Iowa Department of Public Health and the University of Iowa
Division of Child and Community Health

2016 Title V Needs Assessment: Executive Summary

May 2015

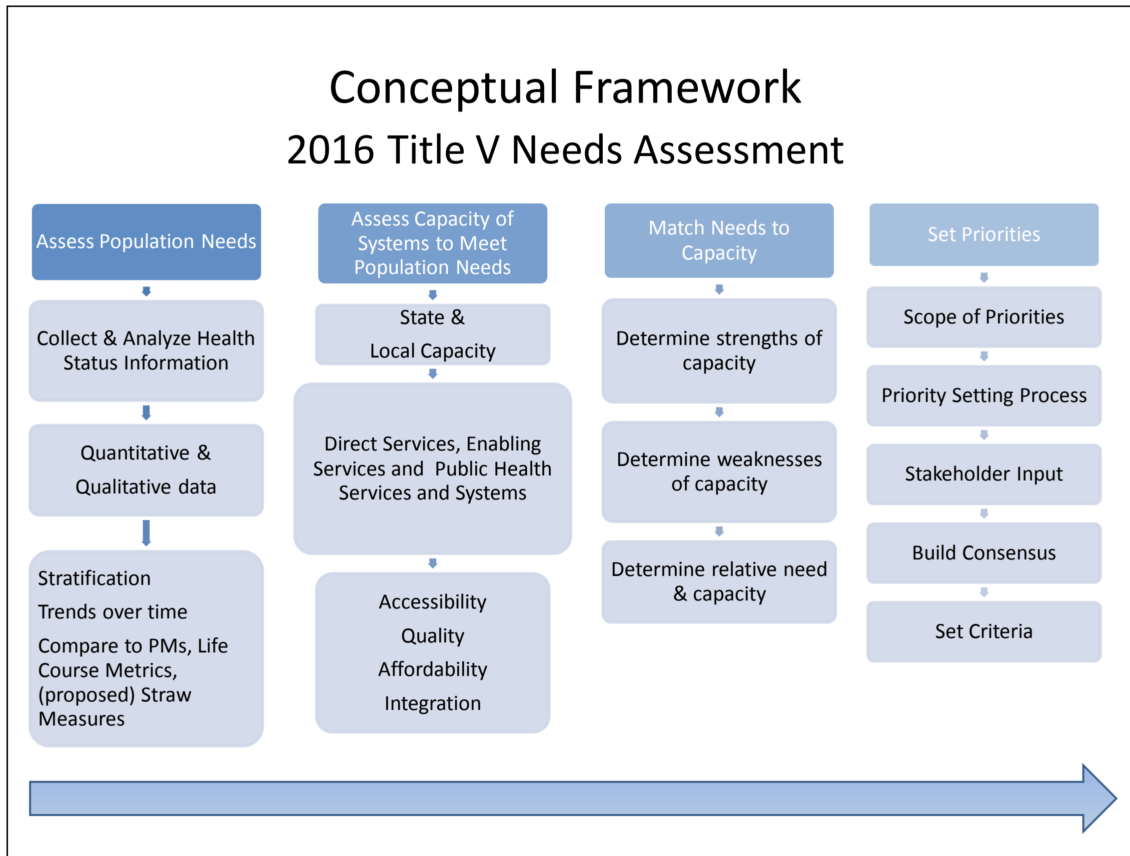
Introduction

Since early 2014, the Iowa Department of Public Health's (IDPH) Bureau of Family Health (BFH) and the Oral Health Center (OHC), along with partners at the University of Iowa Division of Child and Community Health (UI-DCCH) collaborated to conduct the five-year Needs Assessment (NA) for the FFY2016 Title V Maternal and Child Health Block Grant. The full results of the NA can be found at www.idph.state.ia.us/TitleVNeedsAssessment/.

Process

Goals, Framework, Methodology

A conceptual framework was developed to guide analytic efforts. The framework was developed based on a literature review of methodologies from past Title V NA reviews, Iowa's previous NA process, comments from federal reviewers on previous NAs, and Appendix D of the [*DRAFT*] guidance provided by the Maternal and Child Health Bureau (MCHB) at Health Resources and Services Administration (HRSA).



With the immense number of factors that may affect health outcomes for the MCH populations, the Leadership Team (LT) elected to use the question '*What defines a healthy MCH/CYSHCN population?'* and the resource "Developing Structure and Process Standards for Systems of Care Serving Children and Youth with Special Health Care Needs" developed by the Association of Maternal and Child Health Programs (AMCHP) and the Lucile Packard Foundation for Children's Health as guideposts.

From this, the LT generated a list of topic areas to explore more deeply. Topic areas were converted to Data Detail Sheets (DDS) that were then used to generate 24 need statements. Full versions of the DDS can be found at www.idph.state.ia.us/titleVneedsassessment/.

Stakeholder Involvement

Input from focus groups and key informant interviews guided the development of the DDS and need statements. Input from families served, UI-DCCH staff, external subject matter experts (ESME), and the Discovery Survey informed the prioritization survey areas and the selection of Iowa's NPM and state priority areas (SPA). A broad list of stakeholders was invited to participate in the prioritization survey.

Quantitative and Qualitative Methods

To ensure a wide range of information was included in the DDS, potential indicators were developed for each topic. Data from multiple sources, including national surveys, state-level data, and internal data sources were used. Disparities related to geography, race/ethnicity, and income level, etc., were identified, along with comparisons between Iowa's status versus national averages and comparisons to national and state benchmarks.

Stakeholders prioritized the needs statements using an online survey. Respondents ranked each need statement based on six equally-weighted criteria: *Number of individuals affected, Economic impact, Degree of demographic disparity, Severity of issue, Family impact, and Systems change*.

The results of the prioritization survey were examined based on the six criteria for all stakeholders and four additional criteria for the LT, which were selected to reflect the team's knowledge of MCH issues. The four criteria were *Motivation to change, Issue can be tracked and measured, Effective intervention is available,* and *Organizational capacity*. The results of the main and leadership criteria were averaged to examine how the application of the leadership criteria affected the final ranking of the need statements.

Prioritization survey results were grouped to compare responses between different stakeholder groups. These groupings allowed the LT to examine different groups' perception of the need statements and visualize common priorities.

	Main Criteria						Leadership Criteria				Averages		
	Number Affected	Economics	Disparity	Severity	Family Impact	Systems	Motivation to Change	Trackable	Intervention Available	Org Capacity	Main Criteria Avg	Leadership Crit	All
2: Access to Specialists for MCH	4.0	4.0	4.0	4.2	4.0	3.9	4.0	3.5	2.3	2.2	4.0	3.0	3.6
10: Transportation Resources	3.8	3.8	4.2	4.0	4.2	4.0	3.3	3.7	3.1	2.5	4.0	3.2	3.7
24: Transition to Adulthood Planning for CYHSCN	3.6	4.2	3.7	4.0	4.2	4.1	3.9	3.4	3.9	2.7	4.0	3.5	3.8
6: Adolescent Health Systems Coordination	4.0	4.0	3.9	4.0	3.9	3.9	3.9	2.2	2.7	3.0	3.9	2.9	3.5
12: Developmental Screenings	3.7	4.1	3.8	4.0	3.9	3.9	4.1	3.5	4.2	3.5	3.9	3.8	3.9
15: Maternal Mental Health System	3.6	3.8	3.7	4.1	4.3	3.8	4.2	3.2	3.5	2.9	3.9	3.5	3.7
8: Access to Child Care	3.8	3.8	3.9	3.8	4.2	3.8	3.0	2.9	2.6	2.1	3.9	2.7	3.4
19: Care Coordination for CYSHCN	3.4	3.9	3.7	3.9	4.2	3.9	4.3	3.7	4.0	3.6	3.8	3.9	3.9
20: Data Coordination for CYSHCN	4.1	4.1	3.2	3.9	3.4	4.1	4.4	3.0	2.9	2.5	3.8	3.2	3.6
22: Integration of Services for CYHSCN	3.5	3.9	3.7	3.8	4.0	3.9	4.4	3.5	3.5	3.5	3.8	3.7	3.8
1: Insurance Literacy for MCH	3.5	3.9	3.8	4.0	3.8	3.7	3.6	2.6	2.6	3.3	3.8	3.0	3.5
23: CYHSCN Value-Based Financing	3.8	4.2	3.5	3.7	3.7	3.8	3.4	2.5	2.9	2.4	3.8	2.8	3.4
3: Dental Delivery Strategies for MCH	3.8	3.7	3.9	3.8	3.5	3.7	3.6	3.4	3.3	2.8	3.7	3.2	3.5
21: Family Involvement in CYSHCN Decisions	3.8	3.4	3.6	3.6	3.8	3.7	3.4	2.9	4.1	3.3	3.7	3.4	3.6
11: Medical Home for Children & CYSHCN	3.3	3.8	3.8	3.7	3.7	3.5	4.3	4.0	3.9	3.4	3.6	3.9	3.8
7: Bullying Prevention System	3.8	3.0	3.2	3.9	3.9	3.6	3.9	2.1	2.4	2.5	3.6	2.7	3.2
17: Reproductive Health System	3.3	3.7	3.6	3.4	3.6	3.4	3.0	2.9	3.1	2.8	3.5	2.9	3.3
14: Chronic Disease Prevention for Women	3.3	3.4	3.5	3.4	3.4	3.4	3.0	2.3	2.3	2.2	3.4	2.5	3.0
13: Medical Home - Pregnant & PP Women	3.0	3.5	3.5	3.4	3.3	3.4	3.7	3.5	3.0	2.6	3.3	3.2	3.3
16: Prenatal Care System	3.0	3.5	3.6	3.4	3.3	3.3	3.3	3.1	3.0	3.0	3.3	3.1	3.2
4: Breastfeeding Support	3.3	3.3	3.4	3.4	2.8	3.2	3.3	3.6	3.0	2.7	3.2	3.1	3.2
9: Injury/Environmental Risk Prevention	2.7	3.3	3.1	3.0	3.1	3.0	2.7	4.1	2.9	1.9	3.0	2.9	3.0
5: Safe Sleep Resources	2.7	2.5	3.3	3.0	2.7	2.8	3.5	2.8	3.9	3.3	2.8	3.4	3.0
18: Maternal Occupational Risks	2.4	2.8	2.9	2.7	2.8	2.7	2.1	1.7	3.0	1.6	2.7	2.1	2.5

IDPH and UI-DCCH gathered qualitative data using methods specific to their target population. IDPH conducted focus groups with clients of child health (CH) and maternal health (MH) agencies. Thirty-nine clients from eight agencies participated in focus groups or semi-structured interviews. Participants were primarily English-speaking mothers, though Latina and Burmese women, fathers, and grandparents also participated. IDPH also gathered qualitative input through conversations with ESMEs who informed the DDS and need statements. UI-DCCH hired an independent consultant to guide the NA process for CYSHCN and facilitate key informant interviews and focus groups. UI-DCCH focus groups included families of CYSHCN and community providers in rural and small urban communities. To gather information on needs specific to CYSHCN in each community, UI-DCCH conducted: interviews with key informants from various organizations serving CYSHCN and regional center staff; and a web-based survey of health care providers.

Data Sources

Data from national surveys, such as the National Survey of Children's Health, the National Survey of CSHCN, and state-level data, including the 2010 Iowa Household Health Survey (IHHS) and the Behavioral Risk Factor Surveillance System, as well as internal data sources such as Iowa's Vital Records, the Barriers to Prenatal Care Survey, and the state's MCH data systems, were reviewed.

Finalization of Needs and Development of Action Plan

The LT reviewed the results of the prioritization survey and identified top priority needs for Iowa. The team then selected 8 of 15 MCHB defined NPMs. The LT also established five SPA for which State Performance Measures (SPM) will be developed over the next year. The priority needs will be addressed

in Iowa's state action plan. Work groups will examine current evidence-based and evidence-informed strategies to address the state selected priorities and develop SPM for the SPA.

MCH Population Findings

Maternal Health (MH)

While many Iowa women report receiving routine medical and dental care, disparities remain. Women in households earning over $75,000 are more likely to have had a dental visit and a routine medical visit in the previous year. Minority women are more likely to be obese, and alcohol and tobacco use is higher in non-Hispanic White (NHW) women than for minority women. Additionally, Iowa is the most inclusive state in terms of Medicaid income eligibility for pregnant women and infants. However, undocumented women rely on Emergency Medicaid for Non-Qualified Immigrants for delivery when their presumptive eligibility (PE) expires. Access to all types of care is a challenge to the overall health of Iowa women. Lack of specialty providers and low reimbursement rates from public insurance are often cited as drivers of lack of access, along with transportation issues.

The full report on Iowa's NA examined the strengths and needs of MH. Iowa's priorities for MH include: *access to health care, preventive visits, insurance coverage* and *physical activity.*

Access to Health Care

In 2010-2011, 92 of Iowa's 99 counties listed Access to Health Care as a priority need. The most commonly cited challenges were lack of transportation, lack of insurance/underinsurance, economic barriers, and lack of dental providers. Iowa has the fifth lowest number of OB/GYNs per woman of reproductive age in the US (4.18 per 10,000 in IA, versus the US average of 5.39). Only 33 of Iowa's 79 hospitals offering maternity care are located in rural counties and all Level II and III hospitals are in metropolitan counties. Most Iowa women ages 18-64 report having a personal care provider (88.3%); however, 32% of minority women do not, higher than the US average of 25%. Since 2008, the percent of women who received prenatal care in their first trimester has increased almost 10% and surpassed the Healthy People 2020 (HP2020) goal. In 2012, 84% of women entered prenatal care during the first trimester, an increase from 76% in 2008. Women living in households with incomes up to 375% FPL are eligible for Medicaid assistance while pregnant and for 60 days postpartum.

It is estimated that under half of women meeting the criteria for clinical depression receive treatment. In 2013, 24% of women of reproductive age reported ever having been diagnosed with depression. Depression was more common among NHW women (24.8%) than minority women (18.8%). Accessing mental health services continues to be a problem in Iowa, with 70% of counties containing at least one mental health provider shortage area. Iowa is 46th in psychiatrists per capita for the US.

Preventive visits

Women with limited financial resources are less likely to have routine medical and dental visits than women in higher earning households. In 2013, 70% of women age 18-44 yrs reported seeing a doctor in the past 12 months for a routine check-up. NHW women were more likely than non-White or Hispanic women to have had a routine visit (73.4% vs. 69.7%). Women with a higher household income were more likely to have had a routine visit. In 2012, 78% of women reported having a Pap smear within the last three years. In the 2013, less than half (44%) of women of 18-44 yrs reported receiving a flu vaccine in the last 12 months; however, 60% of postpartum women did.

Since 2008, the number of *intended* pregnancies in Iowa has been increasing, surpassing the HP2020 target of 56%. Over two-thirds of women not desiring pregnancy reported that they were not using birth control at the time of conception; this number has decreased slightly from 67% in 2007-08 to 66% in 2013. In 2013, one-third of births had an interpregnancy interval of less than 18 months. For Medicaid births, 67% had an interpregnancy interval of 19 months or more and 9.5% were less than 6 months. Women under 24 yrs had shorter interpregnancy intervals, as did African American (AA) women.

While the number of women ages 15-44 who are currently smoking has declined, it is still 20%. Almost 25% of women of reproductive age report binge drinking in the previous month. This is worrisome, especially when one-third of pregnancies are unintended.

Insurance Coverage

See Cross-Cutting section

Physical Activity

In 2013, 84.3% of women of reproductive age reported eating **less** than the recommended servings of fruits and vegetables per day. In 2013, 58% of Iowa women age 18-44 yrs met the recommended levels of physical activity. White women were more likely to reach recommended levels, as were women with increasing household incomes. In 2012, 12.7% of all people in Iowa were food insecure. Of these, 40% were living above the 185% FPL threshold for all nutrition supplementation programs. Participants in the 2014 Title V Focus Groups reported despite accessing WIC and SNAP, that it was still difficult to eat healthily.

In 2013, 2.6% of women of reproductive age reported ever having been diagnosed with diabetes, with little difference by race/ethnicity. However, 6% of women in households earning less than $15,000 reported having been diagnosed with Type II diabetes, compared to less than 1% of women in households earning more than $75,000. In 2013, 9.2% of women ages 18-44 yrs reported ever having been diagnosed with high blood pressure and 52% of women experience excessive gestational weight gain. Excessive weight gain is more common among overweight and obese women.

Programmatic Approaches

Efforts to be Continued

- Iowa's Title V **Maternal Health Program** serves over 9,000 women annually. Services are provided by 21 community-based MH agencies covering all 99 Iowa counties.
- The **IDPH-Medicaid working relationship** supports the federal mandate for collaboration between Title V and Title XIX. Quarterly meetings of the Medicaid MH Task Force promotes quality improvement practice and policy change.
- The **OB Statewide Task Force** focuses on: reducing preterm births by reducing early elective deliveries and increasing use of 17P, screening for critical congenital heart disease, reducing maternal adverse events, and improving access.
- The **Regionalized System of Perinatal Care**, as defined in Iowa Code, identifies the functional capacity and staff capabilities of Iowa birthing hospitals to provide care to at risk pregnant women and infants.
- The **Iowa Family Planning Network** helps to reduce unintended pregnancies by improving access to family planning services. Title V MH agencies include education on IFPN to all clients.

Areas of Opportunity for New Activities

- Expand **Listening Visits** as an intervention for postpartum depression to address difficulty in accessing mental health services.
- Improve **outreach efforts to vulnerable populations**.
- Improve **postpartum care** uptake and content for Iowa women, specifically visit rates and use of LARCs.
- Amend the Iowa Administrative Rules to restructure the level of care definitions to align with the American Academy of Pediatrics (AAP) 2012 article "**Levels of Neonatal Care.**"

Infant Health (IH)

Iowa newborns generally have a healthy birth weight, however, AA women are more likely to give birth to low birth weight babies than other races (10.9% vs. 6.6% overall). Iowa had a preterm birth rate of 11.1% in 2013 (US average 11.4%). Iowa has a low infant mortality rate, with 4.2 deaths per 1,000 live births overall, lower than the US average of 6 per 1,000. However, Iowa's AA infant mortality rate is three times higher than the NWH rate (11.7 per 1,000 live births vs. 3.7) in 2013. In 2012, 82% of very low birth weight infants were delivered in a Level III hospital. Over 32.1% of Iowa infants are breastfed at 1 year, more than the US average of 27%, though Iowa is still below the HP 2020 objective. Iowa also has developed programs to address Shaken Baby Syndrome and is increasing efforts to increase the number of infants who sleep in a safe sleep environment.

The full IA NA examined the strengths and needs of IH. Iowa's priorities for IH include: *breastfeeding and quality child care.*

Breastfeeding

In 2013, Iowa women initiated breastfeeding at the same rate as the US average, 76.5%. On all measures relating to breastfeeding, Iowa still fails to meet the HP 2020 objectives. 78% of women reported that they had discussed breastfeeding techniques with a healthcare professional and 83% of women reported that they were encouraged to breastfeed in the first 24 hours. However, a higher percentage of NHW and Hispanic mothers are receiving support from healthcare professionals for breastfeeding than AA women. Iowa's hospitals' efforts are not as supportive of breastfeeding as other states. In 2011, only 10.1% of the hospitals had >90% of infants rooming-in, compared to the US average of 37.0%. Almost 48% of Iowa's hospitals have 90% of babies practicing skin-to-skin, as opposed to the US average of 54.4%. Iowa's Maternity Practices in Infant Nutrition and Care score was 69/100, ranking Iowa 45th out of 53 participating states and territories.

Quality Child Care

See Child Health section

Safe Sleep

The incidence of sleep-related deaths has not changed over the last five years. From 2006-11, there were 158 deaths due to SIDS. For sleep-related deaths, in 42% of the deaths, the infant was in an unsafe sleep environment. In 2013, 53% of women reported that they had discussed sleep positions with a healthcare professional, and 45% reported that they had discussed the dangers of shaking an infant. Iowa does not have data on the percentage of infants placed on their back to sleep.

Programmatic Approaches

Efforts to be Continued

- Iowa has four hospitals working towards **Baby Friendly Hospital Certification** and one certified.
- In January 2013, Iowa Medicaid **expanded the availability of 17P** to more women with high risk pregnancies.
- **Update the perinatal regionalization** definitions to match national guidance.
- Participation in the **COIIN to reduce infant mortality**, focusing on SIDS/SUID/safe sleep, preconception/inter-conception health, and prevention of preterm and early term births.
- The **Child Death Review Team** reviews each child death to help find patterns in risk factors for childhood deaths in Iowa and to provide prevention education.

Areas of Opportunity for New Activities

- As Iowa has not met the HP 2020 objective for **breastfeeding initiation and continuation**, the Title program will promote breastfeeding support post-hospital discharge and provide education at MH agencies.
- Iowa has started a **safe sleep pilot** to increase the number of infants with a safe sleep environment through a partnership with the National Cribs for Kids program in four Iowa counties with the highest SIDS death rates.

Child Health (CH)

Overall, Iowa children are in good health. The vast majority of children (97%) are medically insured. Dental coverage for children has increased since 2005, and young children are engaged in physical activity on a daily basis. In 2012, about 14% of children age 0-19 yrs experienced an unintentional injury resulting in either in-patient or out-patient care at an Iowa hospital, down from 19% in 2010. In 2011, there were 342 deaths involving Iowa children ages 17 yrs and younger. Disparities persist for children of low-income and minority families. This is evident in developmental delays, where almost 13% of AA children have a developmental delay compared to 3% of NHW children. Lower-income children are more likely to be overweight or obese than higher income children. Accessing all types of care remains a concern.

The full IA NA examined the strengths and needs of CH. Iowa's priorities for CH include: *access to health care, developmental screenings, nutrition and healthy weight,* and *quality child care.*

Access to Health Care

Out of Iowa's 99 counties, 79 have a designated health professional shortage area (HPSA) for primary medical care, 74 a dental HPSA and 95 a mental health HPSA. Access to health and dental care is a multifaceted issue for Iowa's families. In the 2014 Title V MCH focus groups, parents reported lack of transportation, finding a provider, and ability to schedule visits as primary barriers to receiving health care for their children. Iowa has 8 general practice pediatricians per 100,000 people, located primarily in 30 counties. Despite the low number of children's pediatricians and pediatric dentists, 71% of Iowa children ages 1-17 yrs received both routine medical and dental care visits in the year prior. Hispanic children and children in low-income families were less likely to have received *both* preventive medical and dental visits.

Children in lower income groups were less likely to meet the definition of having a medical home; 68% of children living below 133% FPL had a medical home, compared to 75% of those between 134-199% FPL, and 84% of those over 200% FPL. In 2010, of all children, 29% needed a referral to see other doctors or receive other services. Of those who needed referrals, 86% were able to receive them without a problem. Families between 100- 133% FPL had the most trouble receiving a referral, with 26% reporting a problem receiving referrals.

Transportation was repeatedly identified as a barrier to accessing health and dental care in the 2014 Title V focus group discussions. From 2008-13, over 11,000 transportation services and over 1,800 interpretation services were provided to Title V clients without special health care needs.

Developmental Screenings

Minority children are disproportionately reported to be at moderate to high risk for developmental, behavioral, or social delays, as are children in households earning less than $20,000 annually. Based on parent report, almost 50% of AA and 63% of Hispanic children are at moderate to high risk, compared to 19% of NHW children. Compared to the US, Iowa's minority families have more concerns regarding their children's physical, behavioral, or social development (83% IA vs. 45% US). Iowa parents in lower-income brackets were also more concerned about their children's development compared to lower-income parents nationwide.

In 2013, Iowa had only 43 psychiatrists seeing children, most of whom were located in three urban centers with many not accepting children <14 yrs. In 2012, Iowa ranked 42nd in the nation for child and

adolescent psychiatrists. Among children and youth who needed behavioral or emotional care, approximately 15% could *not* get the needed care in the previous 12 months.

Nutrition and Healthy Weight

In 2012, almost 14% of Iowa 10-17 year olds were obese (US 16%), and another 15% were overweight (US 16%). Almost 50% of Iowa Hispanic children 10-17 yrs were either overweight or obese compared to 25% of AA children and 26% of NHW children.

In 2012, Iowa children ages 6-11 yrs were more likely to get 20 minutes of strenuous physical activity *everyday* than those aged 12-17 yrs. In the 2010 IHHS, approximately 80% of families reported that their neighborhoods have sidewalks or walking paths. In 2010, 70% of all Iowa children ate 2 or more servings of fruit per day, and 22% ate 3 or more servings of vegetables per day. However, 61% of children 12-17 yrs met recommendations for fruit consumption, but only 19% met recommendations for vegetables.

Quality Child Care

In 2013, almost 77% of Iowa families with children <6 yrs were households where all parents living in the household were active in the workforce. Since 2008, the number of known child care slots has been decreasing. There are approximately 1,300 licensed centers in Iowa and over 3,500 registered in-home care providers. There are almost 3,000 non-registered home care providers participating in some type of state sponsored program. Challenges to providing quality child care in Iowa are variable numbers of providers and locations are unevenly distributed across the state. Iowa has historically had a difficult time tracking the number of slots available and in various facilities. Of the licensed programs in Iowa, 50% have participated in a Quality Rating System (QRS). For registered in-home care, 14% are participating in QRS.

Programmatic Approaches

Efforts to be Continued

- Iowa's Title V **Child Health Program** serves nearly 200,000 children annually. Services are provided by 22 community-based CH agencies covering all of Iowa's 99 counties.
- **Informing and care coordination** services provided through local agencies to help families understand and utilize these benefits to promote health and prevent chronic disease.
- The **Healthy Child Care Iowa** campaign promotes safe and healthy child care environments.
- Expand the use of **Child Care Nurse Consultants** across the state through the local MCH agencies.
- ***hawk-i*** (Iowa's SCHIP) outreach ensures children have access to healthcare coverage.
- **Developmental screening** efforts, including Early ACCESS and 1st Five in local MCH agencies, provide early identification of developmental concerns and ensure appropriate referrals.

Areas of Opportunity for new activities

- Collaborate with ACOs and private practice providers on **care coordination**, including promoting the experience and expertise of local Title V CH agencies on addressing population health outcomes.
- Expand **1st Five** to statewide capacity to promote healthy mental development for Iowa children.
- Develop partnerships to attain recommended levels of **physical activity** to improve attainment of healthy weight and potential reduction in chronic diseases.

Adolescent Health (AH)

Iowa's overall teen pregnancy rate has declined by nearly 50% since its peak in 1991. This decline is seen in all racial and ethnic groups; however, racial disparities still exist between young women who are NHW and those that are AA or Hispanic. Iowa adolescents receive well visits at a high rate relative to the national average, with 84.5% of all Iowa adolescents reporting having a preventive medical visit in the last year. However, Iowa still needs to improve the quality of the well visits and address disparities among youth covered by Medicaid. Iowa adolescents have critical mental health needs that are not always addressed, and access to mental health professionals is difficult throughout Iowa. The occurrence of bullying is lower in older students, and students are finding ways to address bullying by building stronger social connections with each other. However, too many students still report being bullied and feeling depressed.

The full report on Iowa's NA examined the strengths and needs of AH in Iowa. Iowa's priorities for AH include: *bullying prevention* and *preventive visits.*

Bullying Prevention

Bullying rates are higher than the national average. There were laws enacted to reduce bullying, but there is a lack of enforcement of the legislation. From 2009-2013, 139 adolescents died from suicide, the second leading cause of death for that age group. Bullying is increasingly recognized as a source of harm to an adolescent's mental health and wellbeing. The percent of adolescents who are bullied has remained level at nearly 57% from 2008-12. Bullying is more prevalent in younger grades, mirroring findings from adolescent focus groups of high school students who reported bullying was less of a concern, than when they were younger. Both genders report being bullied electronically (26.4% for females and 23.5% for males); males report higher rates of in-person bullying (18.6% vs. 10.2% for females).

Among Iowa's high school students, 22.8% reported that they had felt sad or hopeless almost every day for two weeks, and 14.6% had seriously considered attempting suicide in the last year. Access to mental health care is a challenge for adolescents, especially in rural areas. As stated above, Iowa has a shortage of mental health providers, and those that are practicing may not see patients younger than 14.

In 2011, 6.9% of teens reported that they were physically forced to have sexual intercourse, 24.4% reported that they had been in a physical fight in the last 30 days, and 6.3% had been threatened or injured with a weapon on school property.

Preventive Visits

In 2012, 84.5% of adolescents 12-17 yrs reported receiving a preventive medical care visit in the last year (US average - 81.7%). In FFY13, only 72% of Medicaid-enrolled adolescents 12-17 yrs received their well-child visit, below the federal mandate of 80%. In 2013, 41.9% of Iowa females 13-17 yrs, and 13.7% of Iowa males 13-17 yrs had received a complete series of the HPV vaccine, similar to the national average. The Tdap vaccine was received by 79.6% of Iowa adolescents and 63.7% received the Meningococcal vaccine. Both rates are below the national average. Iowa high school students are more physically active than the national average, with 91.0% reporting at least 60 minutes of physical activity on one or more days in the last week compared to 86.2% of the as a whole. Alcohol is the most commonly used substance among Iowa's 6th, 8th and 11th grade students with 23% reporting having used alcohol, and 13% reporting having used alcohol in the last 30 days. Of all 11th grade students, 48% reported having ever used alcohol.

In 2011, 56.1% of 9th-12th graders reported that they had never had sexual intercourse, and 67.0% were not currently sexually active. Most (93.3%) of adolescents who were sexually active reported that they used at least one method to prevent pregnancy during their last sexual intercourse, with 61.4% reporting that they used a condom. Teen pregnancy is declining in Iowa, falling to 22.1 births per 1,000 young women 15-19 yrs (US average is 29.4 per 1,000) in 2012. The 2012 rate was 19.8 per 1,000 young women who were NHW, and 51.4 for AA women and 57.9 for Hispanic women. The teen pregnancy rate is also higher in rural counties than in urban ones. In 2013, there were 7,560 cases of chlamydia diagnosed among Iowans 15-24 yrs, making up over two-thirds of all cases in Iowa. For Iowans 15-24 yrs, there were 808 cases of gonorrhea, about 55% of all cases.

Programmatic Approaches

Efforts to be Continued

- **Care coordination** services through local CH agencies to help adolescents and their families understand and utilize Title V and Medicaid benefits to promote health and prevent chronic disease.
- The **Adolescent Health Collaborative (AHC)** is an intra-agency collaborative, consisting of programs and services offered to Iowa's youth. These programs include: tobacco use prevention; HIV, STI, and hepatitis prevention and awareness; substance abuse prevention and surveillance; pregnancy prevention; immunization promotion and provision; as well as programs to address adolescent health needs among minority and multicultural populations.
- Iowa's **Personal Responsibility Education Program (PREP)** is an adolescent development initiative that provides comprehensive sexuality education to assist youth in reducing their risk of unintended pregnancy, HIV/AIDS, and other STIs while addressing life skills to prepare youth for a successful adulthood.
- The **Abstinence Education Grant Program (AEGP)** supports decisions to abstain from sexual activity by providing abstinence education, along with mentoring, counseling and adult supervision.
- The **Youth Suicide Prevention Program** includes specific steps to reduce suicides, suicidal behaviors, and suicide risk among youth and young adults aged 10-24 by implementing evidence-based screening at substance abuse treatment programs, implementing an evidence-based gatekeeper training program for middle and high school educators in all middle/junior high and high schools, and reaching youth using social media.
- The **Strategic Prevention Framework of Iowa** develops plans for prevention infrastructure and supporting selected local communities in implementing effective programs, policies and practices to reduce substance abuse and its related problems.
- **Iowa Adolescents Making Choices to Control Their Future** (www.IAMincontrol.org) includes personal stories, information and resources on topics ranging from fitness and nutrition to bullying and suicide.

Areas of Opportunity for new activities

- A **Well-visit Promotion and Education program** which could develop and distribute new resources targeting providers and parents.
- **Positive Youth Development** promotes positive outcomes for young people that are important to Iowa, such as teen pregnancy risk reduction and increased graduation rates.
- **Systems building activities for the AHC** will be focused on continued involvement and raising awareness with new partners to address adolescent health issues at the local and state levels.
- **Mental health programs targeted at adolescents** need to be developed for Title V funded agencies, including engaging Title V agencies in local bullying prevention efforts.

Children and Youth with Special Health Care Needs (CYSHCN)

The most common conditions among Iowa CYSHCN are: Attention Deficit Hyperactivity Disorder (40%), Asthma (35%), Anxiety, (22%), Depression (19%), Behavioral/Conduct Issues (17%), Autism Spectrum Disorder (10%), Brain Injury (7%) and Intellectual Disability (6%). CYSCHN and their families typically receive services and supports from multiple systems, providers, and community based agencies: health care; public health; education; mental health; juvenile justice; and social services. Many CYSHCN require extra coordination among fragmented medical and mental health care systems and outside entities such as schools or social service agencies. Navigating these complex and fragmented systems of care can be difficult for families, and socioeconomic factors such as poverty and lack of insurance may exacerbate difficulties.

The full report on Iowa's NA examined the strengths and needs of CYSHCN using the Lucile Packard Standards' Overall Systems Outcomes for CYSHCN. Iowa's top three priority needs of CYSHCN are *care coordination through a medical/health home, transition to adulthood and integration of services*.

Medical/Health Home

The 2009/10 National Survey of CSHCN (NS-CSHCN 09/10) reports 47% of Iowa's CYSHCN received all necessary components of care through a medical home. Because CYSHCN need services and supports from multiple sources, they would benefit from receiving care through a medical/health home approach that provides holistic, coordinated and comprehensive care. Iowa selected Medical Home as a NPM and will focus its efforts on increasing the percent of CYSHCN that receive care through a medical/health home approach.

To advance the availability of medical/health homes to CYSHCN, UI-DCCH intends to expand to the model of the Pediatric Integrated Health (PIH) model for children covered by Medicaid that are diagnosed with a Serious Emotional Disturbance (SED). PIH program services are delivered by a team of providers and community resources and include care coordination, family to family support, health and wellness education, resource direction, and transitional care support. Providers receive support to deliver a wraparound System of Care approach that addresses multiple needs, such as physical health, mental health, education, recreation, and social services.

Expanding the PIH model beyond children with a SED and receiving Medicaid would address a significant need to increase primary care providers' knowledge of community resources for CYSHCN and how to refer CYSHCN to needed resources and services. Also, Iowa families of CYSHCN would benefit from an increased number of qualified care coordinators collaborating with primary care medical practices, specialty clinics, and other organizations serving large numbers of CYSHCN and their families.

Transition to Adulthood

Only 45% of Iowa YSHC) received all needed transition services as specified by the NS-CSHCN 09/10. The rates are lower for racial/ ethnic minority groups and for YSHCN who are uninsured, do not have a medical home, or have specific diagnoses. A focus group of community providers noted that YSHCN would benefit from a range of supportive housing options and vocational resources, especially in rural areas. Specialized support groups and other resources would help YSHCN acquire skills needed for independent living.

Iowa selected Transition to Adulthood as a NPM to monitor the state's progress in increasing transition services for YSHCN over the next five years. This priority will address the increasing prevalence of special

health care needs in older children and related service disparities. Of Iowa's total child population, 8.5% of children 0-5 yrs have a SHCN, compared to 17.2% for those 6-11 yrs and 19.0% of those 12-17 yrs. Although Iowa has many programs to support the healthy development of young children, this support drops off as children enter middle childhood and adolescence, which has the potential to reverse the positive effects of support received earlier in life.

<u>Integration of Services</u>
Iowa's NA identified a significant need for an integrated system of care for CYSHCN. One of Iowa's SPM will focus on the Triple Aim for the System of Care for CYSHCN, and the integration of services and supports for CYSHCN will be a key component of this measure. The Triple Aim includes enhancing the patient experience, improving population health and controlling the per capita cost of health care. For families of CYSHCN, easing the burden of obtaining needed services and providing family to family support are key elements of improving the patient experience.

Service integration will include efforts to improve cultural competency to address racial disparities in the prevalence of CYSHCN. Twenty-one percent of African American and 20.8% of children from other minority groups are identified as having a SHCN, while only 14.7% of NHW children and 10.2% of Hispanic children have a SHCN.

UI-DCCH's MCH Title V efforts will be blended with Iowa's HRSA funded Systems Integration Grant (SIG). The SIG uses the Triple Aim as its guide to develop a systematic approach to synergize the many activities of multiple partners, facilitate cross-system collaboration, and reduce "silos." The outcomes of the SIG will be a revised state plan to improve coordination among programs in the medical, education, and social service systems for CYSHCN and their families. At the family level, providers will be able to easily communicate with the family and community-based organizations, to help ease the burden on families and reduce gaps in service and duplication of services. UI-DCCH will use MCH Title V funds to sustain evidence based activities.

Programmatic Approaches

Efforts to be Continued

- Spread the use of **transition tools**.
- Utilize **telehealth** to improve access to families of CYSHCN.
- Provide **family to family support and care coordination** through Community Child Health Teams.
- Assure **families are involved at all levels of decision making** by including family members on advisory committees and MCH Title V Block Grant review teams.

Areas of Opportunity for new activities

- Expand the **PIH model** beyond children covered by Medicaid that are diagnosed with a SED.
- Collaborate with **SIG Implementation Resource Teams**.
- Develop **new partnerships with faith-based and community-based programs** to reach additional underserved and minority populations.
- Maximize opportunities to work with new **Medicaid Managed Care Organizations** to enhance their program of services for CYSHCN.
- Partner with SIG to post resources, tools, and training on SIG web portal.

Cross-cutting Findings

Oral health, insurance coverage, and tobacco use all have cross-cutting effects for the MCH population. Iowa's Medicaid program provides comprehensive care for adults, yet dentists may choose not to participate in Medicaid or limit the number of Medicaid enrollees in their practice. Dental visits for children enrolled in Medicaid have been on the rise since 2005. Most Iowa women have health insurance at rates higher than the US average, and Iowa has the highest income eligibility for pregnant women to enroll in Medicaid. The vast majority of children are medically insured, and dental coverage for children has increased since 2005. Despite the majority of CYSHCN having insurance coverage, over one-third of families report that their coverage does not meet their needs. While the number of women who are currently smoking has declined, it is still about 20% for women 18-44 yrs. NHW women are more likely to smoke cigarettes in Iowa than minorities (22.6% vs. 16.6%). Children in low-income families are more likely to live in a household where someone smokes. Although less than the US average (9.4%), 6.7% of Iowa children live in a home where someone smokes indoors. 11.3% of Iowa's CYSHCN lived in a home where at least one person smokes inside the home, which is higher than the US average for CYSHCN of 7.7%. In 2011, 18.1% of Iowa's high school students have smoked in the last 30 days, equal to the US average.

Iowa's cross-cutting priorities include: *system building for delivery of oral health services* and *insurance coverage for all MCH populations.*

Oral Health - Women

In 2013, 75.2% of Iowa women ages 18-44 yrs visited a dentist. Nearly 71% of women in households earning less than $15,000 had visited the dentist, compared to 95% of women in household earning more than $75,000. Data show that a very limited number of Medicaid-enrolled MH clients are receiving dental cleanings or treatment for periodontal disease, despite Medicaid providing comprehensive oral health care. In 2011, 56% of women had a preventive dental visit during their last pregnancy compared to19% of Medicaid-enrolled women. In 2009, only 331 of Iowa's 1,867 dentists cared for 50 or more Medicaid-enrolled adults in their practices. Less than 200 dentists cared for 100 or more Medicaid-enrolled adults. Reimbursement from Iowa Medicaid is less than half of commercial insurance rates.

Oral Health – Children and CYSHCN

While access to dental care has improved in the past 10 years, there is still a lack of access to oral health care in Iowa. Disparities are reported for Iowa children from lower income families, with those at less than 134% FPL more likely to report poor oral health status. AA and Hispanic children were more likely to experience delays accessing dental care. Most families of CYSHCN (95%) report a regular source of dental care.

Since Iowa's I-Smile™ dental home initiative began in 2005, there has been a 61% increase in the number of Medicaid-enrolled children seeing a dentist, but only 18% of Medicaid-enrollees younger than 3 years saw a dentist in 2013. For children in grades 2 to 8, 18% of children have untreated decay; the rate is 21%for children on Medicaid. While 97% of children ages 0-18 yrs have medical insurance, 18% do not have dental coverage. In 2013, 55 fewer dentists saw Medicaid-enrolled children than in the previous year. Over 28,000 Medicaid-enrolled children 0-12 yrs received preventive services in 2013.

Insurance coverage – Women

In 2013, almost 12% of Iowa women 15-44 yrs reported having no health insurance, compared to almost 20% for the US average. Almost 90% of NHW women reported having health insurance, compared to

79% of AA and 74% of Hispanic women in Iowa. Iowa women living in households up to 375% FPL are eligible for Medicaid assistance while pregnant and for 60 days postpartum. Iowa is the most inclusive state in the US in terms of Medicaid income eligibility for pregnant women and infants. In FY2013, over 3,000 pregnant Iowa women were granted PE for Medicaid, with nearly 30% of those women going on to some type of Medicaid after the presumptive period ended. Medicaid coverage ends 60 days postpartum, and many women report not knowing where or how to enroll in health coverage after this period. While Iowa has made progress in assuring access to insurance coverage for women, undocumented women rely on Emergency Medicaid for Non-Qualified Immigrants to cover delivery costs when their PE expires. Coverage only lasts for the length of the woman's labor and delivery. Nearly 1,000 undocumented women a year in Iowa have a delivery that is reimbursed by Emergency Medicaid for Non-Qualified Immigrants.

Insurance Coverage – Children and CYSHCN

In 2011, the majority (75%) of Iowa children ages 0-18 yrs were covered by private medical insurance, 22% by public insurance, and 3% were uninsured. In 2010, approximately 60% of uninsured children in Iowa were eligible for Medicaid or ***hawk-i***. Since 2010, children eligible for ***hawk-i*** and Medicaid have been able to obtain immediate, temporary Medicaid coverage through PE. Between 2010 and 2013, over 6,000 children were approved for PE. The percent of children ages 0-18 yrs without dental coverage declined from 25% in 2005 to 18% in 2010. Unmet dental needs were reported by 20% of families of dentally uninsured children. The majority of CYSHCN have insurance coverage, with approximately 64% on Medicaid. However, over one-third of families of CYSYCN with insurance report that their insurance coverage does not meet their needs. Through the HCBS Waiver program, the most medically complex children automatically qualify for Medicaid and additional services, though these waivers have a complicated application process. As of March 2015, there are 3,929 children on the waiting list for Iowa's HCBS waivers. In 2010-11, the average out-of-pocket spending among Iowa's families, including those with SHCN, was $3,513, compared to a US average of $3,456.

Cross-cutting Programmatic Approaches

Oral Health Activities

Oral health care is integrated into Title V program activities throughout the state. Iowa's Title V funded agencies are able to provide oral health services to clients, including establishing a dental home for women and children. Oral health activities are a required component of services. I-Smile™ continues to promote access to preventive oral healthcare for children, in addition to building referral networks with dentists. The UI College of Dentistry operates a dental clinic where dental students gain first-hand experience in working with CYSHCN, utilizing a multi-disciplinary care team approach.

Insurance Activities

Iowa is entering an expanded managed care environment. The Medicaid and ***hawk-i*** programs are transitioning nearly all publicly insured individuals into managed care organizations. This effort will not exclude CYSHCN or those covered through HCBS waivers. This initiative presents many opportunities for improved coverage for Iowa's Medicaid and ***hawk-i*** populations. For example, postpartum insurance coverage for women enrolled in Medicaid during pregnancy, because women with chronic conditions are often left without a source of care once their Medicaid eligibility expires.

Tobacco Activities

IDPH continues to investigate how the Quitline is being promoted and accessed by at-risk populations. Quitline provides quit aids (nicotine replacement therapy) and personalized coaching to support the

client. The recent QIP with Medicaid has resulted in renewed efforts to train providers in accessing Quitline for their patients. One aim of the interagency AHC is the prevention of tobacco use.

Title V Program Capacity

Organizational Structure

The Iowa legislature designates IDPH, a cabinet level agency, as the administrator for Title V and MCH services. The legislature also directs IDPH to contract with Child Health Specialty Clinics within the UI-DCCH to administer the CYSCHN program. Statutory authority identified in the Code of Iowa (Chapter 135, Iowa Administrative Code 641, Chapter 76) provides further reference for the purpose and scope of Iowa's program. Legislative authorization for state expenditure of federal funding under the federal block grant is identified through the appropriations process of the Iowa General Assembly. Contracts between IDPH and UI-DCCH outline the responsibilities of both agencies for fulfilling the mandate for MCH services.

Agency Capacity

Iowa's MCH/CYSHCN programs promote the development of systems of health care for children (with and without SHCN) ages 0-21 yrs, pregnant women, and their families. Iowa strives for services that are collaborative, comprehensive, flexible, coordinated, culturally competent, developmentally appropriate, family-centered and community- based. Iowa's Title V program serves to advance the service delivery of the core public health functions of assessment, policy development and assurance.

MCH Workforce Development and Capacity

Iowa's Title V MCH System is implemented through a community utility model and strives to improve access to care for pregnant women, children, and families. At the state level there are a total of 6.2 FTEs directly funded by Title V. Within BFH there are 32 professional staff and 3 support staff that work (directly and indirectly) on behalf of the Title V program. Iowa has 24 local MCH agencies with a combined workforce of 156.12 FTEs covering Iowa's 99 counties. Local MCH agencies are chosen through a competitive selection process every five years. Local and state MCH partners focus on fostering integration within the public health system and across organizational boundaries/sectors.

Key MCH Leadership Staff

Marcus Johnson-Miller has served as Iowa's Title V MCH Director and Bureau Chief of the Bureau of Family Health at the Iowa Department of Public Health since September 2014, but has been involved in Title V coordination and implementation for over 13 years.

Bob Russell, DDS, MPH has been the Public Health Dental Director at the Iowa Department of Public Health for 10 years. Dr. Russell assures the Title V program is infusing dental practices in all aspects of the programs.

Debra Kane, PhD, is a MCH epidemiologist assigned to IDPH through a contractual agreement with the Centers for Disease Control and Prevention.

CYSHCN Workforce Development and Capacity

UI-DCCH administers Iowa's Title V program for CYSHCN. UI-DCCH delivers its public health, systems building, enabling and direct services through 15 community-based centers across Iowa. The total number of UI-DCCH employees is 117, with 93 FTEs. MCHB Title V funds support 89 employees, equating to 24.8 FTEs.

Key CYSHCN Leadership Staff

Debra Waldron, MD, MPH, FAAP is Professor of Pediatrics at the UI Colleges of Medicine and Public Health, Director of UI-DCCH and Vice Chair of Child Health Policy at the UI Children's Hospital since 2008. She is a board certified pediatrician specializing in children with developmental disabilities and chronic conditions.

Martha Hanley, MA has been a Family Navigator since 2010. She has participated in AMCHP activities as a Family Scholar and Family Mentor and is currently Iowa's MCH Title V Family Delegate. Martha is a trainer for the Family Peer Support Specialist Training Program, and she is a family faculty member with Iowa's Leadership in Education of Neurodevelopmental Disabilities program.

Doris Montag, MHA is the UI-DCCH Associate Director, and has over 35 years of progressive responsibility in academic department administration. For the past 17 years she has served as the Department of Pediatric administrator at the UI.

Promoting and Providing Culturally Competent Delivery of Services

Although Iowa is less racially diverse than some states, its diversity is increasing. Iowa's Asian and Hispanic communities are the fastest growing population groups. Key informants noted there has been an increase in immigrant and refugee populations, resulting in small groups of people from several different countries, residing within a single community.

IDPH has an Office of Minority and Multicultural Health charged with developing, improving and implementing effective methods to increase access to culturally and linguistically competent health care for all racial/ethnic populations in Iowa.

UI-DCCH collects race/ethnicity data for CYSHCN receiving services through UI-DCCH. UI-DCCH recognizes that collection, analysis, and dissemination of data related to health disparities and greater outreach to minority and underserved populations are essential to improving Iowa's system and the availability of culturally competent care for CYSHCN.

Partnerships

IDPH and UI-DCCH maintain many formal and informal partnerships benefiting Iowa families. This leveraging of resources to plan and implement MCH, including CYSHCN, programs results in a strong statewide network.

MCHB Investments: Iowa manages several MCHB projects, including the State System Development Initiative and Maternal, Infant, and Early Childhood Home Visiting, Early Childhood Systems of Care grants. Other projects include participation in the MCH Public Health Leadership Institute, Regional Autism Assistance Program, the National MCH Workforce Development Center, and Innovative Evidence-based Models for Improving System Services for CYSHCN.

Other Federal Investments: IDPH and UI-DCCH manage and/or work closely with other federal agency's programs that include the PREP, AEGP, Title X Family Planning, Infant and Child Death Review, the Council for State and Territorial Epidemiologists, the National Science Foundation, and Head Start. Projects through the Centers for Disease Control and Prevention include an Oral Disease Prevention grant, a MCH Epidemiologist (CDC assignee), the Pregnancy Risk Assessment Monitoring System, and Early Hearing Detection and Intervention. Strong collaborations exist with the US Department of Agriculture's Special Supplemental Nutrition program for Women, Infants, and Children and the University of Iowa eHealth Extension Network Project.

Other HRSA Programs: Federally Qualified Health Centers and Rural Health Clinics are important referral sources for MCH contractors for provision of medical and dental care for Medicaid-enrolled families. The MCH program also works with the Behavioral Treatment through In-Home Tele health for Young Children with Autism and the IPDH STD/HIV/AIDS program.

State and Local MCH Programs: IDPH contracts with local health departments and private, non-profit agencies to conduct MCH program activities. In addition to families, these local MCH contractors work with each county board of health within their service area, including participation in regular community health needs assessments and health planning. IDPH programs such as the 1st Five Healthy Mental Development and I-Smile™ dental home programs are administered through CH contractors. Both projects rely on local program-specific coordinators to facilitate partnerships and referrals with medical and dental offices and community organizations. Other state and local partnerships include programs addressing adolescent health, bullying prevention, and the Child and Youth Psychiatric Consult Project of Iowa.

Other Programs within IDPH: The MCH program, including CYSHCN, has strong linkages within IDPH Bureaus of Immunizations, Oral and Health Delivery Systems, Chronic Disease Prevention and Management, as well as Vital Records & Health Statistics, Multicultural and Minority Health, and Substance Abuse Prevention and Treatment programs. IDPH's Office of Disability, Injury & Violence Prevention supports state and local efforts to improve services for victims of domestic and sexual violence.

Other Governmental Agencies: A strong partner of the MCH program is Iowa's DHS. A Medicaid policy specialist at DHS provides technical assistance and support to state and local MCH staff. Interagency contracts between IDPH and DHS cover quality service provision for MCH, 1st Five, and I-Smile™; ***hawk-i*** outreach and PE; data sharing; and care coordination reimbursement. Collaborations also include the Healthy Child Care Iowa program, work with the Autism Support Program, and training and certification

for adults with serious persistent mental illness and families of children with SED. Early Childhood Iowa and the Department of Education's Early ACCESS (IDEA, Part C), Regional Autism Assistance, Head Start State Collaboration Office, and School Nurse Consultant are also partners.

Public Health and Health Professional Educational Programs and Universities: Iowa's Title V program benefits from long-standing collaborations with several public health and health professional education programs, including UI Colleges of Nursing, Medicine, Public Health, and Dentistry; the University of Northern Iowa; Des Moines University; and community colleges. Activities include education and training for students within health provider training programs, training for MCH contractors about depression screening and Listening Visits, and assistance developing standards of care and evaluating quality of care to reduce mortality and morbidity of infants.

Family/Consumer Partnership and Leadership Programs: Some of the ways that IDPH and UI-DCCH hear family and consumer viewpoints are through focus groups, advisory councils, the Access for Special Kids Resource Center, and Family Voices.

Other State and Local Public and Private Organizations that Serve the State's MCH Population: IDPH and UI-DCCH appreciate many public-private partnerships with organizations such as Delta Dental of Iowa Foundation, the Iowa AAP, ChildServe, Blank Children's Hospital, the Iowa Primary Care Association, Magellan Behavioral Health, Meridian Health Plan of Iowa, the National Alliance on Mental Illness Iowa Chapter, and Child and Family Policy Center. Opportunities range from funding for school-based dental sealant programs, participation on health advisory councils, and evaluating program data.

Family/Consumer Partnerships

<u>Nature and substance</u>: The UI-DCCH employs 41 family members of CYSHCN as Family Navigators (FN). FN work in regional centers, contributing to Title V activities and other programs for CYSHCN and their families. A Family Advisory Council (FAC) began in 2014. IDPH maintains family partnerships through 21 MH and 22 CH contract agencies that work directly with families within their service areas, providing care coordination, referral assistance, and gap-filling preventive health services. Families are represented on the Title V MCH Advisory Council (MCHAC) and on local health coalitions and similar types of councils.

<u>Diversity of members engaged</u>: The UI-DCCH FN vary in age, urban or rural geographic location, military family status, and special health care need of their child. Members of the FAC are diverse regarding gender, race and ethnicity, socio-economic descriptors, and age. Family diversity is woven into the fabric of the MCH program. Contractors regularly respond to the changing needs and backgrounds of families served using assessments and feedback from those families and incorporating specific outreach to racial and ethnic minorities. In 2014, 34% of CH clients and nearly 20% of MH clients were of Hispanic or Latino ethnicity. Racial makeup of MCH clients included African-American, American Indian, and Asian.

<u>Number engaged, the degree of engagement, compensation, and MCH core competencies</u>: The UI-DCCH FN are employed full-time, permanent part-time or hourly part-time. Members of the FAC are compensated for meeting attendance and receive stipends for mileage. The FN and members of the FAC receive training on MCH core competencies. The MCHAC includes three family representatives. All members of the MCHAC are given resources for self-training in the MCH core competencies and orientation to the Title V program. Compensation is not provided for participation on MCHAC. The MCHAC assists with assessing needs, prioritizing services, establishing objectives, and encouraging

public support for MCH and family planning programs. MCH contractors engage families often and respond to families' needs based upon interactions. Client surveys help evaluate satisfaction, determine if program services meet client needs, and identify changes to improve program quality. This feedback is not typically compensated.

Evidence and range of issues being addressed: UI-DCCH uses family-to-family and peer support, to help families develop self-advocacy skills. FN promote the importance of family priorities and concerns as part of care planning and management to health care providers. UI-DCCH engages child-serving systems through support networks that benefit CYSHCN and their families and include family-driven principles when developing policies and procedures. IDPH works through local Title V MCH contractors to assure health services for families, which include helping clients become better consumers and navigators of the health care system. Contractors report that the majority of family issues they address are related to medical/dental appointments and health issues and services. Contractors also work with families to find assistance with transportation, translation, food, clothing, and housing as well as referrals to other programs such as WIC.

Impact on programs and policies: UI-DCCH values the perspectives of FN and is committed to supporting development of family leadership among employees and families of CYSHCN. FN communicate gaps and barriers to care during policy discussions, providing realistic perspectives on family life for CYSCHN. FN are represented as AMCHP Family Scholars and Delegates, and one FN is on the AMCHP Family and Youth Leadership Committee. MCH contractors seek input of families/consumers and respond through changes to programs and policies (e.g. using text messaging for care coordination, use of language lines, and transportation to mental health services).

Efforts to build and strengthen for all MCH populations: UI-DCCH has built a virtual meetings network to deliver training and support to FN. Monthly meetings build staff competencies, provide updates on issues affecting Iowa families of CYSHCN, and foster collaboration among FN. UI-DCCH disseminates best practices and also provides training opportunities that include Bridges out of Poverty, Trauma Informed Care, Behavioral Health Ethics, and Mental Health First Aid. IDPH provides oversight and consultation for MCH contractors through phone and email communication, annual site visits, quarterly regional meetings, an annual seminar, and regular program-specific meetings such as I-Smile™ trainings. Staff provides technical assistance, monitors data, discusses promising practices, and verifies contractors' progress toward performance objectives to assure family-centered approaches and overall program quality.

Conclusion

Through this NA process, Iowa was able to answer the original question '*What defines a healthy MCH/CYSHCN population?'* IDPH and UI-DCCH will use the results to develop a comprehensive action plan to address the eight NPMs and five SPMs over the next five years for the MCH population, including CYSHCN. See www.idph.state.ia.us/TitleVNeedsAssessment/ for more information.