHHS (2,3,4)** • **Counseling about reproductive life plans and preconception health** • **Outreach through marketing, social networking, and linkages with other community partners**	Activities: Applicants will describe the methodologies that will be undertaken to implement the FP program on the FP Activity Worksheet.	• Number of female FP clients served • Number of male FP clients served • Number of adolescents served (<20) • Number of unduplicated Hispanic clients served • Number of unduplicated African American clients served • Number of clients under 200% poverty served • SPM 4 - Percent of women who are counseled about developing a reproductive life plan • Outreach and education activities • Percent of FP users that adopt or continue to use a most or	• Increased number of female FP clients served (Ahlers) • Increased number of male FP clients served (Ahlers) • Increased number of adolescents served (Ahlers) • Increased number of unduplicated Hispanic clients served (Ahlers) • Increased number of unduplicated African American clients served (Ahlers) • Increased number of clients under 200% poverty status served (Ahlers)

Facility: • Clinic space • Office space • Equipment and supplies • Laboratory capacity • Scheduling and billing capacity Supplies: • Contraceptive supplies • Computer, printer, software, copier, telephones, internet access and email Funding: • Fee for service billing, • Title X funds • IPP resources as funding is available • Iowa Initiative resources, as funding is available • Medicaid fee for service billing • IFPN fee for service billing • In-kind • Other grants and resources	• Participation in quality assurance activities including client satisfaction surveys, annual internal chart audit, annual summary of outreach activity, annual cost analysis, site visits from IDPH staff regarding compliance with Title X guidelines (1)(5), financial audit every other year • Use Family Planning Data System administered by Ahlers • Bill all third parties responsible for paying for direct care services • Apply Title X funds as payment for client services appropriately • On- site enrollment of clients in IFPN • Public education Optional services: • Immunizations • Health promotion and disease prevention activities		moderately effective contraceptive method	• Reproductive Life Planning counseling (Ahlers) • Increased number and/or variety of outreach activities reported (Agency records)

	• Broad STI screening and testing, including HIV, Syphilis, Hepatitis, Herpes, and other STIs (STI screening is required for IUC services) • Gynecologic services • Counseling and referral around substance use and abuse, domestic violence, nutrition, sexual function, tobacco cessation other than what is required by Title X guidelines as related services • Genetic information and referral • Post partum care • Other-specify			

1. http://www.hhs.gov/opa/program-guidelines
2. http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-priorities/
3. http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/title-x-key-issues/
4. http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/legislative-mandates/
5. http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program-instructions/
6. http://www.hhs.gov/opa/title-x-family-planning/title-x-policies/program_policy_notice/