IOWA | Health and Human Services

Meeting Agenda

Division: Public Health

Meeting Topic: State Mortality Review Committee

Facilitators: Jill Lange and Marcus Johnson-Miller

Date: June 13, 2025

Time: 10:00-12:00

Location: Virtual (Teams)

Attachments: Agenda, Legal Overview, Iowa Code and Subcommittee Overviews

Meeting Objectives

To initiate the first State Mortality Review Committee (SMRC).

Meeting Participants

State Mortality Review Committee		
Casey Manser	Dr. Alison Lynch	Rachel Zimmerman
Captain Sadie Weekley	Abby Schueller	Dr. Stephanie Radke
Dr. Dennis Klein	Clerk of District Court - Vacant	Judicial Officer - Vacant
Liaisons		
Vera Wallican	Matthew Burns	Ryan Kedley
Nicole Leonard	Ryan Baldridge	Dennis Kleen
Sonia Parras	Melissa Walker	
Iowa HHS Staff		
Dr. Robert Kruse	Jill Lange	Marcus Johnson-Miller
Michelle Holst	Nafla Poff-Dainty	Sylvia Navin
Analisa Pearson	Jancy Nielson	Derma Rivera
Sonya Streit		

IOWA | Health and Human Services

Agenda Topic and Items

I. Call meeting to order – Jill Lange

II. Introductions/Roll Call – Marcus Johnson-Miller
   a. SMRC Members
   b. Liaisons
   c. HHS Staff

III. Welcome and Committee Overview – Dr. Robert Kruse

IV. Legal Overview – Jancy Nielson

V. Elect Chair and Vice Chair – Jill Lange and Marcus Johnson-Miller
   a. Nominations and self-nominations
   b. Vote
   c. Election of other officers
   d. Vote

VI. Establishment of SMRC Subcommittees – Jill Lange and Marcus Johnson-Miller
   a. Overview of Child Death Review Subcommittee, Maternal Mortality Review Subcommittee and Domestic Abuse Death Review Subcommittee – Health and Human Services Staff
   b. Discuss need for additional subcommittees.
   c. Vote to Establish Subcommittees – SMRC Chair

VII. Q&A

VIII. Next Meeting
   a. Schedule meeting
   b. SMRC Operations - Establish appointment provisions, membership terms, operating guidelines, and meeting cadence.
   c. Discuss role of liaisons

Legal Overview for the State Mortality Review Committee

Updated June 2025

Jancy Nielson, Legal Counsel
HHS Compliance Division
Jancy.nielson@hhs.iowa.gov

IOWA Health and Human Services

Disclaimer

This outline provides a general overview of laws and is not intended to cover all applicable laws or the nuances of applicable laws. This document does not constitute legal advice. Specific questions should be directed to committee staff and HHS legal counsel, Jancy Nielson or Kayla Burkhiser Reynolds.

Authority

1. The State Mortality Review Committee is established in Iowa Code 135.43. All state boards and commissions, including this committee, may only work within the authority bestowed upon it by the legislature and may not expand it.
2. A committee's mission is always serving a public purpose. While serving on this, or any, committee, you are representing Iowans. Always make decisions with that public purpose and service to Iowans in mind.

Responsibilities and Duties

The duties of the committee are found in Iowa Code chapter 135.43, 135.110, and 641 IAC 90:

1. Collect, review, and analyze child and domestic abuse death information to prepare reports concerning the causes and manner of deaths, including recommendations for preventing future child and domestic abuse deaths.
    a. Child death reports require annual submission
    b. Domestic abuse reports are biennial
2. Recommend to the agencies represented on the review committee changes which may prevent child and domestic abuse deaths.
3. Recommend to the department, 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.
4. Develop protocols for the committee to immediately review the child abuse assessments which involve the fatality of a child under age eighteen.
5. 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.

6. Establish subcommittees to which the committee may delegate some or all of the committee's responsibilities.

Membership

1. The committee is comprised of the following members pursuant to Iowa Code 135.43:
    a. The state medical examiner or the state medical examiner's designee;
    b. A licensed physician knowledgeable concerning the causes of death;
    c. A certified or licensed professional knowledgeable regarding substance use disorder;
    d. An attorney experienced in prosecuting domestic abuse cases;
    e. An expert in unexpected or unexplained infant deaths;
    f. A clerk of a district court, to be appointed by the chief justice of the supreme court;
    g. A judicial officer, to be appointed by the chief justice of the supreme court;
    h. A local law enforcement official;
    i. A social worker knowledgeable about deaths of children;
    j. Additional members as determined by the director.
2. Membership terms are for 3 years.

Decision Making

1. No singular member makes decisions for the committee. Decisions are made by taking votes at committee meetings.
2. A "quorum" of the committee is required to conduct business. Because Iowa Code 135.43 does not set a specific quorum requirement, quorum for this committee is no

less than two thirds of the eligible voting members (Iowa Code 17A.2(1)). There are 9 members required in Iowa Code 135.43, therefore 6 members need to be present to meet quorum regardless of vacancies. If additional members are appointed pursuant to Iowa Code 135.43(2)(j), the number to reach quorum may change.

3. If there is a quorum, a position is carried by a majority of the present committee members.
4. There are important exceptions, however, such as committee may only go into closed session upon a public vote by two-thirds of the members or all members present pursuant to Iowa Code 21.5.
5. The votes of all members must be public and clear during the meeting and in the minutes. Secret voting is not allowed.
6. Voting members with a conflict of interest shall not vote on any action pertaining to that conflict. A statement by the conflicted member shall be conclusive for voting purposes and any vote by the member with a conflict shall be excluded pursuant to Iowa Code 216A.113(3) and Iowa Administrative Code 421—1.7.
7. Conflicted members, while excluded from voting, may still be counted for the purpose of establishing quorum pursuant to Iowa Administrative Code 421—1.7.

Open Meetings Law

1. Iowa Code chapter 21 governs all committee meetings. Chapter 21 requires four things: (1) public notice; (2) an agenda must be posted; (3) the public must be allowed to be present; (4) minutes must be kept.
2. Committee meetings allow the opportunity of participating virtually. The General Assembly enacted a requirement in 2019 requiring that all statutorily established boards, councils, and commissions under HHS's purview have a virtual option for members. (Iowa Code § 135.12). Participating virtually or by other electronic methods constitute presence at the meeting for all legal purposes.
3. Exercise caution – the definition of "meeting" in Chapter 22 "means a gathering in person or by electronic means, formal or informal, of a majority of the members of a governmental body where there is deliberation or action upon any matter within the scope of the governmental body's policy-making duties."

a. If a majority of the committee is present either in person or electronically, do not discuss committee business unless you are at a committee meeting preceded by proper notice to the public and a posted agenda.

b. Ministerial and social gatherings are not considered meetings so long as committee business is not discussed – but exercise caution in giving the appearance of an illegal meeting being held.

Agendas

1. Agendas aren't just an organizational tool, it is also a guiding document for public notice. You should be sure to:
    a. Post agendas at least 24 hours in advance; and
    b. Clearly outline all topics going to be discussed and which topics will require a vote be taken.
2. To determine whether the committee's agendas are transparent and easy to understand for the public, it is a good rule of thumb to read the committee's posted agendas for the previous year. If it is hard to determine what the committee discussed or voted on, the committee might look to include more detail in its agendas.
3. Follow the posted agenda. If a new idea or topic comes up at a committee meeting, it should be placed on the next meeting's agenda, unless there is an emergency requiring immediate action.

Transparency and the Public

1. While the public does not have the right to participate, they do have the right to observe, record, and photograph open sessions unless uses of technology obstruct the meeting.
2. The committee may provide opportunities for public input at meetings.

Keeping Minutes

1. In the spirit of transparency, keeping minutes creates a permanent record of who met, when they met, discussion and decision points, and by what votes decisions were solidified.

2. Minutes are a vital tool for conducting the public's business in a transparent way. They also:
    a. Help the committee with organization; and
    b. Allow Iowans to review public action taken on their behalf.
3. Mechanics of Minutes. Minutes must always include:
    a. The date, time, and place of a meeting;
    b. Members present; and
    c. Actions taken, with sufficient information to reflect member's votes.
4. If a closed session is held:
    a. The minutes of the open session must include the legal grounds for a closed session;
    b. The vote of each member on whether to go into closed session; and
    c. Any final action taken.
    d. NO FINAL VOTES MAY BE TAKEN IN CLOSED SESSION.
5. Alternative meeting modalities. If a meeting has to be held telephonically, not reasonably accessible to the public, or in cases of emergency, the minutes must explain the legal basis for doing so.
    a. Emergency meetings are those with less than 24 hours notice.

Closed Sessions

1. Closed sessions are to be taken very seriously. Never ask the public to leave a meeting so that the committee may discuss in private unless there is a sound legal basis to do so.
2. The committee cannot go into closed session unless the committee first meets in an open session with all proper notice requirements (24 hour notice and a posted agenda).
3. The committee is only allowed to close an open session if clearly given authority in statute. For example, a board, commission, or council is allowed to go into closed session to discuss:

   a. Pending litigation with counsel;
   b. Confidential records;
   c. Certain personnel matters; or
   d. The decision to be issued in a contested case.
4. To be certain that there are sound legal grounds for entering a closed session, always consult with the committee's assigned legal counsel. Be sure to get the advice in writing or ensure that the advice is reported in the meeting minutes.
5. After announcing the legal basis for a closed session, be sure to take a roll call vote.
   a. The committee can only enter closed session with an affirmative vote of two-thirds of the members or all members present.
6. After entering a closed session, the committee must:
   a. Record the session and retain the recording for at least a year.
   b. Take detailed minutes.
   c. Limit the discussion to the announced basis for the closed session.
7. Final action can only be taken in open session. When closed discussion has finished, return to open session, allow individuals back into the room, make a motion, and take a vote on any final action in open session.

Public Records Law

1. Boards and councils are subject to Iowa Code Chapter 22 – Public Records Law.
   a. The committee's records are open to public examination unless they are specifically made confidential under law.
2. Public records can be in any form, including e-mail. Do not commingle official committee business emails with your personal email. Committee staff or assigned legal counsel can advise on methods to separate emails.
3. It is prudent to assume any record you create or receive as a committee member is a public record that may be open to the public upon request.
4. The public records contact for your committee is HHS's Open Records Compliance Officer.
   a. Requests you receive for public records should be referred to the committee's public records contact at HHSOpenRecords@hhs.iowa.gov.

   b. The public records contact is familiar with the law and can assure proper response to requests for public records, including consultation with legal counsel.
5. Exercise caution in creating or receiving any records that may be confidential. This committee receives confidential records often and there may be severe penalties for releasing certain types of confidential records.
6. Examples of records that may be fully or partially confidential include, but are not limited to:
   a. Applications containing social security numbers or credit card numbers;
   b. Mental health or other health records;
   c. School records;
   d. Complaints against licensees; or
   e. Criminal history background reports.

Open Meetings Enforcement

1. Actions to enforce Iowa's Open Meetings and Public Records laws can be brought by any of the following:
   a. A citizen of Iowa;
   b. A person who pays taxes of any type to the state of Iowa;
   c. A person individually aggrieved by a violation;
   d. A county attorney; and
   e. The Attorney General.
2. Actions can be brought either in court or before the Iowa Public Information Board (IPIB)
3. Complaints about alleged violations may be made directly to:
   a. The committee:
   b. The committee's staff or counsel;
   c. The Ombudsman's Office;
   d. The Attorney General;
   e. The Governor's Office;
   f. The Iowa Public Information Board (IPIB); or
   g. Elected Officials.

4. Take all violations very seriously. Remedies include removal from office upon a second violation, damages up to $2,500 for a knowing violation, expenses and attorneys fees, and injunctive relief.
5. Even honest mistakes can be violations of Iowa's open meetings laws, but committee members can avoid personal liability by relying upon the advice of counsel, formally given in writing or provided orally and memorialized in the meeting minutes.

Additional Laws Governing Commission Members

Gift Law

Committee members may not accept gifts from individuals you regulate or contract with in a professional capacity as a member of the State Mortality Review Committee.

1. This is defined as receiving something for free or for less than it is worth.
2. Ask your assigned legal counsel, committee staff, or the Ethics and Campaign Disclosure Board for guidance on gift law compliance.

Sales or Leases of Goods or Services

If you sell or lease goods or services to those regulated by your committee, ask your assigned counsel, committee staff, or the Ethics and Campaign Disclosure Board for guidance on applicable laws.

Lobbying

Iowa HHS has a designated team of registered government relations liaisons who represent the committee. Individual committee members should not lobby legislators on behalf of the committee or the Department. Engage your assigned legal counsel if you have specific lobbying questions.

Conflicts of Interest

Committee members should avoid conflicts of interest, but how and when they arise can be unique to certain boards, commissions, and councils. Iowa law often requires the appointment of at least some persons who are regulated by the committee.

Any time your objectivity may be impaired or there is an appearance of impropriety, seek advice from your assigned legal counsel.

Judicial Review

All committee action or inaction is subject to review in court on a variety of grounds including whether action is:

a. Compliant with the United States or Iowa Constitutions, statutes, or rules.
b. Consistent, nonarbitrary, logical, and reasonable.
c. Supported by facts and law.

Litigation

If the committee or its individual members are sued related to committee action, members acting in good faith in their official committee capacity are generally defended by the Attorney General and indemnified by the State.

CHAPTER 135

DEPARTMENT OF HEALTH AND HUMAN SERVICES — PUBLIC HEALTH

Referred to in §135B.5, 163.3A, 195.10, 225C.6A

SUBCHAPTER I

GENERAL PROVISIONS

SUBCHAPTER II

MISCELLANEOUS PROVISIONS

SUBCHAPTER III

MORBIDITY AND MORTALITY STUDY

SUBCHAPTER IV

STATE MORTALITY REVIEW COMMITTEE — CHILDREN

SUBCHAPTER V

RENAL DISEASES

SUBCHAPTER VI

HEALTH FACILITIES COUNCIL

SUBCHAPTER VII

RESERVED

SUBCHAPTER VIII

LEAD POISONING PREVENTION PROGRAM — BLOOD LEAD TESTING

SUBCHAPTER IX

HEALTHY FAMILIES PROGRAM

SUBCHAPTER X

RURAL HEALTH AND PRIMARY CARE

SUBCHAPTER XI

STATE MORTALITY REVIEW COMMITTEE — DOMESTIC ABUSE

SUBCHAPTER XII

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

SUBCHAPTER XIII

TAXATION OF ORGANIZED DELIVERY SYSTEMS

SUBCHAPTER XIV

SUBSTANCE USE DISORDER TREATMENT FACILITY FOR PERSONS ON PROBATION

SUBCHAPTER XV

NEWBORN AND INFANT HEARING SCREENING

SUBCHAPTER XVI

INTERAGENCY PHARMACEUTICALS BULK PURCHASING COUNCIL

SUBCHAPTER XVII

DISASTER PREPAREDNESS

SUBCHAPTER XVIII

GAMBLING TREATMENT PROGRAM

SUBCHAPTER XIX

OBSTETRICAL AND NEWBORN INDIGENT PATIENT CARE PROGRAM

SUBCHAPTER XX

COLLABORATIVE SAFETY NET PROVIDER NETWORK

SUBCHAPTER XXI

IOWA HEALTH INFORMATION NETWORK

SUBCHAPTER XXII

PATIENT-CENTERED HEALTH

SUBCHAPTER XXIII

PREVENTION AND CHRONIC CARE MANAGEMENT

SUBCHAPTER XXIV

HEALTH CARE ACCESS

SUBCHAPTER XXV

HEALTH DATA

SUBCHAPTER XXVI

ALZHEIMER'S DISEASE SERVICE NEEDS

SUBCHAPTER XXVII

STATE CHILD CARE ADVISORY COMMITTEE

SUBCHAPTER I

GENERAL PROVISIONS

135.1 Definitions.

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

1. *"Director"* means the director of health and human services.

2. *"Health officer"* means the physician, physician assistant, advanced registered nurse practitioner, or advanced practice registered nurse who is the health officer of the local board of health.

3. *"Local board"* means 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"* include regulations and orders.

6. *"State department"* or *"department"* means the department of health and human services.

[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; 2020 Acts, ch 1083, §1; 2023 Acts, ch 19, §125; 2024 Acts, ch 1043, §52

Referred to in §10A.533, 135C.1, 144.26, 237A.12, 514.21

Unnumbered paragraph 1 amended

135.2 Appointment of director and acting director. Repealed by 2023 Acts, ch 19, §1357.

135.3 Disqualifications. Repealed by 2023 Acts, ch 19, §1357.

135.4 and 135.5 Reserved.

135.6 through 135.10 Repealed by 2023 Acts, ch 19, §1357.

135.11 Public health duties of department.

The department shall:

1. Exercise general supervision over the public health, promote public hygiene and sanitation, prevent substance use disorder, 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 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.

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

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. 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.

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

12. 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.

13. 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 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.

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

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

20. 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 (2), subparagraph division (b). The department shall adopt rules relating to the awarding of the grants.

21. 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.

22. 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 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.

23. 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.

24. 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.

25. Adopt rules requiring ambulatory surgical centers to report quality data to the department of health and human services that is consistent with the data required to be reported to the centers for Medicare and Medicaid services of the United States department of health and human services as authorized by the Medicare Improvements and Extension Act of 2006 under Tit. I of the Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, and the regulations adopted under such Acts. Notwithstanding any provision of law to the contrary, nothing in this subsection shall require an ambulatory surgical center to provide health data to the department of health and human services or any other public or private entity that is in addition to, different than, or exceeds the quality data required to be reported to the centers for Medicare and Medicaid services of the United States department of health and human services.

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; 2019 Acts, ch 91, §1; 2023 Acts, ch 16, §31; 2023 Acts, ch 19, §126; 2024 Acts, ch 1170, §210
Referred to in §237.3, 455E.11
Laboratory tests, §263.7, 263.8
For future amendment to subsection 11, effective July 1, 2025, see 2024 Acts, ch 1161, §21, 137
Subsection 22 amended

135.11A Licensing boards — expenses — fees. Transferred to §10A.503; 2023 Acts, ch 19, §1711.

135.11B Appointment of certain executive directors. Transferred to §10A.504; 2023 Acts, ch 19, §1711.

135.12 Statutory board, commission, committee, or council of committee — teleconference option.
Any statutorily established board, commission, committee, or council established under the purview of the department shall provide for a teleconference option for board, commission, committee, or council members to participate in official meetings.
2019 Acts, ch 85, §80
Former §135.12 repealed by 2017 Acts, ch 174, §99

135.13 Reserved.

135.14 State public health dental program.
The department shall perform all of the following duties:
1. Plan and direct all work activities of the statewide public health dental program.
2. Develop comprehensive dental initiatives for prevention activities.
3. Evaluate the effectiveness of the statewide public health dental program and of program personnel.
4. Other related work as required.
2007 Acts, ch 159, §13; 2021 Acts, ch 76, §28; 2023 Acts, ch 19, §127

135.15 Oral and health delivery systems.
The department 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 department.

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; 2021 Acts, ch 76, §29; 2023 Acts, ch 19, §128

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

As a component of the federal funding received by the department as the administering agency for the special supplemental nutrition program for women, infants, and children, from the United States department of agriculture, food and nutrition 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; 2021 Acts, ch 76, §30

135.16A Vendors participating in federal nutrition 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 nutrition program"* means the special supplemental nutrition 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, appeals, and licensing 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, appeals, and licensing shall assist the department in adopting rules necessary to implement and administer this section.

b. If necessary to implement, administer, and enforce this section, the department, 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 department.

3. A grocery store that is a vendor participating in a federal nutrition 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 nutrition 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 nutrition program unless otherwise authorized by the United States department of agriculture.

2018 Acts, ch 1025, §1; 2018 Acts, ch 1172, §19; 2021 Acts, ch 76, §31; 2023 Acts, ch 19, §129, 1880, 1881; 2024 Acts, ch 1018, §1, 13, 14

2024 amendment to subsection 2, paragraph b applies retroactively to reports due on or after January 1, 2024; 2024 Acts, ch 1018, §14

Subsection 2, paragraph b amended

135.16B Raw milk — associated products.

The department of health and human services may demand that a raw milk producer provide the department with all records required to be retained by the raw milk producer as provided in section 195.6, including any of the following:

1. The coliform count and standard plate count of dairy animals maintained at a raw milk dairy owned or operated by the raw milk producer.

2. The administration of antibiotic drugs to dairy animals maintained at a raw milk dairy owned or operated by the raw milk producer.

2023 Acts, ch 75, §1

135.16C Federal nutrition programs — cultivated-protein food products.

1. As used in this section, unless the context otherwise requires:

a. *"Cultivated-protein food product"* means the same as defined in section 137E.1.

b. *"Federal nutrition program"* or *"program"* means any of the following:

(1) The special supplemental nutrition program for women, infants, and children as provided in 42 U.S.C. §1786 et seq.

(2) The supplemental nutrition assistance program as provided in 7 U.S.C. ch. 51.

2. If the United States department of agriculture approves cultivated-protein food products for purchase under a federal nutrition program, the department of health and human services shall submit a request to the United States department of agriculture for a waiver or other exception that excludes cultivated-protein food products from program eligibility in this state.

2024 Acts, ch 1158, §1

NEW section

135.16D Federal nutrition programs — fabricated-egg products.

1. As used in this section, unless the context otherwise requires:

a. *"Fabricated-egg product"* means the same as defined in section 137A.1.

b. *"Federal nutrition program"* or *"program"* means any of the following:

(1) The special supplemental nutrition program for women, infants, and children as provided in 42 U.S.C. §1786 et seq.

(2) The supplemental nutrition assistance program as provided in 7 U.S.C. ch. 51.

2. If the United States department of agriculture approves fabricated-egg products for purchase under a federal nutrition program, the department of health and human services shall submit a request to the United States department of agriculture for a waiver or other exception that excludes fabricated-egg products from program eligibility in this state.

2024 Acts, ch 1158, §21

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 prevention of the United States department of health and human services, 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; 2021 Acts, ch 76, §32

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 Brain injuries — policy — department as lead agency.

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 council on health and human services.

2. 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 as necessary.

3. 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 2, paragraphs *"a"* through *"c"*.

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; 2023 Acts, ch 19, §130; 2024 Acts, ch 1170, §426

Recognition of "brain injury" as a disability, §225C.23
Section amended

135.22B Brain injury services program.

1. *Definitions.* For the purposes of this section, *"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.

2. *Program created.*

a. A brain injury services program is created and shall be administered by the department in cooperation with counties.

b. The department's 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 department shall consult with the council 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 Hawki 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 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 for the assessment.

c. The department 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 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; 2023 Acts, ch 19, §131; 2024 Acts, ch 1170, §427
Subsection 2, paragraph c amended

135.23 Reserved.

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 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 behavioral health professionals, 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 department of inspections, appeals, and licensing, 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 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, 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; 2019 Acts, ch 85, §66; 2023 Acts, ch 19, §132, 1581; 2023 Acts, ch 73, §1; 2024 Acts, ch 1170, §485

Referred to in §135.24A, 135M.2, 249A.4A
Subsection 2, paragraph a 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 record check evaluation system of the department of health and 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 record check evaluation system and shall be approved by the department.

2018 Acts, ch 1104, §1, 5; 2023 Acts, ch 19, §133
Referred to in §235A.15, 235B.6

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, amounts transferred pursuant to section 602.8108, subsection 4, 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 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; 2020 Acts, ch 1074, §49, 93; 2023 Acts, ch 19, §134
Referred to in §144.45A, 147A.6, 147A.23, 321.34, 602.8108

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.

SUBCHAPTER 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 of certain health care professions — rulemaking. Transferred to §10A.505; 2023 Acts, ch 19, §1711.

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 department 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]
2023 Acts, ch 19, §135

135.37 Tattooing — permit requirement — penalty. Transferred to §10A.531; 2023 Acts, ch 19, §1711.

135.37A Natural hair braiding. Transferred to §10A.532; 2023 Acts, ch 19, §1711.

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]
Referred to in §135.39E

135.39 Federal aid.

The department may accept financial aid from the government of the United States for the purpose of assisting in carrying on public health or substance use disorder 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; 2023 Acts, ch 19, §136

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. If an emergency or epidemic is determined to exist by the director under this subsection, the director shall notify the council on health and human services, the governor, and the legislative council, and shall notify the public upon request.

2004 Acts, ch 1159, §1; 2023 Acts, ch 19, §137

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
Student eye care, see §280.7A

135.39E Fluoridation in public water supply — notice of discontinuance.

1. At least ninety days prior to taking any action to permanently discontinue fluoridation in its water supply, an owner or operator of a public water supply system, as defined in section 455B.171, shall provide notice to the department and the public water supply system's customers.

2. In order to provide notice to its customers, the owner or operator of the public water supply system shall place a notice on each customer's water bill or provide notice in a way that is reasonably calculated so that all customers will receive the notice.

3. Section 135.38 does not apply to violations of this section.

2021 Acts, ch 63, §1; 2023 Acts, ch 19, §138

SUBCHAPTER 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 subchapter 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 in this subchapter 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 subchapter.

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

2019 Acts, ch 24, §104; 2020 Acts, ch 1063, §59

SUBCHAPTER IV

STATE MORTALITY REVIEW COMMITTEE — CHILDREN

135.43 State mortality review committee established — duties.

1. A state mortality review committee is established in the department. The department shall provide staffing and administrative support to the committee.

2. The membership of the review committee is subject to the provisions of section 4A.12 relating to political affiliation. Review committee members who are not designated by another appointing authority shall be appointed by the director. Membership terms shall be for three years. A membership vacancy shall be filled in the same manner as the original appointment. The review committee shall elect a chairperson and other officers as deemed necessary by the review committee. The review committee shall meet upon the call of the director or as determined by the review committee. The review committee shall include the following:

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

b. A licensed physician knowledgeable concerning the causes of death.

c. A certified or licensed professional knowledgeable regarding substance use disorder.

d. An attorney experienced in prosecuting domestic abuse cases.

e. An expert in unexpected or unexplained infant deaths.

f. A clerk of a district court, to be appointed by the chief justice of the supreme court.

g. A judicial officer, to be appointed by the chief justice of the supreme court.

h. A local law enforcement official.

i. A social worker knowledgeable about deaths of children.

j. Additional members as determined by the director.

3. The review committee 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 committee 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 committee 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, 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.

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 committee 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 the department in performing the department's duties, if the department does not otherwise have access to the information, share information possessed by the review committee. The recipient of 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 department shall develop protocols for the state mortality review committee to immediately review the child abuse assessments which involve the fatality of a child under age eighteen.

a. The purpose of the review shall be to determine whether the department 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. The protocols shall also ensure that a member of the committee does not have a conflict of interest regarding the child fatality under review.

b. The committee shall have access to patient records and other pertinent confidential information and, subject to the restrictions in this subsection, may redisseminate 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 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 receipt by the department 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 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, 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 committee in fulfilling its responsibilities:

(1) The director of health and human services.

(2) The commissioner of public safety.
(3) The attorney general.
(4) The director of transportation.
(5) The director of the department of education.

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

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

7. *a.* The department shall adopt rules providing for disclosure of information which is confidential under chapter 22 or any other provision of state law, to the review committee 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 department upon the request of the department, to be used only in the administration and for the duties of the state mortality review committee. Except as provided for a report on a child fatality by the 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 as required under and in compliance with this section.

8. Review committee 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 committee member or agent provided that the review committee members or agents acted in good faith and without malice in carrying out their official duties in their official capacity. The department 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 committee 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; 2019 Acts, ch 85, §82; 2021 Acts, ch 76, §33, 34; 2023 Acts, ch 19, §139; 2024 Acts, ch 1004, §17; 2024 Acts, ch 1170, §211 – 218

Referred to in §135.108, 216A.133
Legislative findings and purpose; 95 Acts, ch 147, §1
See Code editor's note on simple harmonization at the beginning of this Code volume
Subsections 1 and 2 amended
Subsection 3, unnumbered paragraph 1 amended
Subsection 3, paragraphs a, c, e, f, and g amended
Subsection 4, unnumbered paragraph 1 amended
Subsection 4, paragraph a amended
Subsection 5, paragraph a, unnumbered paragraph 1 amended
Subsection 5, paragraph b amended
Subsections 6, 7, and 8 amended

135.44 Reserved.

SUBCHAPTER V

RENAL DISEASES

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

135.49 through 135.60 Reserved.

SUBCHAPTER VI

HEALTH FACILITIES COUNCIL

135.61 through 135.76 Transferred to §10A.711 through 10A.726; 2023 Acts, ch 19, §1443.

135.77 Report to governor and legislature. Repealed by 97 Acts, ch 203, §18.

135.78 Data to be compiled. Transferred to §10A.727; 2023 Acts, ch 19, §1443.

135.79 Civil penalty. Transferred to §10A.728; 2023 Acts, ch 19, §1443.

135.80 through 135.82 Reserved.

135.83 Contracts for assistance with analyses, studies, and data. Transferred to §10A.729; 2023 Acts, ch 19, §1443.

135.84 through 135.89 Reserved.

SUBCHAPTER VII

RESERVED

135.90 through 135.99 Reserved.

SUBCHAPTER VIII

LEAD POISONING PREVENTION PROGRAM — BLOOD LEAD TESTING

135.100 Definitions.

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

1. *"Department"* means the department of health and human services.
2. *"Local board"* means the local board of health.

87 Acts, ch 55, §1; 2019 Acts, ch 24, §104; 2023 Acts, ch 19, §141

135.101 Childhood lead poisoning prevention program.

There is established a childhood lead poisoning prevention program within the department. 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; 2023 Acts, ch 19, §142

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. Transferred to §10A.902; 2023 Acts, ch 19, §1711.

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. Transferred to §10A.903; 2023 Acts, ch 19, §1711.

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

SUBCHAPTER IX

HEALTHY FAMILIES PROGRAM

135.106 Healthy families programs — HOPES-HFI program.

1. The department 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 department, 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 department, 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 department and the 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; 2023 Acts, ch 19, §143 – 145

Referred to in §232.69, 256I.13

SUBCHAPTER X

RURAL HEALTH AND PRIMARY CARE

135.107 Rural health and primary care — duties.

1. The department 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 department 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 department 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 safety and health 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.

2. The department 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 department may enter into an agreement with the college student aid commission for the administration of the department's grant and loan repayment programs.

a. Health care workforce and community support grant program.

(1) The department shall adopt rules establishing flexible application processes based upon the department's strategic plan to be used by the department 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 department. 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 department 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.

3. *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 department 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 department 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 department are appropriated for the purpose set forth in such federal grants or receipts. Funds appropriated by the general assembly to the department 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 department 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.

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; 2019 Acts, ch 85, §70; 2022 Acts, ch 1032, §35; 2023 Acts, ch 19, §146

Referred to in §262.78, 263.17

Legislative findings; 94 Acts, ch 1168, §1

SUBCHAPTER XI

STATE MORTALITY REVIEW COMMITTEE — DOMESTIC ABUSE

135.108 Definitions.

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

1. *"Committee"* or *"review committee"* means the state mortality review committee established in section 135.43.
2. *"Department"* means the department of health and human services.
3. *"Director"* means the director of health and human services.
4. *"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.

2000 Acts, ch 1136, §1; 2019 Acts, ch 24, §104; 2023 Acts, ch 19, §147; 2024 Acts, ch 1170, §219, 220

Referred to in §135.112

NEW subsection 1 and former subsections 1 – 3 renumbered as 2 – 4

Former subsection 4 stricken

135.109 Iowa domestic abuse death review team membership. Repealed by 2024 Acts, ch 1170, §368.

For proposed amendments to this section by 2024 Acts, ch 1004, §18, see Code editor's note on simple harmonization at the beginning of this Code volume

135.110 Committee powers and duties.

1. The review committee 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 state agencies regarding program and regulatory changes that may prevent domestic abuse deaths.

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

2. In performing duties pursuant to subsection 1, the review committee 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 committee shall consider such conclusions in making recommendations pursuant to subsection 1.

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

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

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

6. Members of the committee 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 committee that involves a case in which the committee member is presently involved in the member's professional capacity.

b. Development of protocols by the committee for domestic abuse death investigations and committee 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; 2024 Acts, ch 1170, §221 – 223

Referred to in §135.112
Subsection 1, unnumbered paragraph 1 amended
Subsection 1, paragraphs b and c amended
Subsections 2 – 6 amended

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 committee, to be used only in the administration and for the official duties of the committee. 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; 2024 Acts, ch 1170, §224
Referred to in §135.112
Subsection 1 amended

135.112 Rulemaking.

The department shall adopt rules pursuant to chapter 17A relating to the administration of the committee and sections 135.108 through 135.111.

2000 Acts, ch 1136, §5; 2024 Acts, ch 1170, §225
Section amended

135.113 through 135.117 Reserved.

SUBCHAPTER 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 department in accordance with this section. The department 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 use disorder, 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 health and human services and justice, 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; 2023 Acts, ch 19, §149 – 151

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

SUBCHAPTER 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.

SUBCHAPTER XIV

SUBSTANCE USE DISORDER TREATMENT FACILITY FOR PERSONS ON PROBATION

135.130 Substance abuse treatment facility for persons on probation. Repealed by 2017 Acts, ch 148, §24.

SUBCHAPTER 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 10A.711.

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

SUBCHAPTER 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.

SUBCHAPTER XVII

DISASTER PREPAREDNESS

135.140 Definitions.

As used in this subchapter, 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 department of health and human services.

3. *"Director"* means the director of health and human services or the director's designee.

4. *"Disaster"* means disaster as defined in section 29C.2.

5. *"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.

6. *"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; 2019 Acts, ch 24, §104; 2023 Acts, ch 19, §152

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

135.141 Department duties related to acute disease prevention and emergency response.

1. The department shall coordinate the administration of this subchapter 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 subchapter.

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 subchapter 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 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; 2019 Acts, ch 24, §99, 100; 2023 Acts, ch 19, §153; 2024 Acts, ch 1170, §387

Subsection 2, paragraph i amended

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 subchapter 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; 2019 Acts, ch 24, §101

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 subchapter, 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 subchapter, 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 subchapter, 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 subchapter.

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; 2019 Acts, ch 24, §102

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 or physician assistant 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; 2022 Acts, ch 1066, §5

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.

SUBCHAPTER 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.

SUBCHAPTER 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.

SUBCHAPTER XX

COLLABORATIVE SAFETY NET PROVIDER NETWORK

135.153 Iowa collaborative safety net provider network established. Repealed by 2019 Acts, ch 85, §68.

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

SUBCHAPTER XXI

IOWA HEALTH INFORMATION NETWORK

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

SUBCHAPTER 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. Repealed by 2019 Acts, ch 85, §75.

SUBCHAPTER 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.

SUBCHAPTER 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.

SUBCHAPTER 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 shall enter into a memorandum of understanding with the contractor selected through a request for proposals process 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 contractor 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 or name of the individual subject of the data.

2009 Acts, ch 118, §57; 2014 Acts, ch 1026, §143; 2017 Acts, ch 148, §104; 2019 Acts, ch 85, §96; 2022 Acts, ch 1131, §61; 2023 Acts, ch 19, §154

135.167 through 135.170 Reserved.

SUBCHAPTER 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

Alzheimer's disease services and assistance, see §231.62

135.172 Reserved.

SUBCHAPTER 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. Repealed by 2024 Acts, ch 1170, §368.

135.174 Lead agency and other state agencies. Repealed by 2010 Acts, ch 1031, §308.

SUBCHAPTER 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 dental program of the department, the primary care office and shortage designation program, and the state office of rural health of the department; 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 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 in accordance with section 135.163, or to address workforce shortages as otherwise designated by the department. 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; 2023 Acts, ch 19, §156

Referred to in §135.176, 135.178, 135.179, 249M.4

SUBCHAPTER 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.

d. For the period beginning July 1, 2021, and ending June 30, 2026, the payment by the sponsor of medical residency program liability costs subject to provision by the sponsor of dollar-for-dollar matching funds used for payment of such costs. This paragraph shall not apply to medical residency programs to which chapter 669 applies.

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 and preference for candidates who are residents of Iowa, attended and earned an undergraduate degree from an Iowa college or university, or attended and earned a medical degree from a medical school in Iowa.

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"*, the funding of residency positions which are in excess of the federal residency cap as defined in subsection 1, paragraph "c", or the funding of the payment by the sponsor of medical residency program liability costs subject to provision by the sponsor of dollar-for-dollar matching funds used for payment of such costs as specified in subsection 1, paragraph *"d"*, 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. For the period beginning July 1, 2021, and ending June 30, 2026, use of the funds awarded may include payment by the sponsor of medical residency program liability costs in accordance with subsection 1, paragraph *"d"*, and subject to provision by the sponsor of dollar-for-dollar matching funds used for payment of such costs.

g. A requirement that the residency program offer persons to whom a primary care residency position is awarded, the opportunity to participate in a rural rotation to expose the resident to the rural areas of the state. For the purposes of this paragraph, *"primary care"* shall include psychiatry, obstetrics, gynecology, family medicine, internal medicine, and emergency medicine.

2015 Acts, ch 30, §213, 218, 219; 2015 Acts, ch 57, §18 – 21; 2016 Acts, ch 1073, §57; 2019 Acts, ch 55, §1, 2; 2020 Acts, ch 1082, §1; 2021 Acts, ch 182, §63, 64

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

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

SUBCHAPTER XXX

STATE-FUNDED PSYCHIATRY RESIDENCY AND FELLOWSHIP POSITIONS

135.180 State-funded psychiatry residency and fellowship positions — fund — appropriations.

1. *a.* The university of Iowa hospitals and clinics shall administer state-funded psychiatry residency and fellowship positions for up to seven residents and up to two fellows, annually. In addition, a county medical center, and a medical center operating for more than one hundred forty years, that are members of separate health systems, administer psychiatry residency programs, and are located in a county with a population over five hundred thousand shall each administer state-funded psychiatry residency positions for one resident, annually. The university of Iowa hospitals and clinics and the specified medical centers shall expand their psychiatry residency programs to provide additional residency positions by providing financial support for residency positions which are in excess of the federal residency cap established by the federal Balanced Budget Act of 1997, Pub. L. No. 105-33.

b. The university of Iowa hospitals and clinics and the specified medical centers shall cooperate with the state mental health institutes at Independence and Cherokee, the state

resource center at Woodward, the state training school at Eldora, and the Iowa medical and classification center at Oakdale in administering the positions. Participating residents and fellows shall complete a portion of their psychiatry training at one of the state mental health institutes, the state resource center, the state training school, or the Iowa medical and classification center at Oakdale. For accreditation-required clinical experiences not available at the state mental health institutes, the state resource center, the state training school, or the Iowa medical and classification center at Oakdale, the residents awarded the residency positions administered by the university of Iowa hospitals and clinics may utilize clinical rotations at the university of Iowa hospitals and clinics and its affiliates across the state and the residents awarded the residency positions administered by the specified medical centers may utilize clinical rotations at affiliates of such medical centers across the state.

2. The university of Iowa hospitals and clinics shall apply to the accreditation council for graduate medical education for approval of seven additional residency positions for each class of residents and shall award the total number of residency positions approved for each class of residents. The university of Iowa hospitals and clinics shall approve and award up to two fellowship positions annually. The specified medical centers shall apply to the accreditation council for graduate medical education for approval of one additional residency position each for each class of residents and shall award the total number of residency positions approved for each class of residents. Preference in the awarding of residency and fellowship positions shall be given to candidates who are residents of Iowa, attended and earned an undergraduate degree from an Iowa college or university, or attended and earned a medical degree from a medical school in Iowa.

3. A psychiatry residency and fellowship positions fund is created in the state treasury consisting of the moneys appropriated or credited to the fund by law. Notwithstanding section 8.33, moneys in the fund at the end of each fiscal year shall not revert to any other fund but shall remain in the psychiatry residency and fellowship positions fund for use in subsequent fiscal years. Moneys in the fund are appropriated to the university of Iowa hospitals and clinics to be used for the purposes of this section. For the fiscal years beginning on or after July 1, 2023, there is appropriated from the general fund of the state to the psychiatry residency and fellowship positions fund one hundred thousand dollars for each residency position approved and awarded and one hundred fifty thousand dollars for each fellowship position approved and awarded under this section. Of the amount appropriated annually from the fund to the university of Iowa hospitals and clinics, the university of Iowa hospitals and clinics shall distribute one hundred thousand dollars to each of the specified medical centers for each residency position approved and awarded.

2022 Acts, ch 1131, §82; 2023 Acts, ch 37, §1; 2024 Acts, ch 1157, §72
Section amended

SUBCHAPTER 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.

2015 Acts, ch 137, §68, 162, 163; 2016 Acts, ch 1139, §57, 58; 2024 Acts, ch 1018, §2, 13, 14
2024 strike of subsection 4 applies retroactively to reports due on or after January 1, 2024; 2024 Acts, ch 1018, §14
Subsection 4 stricken

135.182 through 135.184 Reserved.

SUBCHAPTER 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, 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; 2023 Acts, ch 19, §157
Referred to in §155A.27

135.186 through 135.189 Reserved.

SUBCHAPTER XXXIII

OPIOID ANTAGONISTS — QUALIFIED IMMUNITY — MEDICATION FUND

135.190 Possession and administration of opioid antagonists — immunity.

1. For purposes of this section, unless the context otherwise requires:

a. *"Community-based organization"* means a public or private organization that provides health or human services to meet the needs of a community including but not limited to a nonprofit organization, a social service provider, or an organization providing substance use disorder prevention, treatment, recovery, or harm reduction services.

b. *"Licensed health care professional"* means the same as defined in section 280.16.

c. *"Opioid antagonist"* means the same as defined in section 147A.1.

d. *"Opioid-related overdose"* means the same as defined in section 147A.1.

e. *"Person in a position to assist"* means a family member, friend, caregiver, community-based organization, health care provider, employee of a substance use disorder treatment facility, school employee, first responder as defined in section 147A.1, or other person who may be in a place to render aid to a person at risk of experiencing an opioid-related overdose.

f. *"Secondary distributor"* means a law enforcement agency, emergency medical services program, fire department, school district, health care provider, licensed behavioral health provider, county health department, or the department of health and human services.

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 or to a secondary distributor.

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 or to a secondary distributor.

(2) A pharmacist or secondary distributor who dispenses, furnishes, or otherwise provides an opioid antagonist pursuant to a valid prescription, standing order, or collaborative agreement shall provide written instruction, which shall include emergency, crisis, and substance use referral contact information, 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. Notwithstanding any other provision of law to the contrary, the chief medical officer of the department may issue a standing order that does not identify individual patients at the time it is issued for the purpose of dispensing opioid antagonists to a person in a position to assist.

5. A person in a position to assist may distribute an opioid antagonist to any individual pursuant to this section.

6. A person in a position to assist, a secondary distributor, 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.

7. A school district may obtain a valid prescription for an opioid antagonist and maintain a supply of opioid antagonists in a secure location at each location where a student may be present for use as provided in this section.

8. 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; 2022 Acts, ch 1121, §2, 3; 2023 Acts, ch 19, §158; 2023 Acts, ch 86, §15 – 18; 2024 Acts, ch 1043, §53

Referred to in §147A.18, 155A.3, 155A.27

Subsection 1, paragraph a amended

135.190A Opioid antagonist medication fund.

1. An opioid antagonist medication fund for first responders is created within the state treasury under the control of the department. The fund shall consist of moneys appropriated to or deposited into the fund.

2. Moneys in the fund are appropriated to the department for the purchase, maintenance, and replacement of opioid antagonist medication administered by first responders to persons experiencing an opioid-related overdose. The department is authorized to designate moneys in the fund for the purchase, maintenance, and replacement of opioid antagonist medication used by the department or other entities under this section.

3. First responders may contact the department for the procurement of opioid antagonist medication. The department shall keep a record of the distribution of moneys from the fund.

4. The fund may consist of available federal or state moneys available, as well as any available opioid lawsuit settlement moneys. Funds may be transferred between other state agencies and the fund as appropriate.

5. Notwithstanding section 8.33, moneys in the fund that remain unencumbered or unobligated at the close of a fiscal year shall not revert but shall remain available for expenditure for the purposes designated unless federal regulations otherwise require. Notwithstanding section 12C.7, subsection 2, interest or earnings on moneys in the fund shall be credited to the fund.

6. The department shall submit a report to the general assembly on or before December 31 of each year which shall contain a list of deposits and expenditures from the fund for the prior fiscal year and the amount of carryover funds, if any, to be distributed in the next fiscal year.

7. For purposes of this section:

a. "First responder" means an emergency medical care provider, a registered nurse staffing an authorized service program under section 147A.12, a physician assistant staffing an authorized service program under section 147A.13, a physician staffing an authorized

service program under section 147A.13A, a fire fighter, or a peace officer as defined in section 801.4 who is trained and authorized to administer an opioid antagonist.

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.

2022 Acts, ch 1121, §4; 2023 Acts, ch 19, §159; 2024 Acts, ch 1044, §1
Referred to in §12.51
Subsection 7, paragraph a amended

SUBCHAPTER 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 health and human services and shall not require appropriation of additional funding; 2017 Acts, ch 26, §2

SUBCHAPTER XXXV

RECIPIENTS OF ANATOMICAL GIFTS — PROTECTIONS

135.192 Protections of certain prospective recipients of anatomical gifts.

1. A hospital, physician, or other person shall not determine the ultimate recipient of an anatomical gift based upon a potential recipient's disability, except to the extent that the disability has been found by a physician, following a case-by-case evaluation of the potential recipient, to be medically significant to the provision of the anatomical gift.

2. Subsection 1 shall apply to each part of the anatomical gift process including all of the following:

a. The referral from a primary care provider to a specialist.

b. The referral from a specialist to a transplant center.

c. The evaluation of the patient for the transplant by the transplant hospital.

d. The consideration of the patient for placement on the list of potential transplant recipients pursuant to 42 C.F.R. §121.7.

3. A person with a disability shall not be required to demonstrate postoperative independent living abilities in order to be placed on the list of potential transplant recipients

pursuant to 42 C.F.R. §121.7 if there is evidence that the person will have sufficient, compensatory support and assistance.

4. A court shall accord priority on its calendar and handle expeditiously any action brought to seek any remedy authorized by law for purposes of enforcing compliance with this section.

5. This section shall not be deemed to require referrals or recommendations for, or the performance of, a medically inappropriate transplant of a part.

6. As used in this section:

a. "Anatomical gift" means the same as defined in section 142C.2.

b. "Disability" means the same as defined in the federal Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq.

2020 Acts, ch 1101, §1

SUBCHAPTER XXXVI

FAMILY MEDICINE OBSTETRICS FELLOWSHIP PROGRAM

135.193 State-funded family medicine obstetrics fellowship program — fund.

1. The department shall establish a state-funded family medicine obstetrics fellowship program to increase access to family medicine obstetrics practitioners in rural and underserved areas of the state. A person who has completed an accreditation council for graduate medical education residency program in family medicine is eligible for participation in the fellowship program. Participating fellows shall enter into a program agreement with a participating teaching hospital which, at a minimum, requires the fellow to complete a one-year fellowship and to engage in full-time family medicine obstetrics practice in a rural or underserved area of the state for a period of at least five years within nine months following completion of the fellowship and receipt of a license to practice medicine in the state.

2. Each fellow participating in the program shall be eligible for a salary and benefits including a stipend as determined by the participating teaching hospital which shall be funded through the family medicine obstetrics fellowship program fund.

3. The department shall adopt rules pursuant to chapter 17A to administer the program, including defining rural and underserved areas for the purpose of the required full-time practice of a person following completion of the fellowship.

4. *a.* A family medicine obstetrics fellowship program fund is created in the state treasury consisting of the moneys appropriated or credited to the fund by law. Notwithstanding section 8.33, moneys in the fund at the end of each fiscal year shall not revert to any other fund but shall remain in the fund for use in subsequent fiscal years. Moneys in the fund are appropriated to the department to be used to fund fellowship positions as provided in this section.

b. For the fiscal year beginning July 1, 2023, and each fiscal year beginning July 1 thereafter, there is appropriated from the general fund of the state for deposit in the family medicine obstetrics fellowship program fund an amount sufficient to support the creation of four fellowship positions as provided in this section.

5. The department and the participating teaching hospitals shall regularly evaluate and document their experiences including identifying ways the program may be modified or expanded to facilitate increased access to family medicine obstetrics practitioners in rural and underserved areas of the state. The department shall submit an annual report to the general assembly by January 1. The report shall include the number of fellowships funded to date and any other information identified by the department and the participating teaching hospitals as indicators of outcomes and the effectiveness of the program.

6. For the purposes of this section, *"teaching hospital"* means a hospital or medical center that provides medical education to prospective and current health professionals.

2023 Acts, ch 112, §67

SUBCHAPTER XXXVII

MINOR ELECTRONIC PROTECTED HEALTH INFORMATION — DISCLOSURE TO LEGAL GUARDIAN

135.194 Electronic protected health information of minor — disclosure to legal guardian — option to provide printed copy.

1. A health care provider or facility that maintains or transmits electronic protected health information shall disclose to the legal guardian of a minor the minor's electronic protected health information, with the following exceptions:

a. Electronic protected health information that relates to health care for which the minor is legally authorized to consent without the consent of a legal guardian.

b. If disclosure of the electronic protected health information to a legal guardian is otherwise prohibited by state law or federal law, including federal statute, regulation, or centers for disease control and prevention guidelines.

2. In lieu of disclosing the minor's electronic protected health information to the legal guardian of a minor as required pursuant to subsection 1, a health care provider or facility may comply with this section by providing a printed copy of the minor's electronic protected health information, subject to the exceptions prescribed pursuant to subsection 1, and at no charge to the legal guardian of the minor.

3. For the purposes of this section:

a. "*Disclosure*" means the release, transfer, provision of access to, or divulging in any manner of electronic protected health information outside the entity holding the electronic protected health information.

b. "*Electronic media*" means electronic storage material on which data is or may be recorded electronically and transmission media used to exchange information already in electronic storage media.

c. "*Electronic protected health information*" means protected health information that is transmitted or maintained by or in electronic media.

d. "*Facility*" means a health care delivery system location that provides a range of primary, secondary, and tertiary inpatient, outpatient, and physician services; an institution providing health care services; and any other health care setting including but not limited to a hospital or other licensed inpatient center, ambulatory surgical center or treatment center, skilled nursing center, residential treatment center, diagnostic, laboratory or imaging centers, rehabilitation or other therapeutic health setting, or the private office or clinic of an individual health care provider or group of health care providers.

e. "*Health care*" means care, services, or supplies related to the health of a person and includes but is not limited to:

(1) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and any counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status of a person, or that affects the structure or function of the body.

(2) The sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

f. "*Health care provider*" means a physician or osteopathic physician licensed under chapter 148, a physician assistant licensed under chapter 148C, a podiatrist licensed under chapter 149, a chiropractor licensed under chapter 151, a licensed practical nurse, a registered nurse, or an advanced registered nurse practitioner licensed under chapter 152 or 152E, a dentist licensed under chapter 153, an optometrist licensed under chapter 154, a pharmacist licensed under chapter 155A, or any other person who is licensed, certified, or otherwise authorized or permitted by the law of this state to administer health care in the ordinary course of business or in the practice of a profession.

g. "*Health information*" means health information as defined in 45 C.F.R. §160.103 that is maintained or transmitted by a health care provider or facility.

h. "*Legal guardian*" means a person appointed by a court as the guardian of a minor pursuant to chapter 232D, or the parent or other person responsible for the care of the minor.

i. "*Protected health information*" means protected health information as defined in 45 C.F.R. §160.103 that is maintained or transmitted by a health care provider or facility.

2024 Acts, ch 1130, §4; 2024 Acts, ch 1154, §12
NEW section

SUBCHAPTER XXXVIII

CENTERS OF EXCELLENCE GRANT PROGRAM

135.195 Centers of excellence grant program.

1. The department shall administer a centers of excellence grant program to encourage innovation and collaboration among regional health care providers in rural areas, based upon the results of a regional community needs assessment, in order to transform health care delivery that provides quality, sustainable care in meeting the needs of the local community.

2. There is appropriated from the general fund of the state to the department, beginning July 1, 2024, and for each subsequent fiscal year, the sum of four hundred twenty-five thousand dollars to award two program grants.

3. An applicant for a grant shall specify how the grant will be expended to accomplish the goals of the program and shall provide a detailed five-year sustainability plan prior to being awarded the grant.

4. Following receipt of a grant, a recipient shall submit periodic reports as specified by the department to the governor and the general assembly regarding the recipient's expenditure of the grant and progress in accomplishing the program's goals.

2024 Acts, ch 1157, §59
NEW section

CHAPTER 90
STATE MORTALITY REVIEW COMMITTEE

Chapter rescission date pursuant to Iowa Code section 17A.7: 4/1/30

641—90.1(135) Definitions.

"Child abuse assessment" means an assessment performed in accordance with Iowa Code section 232.71B.

"Child fatality" means the death of a child under the age of 18.

"Committee" means the state mortality review committee.

"Maternal death" means any death occurring while a woman is pregnant or within one year of the end of the pregnancy from any cause. This includes deaths resulting from abortions, ectopic pregnancies and all deaths during pregnancy, childbirth, puerperium or deaths from complications of childbirth.

"Multidisciplinary team" means the group of individuals as defined in Iowa Code section 235A.13.

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.2(135) Agency. The state mortality review committee is established in the department. The department will provide staffing and administrative support to the committee.

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.3(135) Membership. Committee membership will be determined pursuant to Iowa Code section 135.43(2).

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.4(135) Officers. The committee will elect a chairperson, a vice chairperson, and other officers as deemed necessary by the committee. Officers will be elected at the first meeting of each fiscal year. Vacancy in the office of the chairperson will be filled by elevation of the vice chairperson. Vacancy in the office of the vice chairperson will be filled by election at the next meeting after the vacancy occurs. The chairperson will preside at all meetings of the committee. If the chairperson is absent or unable to act, the vice chairperson will perform the duties of the chairperson. When so acting, the vice chairperson will have all the powers of and be subject to all restrictions upon the chairperson. The vice chairperson will also perform such other duties as may be assigned by the chairperson.

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.5(135) Subcommittees.

90.5(1) The committee may establish temporary or permanent subcommittees pursuant to Iowa Code sections 135.40, 135.43 and 135.110.

90.5(2) The committee shall establish appointment provisions, membership terms, operating guidelines, and other operational requirements for any subcommittees established.

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.6(135) Liaisons. Liaisons will be designated pursuant to Iowa Code section 135.43(5).

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.7(135) Meetings. The committee will meet pursuant to Iowa Code section 135.110(3).

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.8(135) Duties and responsibilities.

90.8(1) The committee will be responsible for the duties established in Iowa Code sections 135.43(3) and 135.110(1).

90.8(2) The committee will conduct comprehensive, multidisciplinary reviews of maternal deaths or other deaths in Iowa to residents to identify factors associated with the deaths and make recommendations for system changes to prevent future deaths.

The department annually shall systematically ascertain maternal deaths using birth, fetal death and death vital records.

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.9(135) Disclosure of information.

90.9(1) The committee and subcommittees shall have access to patient records and other confidential information. In preparation for review of an individual death by the committee or subcommittee, the chairperson of the committee or the chairperson's designee is authorized to gather all information pertinent to the review. A person in possession or control of medical, investigative or other information pertaining to a child death, child abuse, domestic abuse, maternal death, or other death review with an established subcommittee shall allow the inspection and reproduction of the information by the department, upon the request of the department, to be used only in the administration and for the duties of the committee. A person does not incur legal liability by reason of releasing information to the department as mandated under and in compliance with this rule.

The committee and subcommittees will maintain the confidentiality of all information and records used in the review, including disclosure of information that is confidential under Iowa Code chapter 22 or any other provisions of state law.

90.9(2) In the event of a maternal death, the certifying physician shall indicate that circumstance on the certificate of death.

90.9(3) Any person, hospital, sanatorium, or other organization shall make available to the department for inspection records, reports, statements, interviews or other data necessary to fulfill the duties of the committee or subcommittees.

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

641—90.10(135) Immunity and liability. Committee and subcommittee members are immune from any liability, civil or criminal, as established in Iowa Code section 135.43(8). A person who releases or discloses confidential data, records, or any other type of information in violation of this chapter is guilty of a serious misdemeanor.

[**ARC 8971C**, IAB 2/19/25, effective 4/1/25]

These rules are intended to implement 2024 Iowa Acts, Senate File 2385, and Iowa Code sections 135.40, 135.43, 135.108, 135.110, and 135.111.

[Filed 3/15/96, Notice 1/31/96—published 4/10/96, effective 5/15/96]
[Filed 7/10/98, Notice 4/22/98—published 7/29/98, effective 9/2/98]
[Filed 11/30/00, Notice 10/4/00—published 12/27/00, effective 1/31/01]
[Filed ARC 9248B (Notice ARC 8973B, IAB 7/28/10), IAB 12/1/10, effective 1/5/11]
[Filed ARC 4703C (Notice ARC 4539C, IAB 7/17/19), IAB 10/9/19, effective 11/13/19]
[Filed ARC 8971C (Notice ARC 8569C, IAB 12/25/24), IAB 2/19/25, effective 4/1/25]

IOWA | Health and Human Services
Public Health

State Mortality Review Committee

Child Death Review Subcommittee Purpose

The Child Death Review Subcommittee (CDRS) will advise the State Mortality Review Committee (SMRC) by reviewing fatalities of children live birth through 17 years of age who die in the state of Iowa.

Membership

Membership will include the following areas of expertise. Initial membership beginning June 13, 2025 to June 30, 2026:

Expertise/Specialty	Name
Substance Use Disorder	Andrew Allen
Assistant Attorney General Liaison	Ryan Baldridge
Statewide System Mental Health	Emily Blomme
Neonatologist	John Dagle
Local Law Enforcement	Lisa DuFour
Health Statistics/Vital Records	Melissa Ellis
Health Insurance Industry	Jerry Fiala
State Child Protective Services Director	Lori Frick
Child Care Nurse Consultant	Kim Gonzales
ED Physician, Pediatrician	Amy Groen
Juvenile Justice	Chad Jensen
County Attorney	Peter Johnson
Department of Transportation	Dennis Kleen
State Medical Examiner	Dennis Klein
Department of Natural Resources	Tammie Krausman
HHS Medical Director	Robert Kruse
Sudden Infant Death	Casey Manser
Mental Health Nurse Practitioner	Amy McCormick
Department of Public Safety	Matthew Burns
Family Practice Physician	Dawn Schissel

Expertise/Specialty	Name
Domestic Abuse and Injury Prevention	Abby Schueller
Deputy State Medical Examiner	Jonathan Thompson
Emergency Room Nurse, Medical Examiner Investigator	Marvin Van Der Wiel
Child Protection Policy Program Manager	Vera Wallican
Department of Education, School Nursing	Melissa Walker
Medicolegal Death Investigator	Kelly Wandishion

Operations

- Meetings
  - The subcommittee will meet six times a year from 10am to 3pm, approximately every other month.
  - Meeting format is anticipated to be half of the meetings virtual and half in-person.
- Cases
  - Based on history, the subcommittee expects to review approximately 280 cases per year.
  - Iowa HHS staff for CDRS review and enter case information into the National Center for Fatality Review and Prevention Case Reporting System. In addition, staff analyze and compile aggregate data for all manners of death.
  - For accident, homicide, suicide and undetermined manners of death the CDRS members review and discuss the cases and make recommendations on the prevention of similar deaths in the future.
- Reports
  - Once each year, the SMRC will approve a report discussing the subcommittee's activities and recommendations.

State Mortality Review Committee

The Domestic Abuse Death Review Subcommittee Purpose

The Domestic Abuse Death Review Subcommittee (DADRS) will inform the SMRC on the causes and manner of deaths resulting from domestic abuse in Iowa. This is done through multi-disciplinary team case review of homicide and suicide fatalities resulting from domestic violence. The DADRS will share recommendations to prevent future domestic abuse-related deaths in Iowa.

Membership

Membership will include the following areas of expertise. Initial membership beginning June 13, 2025 through June 30, 2026 is included.

Expertise/Specialty	Name
The state medical examiner or the state medical examiner's designee.	Kelly Kruse
A licensed physician or nurse who is knowledgeable concerning domestic abuse injuries and deaths, Including suicide.	Maria Sue Nelson
A licensed mental health professional who is knowledgeable concerning domestic abuse.	Dianne Fagner
A representative or designee of the Iowa coalition against domestic violence.	Lindsay Pingel
A certified or licensed professional who is knowledgeable concerning substance abuse.	Jennifer Robertson-Hill
A law enforcement official who is knowledgeable about domestic abuse.	Sadie Weekley
A law enforcement investigator experienced in domestic abuse investigation.	Steve Kivi
An attorney experienced in prosecuting domestic abuse cases.	Rachel Zimmerman
A judicial officer appointed by the chief justice of the supreme court.	David Porter
A clerk of the district court appointed by the chief justice of the supreme court.	Vacant
An employee or subcontractor of the department of corrections who is a trained batterers' education program facilitator	Christine Parmerlee
An attorney licensed in this state who provides criminal defense assistance or child custody representation, and who has experience in dissolution of marriage proceedings.	Andrea McGinn
A female former victim of domestic abuse.	Tiffany Allison
A male former victim of domestic abuse.	Matt Denner
A family member of a decedent whose death resulted from domestic abuse	Vacant

Operations

- Meetings
  - The subcommittee will meet every three months the second, Friday of the month for 6 hours beginning at 9:30am.
  - Meetings will be held in person or virtually or both.
- Cases
  - Based on history, the subcommittee expects to review approximately 15-20 cases per year.
  - Cases include domestic abuse homicide or suicide fatalities that involve or are a result of an assault as defined in Iowa Code section 708.1 and the parties involved were:
    - current, separated, or former spouses,
    - current or former cohabiting partners,
    - parents of the same minor children,
    - current or former dating partners,
    - related by blood or affinity to someone in the same household or workplace, or
    - subject to an order of protection between the perpetrator and victim.
- Reports: Once each year, the SMRC will approve a report discussing the subcommittee's activities and recommendations

IOWA | Health and Human Services
Public Health

State Mortality Review Committee

Maternal Mortality Review Subcommittee Purpose

The Maternal Mortality Review Subcommittee (MMRS) will advise the State Mortality Review Committee (SMRC) for purposes of providing context of the drivers of maternal mortality and pregnancy complications, data driven interventions to prevent maternal deaths, and general maternal health expertise.

Membership

Membership will include the following areas of expertise. (The Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program funding requires that MMRS membership move towards becoming 40% non-clinical.) Initial membership beginning with the June 13, 2025 to June 30, 2026 is included.

Expertise/Specialty	Name
Subcommittee Chair/OB-GYN	Stephanie Radke, MD
Violence Prevention	Derma Rivera
Perinatal Psychiatry	Rebecca Lundquist, MD
OB/GYN	Debra Piehl, MD
Anesthesiology	Kokila Thenuwara, MD
MCH Epidemiologist	Debbie Kane, PhD, RN
Pathology	Stephanie Stauffer, MD
Healthy Start Director	Cindy Winn,
State Medical Director	Robert Kruse, MD, MPH
Maternal Fetal Medicine	Christian Pettker, MD
Family Medicine/OB	Trish Millner, MD
Family Medicine/OB	Amy Jochims, MD,
Clinical Nurse Improvement Coach	Kristal Graves, DPN, RN
OB/GYN	Diana Kaufman, MD
Director of Maternal/Child Services	Amy Dagestad, MSN, RN
Doula	Jazzmine Brooks, MPA
Psychiatry, Director of Opioid Addiction Clinic	Alison Lynch, MD
OB/GYN	Kimberly Marshall, MD

Expertise/Specialty	Name
OB/GYN	Emily Boevers, MD
Certified Nurse Midwife	Karlea Norby
Emergency Medicine	Stacey Marlow Fisher, MD
Law Enforcement	Ryan Kedley
Emergency Medical Services	Gary Ronzheimer
Emergency Medical Services	Andy Littler
OB/GYN, Maternal Fetal Medicine Fellow	Emma James, MD
OB/GYN	Shannon Leveridge, MD
Maternal Fetal Medicine	Stephen Pedron, MD, MBA

Operations

- Meetings
  - The subcommittee will meet up to 3 times annually for 7 hours beginning at 9:00am, on dates that will be set a year in advance based on the availability of committee members.
  - Meetings will be held virtually, with occasional hybrid meetings.
- Cases
  - Based on history, the subcommittee expects to review approximately 12 cases per year.
  - MMRS reviews all pregnancy-associated deaths (the death of a woman during or within one year of the end of pregnancy, irrespective of cause) that occur in the state.
  - Iowa HHS staff for the MMRS review and enter case information into the Maternal Mortality Review Information Application (MMRIA), a CDC data system designed to facilitate MMRS functions through a common data language. In addition, the Iowa HHS MMRS staff team uses the MMRIA form as a basis for the structure of MMRS meetings and recommendations for prevention.
- Reports
  - Once every three years, the SMRC will approve a report discussing the subcommittee's activities and recommendations. This is not done more frequently due to confidentiality breaches that could occur given the small number of annual cases.

- Funding and Associated Requirements
  - Iowa HHS receives funding from the CDC through the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program to support maternal mortality review.
  - The ERASE MM grant includes the following parameters:
    - aims to create subcommittee membership that is 40% non-clinical
    - sets a review timeframe goal within 24 months of death
    - requires review information to be entered into the MMRIA system