

The Update is a bi-weekly Web newsletter published by the Iowa Department of Public Health's Bureau of Family Health. It is posted the second and fourth week of every month, and provides useful job resource information for departmental health care professionals, information on training opportunities, intradepartmental reports and meetings, and additional information pertinent to health care professionals.

In this issue...

1 Colorectal and Breast Cancer Screening

2 The State Public Health Autism Resource Center

2 Family Planning Update Save the Date

2 Births to Mothers on Medicaid

3 Calendar of Events

4 Directory

5-27 Additional Information



Colorectal and Breast Cancer Screening

CDC Vital Signs is a new series of MMWR reports that will announce the latest results for key public health indicators.

Most adults are getting recommended breast and colorectal cancer screenings. Yet a new CDC report says more than 22 million adults have not had screening tests for colorectal cancer, and more than 7 million women have not had a recent mammogram to screen for breast cancer as recommended. This CDC report also points out why more people need to get tested for colorectal and breast cancer and what can be done to increase screening.

Latest Findings:

Colorectal Cancer

22 million adults ages 50-75 still need to be tested.

Breast Cancer

7 million women still need to be screened for Breast Cancer.

U.S. State Info:

Colorectal Cancer

The number of people who get screened for colon cancer is very different from state to state. The highest number of people who get tested are in the northeastern United States.

Breast Cancer

The number of people who get screened for breast cancer is very different from state to state. The highest number of people who get tested are in the northeastern United States.

For more information, go to:
www.cdc.gov/vitalsigns.

The State Public Health Autism Resource Center (SPHARC)

The State Public Health Autism Resource Center (SPHARC) is a comprehensive resource for state Title V agencies and others interested in improving systems for children, youth and families with Autism Spectrum Disorders. SPHARC provides ongoing technical assistance and facilitates cross-state learning.

To learn more about SPHARC go to www.amchp.org/spharc to find the latest State Spotlight, publications, resources, and technical assistance call recordings and presentations. SPHARC's newly added Expert's Corner provides insight and advice from leaders in the public health field. For more information, contact Melody Gilbert at (202) 266-3049.



Iowa Family Planning Update

Celebrating 40 Years of Title X

September 14 - 15, 2010
Sheraton West Hotel
1800 50TH St.
West Des Moines, IA



Births to Mothers on Medicaid

The Bureau of Family Health and the Bureau of Health Statistics are pleased to announce the release of four fact sheets that describe births to women enrolled in Medicaid during 2009.

To view the facts sheets, go to pages 5-27 of **The Update**.

Calendar

August 31, 2010

Cost Analysis Training for new contractors/contractor new employees, 10 a.m. - 2 p.m., Lucas Bldg., 517-518

September 1, 2010

Cost Analysis Training for experienced contractor personnel, 9 a.m. - 12 p.m., 'Go To Meeting', Lucas Bldg. 517

***October 13-14, 2010**

BFH-CHSC Fall Seminar, Gateway Conference Center, Ames

AUGUST Contract Required Due Dates

10 - Due: CCNC Encounter Data

15 - Due: GAX & Expenditure Report

28 - Export WHIS Records to IDPH



THE UPdate



Bureau of Family Health: 1-800-383-3826

Teen Line: 1-800-443-8336

Healthy Families Line: 1-800-369-2229

FAX: 515-242-6013

NAME	PHONE	E-MAIL
Beaman, Janet	281-3052	jbeaman@idph.state.ia.us
Boltz, Rhonda	281-5608	rboltz@idph.state.ia.us
Borst, M. Jane (Bureau Chief)	281-4911	jborst@idph.state.ia.us
Brown, Kim	281-3126	kbrown@idph.state.ia.us
Clausen, Sally	281-6071	sclausen@idph.state.ia.us
Connet, Andrew	281-7184	aconnet@idph.state.ia.us
Cox, Jinifer	281-7085	jcox@idph.state.ia.us
Dhooge, Lucia	281-7613	ldhooge@idph.state.ia.us
Ellis, Melissa	242-5980	mellis@idph.state.ia.us
Goebel, Patrick	281-3826	pgoebel@idph.state.ia.us
Hageman, Gretchen	281-7585	ghageman@idph.state.ia.us
Hinton, Carol	281-6924	chinton@idph.state.ia.us
Hobert Hoch, Heather	281-6880	hhobert@idph.state.ia.us
Hoffman, Andrea	281-7044	ahoffman@idph.state.ia.us
Horak, Shelley	281-7721	shorak@idph.state.ia.us
Hummel, Brad	281-5401	bhummel@idph.state.ia.us
Johnson, Marcus	242-6284	mjohnson@idph.state.ia.us
Jones, Beth	242-5593	bjones@idph.state.ia.us
Mathews, Renee	281-6071	rmathews@idph.state.ia.us
McGill, Abby	281-3108	amcgill@idph.state.ia.us
Miller, Lindsay	281-7368	lmiller@idph.state.ia.us
Montgomery, Juli	242-6382	jmontgom@idph.state.ia.us
O'Hollearn, Tammy	242-5639	tohollea@idph.state.ia.us
Pearson, Analisa	281-7519	apearson@idph.state.ia.us
Peterson, Janet	242-6388	jpeterso@idph.state.ia.us
Piper, Kim	281-6466	kpiper@idph.state.ia.us
Thorud, Jennifer	281-0219	jthorud@idph.state.ia.us
Trusty, Stephanie	281-4731	strusty@idph.state.ia.us
Ubiñas, Mary	281-4653	mubinas@idph.state.ia.us
Wheeler, Denise	281-4907	dwheeler@idph.state.ia.us
Wolfe, Meghan	242-6167	mwolfe@idph.state.ia.us

Area code is 515



Births to Women on Medicaid

Iowa 2008 Prenatal Care Entry



BACKGROUND

Medicaid is a health insurance program for low-income families, including pregnant women. It is funded by both state and federal dollars and is administered by the State of Iowa, Department of Human Services. In Iowa, the household income limit for pregnant women to be eligible for Medicaid coverage is 300 percent of the federal poverty level. The overall proportion of live birth deliveries reimbursed by Medicaid in calendar year 2008 was 38 percent (n=15,297 of 40,221 births).

IMPORTANCE OF EARLY PRENATAL CARE

Entry into prenatal care in the first trimester of pregnancy is important because of its potential for improving the health of pregnant women and their newborns through early identification and treatment of medical conditions such as diabetes and high blood pressure. Early entry into prenatal care is also an opportunity for women to receive health education to promote folic acid supplement (to prevent certain birth defects) and to address behavioral factors such as poor nutrition and smoking.

RESULTS OVERVIEW

Women whose deliveries were reimbursed by Medicaid started prenatal care (PNC) later than women whose deliveries were not reimbursed by Medicaid.

Regardless of Medicaid status, first trimester initiation of PNC differed by maternal age and maternal race/ethnicity. Younger women (less than 17) were less likely to start PNC in

their first trimester compared to older women. However, early PNC initiation by age was greater among non-Medicaid participants.

Regardless of Medicaid status, non-Hispanic Blacks and Hispanics (all races) were less likely to start PNC in the first trimester compared to non-Hispanic whites.

PRENATAL CARE INITIATION BY MEDICAID STATUS

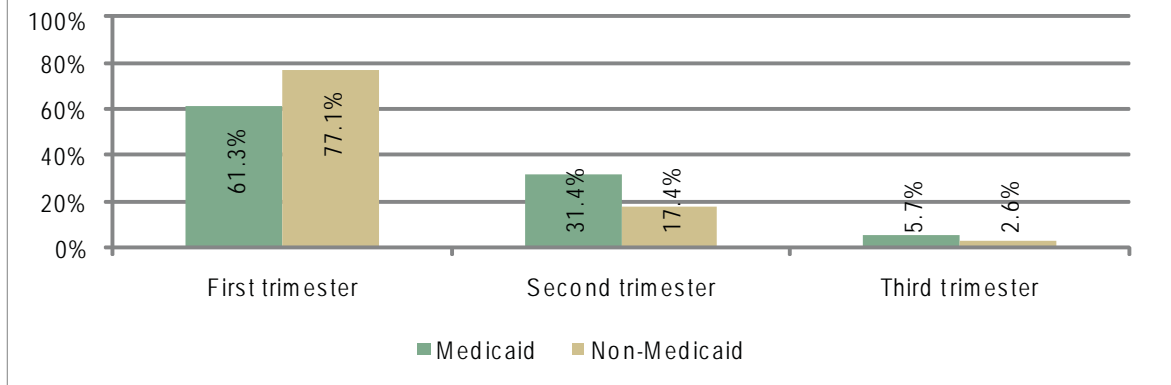
Initiation of prenatal care is based on the reported date of a woman's first prenatal care visit and her last menstrual period.

Overall 71 percent of women started PNC in their 1st trimester (n=28,604). Overall 22.7% (n=9,127) of women started PCN in their 2nd trimester and 3.7 percent (1,511) of women started PNC in their 3rd trimester.

Sixty-one percent of women whose deliveries were reimbursed by Medicaid started PNC in the 1st trimester compared to 77.1 percent of women whose deliveries were not reimbursed by Medicaid (Figure 1).

The proportion of women who started PNC in their 2nd and 3rd trimesters was higher among women whose deliveries were reimbursed by Medicaid compared to those whose deliveries were not reimbursed by Medicaid. Thirty-one percent of Medicaid recipients started PNC in their 2nd trimester compared to 17.4 percent of non-recipients. Although the majority of pregnant women in Iowa start PNC prior to their 3rd trimester, a greater proportion of Medicaid recipients (5.7%) started PNC in the third trimester compared to non-Medicaid recipients (2.6%).

Figure 1. Prenatal care initiation by trimester and Medicaid status, Iowa 2008

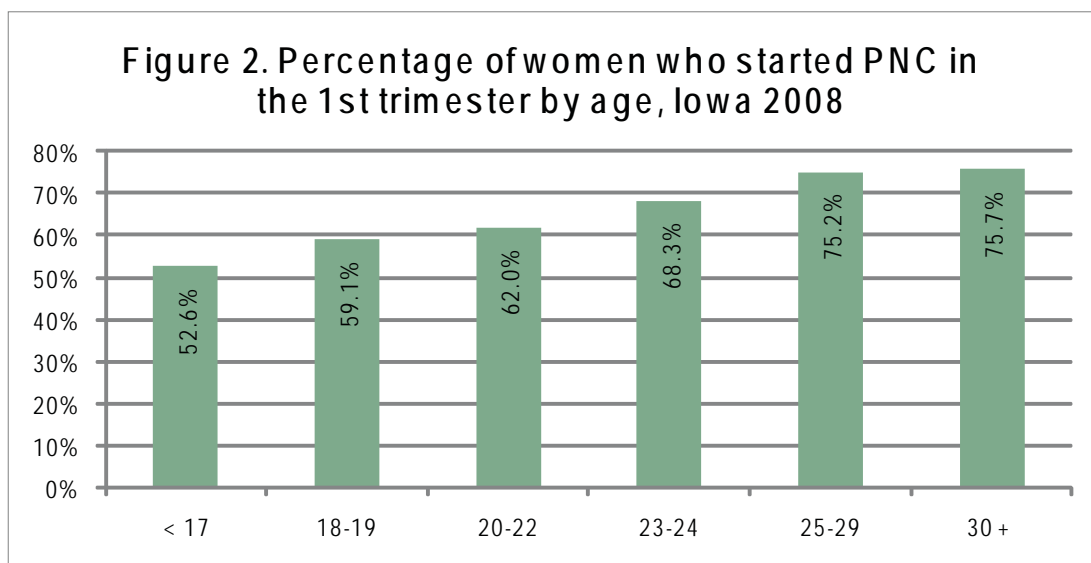


PRENATAL CARE INITIATION BY MATERNAL AGE

Overall, PNC initiation was inversely related to age (Figure 2). Specifically, the proportion of women who started PNC in their first trimester increased with age. Fifty-two percent (n=559) of girls, 17 or younger, started PNC in the first trimester compared to 59.1 percent (n=1,517) of women 18-19 years of age, 62 percent (n=3,443) of women 20-22 years of age, and 68.3 percent (n=3,118) of women 23-24 years of age. Women aged 25-29 and those 30 years of age and older started PNC in the first at the highest proportions, 75.2%; n=10,066 vs. 75.7% n=9,901).



Figure 2. Percentage of women who started PNC in the 1st trimester by age, Iowa 2008



PRENATAL CARE INITIATION BY MATERNAL AGE AND MEDICAID STATUS

Overall, girls 17 or younger and women aged 18-19 started PNC later than older women. However, among these same groups, the proportion of those that started PNC in the first trimester was greater among Medicaid recipients (girls 17 or less [53.4% vs. 50.5%]) compared to non-recipients (Figure 3).

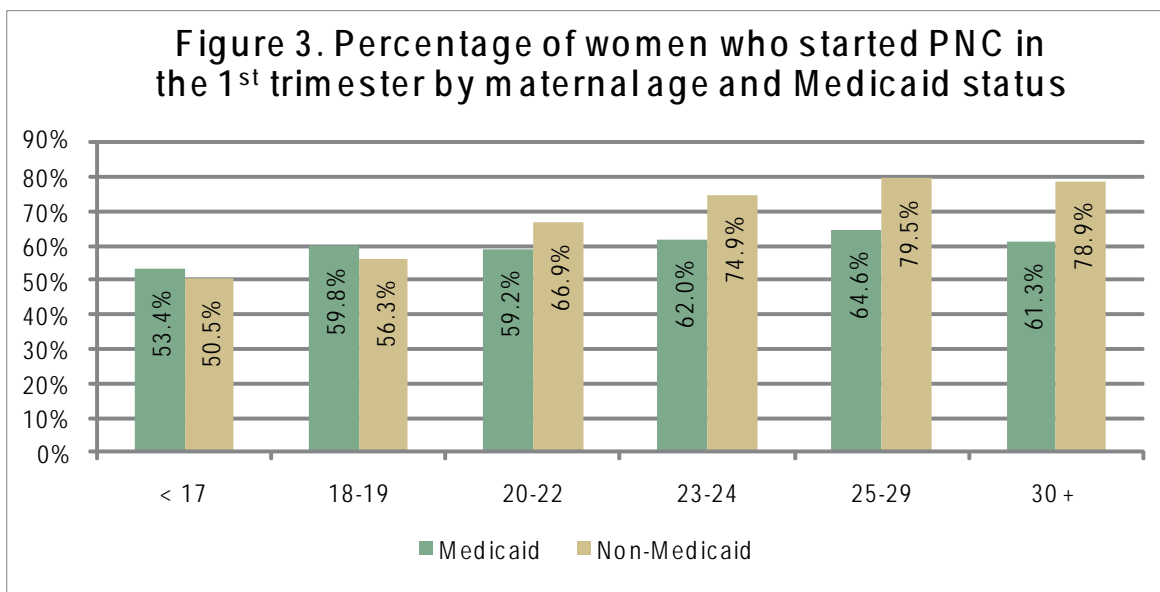
Likewise the proportion of women aged 18-19 who started PNC in the first trimester was greater among Medicaid recipients (59.8% vs. 56.3%) compared to non-Medicaid recipients.

When comparing Medicaid to non-Medicaid recipients by age groups, after age 20, the proportion of women who started PNC in their first trimester were consistently lower among Medicaid recipients compared to non-recipients (Figure 3). Among women aged 20-22, 59.2 percent of Medicaid recipients compared to 66.9 percent of non-recipients started PNC in the first trimester; of those 23-24, 62.0 percent of Medicaid recipients compared to 74.9 percent of non-recipients started PNC in the first trimester; of those 25-29, 64.6 percent of Medicaid recipients compared to 79.5 percent of non-recipients started PNC in the first trimester; of those 30+, 61.3 percent of Medicaid recipients compared to 78.9 percent of non-recipients started PNC in the first trimester.

percent of Medicaid recipients compared to 74.9 percent of non-recipients started PNC in the first trimester; of those 25-29, 64.6 percent of Medicaid recipients compared to 79.5 percent of non-recipients started PNC in the first trimester; and of those 30 or more, 61.3 percent of Medicaid recipients compared to 78.9 percent of non-recipients started PNC in the first trimester.

PRENATAL CARE INITIATION BY MATERNAL RACE/ETHNICITY

Non-Hispanic white women started PNC in the 1st trimester at a higher proportion (73.9%; n=24,957) than women of other racial and ethnic groups. The next highest proportion of women to start PNC in the 1st trimester was Non-Hispanic women of other races (62.7%; n=931). Non-Hispanic Black women were the least likely to start PNC in the 1st trimester (54.1%; n=889). The proportion of non-Hispanic women (all races) who started PNC in their 1st trimester was 54.8 percent (n=1821).



PRENATAL CARE INITIATION BY MATERNAL RACE/ETHNICITY BY MEDICAID STATUS

Regardless of race/ethnicity, the proportion of women who started PNC in the first trimester was less among Medicaid recipients compared to non-Medicaid recipients.

The greatest difference in 1st trimester PNC initiation by Medicaid status and race/ethnicity was among non-Hispanics of other races (Medicaid = 49.7% vs. non-Medicaid = 71.7%). The next greatest difference was among non-Hispanics whites for 1st trimester PNC initiation (Medicaid = 78.8% vs. non-Medicaid = 64.5%).

The difference in 1st trimester initiation of PNC when comparing Medicaid status by race/ethnicity was much less disparate among non-Hispanic Blacks (Medicaid = 54.7% vs. non-Medicaid = 57.6%) and Hispanics (Medicaid = 52.6% vs. non-Medicaid = 59.4%).

Figure 4. Percentage of women who started PNC in the 1st trimester by race/ethnicity

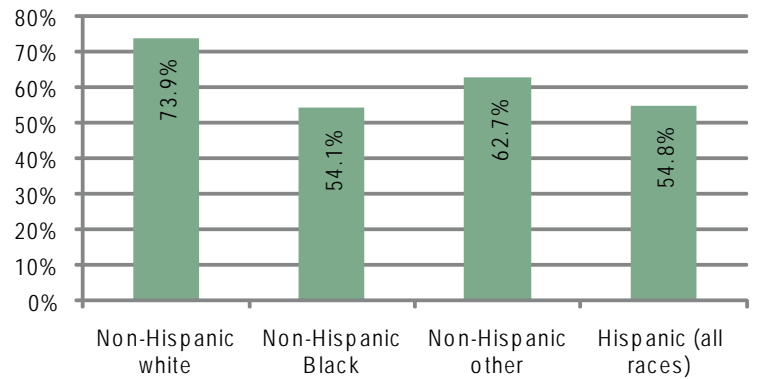
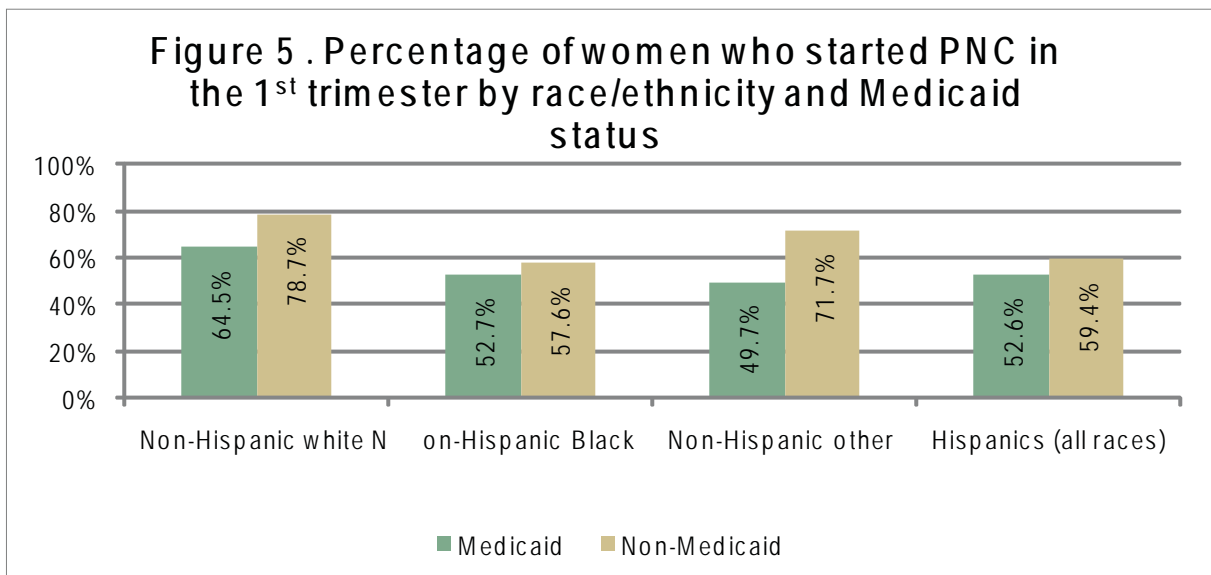


Figure 5. Percentage of women who started PNC in the 1st trimester by race/ethnicity and Medicaid status



DISCUSSION

Early initiation of PNC (1st trimester) is an important factor in promoting healthy pregnancies and in preventing adverse birth outcomes. Women on Medicaid tend to start prenatal care later than women who were not on Medicaid.

Regardless of Medicaid status, younger women (less than 17 & 18-19) were less likely to start PNC in the first trimester compared to women of other age groups.

Regardless of Medicaid status, non-Hispanic Black women and Hispanic women were less likely to start PNC in the first trimester compared to non-Hispanic white women and non-Hispanic women of other races.

CONCLUSIONS

Ideally all pregnant women would start prenatal care in the first trimester. However PNC initiation differs by age, race/ethnicity and Medicaid status.

POLICY AND PROGRAM IMPLICATIONS

Entry into prenatal care in the first trimester of pregnancy is important because of its potential for improving the health of pregnant women and their newborns.

Outreach to women of child-bearing age, particularly young women, those of racial and ethnic minorities, and Medicaid eligible women, about the importance of starting prenatal care early in pregnancy is important.

The IDPH would like to acknowledge the Maternal and Child Health Epidemiology Program, Applied Sciences Branch, Division of Reproductive Health, National Center for Chronic Disease Prevention and Public Health Promotion, Centers for Disease Control and Prevention for analytic support and preparation of this fact sheet.

At the same time, it is important that once women get this message, that a sufficient number of health care providers will accept Medicaid-eligible patients.

What is the Iowa Medicaid - Birth Certificate Match Project?

The Iowa Medicaid Birth Certificate match project is supported by an inter-departmental agreement between the State of Iowa Department of Human Services and the Iowa Department of Public Health. The purpose of this project and report is to describe the characteristics of pregnant Medicaid recipients, their receipt of pregnancy related services, and their birth outcomes relative to women whose deliveries were not reimbursed by Medicaid. The data file to complete this report was created by linking calendar year birth certificates to relevant Medicaid claims data.

ADDITIONAL INFORMATION

For additional information or to obtain copies of this fact sheet, write or call the Iowa Department of Public Health, Bureau of Family Health,
321 E. 12th Street, Des Moines, IA 50309;
1-800-383-3826





Births to Women on Medicaid

Iowa 2008 Demographic Characteristics



BACKGROUND

Medicaid is a health insurance program for low-income pregnant women. It is funded by both state and federal dollars and is administered by the State of Iowa, Department of Human Services. In Iowa, the household income limit for pregnant women to be eligible for Medicaid coverage is 300 percent of the federal poverty level.

The overall proportion of live birth deliveries reimbursed by Medicaid in calendar year 2008 was 38 percent (n=15,297 of 40,221 births).

RESULTS OVERVIEW

The proportion of live birth deliveries reimbursed by Medicaid varies by maternal demographic characteristics including maternal age, race/ethnicity, educational attainment and marital status.

MATERNAL AGE

Maternal age is a computer generated number based on the woman's date of birth and the infant's date of birth.

In 2008, girls 17 years old or younger gave birth to 2.6 percent (n= 1,063) of live births in Iowa (Figure 1). Women aged 18 to19 gave birth to 6.4 percent of live births (n= 2,566), women aged 20 to 22 gave birth to 13.8 percent of live births, and women aged 23-24 gave birth to 11.4 percent (n=4,457) live births during 2008. Births to women ages 25 and older accounted for approximately 65 percent of all live births for calendar year 2008 (n=26,472).

MATERNAL AGE BY MEDICAID STATUS

Among girls aged 17 and younger, 72.1 percent were reimbursed by Medicaid compared non-Medicaid recipients (27.9%) (Figure 2). Like girls 17 and younger, a greater proportion of births to women ages 18 to 19 were reimbursed by Medicaid compared to non-Medicaid recipients (80.7% vs. 19.3%). Similarly, a greater proportion of births to women ages 20 to 22 were reimbursed by Medicaid compared to non-Medicaid recipients (69.8% vs. 30.2%).

Maternal Age by Medicaid Status continued

Figure 1. Percentage of live births by maternal age, Iowa, 2008

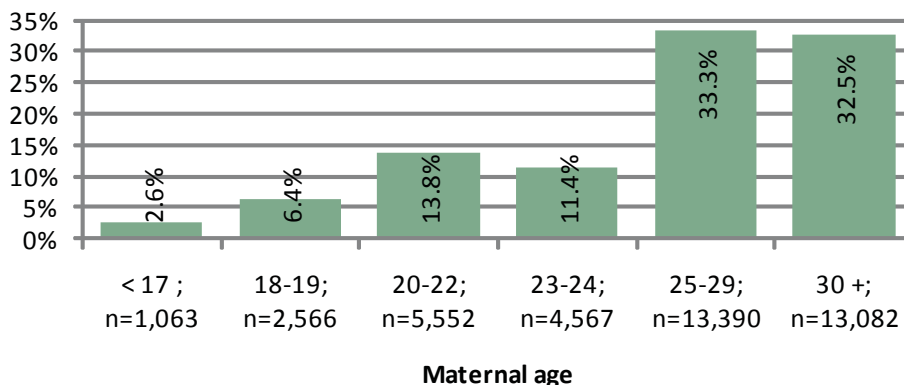
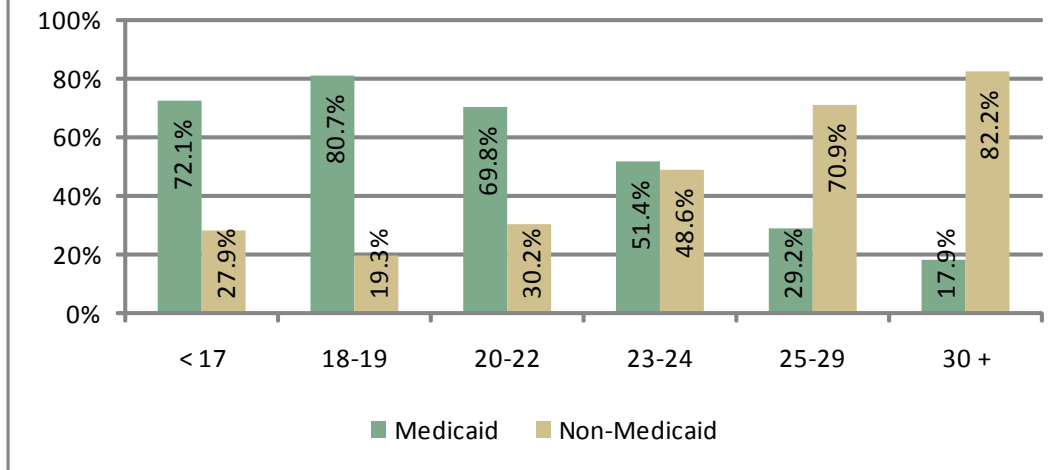


Figure 2. Percentage of live births by maternal age and Medicaid status, Iowa 2008



By the maternal age of 23 to 24 the proportion of births reimbursed by Medicaid was separated by just 2.8 percentage points compared to births not reimbursed by Medicaid (51.4% vs. 48.6%). At ages 25-29, the proportion of births reimbursed by Medicaid drops to 29.2 percent of all births. The proportion of births reimbursed by Medicaid is the lowest among women aged 30 and older (17.9%).

MATERNAL RACE AND ETHNICITY

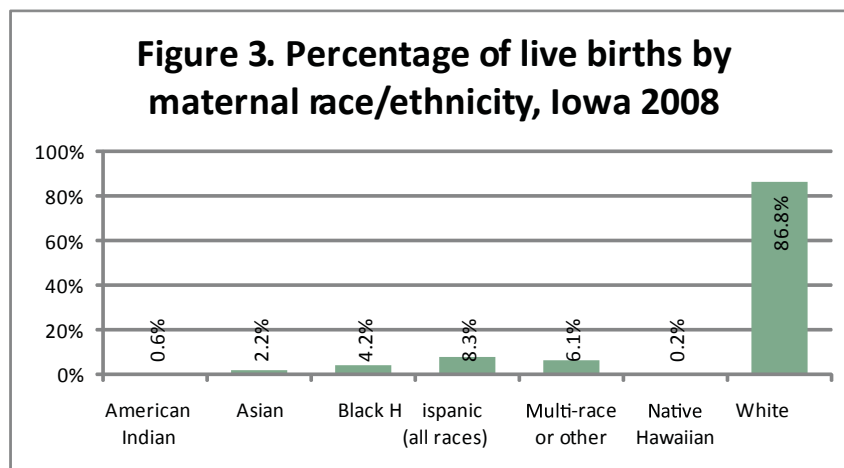
Maternal race and ethnicity categories are based on the mother's self-reported indication for race and ethnicity on the certificate for live births.

American Indian mothers accounted for less than 1 percent of births in Iowa (n=230) (Figure 3). Births to Asian mothers accounted for 2.2 percent of births (n=867). Births to Black mothers accounted for 4.2 percent of births in 2008 (n=1,675).

Births to Hispanic mothers of all races accounted for 8.3 percent (n=3,323) of births. Other racial groups and multi-race groups accounted for 5.3 percent (n= 2,147) and less than 1 percent (n=323) of births respectively. Births to Native Hawaiian mothers also accounted for less than 1 percent of births (n=59).

Births to white mothers accounted for 86.8 percent (n=34,912) of births in Iowa.

Figure 3. Percentage of live births by maternal race/ethnicity, Iowa 2008



MATERNAL RACE AND ETHNICITY BY MEDICAID STATUS

Of these births, American Indian mothers accounted for less than 1 percent of births in Iowa, of these births. However, 73 percent (n=168) were reimbursed by Medicaid (Figure 4). Births to Asians accounted for 2.2 percent of births, of these 23.3 percent (n=202) were reimbursed by Medicaid.

Blacks accounted for 4.2 percent of births in 2008. Of these births, 71 percent (n=1,189) were reimbursed by Medicaid.

Hispanics (including all races) accounted for 8.3 percent of births. Of these births, 66.7 percent (n=2,215) were reimbursed by Medicaid.

Other racial groups and multi-race groups accounted for 5.3 percent and less than 1 percent (n=323) of births respectively. The proportion of births to mothers of other racial groups and multi-racial groups reimbursed by Medicaid were 66.5 percent (n=1,427) and 68.7 percent (n= 222) respectively. Births to Native Hawaiian mothers also accounted for less than

1 percent of births. Of these births, 50.9 percent (n=30) were reimbursed by Medicaid. Births to white mothers accounted for 86.8 percent of births in Iowa, of these births 34.5 percent (12,056) were reimbursed by Medicaid.

MATERNAL EDUCATIONAL ATTAINMENT

Maternal educational attainment is a self-reported variable on the certificate of live birth.

Less than 1 percent of women (n=279) did not report their educational attainment. Women who attained up to 12 years of education, but did not graduate from high school accounted for 14.8 percent of live births in Iowa (n=5,892) (Figure 5).

Women who attained high school graduation or a GED, accounted for 21.1 percent of births (n=8,421).

Women who attained more than a high school diploma accounted for 64.2 percent of live births (n=25,629).

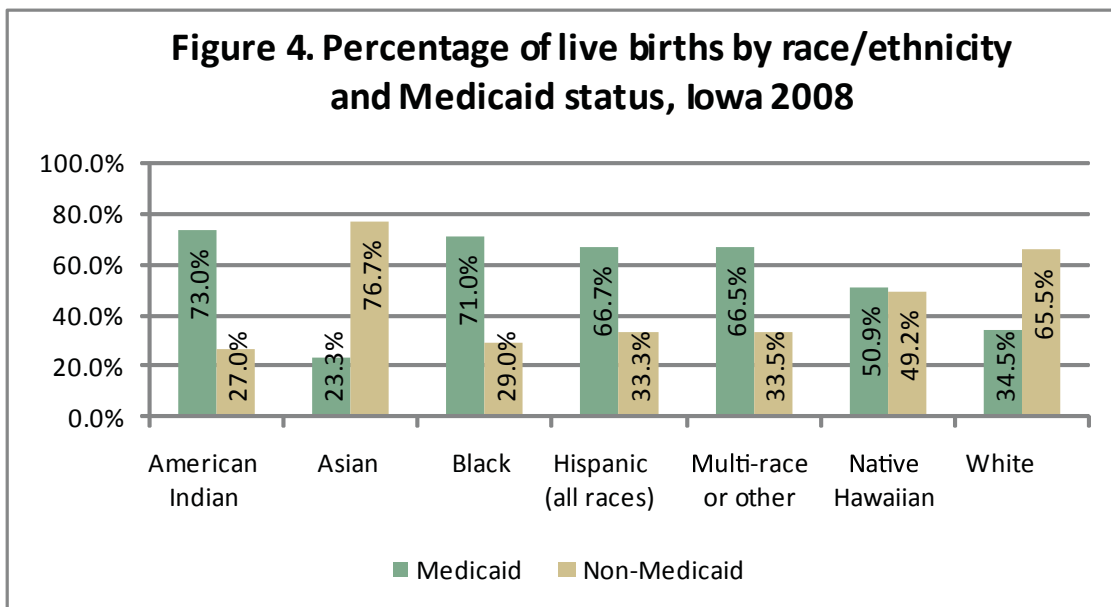
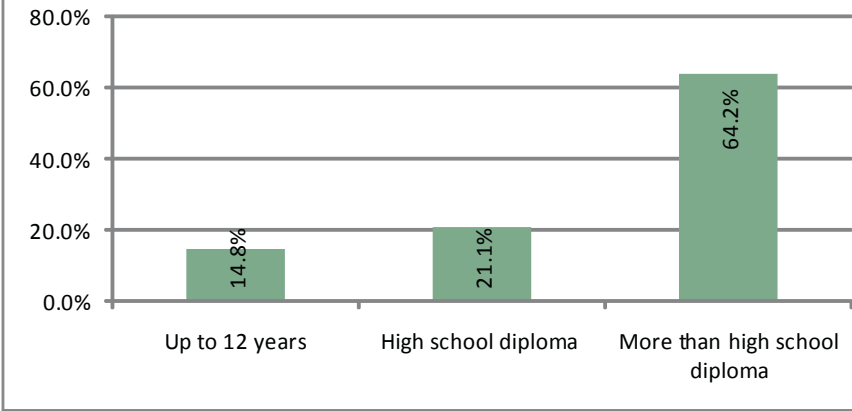


Figure 5. Percentage of live births by maternal education, Iowa 2008



Women who attained high school graduation or a GED, accounted for 21.1 percent of births. Of births to this group of women, 61.8 percent were reimbursed by Medicaid compared to 38.2 percent of non-Medicaid recipients.

Twenty-two percent of births to women who attained more than an high school education were reimbursed by Medicaid compared to 77.2 percent of non-Medicaid recipients.

MATERNAL EDUCATIONAL ATTAINMENT BY MEDICAID STATUS

Women who attained up to 12 years of education, but did not graduate accounted for 14.8 percent of live births in Iowa. Of births to these women, 71.2 percent were reimbursed by Medicaid compared to 28.9 percent of non-Medicaid recipients (Figure 6).

MARITAL STATUS

Marital status is a self-reported variable on the certificate of live birth.

Married women gave birth to nearly sixty-five percent (68.9%; n=26,085) of births in Iowa (Figure 7). Women who reported that they were not married at the time of the infant's birth accounted for 35 percent of births (n=14,132).

Figure 6. Percentage of live births by maternal education level and Medicaid status, Iowa 2008

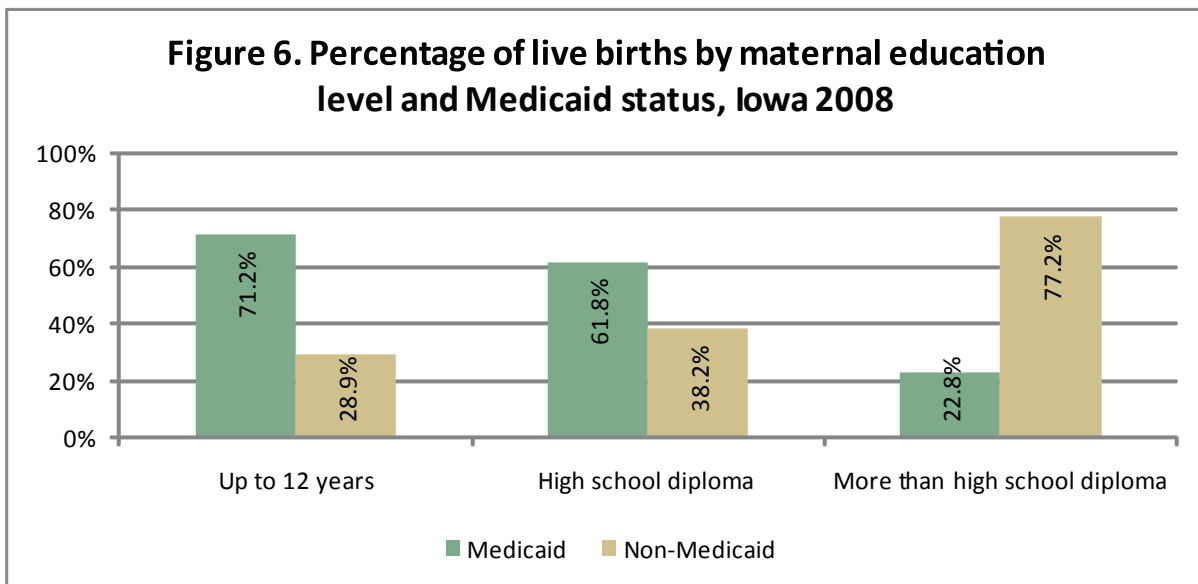
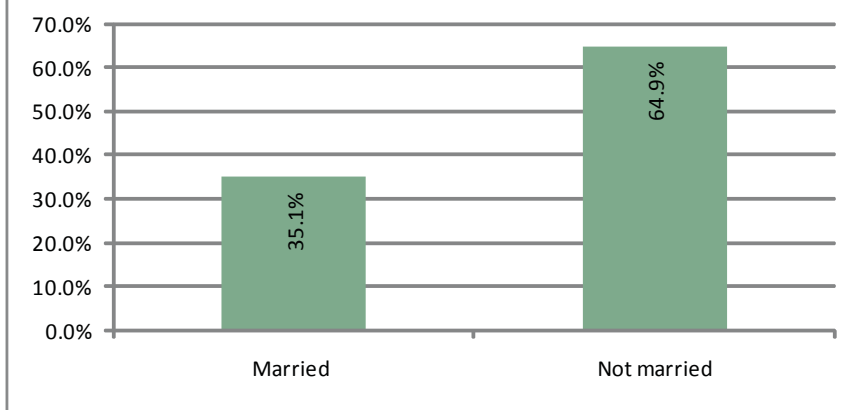


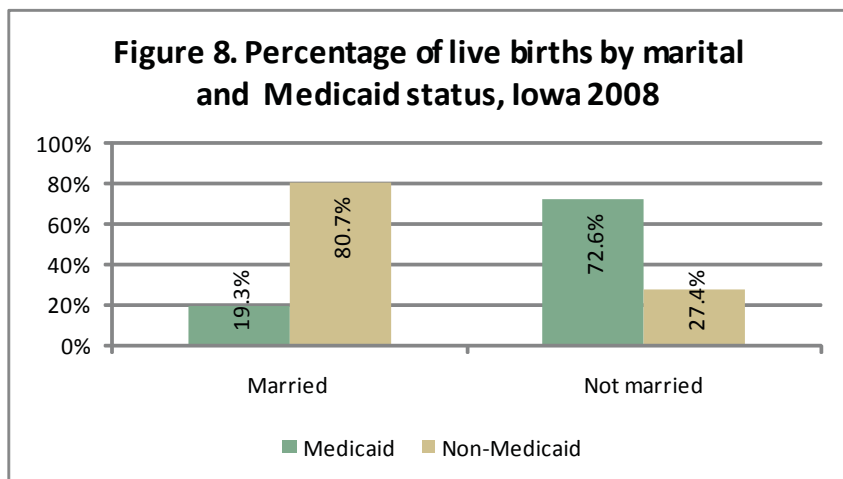
Figure 7. Percentage of live births by maternal marital status, Iowa 2008



MATERNAL MARITAL STATUS BY MEDICAID STATUS

Among births to married women, 19.3 percent were reimbursed by Medicaid. Of births to unmarried women, 72.6 percent were reimbursed by Medicaid.

Figure 8. Percentage of live births by marital and Medicaid status, Iowa 2008



DISCUSSION

Medicaid is an important health insurance resource for low-income pregnant women. Thirty-eight percent of Iowa births in 2008 were reimbursed by Medicaid. Medicaid coverage is particularly important to young women, including those who are still in high school. It is also an important health insurance resource to women of racial and ethnic minorities in Iowa.

PROGRAM & POLICY IMPLICATIONS

Programs that enable young women, particularly those who have not yet completed high school,

to avoid pregnancy and complete their education, can reduce the proportion of births that are reimbursed by Medicaid.

A disproportionate number of births to women of racial and ethnic minorities are reimbursed by Medicaid compared to white women in Iowa. Keeping in mind that Medicaid is a health insurance program for low income families, including pregnant women, programs and policies that address income and health insurance disparities among racial and ethnic minorities in Iowa can also reduce the proportion of births that are reimbursed by Medicaid.



CONCLUSIONS

Insurance coverage during pregnancy is a key factor in ensuring that pregnant women obtain early and adequate prenatal care. In this way Medicaid coverage is key factor in promoting healthy pregnancies among lowan mothers and healthy birth outcomes among their newborns.



What is the Iowa Medicaid - Birth Certificate Match Project?

The Iowa Medicaid Birth Certificate match project is supported by an inter-departmental agreement between the State of Iowa Department of Human Services and the Iowa Department of Public Health. The purpose of this project and report is to describe the characteristics of pregnant Medicaid recipients, their receipt of pregnancy related services, and their birth outcomes relative to women whose deliveries were not reimbursed by Medicaid. The data file to complete this report was created by linking calendar year birth certificates to relevant Medicaid claims data.

ADDITIONAL INFORMATION

For additional information or to obtain copies of this fact sheet, write or call the Iowa Department of Public Health, Bureau of Family Health, 321 E. 12th Street, Des Moines, IA 50309;
1-800-383-3826



The IDPH would like to acknowledge the Maternal and Child Health Epidemiology Program, Applied Sciences Branch, Division of Reproductive Health, National Center for Chronic Disease Prevention and Public Health Promotion, Centers for Disease Control and Prevention for analytic support and preparation of this fact sheet.



Births to Women on Medicaid

Iowa 2008 Newborn Hearing Services



BACKGROUND

Medicaid is a health insurance program for low-income families. It is funded by both state and federal dollars and is administered by the State of Iowa, Department of Human Services. In Iowa, the household income limit for families to be eligible for Medicaid coverage is 300 percent of the federal poverty level.

The overall proportion of live births reimbursed by Medicaid in calendar year 2008 was 40.7 percent (n=16,359 of 40,221 births).

RESULTS OVERVIEW

Greater than 90% of newborns were documented to have received newborn hearing or metabolic screening prior to hospital discharge. The proportion of newborns screened was slightly greater among newborns whose deliveries were reimbursed by Medicaid compared to newborns whose deliveries were not reimbursed by Medicaid.



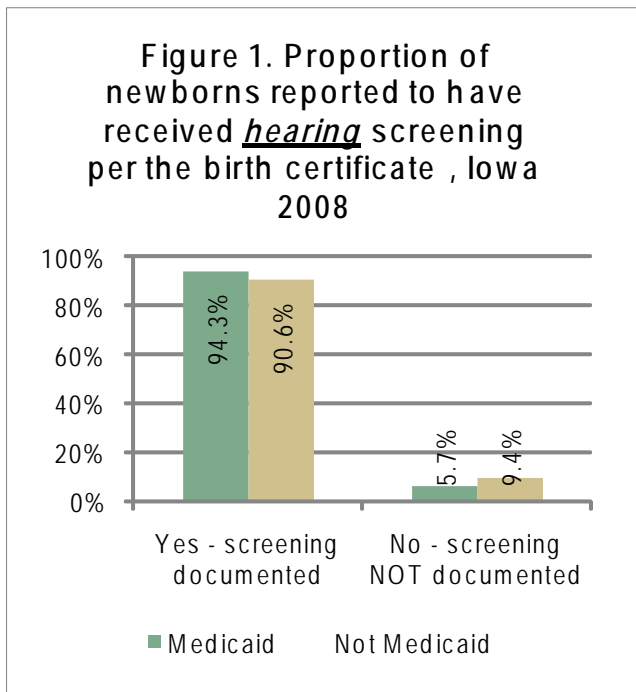
Hospital staff also document the reasons why a newborn may not have received hearing or metabolic screening prior to hospital discharge. The most common reason indicated for infants not being screened was “unknown.” Other reasons screenings were not documented were that the infant was transferred, the infant died, or the parents signed a refusal waiver.

NEWBORN HEARING SCREENING

Receipt of newborn hearing screening is recorded on the birth certificate by hospital staff.

Per birth certificate documentation, overall, 92.1 percent of newborns were reported to have received a hearing screening prior to hospital discharge.

The proportion of newborns having received hearing screening was higher among infants whose births were reimbursed by Medicaid (94.3%) compared to infants whose births were not reimbursed by Medicaid (90.6%) (Figure 1).

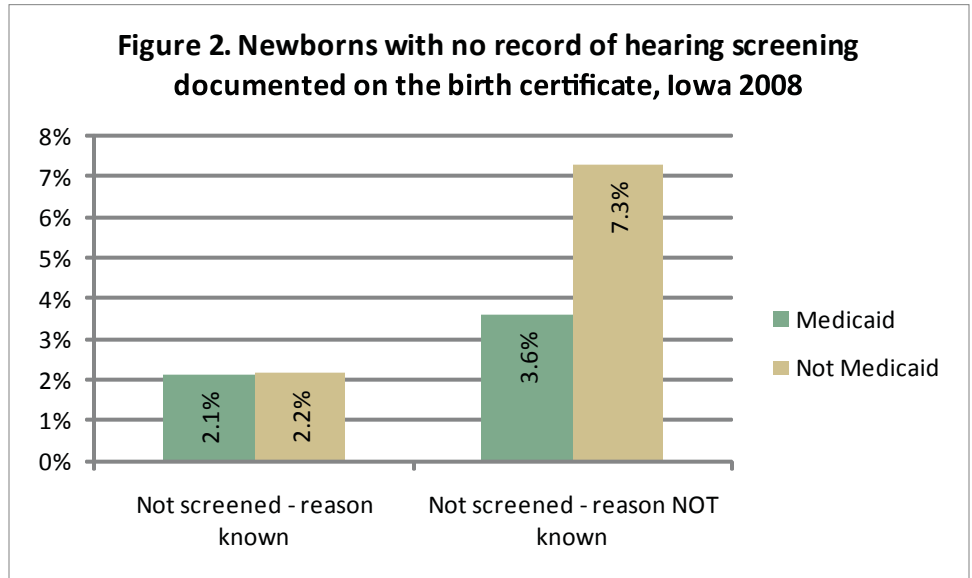


REASONS NEWBORNS DID NOT RECEIVE HEARING SCREENING

Overall, 7.9 percent of newborns did not have a record of having received hearing screening prior to hospital discharge.

Regardless of Medicaid status, no known reason was the most common reason cited for infants not having received a hearing screening prior to hospital discharge (Figure 2). The proportion of non-Medicaid newborns without a record of hearing screening due to an unknown reason was double that of Medicaid infants (7.3% vs. 3.6%).

The known reasons for a lack of documentation of hearing screening were that the infant was transferred, the infant died, or the parents signed a refusal waiver.

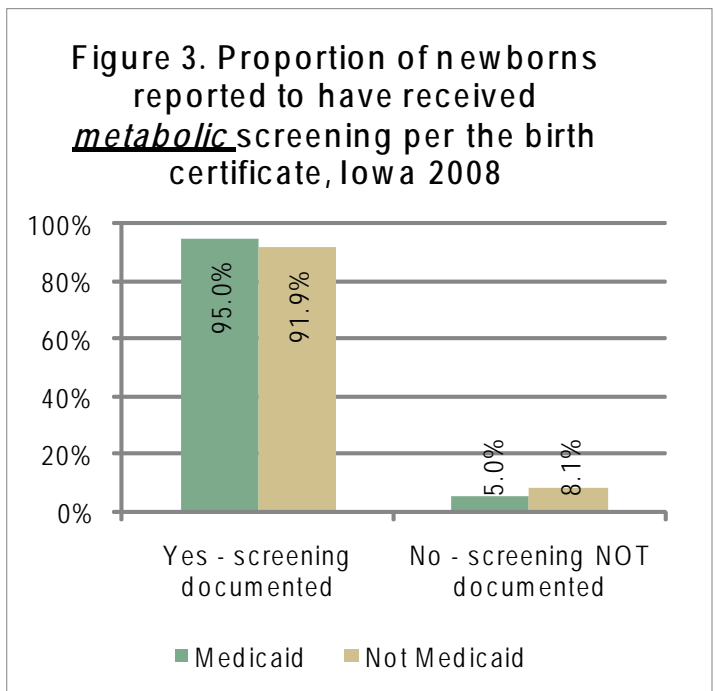


NEWBORN METABOLIC SCREENING

Receipt of newborn metabolic screening is recorded on the birth certificate by hospital staff.

Per birth certificate documentation, overall, 93.2 percent of newborns received metabolic screening prior to hospital discharge.

The proportion of newborns having been screened was higher among the Medicaid infants (95.0%) compared to non-Medicaid infants (91.9%) (Figure 3).



REASONS NEWBORNS DID NOT RECEIVE METABOLIC SCREENING

Receipt of newborn metabolic screening is recorded on the birth certificate by hospital staff.

Overall, 93.2 percent of newborns received metabolic screening prior to hospital discharge. The proportion of newborns having been screened was higher among the women whose deliveries were reimbursed by Medicaid (95.0%) compared to women whose deliveries were not reimbursed by Medicaid (92.1%) (Figure 2).

DISCUSSION

Regardless of Medicaid status, a high proportion of infants were reported to have received newborn hearing screening and newborn metabolic screening.

Ideally all newborns would obtain hearing and metabolic screening prior to hospital discharge. However, screenings may be delayed for infants born outside of the hospital or those who may have been ill at the time of their births.

The birth certificate provides a snapshot of the proportion of newborns that have been screened prior to hospital discharge as well as some indication of newborns that may have been missed.

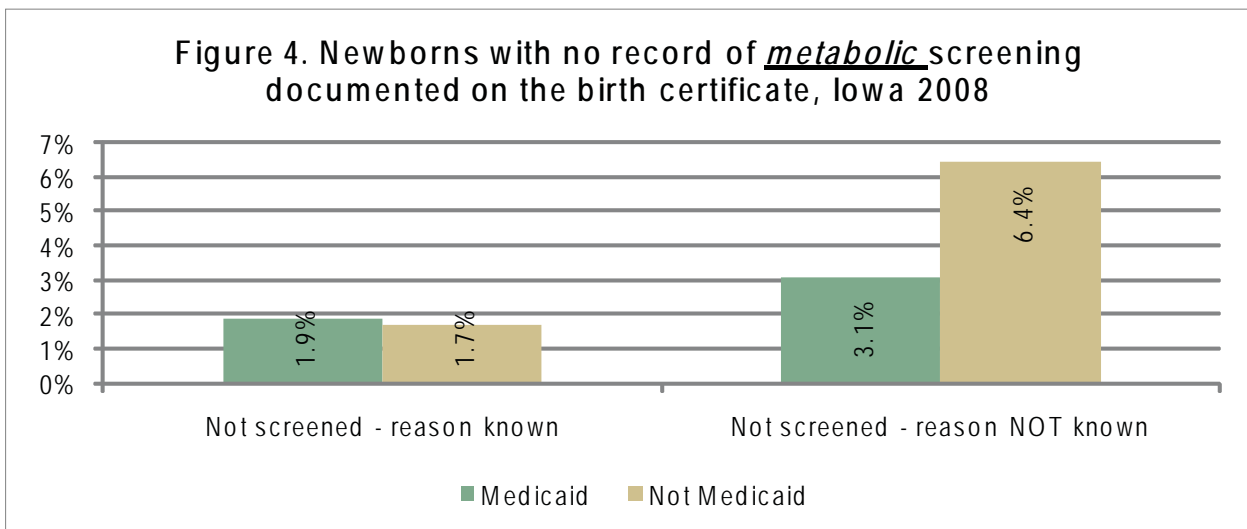
The Iowa Department of Public Health - Bureau of Family Health has numerous mechanisms in place to assure that all newborns receive hearing and metabolic screening early in life.

NEWBORN HEARING SCREENING

Receipt of newborn hearing screening is recorded on the birth certificate by hospital staff.

Per birth-certificate documentation, overall, 92.1 percent of newborns were reported to have received a hearing screening prior to hospital discharge.

The proportion of newborns having received hearing screening was higher among infants whose births were reimbursed by Medicaid (94.3%) compared to infants whose births were not reimbursed by Medicaid (90.6%) (Figure 1).



NEWBORN HEARING SCREENING

Iowa's Early Hearing Detection and Intervention Program works to ensure that all newborns and toddlers with hearing loss are identified as early as possible and provided with timely and appropriate audiological, educational, medical intervention and family support. The EHDI program is also dedicated to providing unbiased support to families of children who are deaf or hard of hearing.

Iowa legislature passed a law (Iowa Code section 135.131) which requires universal hearing screening of all newborns and infants in Iowa. The law further provides that any birthing hospital, birth center, physician, any facility including Area Education Agencies (AEAs), audiologists and other health care professional are legally required to report to the Iowa Department of Public Health (IDPH) the results of a hearing screen, re-screen, or diagnostic assessment for any child under three years of age.

METABOLIC SCREENING

The Iowa Neonatal Metabolic Screening Program (INMSP) conducts universal screening for all Iowa newborns. Neonatal metabolic screening is a blood test for certain treatable metabolic and inherited disorders performed shortly after a baby's birth. Iowa screens for over 40 disorders as part of its screening panel. The INMSP identifies babies who may have a metabolic or inherited disorders and alerts the baby's health care provider to the need for further testing and special care. With early diagnosis and treatment, complications from these serious disorders can usually be prevented.

The IDPH would like to acknowledge the Maternal and Child Health Epidemiology Program, Applied Sciences Branch, Division of Reproductive Health, National Center for Chronic Disease Prevention and Public Health Promotion, Centers for Disease Control and Prevention for analytic support and preparation of this fact sheet.

ADDITIONAL INFORMATION

For additional information or to obtain copies of this fact sheet, write or call the Iowa Department of Public Health, Bureau of Family Health, 321 E. 12th Street, Des Moines, IA 50309; **1-800-383-3826**

What is the Iowa Medicaid - Birth Certificate Match Project?

The Iowa Medicaid Birth Certificate match project is supported by an inter-departmental agreement between the State of Iowa Department of Human Services and the Iowa Department of Public Health. The purpose of this project and report is to describe the characteristics of pregnant Medicaid recipients, their receipt of pregnancy related services, and their birth outcomes relative to women whose deliveries were not reimbursed by Medicaid. The data file to complete this report was created by linking calendar year birth certificates to relevant Medicaid claims data.





Births to Women on Medicaid

Iowa 2008 Smoking During Pregnancy



BACKGROUND

Medicaid is a health insurance program for low-income pregnant women. It is funded by both state and federal dollars and is administered by the State of Iowa, Department of Human Services. In Iowa, the household income limit for pregnant women to be eligible for Medicaid coverage is 200 percent of the federal poverty level. The overall proportion of live birth deliveries reimbursed by Medicaid in calendar year 2008 was 38 percent (n=15,297 of 40,221 births).

PERILS OF SMOKING DURING PREGNANCY

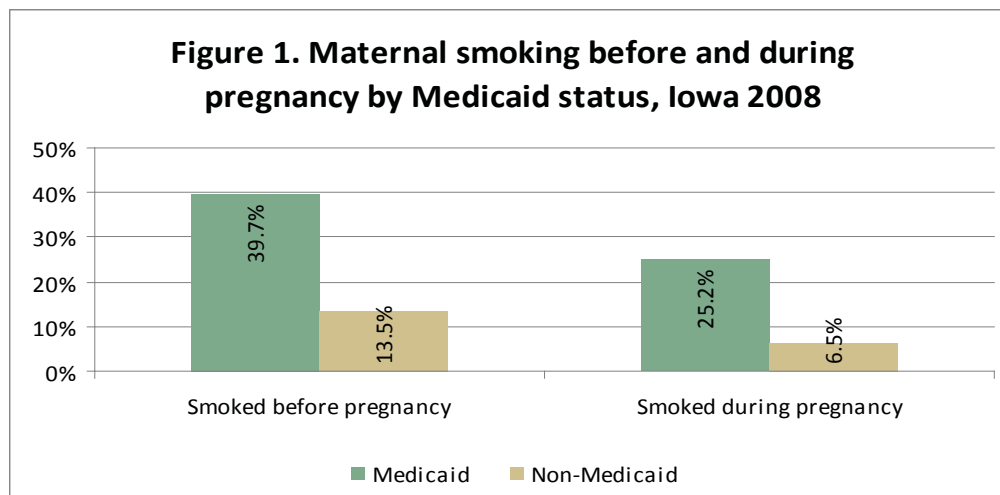
Women who smoke cigarettes during pregnancy are at increased risk of having a low birth weight (LBW) baby or in delivering a baby early (premature infant). Low birth weight and premature babies face greater risks of health complications both immediately after birth and after hospital discharge.

RESULTS OVERVIEW

A greater proportion of women whose deliveries were reimbursed by Medicaid reported that they smoked in the three months before pregnancy compared to women whose deliveries were not reimbursed by Medicaid. The proportion of women who reported that they continued to smoke through out their pregnancies was much greater among Medicaid reimbursed deliveries compared to those not reimbursed by Medicaid (Figure 1).

Regardless of Medicaid status, women who reported that they smoked during pregnancy were predominantly non-Hispanic white. Approximately 43% of the women whose deliveries were reimbursed by Medicaid and reported that they smoked during pregnancies were between 20 to 24 years of age. Women whose deliveries were not reimbursed by Medicaid and who reported that they smoked during pregnancy were primarily between 25-29 years of age and more than 30 years of age.

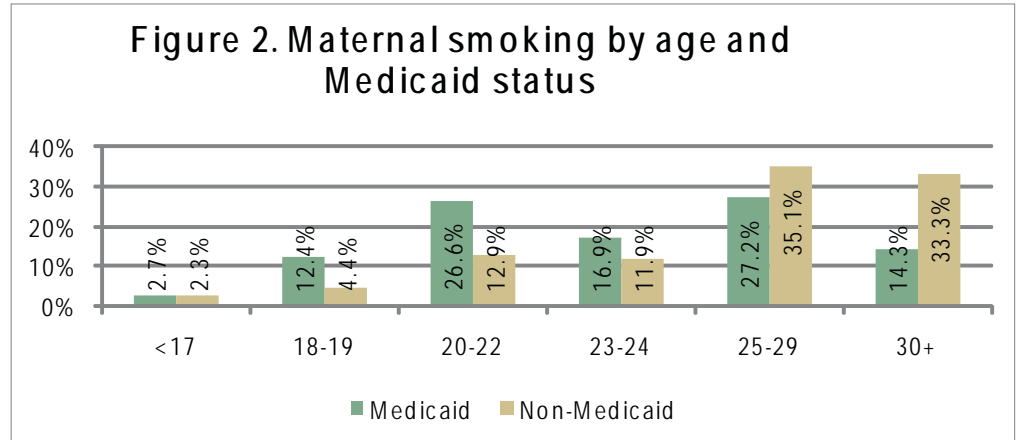
Regardless of Medicaid status, women who smoked during pregnancy gave birth to a greater proportion of low birth weight infants and infants born prematurely compared to women who did not smoke during pregnancy.



MATERNAL SMOKING BY AGE AND MEDICAID STATUS

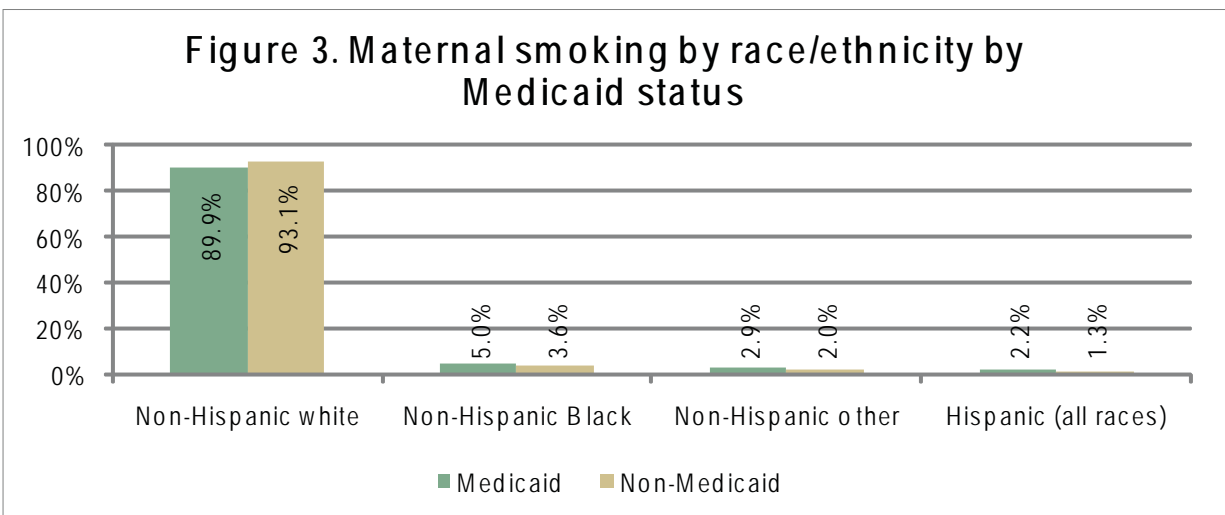
Regardless of Medicaid status, young teens (those 17 or less) reported the lowest proportion of smoking during pregnancy (Figure 2). The proportion of smokers ages 18 to 19, was much higher among Medicaid recipients (12.4%) than non-recipients (4.4%). Likewise, the proportion of smokers ages 20-22 (26.6%) and 23-24 (16.9%) was greater among women Medicaid recipients compared to non-recipients (12.9% & 11.9%).

However, among women aged 25-29 (35.1% vs. 27.2%) and among women older than 30 (33.3% vs. 14.3%), a greater proportion of smokers was among non-Medicaid recipients when compared to Medicaid recipients.



MATERNAL SMOKING BY RACE/ETHNICITY AND MEDICAID STATUS

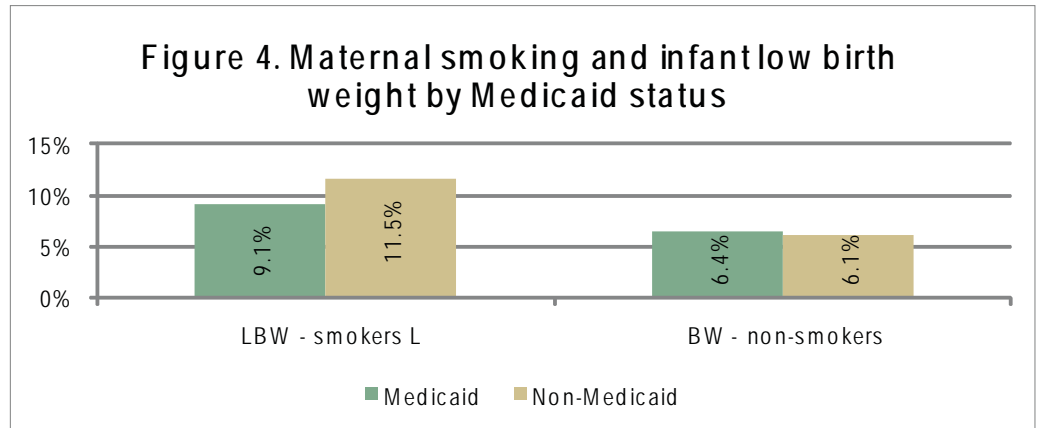
Regardless of Medicaid status, women who smoked during pregnancy were predominantly non-Hispanic whites (89.9% vs. 93.1%) (Figure 3). With the exception of non-Hispanic whites, the proportion of Medicaid recipients who smoked during pregnancy was higher than that of non-Medicaid recipients. However, the differences were small.



INFANT LOW BIRTH WEIGHT BY MATERNAL SMOKING AND MEDICAID STATUS

Infant low birth weight (LBW) is defined as a birth weight of less than 2500 grams (less than 5 lbs-5 oz). Birth weight, in grams is reported on the birth certificate. Overall, 6.7 percent (n= of infants were born with LBW in 2008.

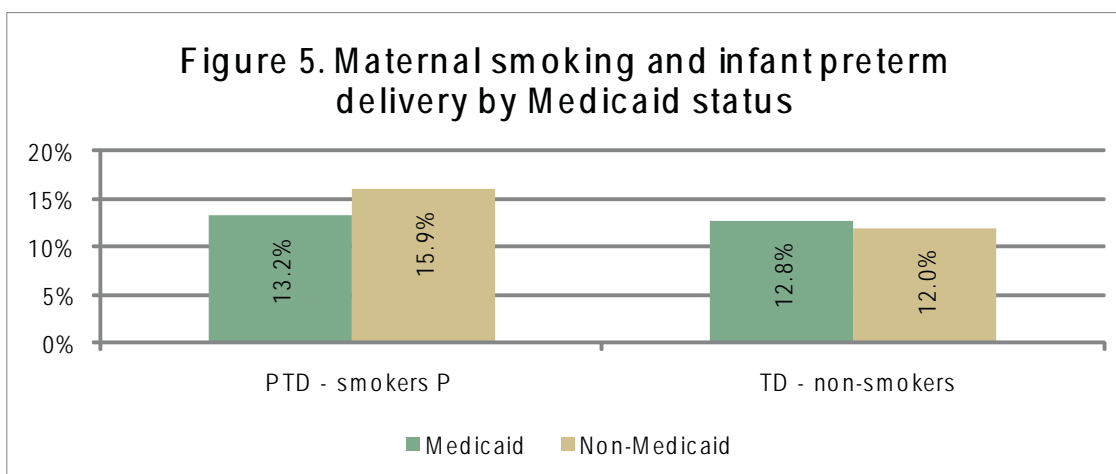
Regardless of Medicaid status, women who smoked during pregnancy had infants with LBW at a greater proportion than women who did not smoke during pregnancy (Figure 4). The proportion of LBW infants born to smokers was less among Medicaid recipients (9.1%) than non-Medicaid recipients (11.5%).



INFANT PRETERM DELIVERY BY MATERNAL SMOKING AND MEDICAID STATUS

Pre-term delivery (PTD) is defined as an infant born prior to 37 week gestation. Pre-term delivery is calculated from the date of the mother's last menstrual period and the infant's date of birth. Overall, 12.5% (n= of infants) were born prior to 37 weeks gestation in 2008.

Regardless of Medicaid status, women who smoked during pregnancy delivered preterm infants at a greater proportion than women who did not smoke during pregnancy (Figure 5). The proportion of PTD infants born to smokers was lower among Medicaid recipients (13.2%) than Medicaid recipients (15.9%).



DISCUSSION

Regardless of Medicaid status, many women quit smoking during their pregnancies. However, Medicaid recipients smoked at a much greater rate than non-Medicaid recipients both prior to pregnancy and during pregnancy.

Maternal smoking differed by age and race. Regardless of Medicaid status, smokers were predominantly non-Hispanic whites. Medicaid recipients who smoked tended to be younger (early to late 20's) compared to non-Medicaid recipients (late 20's to age 30).

Both infant low birth weight and preterm delivery were more likely to occur among women who smoked during pregnancy, regardless of Medicaid status.

RECOMMENDATIONS/ RESOURCES

Ideally women would quit smoking prior to becoming pregnant and remain smoke-free after the baby's birth.

Pre-conception counseling, including the creation of a reproductive life plan, can be instrumental in both screening women for smoking and in promoting smoking cessation prior to pregnancy.

Comprehensive Medicaid coverage for smoking cessation has been linked to higher quit rates. Iowa Medicaid provides reimbursement for smoking cessation medications for pregnant women. However, it appears that few pregnant Medicaid recipients are using of this benefit. It is not clear why. Perhaps recipients and providers are unaware of the benefit.

The IDPH would like to acknowledge the Maternal and Child Health Epidemiology Program, Applied Sciences Branch, Division of Reproductive Health, National Center for Chronic Disease Prevention and Public Health Promotion, Centers for Disease Control and Prevention for analytic support and preparation of this fact sheet.

Regardless of Medicaid status, by reducing the number of women who smoke during pregnancy, Iowa may see a reduction in the number of infants born with LBW and those born early.

What is the Iowa Medicaid - Birth Certificate Match Project?

The Iowa Medicaid Birth Certificate match project is supported by an inter-departmental agreement between the State of Iowa Department of Human Services and the Iowa Department of Public Health. The purpose of this project and report is to describe the characteristics of pregnant Medicaid recipients, their receipt of pregnancy related services, and their birth outcomes relative to women whose deliveries were not reimbursed by Medicaid. The data file to complete this report was created by linking calendar year birth certificates to relevant Medicaid claims data.

ADDITIONAL INFORMATION

For additional information or to obtain copies of this fact sheet, write or call the Iowa Department of Public Health, Bureau of Family Health, 321 E. 12th Street, Des Moines, IA 50309;
1-800-383-3826

