Maternal and Child Health Services Title V Block Grant

Iowa

FY 2021 Application/ FY 2019 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

IDPH
IOWA Department of PUBLIC HEALTH

Protecting and Improving the Health of Iowans

Kelly Garcia, Interim Director | Kim Reynolds, Governor | Adam Gregg, Lt. Governor

August 1, 2020

Michelle Lawler, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Service Administration
Room 18-31, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

RE: Title V Maternal and Child Health (MCH) Block Grant Application for FFY2021 and Annual Report for FFY2019

Dear Ms. Lawler:

The Iowa Department of Public Health is pleased to have the opportunity to apply for federal funds to support the advancement of maternal and child health programs in Iowa. Please accept the face sheet of the Title V Maternal and Child Health Block Grant and the electronic submission of the narrative and data forms.

Thank you.

Sincerely,

Nalo Johnson, PhD
Director, Division of Health Promotion & Chronic Disease Prevention
Iowa Department of Public Health

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DEAF RELAY (Hearing or Speech Impaired) 711 or 1.800.735.2942

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Iowa's Title V MCH program guides priorities and provides foundational support for community based agencies and state-level public health programs. The Iowa Legislature designates the Iowa Department of Public Health (IDPH) as the administrator for Title V and Maternal, Child, and Adolescent Health (MCAH) services through the Bureau of Family Health (BFH). The legislature directs IDPH to contract with Child Health Specialty Clinics (CHSC) within the University of Iowa Stead Family Department of Pediatrics, Division of Child and Community Health (DCCH) for the administration of the Children and Youth with Special Health Care Needs (CYSHCN) program.

The State of Iowa is primarily rural, with approximately 3.1 million people according to United States Census Bureau. In 2018, there were around 595,000 women of reproductive age (15-44 years) and just over 37,500 births. Of the 733,000 children under 18 years of age, about 128,000 were CYSHCN. Of Iowa's population, 18% is covered by Medicaid and/or Hawki. In 2018, 90.2% identified as white, the Hispanic population increased from 2.8% in 2000 to 6.1% in 2018, which is consistent with data showing that Iowa is becoming more diverse. Live births to Hispanic women made up 10.3% of all births in 2018.

Assessment of needs, program planning, and performance reporting

Iowa's Title V program monitors MCH needs through input from family-led organizations, the MCH Advisory Council and organizational leadership. Data from state, national, local, and program-specific sources inform planning and evaluation activities. The SSDI Minimum-Core Dataset Indicator Workbook is a valuable asset for evaluation and performance reporting. The MCH state action plan priorities and measures were built on foundational logic models, and correspond to the Title V Pyramid levels. Contracts with community-based local agencies are designed to build local activities to meet state action plan goals. All activities within Iowa's MCH Title V program, both locally and statewide, must connect to state action plan measures and/or the interagency agreement with Iowa Medicaid. The Iowa Title V CYSHCN program uses the Standards for Systems of Care for CYSHCN 2.0 document as a framework for program planning, reporting, and evaluation. Title V CYSHCN program activities align with DCCH's strategic plan and these standards.

Population needs and Title V priorities

The 5-year needs assessment cycle guides the development of activities, monitoring, and evaluation. These needs are listed below with descriptions of the NPMs and SPMs that were selected to address them.

Infusing Health Equity within the Title V System

SPM 6: Percent of Title V contractors with a plan to identify and address health equity in the populations they serve

Ensure that all Title V NPMs and SPMs work towards addressing health inequities and disparities within the state and local system. Develop and implement a data analysis plan to assess distribution of Title V resources and services through a health equity lens. Develop partnerships with organizations, agencies or programs and/or those specifically designed to serve priority populations, including communities of color.

Access to care for the MCH population

NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Provide education to maternal health clients on the benefits and methods of breastfeeding. Ensure maternal health nursing staff have the education and ability to provide breastfeeding education to clients. Establish links among birthing hospitals and community breastfeeding support networks. Develop partnerships and training opportunities for businesses on the topic of breastfeeding policies and best practices.

NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Promote parent and caregiver awareness of developmental screening. Continue to work with provider champions in associations of health professionals to promote developmental screenings within clinical settings. Facilitate collaboration between Title V, early care and education settings, and home visiting providers on the provision of developmental screenings.

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

Work with local primary care practitioners and other providers serving adolescents to increase the numbers served and enhance the quality of adolescent well visits. Collaborate and share resources with school nurses and adolescent serving organizations across the state to promote adolescent well visits.

MCAH Systems Coordination

NPM 14: A) Percent of women who smoke during pregnancy B) Percent of children, ages 0 through 17, who live in households where someone smokes

MH staff will collaborate with staff from the Division of Tobacco Use and Prevention (DTUP). Title V will support staff in the DTUP in implementing an incentive program for pregnant women who smoke to participate in the Quitline maternal tobacco use program. All local MH agencies providing direct services to pregnant women in Iowa will provide individualized health education, in a culturally and linguistically appropriate manner, on the importance of tobacco use cessation and refer interested clients to the Quitline.

SPM 1: Number of pregnancy-related deaths for every 100,000 live births

Title V staff will provide local agencies training and communication related to the most recent Maternal Mortality Review Committee (MMRC) findings and recommendations. Local Title V MH agencies provide screenings and education on topics specific to preventing maternal mortality. MH agencies are required to conduct screenings for depression, substance abuse, domestic violence, and tobacco all MH clients receiving direct services. Clients also receive health education which includes specific topics related to recommendations from the MMRC recommendations such as the importance of chronic disease management, nutrition, and physical activity.

SPM 4: Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities

Explore and research the use of psychosocial assessments provided to adolescents in primary care settings across the state. If gaps in services are identified, Iowa will partner with the Iowa Medicaid Enterprise (IME) to identify billing codes that local Title V agencies can pursue under their purview of their child screening center designation. Title V staff will continue to be involved in the development and implementation of the newly codified Iowa's Children's Behavioral Health System State Board.

Dental Delivery Structure of the MCAH Population

NPM 13.1: Percent of women who had a preventive dental visit during pregnancy

NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

SPM 5: Percent of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider

Outreach with medical and dental providers to educate on the need for integration. Inform, educate and disseminate scientific evidence on the importance of prenatal dental screening and treatment. Continue to advocate for dental providers to increase the acceptance of new Medicaid covered patients. Assure statewide care coordination network that includes dental home referral, tracking, and follow-up for children. Continue to expand preventive school-based sealant programs such as I-Smile@School.

Safe and Healthy Environments

NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Women who are receiving Title V direct care services will receive safe sleep education based on the mother's needs, taking into account any personal or cultural beliefs the mom or family express, on the following topics: back to sleep, safe sleep environment (crib), no co-sleeping, no extra items in the crib and other recommendations from the AAP and the report from the Child Death review team.

SPM 2: Percent of children ages 1 and 2, with a blood lead test in the past year

Local Title V agencies will coordinate blood lead screening with primary care providers, local public health agencies, local Childhood Lead Poisoning Prevention Programs (CLPPPs) and others providing blood lead testing in the community. Educate parents on the importance of blood lead testing at appropriate intervals. Contractors are encouraged to partner with an agency or group serving one of the priority populations to promote blood lead testing in more culturally targeted ways.

SPM 3: Percent of early care and education programs that receive Child Care Nurse Consultant services

Outreach to local early care and education programs regarding the participation in CCNC services. Promote the utilization of CCNCs to provide Health and Safety pre-service/orientation training for child care providers to meet the requirement within the Child Care Development Block Grant.

Access to services, pediatric specialty providers, and care coordination

NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

To address barriers to access to care for CYSHCN, DCCH will focus on: 1) Providing access to specialty care through CHSC Regional Centers; 2) Strengthening infrastructure and increasing opportunities for specialty care through telehealth; and 3) Increasing Primary Care capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities.

Support for making transitions to adulthood

NPM 12: Percent of children with and without special health care needs who receive services necessary to make transitions to adult health care

DCCH plans to continue existing initiatives and implement new strategies to address needs for youth ages 12 - 21 years who are in the process of transitioning to adulthood and adult health care. A 3-pronged approach will assure that goals are met: 1) Continuing direct services to YSHCN (youth with special health care needs) and families; 2) Provide up-to-date

transition-to-adulthood resources for youth and families; 3) Creating and implementing transition-to-adulthood resources that directly address issues for YSHCN from underrepresented backgrounds.

Support for parenting CYSHCN

SPM 7: Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V

The support for parenting CYSHCN program area focuses on three areas: 1) Providing family support services to Iowa families of CYSHCN, including recruiting and supporting ethnically diverse staff and cultural liaisons; 2) Increasing support for direct services staff statewide to build understanding about barriers to family participation in health care; 3) Assuring caregiver confidence and capacity to advocate for CYSHCN on all levels (personal/family, community, and policy), including family training to underserved/underrepresented populations.

Family centered services

Iowa's Title V program works to ensure all services provided are coordinated and family-centered. Services are provided through a medical home model, a family-centered approach to comprehensive primary care that values the whole person, communication with patients and families, and coordination of care.

Iowa's CYSHCN program leadership includes a full-time Family Engagement Program Manager who works to build the workforce, and assures that the family perspective is represented at all levels of decision-making. Iowa's Title V CYSHCN program includes a Family Advisory Council to provide meaningful input with planning, development, and evaluation of programs and policies. A member of the Family Advisory Council also serves on the MCH Advisory Council to ensure the councils are connected. Each of Iowa's 13 community-based Regional Centers includes at least one member from Iowa's statewide Family Navigator Network to promote the development of family-professional partnerships, provide family support, and assure that the family voice is heard. Family Navigators are paid staff members and primary caregivers of a CYSHCN.

Established partnerships

Title XIX
Iowa's Title V MCH program and Iowa Medicaid have had a mutually beneficial relationship for nearly three decades. The foundation for this relationship is the contract established each year between IDPH and the Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME). This agreement is for six years and renewed annually through an amendment to address program updates. This contract, known as the Omnibus Agreement, does not include services for CYSHCN.

Early ACCESS
Early ACCESS (IDEA, Part C) is an integrated system of early intervention services for infants and toddlers with disabilities and/or at risk for developmental delays and their families. Early ACCESS is a partnership between families with infants and toddlers, the Departments of Education, Public Health, and Human Services, DCCH, and other community partners. The commitments of the four signatory agencies provide the vision, leadership and resources needed to have a coordinated, interagency, family centered system of services.

1st Five Healthy Mental Development
1st Five is a state funded public-private partnership bridging primary care and public health services in Iowa. 1st Five supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children 0-5 years and coordinates referrals, interventions and follow-up. Currently, 1st Five covers 88 of the 99 counties in Iowa. In order to be a recipient of 1st Five funding the agency must be the contract holder for providing Title V services.

Mobile Regional Child Health Specialty Clinics

DCCH, including CHSC, blends resources from several state allocations to complement Title V resources for CYSHCN. The Iowa Department of Public Health (IDPH) Bureau of Family Health awards state appropriations funding to DCCH through a contract called Mobile Regional Child Health Specialty Clinics to assure community-based, family centered and comprehensive services for CYSHCN.

The Regional Autism Assistance Program (RAP)

The Iowa Department of Education (DE) has contracted with DCCH for over 30 years to support the statewide Regional Autism Assistance Program (RAP). RAP aligns with authorizing legislation, Iowa Code 256.35, to "coordinate educational, medical, and other human services for persons with autism, their parents, and providers of services to persons with autism." DCCH combines Title V resources with support from DE and IDPH to provide a comprehensive System of Care for children and youth with Autism Spectrum Disorder (ASD) and their families.

III.A.2. How Federal Title V Funds Support State MCH Efforts

Within the BFH the Title V Block Grant is the backbone of all programs. BFH is organized within four units: Early Childhood, Reproductive Health, Home Visiting, and Child/Adolescent Health. Examples of programs under each unit include: Early Childhood Mental Health, Early Hearing Detection and Intervention, Early ACCESS, 1st Five, Early Childhood Iowa, Title X Family Planning, Personal Responsibility Education Program, Sexual Risk Avoidance Education Program, Pregnancy Risk Assessment Monitoring System, Maternal Infant Early Childhood Home Visiting, HOPES, Data Integration, Hawki Outreach, EPSDT, and Healthy Child Care Iowa. Each of these programs contribute, directly/indirectly, to the Title V system.

Like the BFH, the Title V Block Grant provides a foundation for all of DCCH's CYSHCN programs. Through the University of Iowa, DCCH supports Pediatric Integrated Health Homes, the Regional Autism Assistance Program, Family and Peer Support Services training, the Pediatric Mental Health Access grant and Innovations in Care Coordination for Children and Youth with ASD, the Iowa Family Leadership Training Institute, family support, care coordination, medical services, provider-to-provider education, telehealth support, and outreach to underserved communities. The Title V foundational support allows the University of Iowa's DCCH to build partnerships with other areas of the University of Iowa, state agencies, and local and regional entities.

III.A.3. MCH Success Story

A teenage client delivered a baby with a birth defect which required medical procedures to correct it. The mother was having difficulty breastfeeding the baby, and had minimal support from her family. During the visit the nurse spent time providing positive reinforcement and breastfeeding education to the client. During the visit the mother expressed her gratitude for the extra help. The nurse provided an additional visit with the family, to follow up and reinforce what had been taught. The nurse contacted the mother a couple days after the visit to check on them; the baby had been nursing really well and latching since the visit. She verbalized the baby seemed like a different baby with feedings since receiving assistance.

Iowa's Title V CYSHCN program was able to quickly respond to sudden changes to the healthcare system that occurred due to the COVID-19 pandemic. DCCH has a history of providing telehealth services through the CHSC Regional Center infrastructure. CHSC staff built on that expertise to transition families and providers from receiving telehealth through CHSC Regional Centers into the home. DCCH partnerships enabled a rapid transfer of this information within the University of Iowa Health Care system. DCCH staff provided infrastructure, telehealth software licenses, equipment and training for the Division of Developmental and Behavioral Pediatrics and Pediatric Psychology providers so they could quickly set up to serve children and families.

III.B. Overview of the State

Principal Demographics and Geography of Iowa

Iowa is a rural state with approximately 3.1 million people according to the United States Census Bureau. Iowa typically has had a healthy economy with an unemployment rate of 2.8% (Feb. 2020, Iowa Workforce Development), a figure significantly below the national average. The unemployment rate during the COVID-19 pandemic rose to 8% (June 2020, Iowa Workforce Development). While agriculture and related industries contribute significantly to Iowa's economy, other industries are pivotal as well, such as, advanced manufacturing, biosciences, insurance, and financial services. While the unemployment rate is low, 2017 data showed the percentage of Iowans living below the federal poverty level was 10.7%.

Ten of Iowa's 99 counties have a population of 65,000 or more, 21 counties have between 20,000 and 64,999 people, 66 counties have between 5,000-19,999 people, and two counties have under 5,000 (State Data Center, 2019 population estimates). With the state's predominantly rural population, a lack of transportation is one of the state's most widespread and persistent concerns with regard to access to health services of all types.

Providing access to maternity care is a challenge in rural communities. According to 2010 data from Rayburn and colleagues, Iowa was tied for 46th out of 50 states with 4.2 obstetricians/gynecologists per 10,000 women of reproductive age. Fifty of Iowa's 72 birthing hospitals offering maternity care are located in rural counties, but all Level II and III hospitals are in metropolitan counties. Fortunately, in 2019, Iowa women (93.3%) had health insurance at rates higher than the national average (87.6%). Additionally, Iowa is the most inclusive state in the US in terms of Medicaid income eligibility for pregnant women and infants (up to 375% FPL). However, undocumented women rely on Emergency Medicaid for Non-Qualified Immigrants for delivery when their presumptive eligibility expires.

Overall, Iowa children are in good health. The percent of Iowa children under 18 years old with medical insurance was 95.2% in 2018. According to the US Census Bureau, the 2018 estimates shows 6.3% of Iowa's total population is under the age of five. In 2018, the percent of families with related children under 18 years old living below the poverty level was 11.8%. According to the 2016 National Survey of Children's Health, it is estimated that 128,000 Iowa children and youth have, or are at risk of having, a special health care need. Access to pediatric specialty health care services remains a challenge for children and youth with special health care needs and their families, especially in rural areas.

The state is 90.2% White (American Community Survey, 2018); however, racial and cultural diversity is increasing. The Hispanic population increased from 2.8% in 2000 to 6.1% in 2018. Live births to Hispanic women made up 10.3% of all births (2018 Vital Statistics of Iowa).

Other key demographic data that paint the picture of Iowa includes 29.4% of families are single parent families. In 2018, the percentage of children in families where the head of household lacks a high school diploma was 7.7 percent; this is better than the 2010 rate of 9 percent.

Iowa's MCAH Population

The Bureau of Family Health's (BFH) Maternal, Child, and Adolescent Health (MCAH) programs promote the health of Iowa's women, mothers, infants, children, youth and adolescents through public and private collaborative efforts. The BFH contracts with local agencies to serve as the community utility to link individuals and families to care and services in all of Iowa's 99 counties. Agencies eligible to apply to become MCAH providers include private nonprofit and public entities. Each local agency serves a grouping of counties, ranging from one to 15 counties. Most local agencies provide maternal, child, and adolescent health services; however, a small number of agencies provide only maternal health services or only child and adolescent health services, so some counties have two different agencies that work together to ensure that the MCAH population receive services. The maps below show the current county assignments by agency.

Women/Maternal/Prenatal/Infant Health:

In FFY19, 23 local maternal health agencies provided maternal health services to approximately 5,402 low-income pregnant women. A wide range of health education and support services are available to low-income pregnant women, such as risk assessment, psychosocial screening, oral health screening, delivery planning and presumptive eligibility. The maternal health agencies also provide care coordination to promote early entry into care.

Women/Maternal Health Agency Service Areas*:

Child and Adolescent Health:

In FFY19, 23 local child health agencies provided child health services to approximately 107,375 children, ages 0 to 22 years. Through dental care coordination services, the child health programs help families access dental education and referral through Iowa's I-Smile^{TM} program. CH agencies may also provide gap filling services, such as immunizations; developmental, nutrition and psychosocial screenings; and laboratory tests including blood lead testing. Child health agencies also provide informing and care coordination services for the Medicaid population.

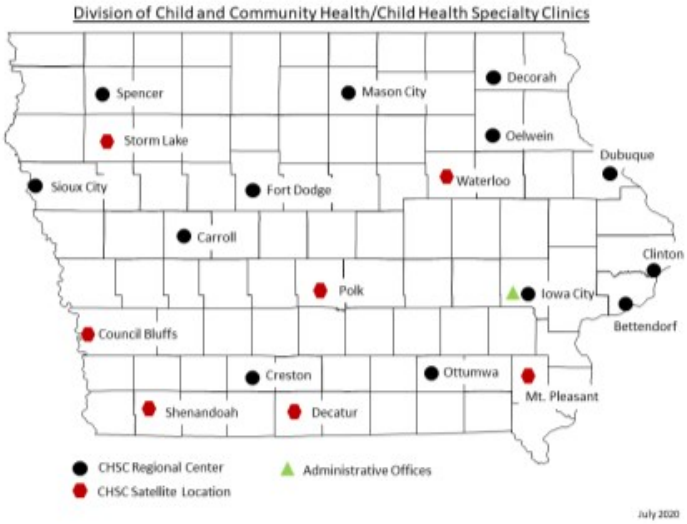
Child and Adolescent Health Agency Service Areas*:

* Service Area maps with local agency information are included in the Attachments.

Children and Youth with Special Health Care Needs:

The University of Iowa Division of Child and Community Health (DCCH) administers Iowa's Title V program for Children and Youth with Special Health Care Needs (CYSHCN), overseeing systems building, enabling, and direct services. DCCH has administrative offices in Iowa City, a network of 13 Child Health Specialty Clinics (CHSC) Regional Centers, and 7 satellite locations across Iowa, employing over 100 public health professionals, clinical providers, and Family Navigators. DCCH provides direct clinical care (in-person and via telehealth), care coordination, and family to family support to CYSHCN ages 0-21 and their families. In FFY19, DCCH provided services and supports to over 7,200 Iowa CYSHCN and their families.

DCCH Regional Center Locations:



DCCH's vision is to assure a systems-oriented approach to care for Iowa's CYSHCN and their families, and is guided by the Standards for Systems of Care for CYSHCN 2.0. The current priorities for Iowa's CYSHCN program are Access to Care, Transition to Adulthood, and Family Support. In addition to administering the MCH Title V program for CYSHCN, DCCH provides services and supports to Iowa CYSHCN and their families through a number of programs including the Pediatric Integrated Health Home program, the Community Circle of Care, the Iowa Regional Autism Assistance Program, and Iowa's Early Intervention program, Early ACCESS.

Workforce development, including increasing cultural diversity of the CYSHCN workforce, is a need within Iowa's System of Care for CYSHCN. The capacity of the CYSHCN workforce is dependent on geographic location with shortages most acute in rural areas of the state. DCCH proudly supports family-centered services and advocates for family-professional partnerships at the local, state, and national levels. DCCH has continued to expand the use of telehealth to connect families with specialists and to train new family advocates through the Iowa Family Leadership Training Institute.

Access to pediatric specialty care is a challenge for families in Iowa, especially for those with complex medical needs and those living in more rural areas of the state. Most pediatric specialty services are concentrated in only a few of Iowa's 99 counties. Iowa ranked in the bottom 20% of states with number of general pediatricians ever certified aged 70 and under per 100,000 of children (American Board of Pediatrics Workforce Data Book, 2017/2018). Iowa has a severe shortage of developmental specialists to assess, diagnose, and treat CYSHCN including those with Autism Spectrum Disorder and Serious Emotional Disorders.

Iowa has seven Home and Community Based Services (HCBS) Waivers that provide funding for services and supports so that people who would otherwise require care in a medical institution can live in their own homes and communities. Five of these waivers apply to Iowa CYSHCN: The Health and Disability Waiver, the Intellectual Disability Waiver, the Brain Injury Waiver, the Physical Disability Waiver, and the Children's Mental Health Waiver. Waivers for CYSHCN currently cover about 16,500 children. Nearly 6,000 children are on waitlists for waiver programs. DCCH also provides consultation, technical assistance, planning and care coordination activities for about 600 individuals who are on the Health and Disability Waiver waiting list and not yet eligible for Medicaid, and provides guidance to all families served about eligibility for waiver programs.

Medicaid In Iowa

In 2016, CMS announced that it approved the launch of IA Health Link (Iowa's Medicaid Modernization initiative). The goals of Medicaid Modernization included improved quality and access, greater accountability for outcomes, and creating a more predictable and sustainable Medicaid budget. Medicaid agencies contract with managed care organizations (MCOs) to provide and pay for health care services. MCOs establish an organized network of providers and utilization guidelines to assure appropriate services are provided at the right time, in the right way, and in the right setting. This shifted the focus from volume to per member, per month capitated payments and patient outcomes.

The Iowa Department of Human Services currently contracts with the following two MCOs for Iowa's Medicaid Modernization initiative to provide and pay for health care services to the vast majority of Medicaid members:

- Amerigroup Iowa, Inc.
- Iowa Total Care

IDPH has had a collaborative relationship with the Iowa Department of Human Services – Iowa Medicaid Enterprise (IME) – for more than 30 years. Medicaid's work with the Title V Maternal and Child & Adolescent Health program began with a

systems change initiative to decrease barriers and assure that pregnant women and children have access to services to which they were entitled. The relationship offered a comprehensive system of care that included outreach, informing of newly eligible families of EPSDT services, and care coordination services. Although linkage with established medical and dental homes is a program priority, local Title V contract agencies are also able to bill Medicaid for direct care maternal and EPSDT services through specific provider packages established by Iowa Medicaid. Title V agencies provide EPSDT gap-filling services under Iowa Medicaid's Screening Center provider status, and Title V agencies provide Maternal Health gap-filling services under Medicaid's Maternal Health Center provider status.

The working relationship between Iowa Medicaid and Bureau of Family Health programs is solidified each year through a contractual arrangement. The current Omnibus Agreement is based upon a collaborative agreement with attachments that address administrative services; EPSDT/MH/OH/1st Five programs; Hawki Outreach; the 1-800 Healthy Families Line; and a Medicaid match project.

Bureau of Family Health program staff meet monthly with the IME Maternal Health Center & Screening Center Project Manager, IME Oral Health Project Manager, and IME Contract Manager. The meetings provide an opportunity for staff to pose questions and concerns, provide input, and receive guidance and updates from IME on Medicaid policy and current issues. Ongoing challenges that local MCAH agency contractors have experienced since the transition to Medicaid Managed Care are presented and discussed. IDPH staff share information on progress within Title V MCAH and other programs of mutual interest.

Iowa Health and Wellness Plan

The Iowa Health and Wellness Plan, Iowa's version of Medicaid expansion, was enacted through bi-partisan legislation to provide comprehensive health care coverage to low income adults. The plan offers coverage to adults age 19-64 with an income up to 133 percent of the Federal Poverty Level (approximately $15,521 per year for an individual and approximately $20,921 per year for a family of two or higher depending on family size). The plan began on January 1, 2014, and currently serves approximately 150,000 Iowans. The Iowa Health and Wellness Plan includes dental services under the Dental Wellness Plan (DWP). Effective July 1, 2017, adult Medicaid members age 19 and older were combined into a single, improved Dental Wellness Program administered by Delta Dental of Iowa and MCNA Dental.

Data Integration

The BFH and Oral Health Center continue to integrate program data including care coordination, referral management, risk assessment, practice management, billing, and client and population level reporting. The data systems consolidated/integrated to the new system, **signify**community (formerly TAVConnect), are the Child and Adolescent Reporting System (CAReS), Women's Health Information System (WHIS) and Ahler's family planning data system.

The CAReS data system included the CAH, 1st Five, Early ACCESS and Oral Health programs, and was replaced by **signify**community on April 3, 2017. The WHIS database that stores the Maternal Health program data was integrated with **signify**community on June 1, 2017. Ahler's, was integrated on April 1, 2018. A billing solution, Softatics, was integrated into the system for a more streamlined billing protocol. Currently, **signify**community and IDPH are importing data from external data interfaces like lead lab results, WIC, MIECHV/HOPES and Immunizations through data feeds and other sharing mechanisms.

IDPH also implemented a system to document screening, further testing, and follow-up/referrals for newborn screening programs. The system name is Iowa Newborn Screening Information System (INSIS). IDPH contracts with Optimization Zorn (OZ Systems, Inc.) of Arlington, Texas for its web-based surveillance software system, eScreener Plus (eSP™). The data system was built to integrate three newborn screening databases (Early Hearing Detection and Intervention [EHDI], Dried Bloodspot [DBS] and Critical Congenital Heart Disease [CCHD]) into one system. INSIS hearing screening and CCHD modules went live in June 2016. The blood spot screening module went live July, 2017; implementation was delayed due to HL7 messaging issues with the State Hygienic Laboratory data system.

Twenty Iowa birthing hospitals are using an admission/discharge/transfer (ADT) interface from OZ called NANI (Newborn Admission Notification Interface) to automatically import ADT information from the hospital electronic medical record system into INSIS. This interface has improved the accuracy and timeliness of data entry of demographic and basic newborn information. All Iowa birthing hospitals are now required to submit their demographic information electronically either through NANI or flat file import.

Public Health Accreditation Board

The Iowa Department of Public Health achieved accreditation from the Public Health Accreditation Board (PHAB) in November 2018. This award marked an important milestone in the department's journey towards adopting a culture of quality. Benefits of the accreditation process included: learning that occurred through the use of cross-department teams, increased focus on the importance of reviewing and updating documents, an opportunity to hone in on both opportunities and gaps, and having quality improvement, health equity, performance management, workforce development and other topics embedded in the work of the department. MCAH program staff were active participants in the site visit process by providing their expertise in site visit interviews. Program staff have also participated in the department's next steps now that

accreditation has been achieved. The department plans to continue to further develop areas of strength and build on opportunities in order to further the quality culture, maintain accredited status and pursue reaccreditation.

Strengths and Challenges Impacting the MCH Population

Challenges

Rural

The rural nature of Iowa presents unique challenges for clients to access services throughout the state. Local Title V MCAH agencies work to ensure needed health services are provided in the rural counties. This is accomplished through building partnerships with health providers and community resources. Likewise, CHSC provides services for families of CYSHCN in many rural areas. In 2019, the Iowa Legislature eliminated the Rural Health and Primary Care Advisory Committee. BFH staff will continue to work with the Center for Rural Health and Primary Care to develop strategies to reach rural clients.

An initiative in Iowa to incentivize providers to practice in underserved areas is the Primary Care Recruitment and Retention Endeavor (PRIMECARRE) which was authorized by the Iowa Legislature in 1994 to strengthen the primary health care infrastructure in Iowa. PRIMECARRE allocations currently support the Iowa Loan Repayment Program, with matching federal and state funds. This initiative offers two-year grants to primary care medical, dental, and mental health practitioners for use in repayment of educational loans. This program requires a two-year practice commitment in a public or non-profit site located in a health professional shortage area (HPSA). While Title V is not directly working on PRIMECARRE, Title V staff communicate regularly with PRIMECARRE staff to address shortages in primary care, OB and dental providers that impact the MCH program.

Medicaid

The transition to Medicaid Managed Care remains one of the biggest challenges for Iowa's Title V local MCAH agencies. Nearly all of Iowa's Medicaid population (all but approximately 5%) were shifted to managed care. Although significant groundwork was laid with each MCO well in advance of startup through meetings addressing Iowa's Title V structure and its strong relationship with Iowa Medicaid, difficulties remained. These include the following:

- Shifting MCO enrollment for individuals has caused difficulties when serving clients. Initially in April 2016, there were three MCOs established – AmeriHealth Caritas, Amerigroup, and UnitedHealthcare. As of November 30, 2017, AmeriHealth Caritas withdrew from Iowa. This resulted in these clients shifting either to Iowa Medicaid (fee-for-service) or UnitedHealthcare. Several months later, once Amerigroup was able to handle greater capacity, some of the clients were shifted to Amerigroup. In March 2019, it was announced that UnitedHealthcare would be leaving the state on June 30, 2019; and on July 1, 2019, a new MCO (Centene's Iowa Total Care) began coverage of services. As a result, effective July 1, 2019 Iowa had two Medicaid MCOs in the state -- Amerigroup and Iowa Total Care. This series of changes in MCO providers has caused significant challenges for both Medicaid members and providers. Title V agencies work to stay abreast of the changes and assist clients in understanding the shifts in MCO assignment.

- Numerous challenges related to payment of certain services allowed under Maternal Health Center and Screening Center provider types have occurred, including inconsistencies in payment and denials of payment. Policies established for payment may vary from one MCO to another. Reasons provided for non-payment may include 'lack of medical necessity,' declaring some services are an 'add on code' requiring another primary procedure, third party liability, stating services are 'not covered,' and limitations on the number of services -- all that did not formerly exist. Bureau of Family Health staff continue to work with Iowa Medicaid staff to try to resolve difficulties as they arise.

- Fiscal challenges have created a burden in working with the MCOs. Submitting claims among multiple MCO providers who have differing processes is not a small undertaking. Handling claim resubmissions, denials, and appeals has taken significantly greater staff time and therefore cost. In addition, tracking payments and recoupments to assure fiscal accountability is not always straight-forward. In some cases, payments are made and subsequently recouped at a later date and at times from a completely different provider type.

Other adjustments to service provision by Iowa's Title V local contract agencies resulted from initiation of managed care. The following include permanent changes that have altered Title V service provision:

- Medical care coordination is included in the MCO's contract with DHS. As a result, local Title V MCAH contract agencies are no longer able to bill for medical care coordination services provided for MCO enrolled clients. This has had a significant impact on the continuity of care that Title V contract agencies are able to provide for their population. Title V MCAH agencies are able to bill IME for medical care coordination provided for the Medicaid fee-for-service population (approximately 5% of the Medicaid population) and for all dental care coordination.

- Transportation services provided by local Title V MCAH agencies were significantly impacted by the advent of Medicaid MCOs. Historically, Title V agencies were able to arrange and bill specific types of transportation services for Medicaid clients through their Maternal Health Center and Screening Center provider types. This enabled local staff to assist clients to gain access to Medicaid covered services/appointments. This ability is now limited to only the Medicaid

fee-for-service population, as each Medicaid MCO has a transportation broker for handling rides for the MCO enrolled population. Agencies have experienced many reports from clients regarding difficulties and the lack of flexibility among the transportation brokers.

The above challenges have resulted in continued financial challenges for MCAH agencies, which typically consist of small private non-profit or county public health agencies. Many have reduced staff and continue to face tough decisions as to the ability to continue services at their former levels. One Title V MH provider made the decision to no longer contract for the Title V program due to such issues October 1, 2019. The counties covered by this MH were accepted by a contiguous MCAH agency.

Strengths

Health Insurance Coverage

In 2018 it was reported that 95.2% of children, 18 years and under, in Iowa had some form of medical insurance. It is estimated that 60% of uninsured children in Iowa are eligible for Medicaid or Hawki. Since 2010, children eligible for Hawki and Medicaid have been able to obtain immediate, temporary Medicaid coverage through the Presumptive Eligibility for Children program. All Title V agencies are able to assist families in applying for Medicaid and presumptive eligibility. Iowa's Hawki program also has a dental-only option to increase access to oral health services for families that have medical coverage but lack dental coverage.

Iowa women with medical insurance was reported to be 94.4%. Iowa is currently one of the most inclusive states in the US in terms of Medicaid income eligibility for pregnant women. Iowa women that make 375% of the Federal Poverty Limit (FPL) or below are eligible for Medicaid assistance during pregnancy and for 60 days postpartum. All Title V funded local Maternal Agencies assist clients in applying for presumptive eligibility, helping women obtain Medicaid coverage early in pregnancy regardless of legal status.

Maternal Mortality Enhancement

Iowa is working towards significant improvements to the maternal mortality review process. Beginning in 2020, Iowa will develop a multidisciplinary Maternal Mortality Review Committee (MMRC); previously Iowa's MMRC only included physicians. IDPH will identify pregnancy-associated deaths within one year of the death and abstract available data to support multidisciplinary review of each death. The comprehensive de-identified information about all deaths related to pregnancy will be entered into a standard data system [Maternal Mortality Review Information Application (MMRIA)]. Annual reviews of the maternal deaths will be done and summaries of the committee decisions will also be entered into MMRIA within 2 years of the maternal death. Previously our MMRC only reviewed maternal deaths once every three years. All de-identified data entered into MMRIA will be shared with the Center for Disease Control (CDC). Quality assurance processes, in partnership with CDC, will be used for improving data quality, completeness, and timeliness. IDPH and the CDC will analyze data and share findings with a broad range of stakeholders to inform policy and prevention strategies to reduce maternal deaths. To accomplish this work, 1.0 FTE for an RN to do data abstraction and oversee the review of maternal deaths was created. Job responsibilities also include oversight of Iowa's Regionalized System of Perinatal Care.

In 2019, Iowa's MMRC found that 18% of Iowa maternal deaths were the result of motor vehicle accidents in the last three years; 71% of the women were not wearing a seatbelt and frequently were ejected from the vehicle. Deaths to these young women occurred during pregnancy and the postpartum period. Iowa's Title V program, in partnership with the newly formed IMQCC, the Governor's Traffic Safety Bureau, the Iowa Department of Transportation- Zero Fatalities, and Safe Kids Iowa at Blank Children's Hospital, is developing a social media campaign on seatbelt use during pregnancy. For more information on safe seat belt use during pregnancy go to the following link:
https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/pregnant-seat-belt-use.pdf

The Iowa Maternal Quality Care Collaborative (IMQCC) was developed through the HRSA Maternal Health Innovation grant that was received by IDPH in 2019. The IMQCC's first quality improvement projects include strategies to prevent pregnancy complications and death that can occur during pregnancy and postpartum. Iowa would like healthcare providers to communicate with patients about warning signs, and use tools to help patients and families identify warning signs early to ensure women can receive timely treatment. It is important for women and their families to communicate their pregnancy history any time care is received in the year after their pregnancy has ended and to know when and who to call for help. Iowa will use AWHONN's POST BIRTH warning signs to provide standard consistent education to postpartum women in Iowa's Birthing Hospitals and by education provided by Title V Maternal Health nurses in local communities. For more information on AWHONN's POST BIRTH warning signs go to https://awhonn.org/education/hospital-products/post-birth-warning-signs-education-program/

I-Smile

The I-Smile program began in December 2006 when child health contractors began to receive funding to administer the program in their communities. Each contractor is required to maintain a dental hygienist as I-Smile coordinator, responsible for strategies that include: developing local partnerships to increase awareness about oral health; working with dental offices to encourage acceptance of referrals of underserved families needing dental care; promoting oral health through

participation in community events and presentations at meetings; training medical providers how to apply fluoride and do oral screenings to build the safety net; and assuring care coordination and gap-filling preventive services (e.g., fluoride applications) are provided for at-risk families.

Each year, Medicaid paid claims are reviewed to measure program impact. Using 2005, the year before I-Smile began, as the baseline, data has shown annual improvements for Medicaid-enrolled children (ages 0-12) receiving care. In 2019:

- Nearly four times as many children received gap-filling preventive care from a dental hygienist or nurse through I-Smile in a public health setting than in 2005 (30,924 in 2019; 7,863 in 2005).
- 73% more Medicaid-enrolled children in Iowa were seen by a dentist than in 2005.
- 60% of children ages 3-12 years saw a dentist, nearing the rate (63%) of privately insured children.
- When adjusting for inflation, the average annual cost to Medicaid per child was just $21.49 more than in 2005, yet nearly twice as many children saw a dentist and four times as many received preventive services from I-Smile in a public health setting (e.g., school).

Iowa Department of Public Health's Current Goals/Strategic Plan and Title V's Role

In 2017, IDPH released a new strategic plan. The plan is focused on the following goals:

- *Strengthen the department's role as Iowa's chief health strategist.*
    - Title V provides leadership on many programs at the state and local level. This grant is intended to develop and implement strategies at all levels to improve the health and well-being of Iowa's children, mothers, and families.
- *Strengthen the department's capability and capacity to improve population health through partnerships, communications, workforce development and quality improvement.*
    - Title V relies heavily on partnerships at the state and local levels to collaborate to impact the eight National Performance Measures and the five State Performance Measures.
    - The Title V Block Grant is looking at the MCH workforce and how to strengthen the skill sets of the employees at the state and local level.
    - Quality Improvement is a cornerstone of the Title V Block Grant. There is a team at the state level that monitors the activities of the grant and looks for ways to make the activities more efficient and quality focused.
- *Implement a collaborative, department-wide approach to addressing Iowa's top health issues.*
    - Title V went through a transformation at the federal level to align with the essential Public Health Services. With these changes staff at the local level has been deliberately involving different programs within the department who have not been actively involved in the past. Iowa Title V selected the NPM focusing on breastfeeding initiation and duration. This directly aligns with obesity, nutrition and physical activity which is the top selected health issue through strategic planning.

Other State Statutes and Regulations that Impact Title V Programs:

Iowa Administrative Code Chapter 641.76 Summary

The Maternal, Child, and Adolescent Health (MCAH) programs are operated by the IDPH as the designated state agency pursuant to an agreement with the federal government. The majority of the funding available is from the Maternal and Child Health Block Grant, administered by the United States Department of Health and Human Services. The purpose of the program is to promote the health of mothers and children by providing preventive, well child care services to low-income children and prenatal and postpartum care for low-income women.

Chapter 641.76 explains how Maternal and Child Health programs will be administered in the state, the relationship between IDPH and CHSC, what services can be provided, who is eligible to provide the services, the eligibility requirements of the clients and the purpose of the MCAH Advisory Council. For more information on Iowa Administrative Code Chapter 76 follow this link: https://www.legis.iowa.gov/docs/ACO/chapter/06-10-2015.641.76.pdf

Other sections of Iowa Code that impact Title V:

CODE OF IOWAREFERENCE	*IOWA ADMINISTRATIVE CODE REFERENCE*	*TITLE*
Chapter 135	641-Chapter 5	Maternal Deaths
Section 135.15	641-Chapter 50	Oral Health Bureau
Section 135.17	641-Chapter 51	Dental Screening Requirement
Section 135.43	641-Chapter 90	Child Death Review Team
Section 135.119		Shaken Baby Prevention Program
Sections 135.131 and 135B.18A	641-Chapter 3	Newborn and Infant Hearing Screening
Chapter 136A, section 144.13A and Chapter 136E	641-Chapter 4	Center for Congenital and Inherited Disorders and Registry for Congenital and Inherited Disorders (formerly the Birth Defects Institute and Registry)
Sections 234.21-.28	641-Chapter 74 441-Chapter 173	Family Planning Services
Chapter 234	441-Chapter 163	Adolescent Pregnancy Prevention and Services to Pregnant and Parenting Adolescents Programs
Chapter 249A	441-Chapter 84	Early and Periodic Screening, Diagnosis, and Treatment
Chapters 505 and 514I	191-Chapter 80	Health Coverage for Well Child Care and Hawki

To review previous code references follow this link: http://search.legis.state.ia.us/nxt/gateway.dll/ic?f=templates&fn=default.htm

III.C. Five-Year Needs Assessment Summary (as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

Process

Goals, Framework, Methodology

The framework of conducting the Needs Assessment was developed based on literature review of methodologies from past Title V NA reviews, Iowa's previous NA process, comments from federal reviewers on previous NAs, and the guidance and resources provided by the Maternal and Child Health Bureau (MCHB) at Health Resources and Services Administration (HRSA). The 2021 Title V Needs Assessment workgroup developed a vision and mission statements to guide the NA process.

Vision:
Families in Iowa are safe, healthy, and connected.

Overall Mission:
To ensure that mothers, infants, children and youth in Iowa, including children and youth with special health care needs, and their families have access to the resources needed to thrive in their communities.

Health Equity Mission:
To work to eliminate differences in health among ethnic, racial and other population groups who have low income or have historically had less access, power or privilege.

Leadership Team

The Needs Assessment Leadership team was composed of IDPH Staff, DCCH staff and staff from the University of Kansas Center for Public Partnerships and Research (KU). IDPH staff included Population Domain Leads, Health Equity Advisory Committee Coordinators, Oral Health Leadership, State Title V Director, and Process Facilitator. DCCH staff included a representative from the Family Navigator Network, the Title V CYSHCN Program Manager and the CYSHCN Title V program coordinator.

Health Equity Advisory Committee

The Health Equity Advisory Committee (HEAC) advised the project overall and assisted with the recruitment of underrepresented populations. HEAC members were recruited utilizing a variety of strategies including internet searches for organizations serving the target population, outreach through community organizations including known organizations working with priority populations, local Title V Agencies and networking through professional and personal relationships. For the Key Informant Conversations, facilitators were recruited through HEAC members and participants were recruited by facilitators, utilizing a variety of strategies including social media, outreach through community organizations (including Title V Agencies), relationships/networking with facilitators and/or HEAC members.

Stakeholder Involvement

IDPH, DCCH and KU program leadership met to identify stakeholders to provide guidance and input throughout the needs assessment process. A network analysis was conducted by over 30 leaders to identify current stakeholders and needed stakeholders. After conducting the network analysis, an initial list was compiled for the overall for the identification of stakeholders for the 2021 Needs Assessment work. Leadership team then conducted a second round of consideration through a health equity lens to broaden the stakeholder base to include nontraditional partners. Stakeholders that were identified included individuals, community organizations, professional organizations, faith based groups, institutions of higher

education, philanthropic organizations, advocacy groups, consumers, providers and governmental entities. Stakeholders were then analyzed and sorted into data collection activities such as focus group and key informant conversation participants and survey respondents.

Quantitative and Qualitative Methods

Data Snapshots

Data Snapshots were created for each of the five population domains. Snapshots contain available data for all National and current State Performance Measures (NPMs and SPMs). In addition to traditional data sets, disparity data was included if available. Emerging issues that were not a current NPM or SPM were identified by staff and included in the discussion portion of the documents. The intent for these documents was to be a concise tool that stakeholders could use to discern current landscape and make recommendations for priority selections. Data Snapshots can be found at: https://chsciowa.org/chsciowa.org/datasnapshots.

Qualitative Data Collection

The Title V and MIECHV needs assessments have significant overlap in target populations, predominantly in the population domains of women/maternal, infant/perinatal, and child health. Coordinating qualitative data collection efforts for both needs assessments provided rich data from diverse voices enhancing both needs assessments. The Iowa Title V Needs Assessment aimed to collect data from participants in each of 6 Title V regions, participants representing each of the 5 population domains, Title V recipients and Title V eligible non-recipients, and participants in each of 8 underrepresented groups: Fathers, People with Disabilities, LGBTQIA+, Refugees/Immigrants, Native American/Alaskan Native, Asian/Pacific Islander, Hispanic/Latinx, and Black/African American.

Focus Groups and Key Informant Conversations

Iowa conducted 7 MIECHV and 15 Title V focus groups, 9 Title V interviews, and 25 Key Informant Conversations (KICs). Focus groups were held for each population domain and had a set of common questions across all groups, with specific domain questions. Focus groups were held in both urban and rural areas. The intention was to conduct at least one KIC with each underrepresented population for each population domain. The advantages were that staff could gather targeted information from families and from each population domain to sample. This precision limited our ability to look in-depth to compare across specific underrepresented populations, because each underrepresented population was asked different question sets beyond the general Title V questions. However; this approach allowed underrepresented voices to be incorporated into each of the Title V population domains examined in the Needs Assessment.

KICs were conducted with 1-5 participants from each of the underrepresented populations identified. Title V utilized trained community champions as facilitators who also acted as recruiters for KICs. KICs were conducted either in-person or through teleconferencing based participant needs. KIC were conducted in MIECHV counties and other communities of interest to Iowa's Title V program. KIC were conducted using interpreters, other than spoken English languages: Spanish, Karen, Tigrinya, Vietnamese, Marshallese and Captioning.

Participation Summary

- 158 focus group/ key informant interviews participants
- 55 targeted Health Equity Voices (35%)
- 59% of the sample was urban
- 41% of the sample was rural
- 12 counties and the Meskwaki Settlement

Non Participant Survey

While Focus Groups and Key Informant Conversations provided insight to the families that received Title V Services, it was

important to engage potentially eligible individuals that are not part of Iowa's Title V system of care. A paper survey was sent to over 200 WIC recipients eligible for Title V services, but have not received Title V services. The paper survey contained the same 5 main questions used in Focus Groups and Key Informant Conversations, collected demographics, and a few questions related to not accessing available services and referrals. Over 30 responses were received. The survey results depicted that the respondents were unsure of Title V services and were not aware that they were eligible for these services. These results gives staff the opportunity to work with WIC to discuss ways to cross promotion of services.

Stakeholder Survey

A survey was conducted to seek input about the greatest health needs and challenges for Iowa's families. A brief video was created to describe the intent and background for the survey (https://tinyurl.com/y5my4t3g). Each population group included a set of questions relating to different national and state priorities. General data about each of the priority areas was embedded into the survey. Consideration of respondents' professional, personal, and community experience was used to answer survey questions. For additional information on each population domain, the data snapshots and themes from Focus Groups and KIC were available by link within the survey.

The survey had one section for each population domain. Participants were asked to rank the importance of issues within each population domain. There was an option to answer questions for one or more of these groups.

Total Participants: 487
Population Group Responses:

- Women/ Maternal Health 172
- Child Health 172
- Perinatal/Infant Health 127
- Adolescent Health 116
- CYSHCN 110

MCAH Capacity Assessment

Local Capacity
Leadership from local agencies were brought together to reflect on local capacity to address the top three measures from the stakeholder survey for each population domain. Narrowed measures were identified by being ranked high in both importance and priority in the Stakeholder Survey. Local leaders were asked to discern what the local capacity was to address the narrowed measures and to identify specific activities that could move the needle to address the needs.

Participants rotated through Population Domains and participated in discussion. There were separate discussion groups for both rural and urban agencies for each Population Domain. Participants worked through a Solvability and Control Matrix to see where they could make the most local impact. Data Snapshots, Thematic Summaries from Focus Groups/ KIC, compilations of research informed practices specific to the domain were used to guide discussion. Members of the HEAC were on site for consultation during small group work to discuss health equity strategies in each domain.

State Level Capacity
Lead state staff for each Population Domain conducted a similar exercise for their respective domain from a state-level perspective. In addition to Data Snapshots, Thematic Summaries, and compilations of research informed practice feedback gathered from the Local Capacity Assessment were considered. For each population domain (Infant/Perinatal, Women/Maternal, Child and Adolescent) staff reviewed each priority based on Need and Capacity.

For Need, they identified whether or not there was a need for Iowa's Title V program to take on work in this measure. Each measure was ranked as either Low, Medium or High.

- Low Need: Another bureau or program within IDPH or state agency is addressing the issue, Title V is already a partner or could be a partner in the work, but don't see Title V as the leader in the work.

- Medium Need: There is work happening in the state, but not a clear leader. Title V could take on the leadership role, but may be better for others to.
- High Need: There is no coordination of the work in the state, or lacks clear vision of the work. Title V is positioned to be the convener/leader of the work.

For Capacity, the group identified the capacity of Iowa's Title V program to move the needle on the NPM, SPM or emerging issue. The group discussed strategies the state Title V program could perform and ranked them in capacity of Low, Medium, or High.

- Low Capacity: Iowa's Title V program could not identify strategies to address the priority.
- Medium Capacity: Iowa's Title V program identified a small number or weak strategies to address the priority.
- High Capacity: There were multiple evidence-based strategies the state Title V program could identify to address the priority.

Title V CYSHCN Program Staff assessment of family needs

About 80% of the approximately 100 staff members from the Iowa CYSHCN program participated in an activity to identify family needs. For the activity, staff wrote on an index card "one thing that families of CYSHCN need to thrive." Staff then traded cards and discussed the needs identified on cards of others with different staff members. Summaries of themes identified by the original needs listed on the cards were used to identify priority needs.

Data Sources

Data from national surveys, such as the National Survey of Children's Health and state-level data, including 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

State Title V staff reviewed the results of the stakeholder survey and capacity assessment for Iowa. The team then selected 6 of 15 MCHB defined NPMs. The team examined the results and the data to address any unmet needs this has resulted in the development of 7 SPMs. Population domain leadership then worked with the subject matter experts within the department to develop the state action plan.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

MCH Population Findings

Maternal Health (MH)

The health of women of childbearing age and access to consistent medical care continues to be a problem in Iowa. The rate of women receiving preventive medical care has decreased from 71.2% in 2013 to 67% in 2017. This decline may be attributed to changes in screening recommendations for breast exams and pap smears. Additionally, it was reported that nearly one-third of pregnancies in Iowa were unplanned in 2017. With this information in mind, it is important to note the racial disparity between mothers who identify as Non-Hispanic Black seek 1st trimester prenatal care at a substantially lower rate (64.6%) than mothers who identify as Non-Hispanic White (77.2%) who received Medicaid benefits during pregnancy. This same disparity holds true for preventive dental care during pregnancy in women who receive Medicaid benefits during pregnancy. Mothers who identify as Non-Hispanic Black, had a dental visit in pregnancy at a significantly lower rate (41%) than mothers who identify as Non-Hispanic White (58.5%). Another impactful health concern among women of reproductive age to note is the significantly higher rate of maternal smoking during pregnancy among those who received Medicaid benefits during pregnancy (24.3%) and the rates among women who have different payer sources; 4.3% for women with private insurance, 6.2% for women with other public health insurance and 5.1% for women who are uninsured.

Comprehensively, the racial and ethnic disparities in accessing care and health outcomes are significant in all areas identified. Iowa's maternal mortality rate rose by 55% from 14.7 deaths per 100,000 live births in 2007 to 22.8 in 2015. Nationally, women who identify as Non-Hispanic Black are roughly 4 times more likely to die from pregnancy related causes than women in all other categories. Data gathered from interviews and surveys obtained during the 2019 needs assessment, reflected the national data. Interviews and surveys revealed barriers to obtaining care including language barriers (including difficulty scheduling appointments), other communication issues such as building trust, feeling judgement because of number and spacing of children as well as problems with insurance and payment.

According to Iowa vital statistics data in 2018, 11.6% of newborns in Iowa were born to mothers who smoked cigarettes compared to 6.5% nationally. These newborns were 1.7 times more likely to be low birth weight (<2500 g) and 34% more likely to be born preterm (<37 weeks).

Three performance measures were selected for the Maternal/Women population domain:

- NPM 13-A: Percent of women who had a preventive dental visit during pregnancy
- NPM 14-A: Percent of women who smoke during pregnancy
- SPM 1: The number of pregnancy-related deaths for every 100,000 live births

These performance measures were selected by IDPH MCAH program staff and incorporated quantitative and qualitative data as well as an assessment of state and local capacity to impact each measure.

NPM 13-A was selected in response to Iowa's continued need of dental services for women and pregnant women in the state from the previous needs assessment. Because the ongoing need was identified through both quantitative and qualitative data analysis, it was not included in the stakeholder survey or capacity assessment.

NPM 14-A was selected in response to a much higher rate of maternal smoking (11.6%) compared to the national rate (6.5%). Maternal smoking was ranked highly both as a top priority (58%) and as extremely important (84%) by respondents to the stakeholder survey. During the capacity assessment, local agencies indicated they have high capacity to address maternal smoking, and state-level capacity to address this need is high as well.

The development of SPM 1 is strongly supported by Iowa's maternal mortality rates and maternal morbidity rates outlined above. Additionally, it was ranked highest in terms of priority (77%) and importance (93%) by survey respondents. State and local capacity to address factors that impact maternal mortality and morbidity ranked very high, as well.

Programmatic Approaches

Efforts to be Continued

Local Title V agencies continue to link pregnant women to a medical home for obstetrical care, promoting access to health insurance for women following the postpartum period, and providing postpartum follow up support to low income women.

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.

Areas of Opportunity for New Activities

The IDPH maternal health team recognizes the barriers and increasing health disparities reported in both the data and the needs assessment surveys and interviews and strives to work with Title V agencies across the state to meet the needs of Iowa's women. Collaborative work with child health and oral health are planned to address program-wide health equity needs.

Planned activities specifically for reducing maternal smoking rates for this project period include providing motivational interviewing training to all Title V direct service providers, and ensuring women receiving enhanced health education from a local Title V MH agency receive education to specifically address tobacco cessation, utilizing Ask, Advise, Refer.

New activities to address maternal mortality include state-level initiatives in collaboration with the HRSA Maternal Health Innovation grant program, and local work through Title V MH agencies include developing the Iowa Maternal Quality Care Collaborative (IMQCC), utilizing the Centers for Disease Control and Prevention Levels of Maternal Care Assessment Tool (LOCATe) to verify neonatal and maternal hospital levels, and participating in Iowa's annual Maternal Mortality Review Committee (MMRC). Local work to address maternal mortality will include ensuring Title V MH staff receive training on health equity. Agencies providing direct services must provide individualized health education specific to recommendations from the MMRC and ensure postpartum follow up for all clients.

Infant and Perinatal Health

The areas of breastfeeding initiation and duration through 6 months of life, the importance of safe sleep environments, and access to appropriate care for infants born preterm continue to top the list of important health factors for infants in Iowa. Breastfeeding is one of the most important things a mother can do to provide lifelong health benefits to her child. Overall, women in Iowa have increased rates of ever having breastfed their infant. There have been some fluctuations, from 2011 (82.1%) to 2015 (81.5%) with a high in 2012 of (83.4%). The rates of women who breastfeed exclusively for the first 6 months of their child's life has increased greatly from 2011 (20.1%) to 2015 (29.5%). Unfortunately, women who receive Medicaid benefits report breastfeeding in the hospital at lower rates (72.6%), than women with private insurance (88%). Additionally, a racial disparity in breastfeeding rates is also present. Women who identify as Non-Hispanic Black breastfed in the hospital at a rate of 66.8% while women who identify as Non-Hispanic White, Hispanic and Non-Hispanic other breastfeed at rates of 82.8% to 83.1%.

Safe sleep environments have impacts on the rates of infant mortality and infant health. The now long standing recommendations to have infants sleep on their back, on a safe sleep surface have decreased infant mortality over the past 3 decades. Unfortunately, in 2016, 43 infant deaths were related to an unsafe sleep environment. Racial disparities exist among how infants are placed to sleep. Infants who are Non-Hispanic Black are placed to sleep on their backs at a rate of 69.8% while Non-Hispanic White infants are put to sleep on their backs at a rate of 89.3%, with Hispanic infants being placed to sleep on their backs at a rate of 83%.

Two performance measures were selected for the Infant/Perinatal population domain:

- NPM 4:
    1. Percent of infants who are ever breastfed
    2. Percent of infants breastfed exclusively through 6 months
- NPM 5:
    1. Percent of infants placed to sleep on their backs
    2. Percent of infants placed to sleep on a separate approved sleep surface
    3. Percent of infants placed to sleep without soft objects or loose bedding

These performance measures were selected by IDPH MCAH program staff and incorporated quantitative and qualitative data as well as an assessment of state and local capacity to impact each measure.

NPM 4 was selected in response to the slight decrease in breastfeeding initiation from 2014 to 2015, and low rates of exclusive breastfeeding for six months (29.5%). Local Title V MH agencies are well-positioned to address both breastfeeding initiation and duration through individualized health education and infrastructure building activities such as educating local employers on breastfeeding laws and the benefits of supporting breastfeeding mothers who return to work. MH agencies have strong relationships with local WIC programs, birthing hospitals, and lactation consultants in their communities.

Promoting a safe sleep environment was one of the highest ranked topics in the stakeholder survey in terms of priority

(90%) and importance (93%). Given the number of infant deaths reported in 2016 that were due to unsafe sleep situations and the statewide and local capacity to address these issues.

Programmatic Approaches

Efforts to be Continued

Local efforts to support and educate women on the benefits of breastfeeding and developing referral processes with local lactation consultants. Local MH agencies will continue to have the opportunity to provide lactation classes for clients as well. IDPH staff will continue participation in the Iowa Breastfeeding Coalition and maintain a strong relationship with the IDPH WIC program by promoting the recently developed infographic about breastfeeding in the workplace and identifying opportunities for collaboration.

Promotion of safe sleep environments will include continuing the contract with the Iowa SIDS Foundation for SIDS prevention and support for families who have experienced SIDS and participation in the child death review team. Local MH agencies currently provide education on safe sleep to clients. MH agencies who provide postpartum home visits have the opportunity to view the infant's sleep environment and provide individualized and culturally competent feedback to the client.

Areas of Opportunity for New Activities

IDPH will work with Title V agencies across the state to implement educational efforts and create community connections to support the health of everyone.

Increase the percentage of infants exclusively breastfed through 6 months include stronger requirements for local MH agencies to work with hospital lactation consultants, local breastfeeding coalitions and local workplaces to create educated, supportive communities for breastfeeding moms, increased expectations for MH agencies to work with local WIC peer counselors and lactation consults, if available, to provide as much breastfeeding support as possible to mothers they work with. MH agencies will provide a list of local breastfeeding support resources to any new or expecting mothers in addition to breastfeeding educational materials and WIC breast pump policies.

Increase the percentage of infants placed to sleep on their backs, on a separate approved sleep surface and without soft objects or loose bedding will include state-level work to implement safe sleep audits in birthing hospitals throughout the state. MH agencies will provide a minimum of one community-based education opportunity for a business or organization that serves pregnant women and connect families with local resources for cribs. Clients who obtain direct services will receive individualized safe sleep education.

Child Health (CH)

Overall, Iowa children are in good health. The vast majority of children (96%) are medically insured; although 72% of parents report they are adequately insured. Non-Hispanic White children were more likely to be adequately insured (72%) than Hispanic children (62%). The percent of children who received a preventive dental visit was 84.7%. In 2016, third graders on Medicaid and Hawki were more likely to have untreated decay than those with private dental insurance. The number of dentists that will treat children on public insurance options continues to decline in Iowa. In general, Iowa does a good job in ensuring that children are tested for lead in their blood at least one time; however the percent of children being tested for lead decreases as children get older. In 2017, 88% of one year olds were tested, compared to 43% of two year olds and 14% of three year olds. Only about one-third of Iowa's children ages 6-11 years were physically active for at least 60 minutes per day.

Four performance measures were selected for the Child Health population domain:

- NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
- SPM 2: Percent of children ages 1 and 2, with a blood lead test in the past year

- SPM 3: Percent of early care and education programs that receive child care nurse consultant services
- SPM 5: Percent of children 0-35 Months who have had fluoride varnish during a well visit with physician/health care provider

These performance measures were selected using quantitative and qualitative data as well as an assessment of state and local capacity to impact each measure.

NPM 6, developmental screening was prioritized by survey respondents as the top NPM for Title V in Iowa. In the capacity assessment, Title V contractors were found to have a high degree of capacity to address this at the local level. In 2016-2017, 28.4% of Iowa children ages 9 to 35 months received a parent-completed developmental screen, falling behind the U.S. level (31.1%).

SPM 2, 72% of survey respondents ranked Blood Lead Testing as Very or Extremely Important. The capacity assessment found Title V contractors capable of addressing this measure with 65% of current contractors already providing testing. The significant difference between children age one being tested (78%) and the children age two being tested (40%) greatly affected the selection of this measure. Work started by Title V involvement in the Maternal and Early Childhood Environmental Health Collaborative Innovation and Improvement Network over the past 3 years strengthened the foundation for continued joint work and uncovered data and strategies to improve the testing rates of young children.

SPM 3, in 2019, 75% of working families with children under the age of 6 utilize child care. Iowa has over 4,200 regulated child care providers (centers, preschools and homes) with 169,945 available child care slots. Currently there are not enough child care spaces to meet the needs of working families and almost one-fourth of Iowans live in areas that have an undersupply of regulated child care options. That number is even higher when looking for infant and toddler child care. Nationwide there has been an increase in childhood chronic health conditions and allergies. Child Care Nurse Consultants (CCNC) provide best practice guidance, assessment visits, medication administration training and care planning for children with special health needs to improve child care quality. In 2019, 37% of child care programs participated with child care nurse consultant services including 4,322 on-site child care visits completed, 6,227 technical assistance provided, 217 group trainings, and 698 children with special health needs identified, 92% with a care plan in place at the child care program.

SPM 5, children are recommended to see a dentist before their first birthday; however, many dentists are not comfortable seeing children this young. Tooth decay is the most common chronic disease in children, five times more common than asthma. Left untreated, children with active tooth decay may experience mouth pain, difficulty learning and concentrating, impaired eating leading to growth delays, and delayed speech development. Children see a physician up to 11 times by their third birthday, yet in 2018 only one in five children saw a dentist before turning 3. Recognizing the need to prevent dental disease, Iowa's Medicaid program adopted a policy several years ago to reimburse physicians for application of topical fluoride varnish during well-child visits for children up to 36 months of age. And although I-Smile™ Coordinators have provided trainings for medical offices for many years on how to apply the fluoride, very few offices have incorporated the service as part of routine care. Cavity Free Iowa is an initiative focused on increasing the number of children who receive preventive fluoride varnish at well-child medical appointments and dental referral. In 2019, 61% more Medicaid-enrolled children ages 0-3 years received a fluoride varnish application from a medical provider than in 2018. As more medical offices participate around the state, the number of children receiving fluoride varnish is expected to increase over the next 5 years and the National Outcome Measure (decay experience) to decline.

Programmatic Approaches

Efforts to be Continued

Gap filling developmental testing by contractors and partnership with Iowa's 1st Five program to encourage providers to include developmental screening as part of the well visit. Provide gap filling blood lead testing by contractors. Sustain and enhance partnership between the Childhood Lead Poisoning Prevention Program and Title V at the state level. CCNC visits,

technical assistance, quality improvement tools, trainings and special needs child care planning with child care providers in Iowa will also continue. 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. 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.

Areas of Opportunity for new activities

New activities include contractors meeting criteria being required to test one and two year olds, environmental scans to determine blood lead testing and developmental screening practices of providers. Title V contractors and Childhood Blood Lead Poisoning Prevention contractors are being required to partner together via both program's contracts.

I-Smile™ Coordinators are required to visit all pediatric medical offices to promote the age one dental visit; offer training on oral screenings and fluoride varnish applications; and provide oral health educational and promotional materials. (Coordinators will make visits to all family practice medical offices in counties with no pediatrician.) I-Smile™ Coordinators will provide onsite training (developed by OHDS staff) for offices interested in becoming a "Cavity Free Iowa" participant and assist with referrals to local dentists for care. OHDS staff is researching options to offer continuing education credits for medical staff who participate in the fluoride varnish training.

Adolescent Health (AH)

Iowa adolescents receive well visits at a high rate relative to the national average, with 81.1% 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. 94% of adolescents ages 12 - 17 received a preventive dental visit in 2016-2017. About 9% of children (ages 0 - 17) in Iowa were reported to have ongoing emotional, developmental, or behavioral conditions that require treatment or counseling. This is true for about 17% of adolescents ages 12-17. Vaping continues to increase in teens in Iowa. When asked if they had done "any vaping" in the last 12 months, 37.3% of 12th graders reported that they had, compared to only 27.8% in 2017.

Two performance measures were selected for the Adolescent population domain:

- NPM 10: Percent of adolescents ages 12 through 17 with a preventive medical visit in the past year
- SPM 4: Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities

These performance measures were selected based on quantitative and qualitative data and an assessment of state and local capacity to impact each measure.

NPM 10 was selected in response to the CAH program's overall vision is to promote healthy outcomes for Iowa's children and adolescents. Adolescents are much less likely to receive a well visit than the 0-5 years population. According to the CMS 416 report in 2018, 51% of 10-14 year olds and 45% of 15-17 year olds received a well visit . Adolescence like early childhood is a time of dramatic physical, psychological and social growth and development.

SPM 4 was selected in response to ongoing concerns for the mental health of youth in our state. When surveyed, Iowa students in 6th, 8th, and 11th grade responded "yes" to the SPM at a rate of 16% in 2012 growing to a rate of 25% in 2018. Mental health conditions such as anxiety, depression, eating disorders and drug and alcohol abuse impact the mental health of the adolescent population. According to the CDC, one in five adolescents 13 - 18 years old has or will have a serious mental illness. The CDC Morbidity and Mortality Weekly Report, reports that emergency department visits for suicidal ideation, self-harm, or both increased by 33.7% among girls ages 10 - 19, and by 62.3% among boys 10 - 19 between 2016 and 2018. Adolescence is also a crucial period for developing and maintaining social and emotional habits important for mental well-being.

Programmatic Approaches

Efforts to be Continued

Efforts to be continued include maintaining partnerships with organizations that support adolescents in receiving an annual full well visit, as well as supporting LGBTQI youth and collaborate in the development of evidence based strategies improving the mental health of adolescents.

Areas of Opportunity for new activities

IDPH recognizes the barriers and increasing health disparities reported in both the data and the needs assessment surveys and interviews and strives to work with Title V agencies across the state to meet the needs of Iowa's Children and Adolescents.

Explore standardized psychosocial assessments for Adolescents in primary care settings and billing options for local Title V agencies to provide gap filling services; providing adolescent mental health training to Title V agencies; collaborate with the Iowa Department of Education and local school districts in assessing gaps or barriers to adolescent mental health services in local communities; and assist in the advancement of the efforts ordered by the Governor of Iowa in the establishment and implementation of Iowa's Children's Behavioral Health System State Board (Children's Board) and promote state and local Title V agency level participation.

Addressing the adolescent well visit as well as adolescent mental health will involve conducting environmental scans to identify which providers are conducting these services, and at what ages they are routinely offered and sharing this with providers and community stakeholders. Partnerships will be formed with other adolescent serving organizations including the Children Mental Health Systems by region. In addition, agencies will work with adolescents or organizations serving adolescents to increase health literacy, promote healthy behaviors and promote well visits. The aim is to also provide culturally and linguistically appropriate resources for adolescents.

Children and Youth with Special Health Care Needs (CYSHCN)

Approximately 18.8% of Iowa's 732,000 children have special health care needs, including a range of diagnoses, conditions, and levels of severity. In Iowa and the US, older children are more likely to have a special health care need than younger children. Iowa's adolescent population has a higher proportion with special health care needs than nationwide.

In Iowa, approximately 9% of children have an ongoing emotional, developmental, or behavioral condition that requires treatment or counselling. Iowa has a higher proportion of adolescents with behavioral and emotional health needs than those nationwide. Behavioral and emotional health is receiving increased attention in Iowa.

Complex health needs can have lasting impacts on children, families, and the health care system. There are various ways to define the concept of "complex health needs." The National Survey of Children's Health (NSCH) through the Data Resource Center for Child and Adolescent Health Initiative defines complex health needs as those whose special health care needs include more special services than just the need for prescription medications. By this definition, 13.2% of Iowa's children have complex health needs, which is comparable to the US as a whole.

CYSHCN in Iowa were less likely to be reported as having a medical home than those without special health care needs (51.9% vs 57.4%). For children with more complex health needs, 43.9% were reported to have a medical home. Most children in Iowa have a primary care provider, often a family practitioner. The Standards for Systems of Care for CYSHCN list "pediatric specialty care integrated with the medical home and community-based services" as a core component. Pediatric specialty providers are primarily located in central and east central Iowa. Families often travel long distances for visits, and those who do not have reliable transportation often face obstacles to attending their appointments. Telehealth is becoming more readily available and is increasingly seen as an alternative to travel for psychiatric visits, as well as for follow-up appointments with other pediatric specialty providers.

In Iowa, 23.1% of CYSHCN received services necessary to transition to adult health care. When looking specifically at

children with more complex health needs, it was 15.1%. Among focus group participants, many stated that they are not prepared to help their child navigate this transition. Many families interviewed stated that they predict that preparing for their child's transition to adult health care will be challenging.

Iowa NSCH data show that 16% of CYSHCN live in a household with parenting stress, compared with 2% of those without special healthcare needs. For children with complex health needs, the percent is even higher (20% often feel aggravated). The discrepancy is so stark that DCCH conducted a more thorough analysis. Using a definition of Complex Health Needs where respondents needed to answer affirmatively to 3 or more screener questions, we found that children with complex health needs had 11.5 times the risk of experiencing parenting stress.

Most quantitative data for the above profiles of CYSHCN in Iowa came from the population-based National Survey for Children's Health. The sampling strategy allows for estimating various state level factors. In Iowa, the data collected for this survey generally does not allow for reporting by race or ethnicity due to small sample size. Although there were attempts to address this through qualitative methods, this is an area that needs more in-depth study to truly determine needs.

Three performance measures were selected for the CYSHCN population domain:

- NPM 11: Percent of children with and without special health care needs who have a medical home
- NPM 12: Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- SPM 7: Family support: Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V

These performance measures were selected based on needs identified through data collected during the needs assessment process.

NPM 11 was selected because findings revealed that access to health care remains a major concern for families of CYSHCN, especially access to pediatric specialty providers. Having a medical home can help provide support for families who need to access care for their child.

NPM 12 was selected because the percent of youth with families reporting that they received services associated with transition to adulthood for their child was low. Families reported that they were anticipating challenges associated with this transition.

SPM 7 was selected because data showed that having a source of support can help mitigate some of the stress associated with parenting CYSHCN. Significant stress associated with raising CYSHCN was well documented in all aspects of the needs assessment data collection.

Programmatic Approaches

Efforts to be Continued

Iowa Title V CYSHCN efforts will continue to build on the existing Family Navigator Network to provide family-to-family support and systems navigation for parents. Workforce development for family leadership and primary care providers will continue. Additionally, gap-filling services and supports including care coordination, will be provided through 13 Child Health Specialty Clinic Regional Centers and 7 satellite locations located throughout the state.

Areas of Opportunity for new activities

The focus of activities for the Iowa Title V CYSHCN program will be on building infrastructure and providing gap-filling services and supports primarily focused on children with chronic and complex health needs, developmental and intellectual disability, and children with mental health service needs. The approaches will focus on workforce development, family partnerships, and direct and enabling services. The CYSHCN program will seek new ways to increase opportunities to partner with families of CYSHCN from traditionally underserved backgrounds.

In late 2020, a comprehensive CYSHCN-specific Needs Assessment report will be available upon request.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Organizational Structure

The Iowa legislature designates IDPH as the administrator for Title V services. The legislature also directs IDPH to contract with CHSC within the 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 DCCH outline the responsibilities of both agencies for fulfilling the mandate for MCH services.

III.C.2.b.ii.b. Agency Capacity

Agency Capacity

Iowa's Title V 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.

III.C.2.b.ii.c. MCH Workforce Capacity

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 11.75 FTEs directly funded by Title V. Within BFH there are 39 professional staff and 4 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 314.89 FTEs covering Iowa's 99 counties. Local and state MCH partners focus on fostering integration within the public health system and across organizational boundaries/sectors.

Key MCH Leadership Staff

Nalo Johnson, PhD, is the Division Director for Health Promotion and Chronic Disease Prevention at IDPH, where the Bureau of Family Health resides. Dr. Johnson has extensive experience in public health and community health efforts at state and local levels, and has specific experience in reducing health disparities among vulnerable and underserved populations through the use of participatory, evidence based methods.

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 18 years.

Bob Russell, DDS, MPH has been the Public Health Dental Director at the Iowa Department of Public Health for 15 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

DCCH administers Iowa's Title V program for CYSHCN. DCCH delivers its public health, systems building, enabling and

direct services through 13 community-based Regional Centers and 7 satellite locations across Iowa. The total number of DCCH employees is 95, with 73.08 FTEs. MCHB Title V funds support 64 employees, equating to 20.07 FTEs.

Key CYSHCN Leadership Staff

Thomas Scholz, MD is Professor of Pediatrics in Cardiology and Child and Community Health at the UI Carver College of Medicine. He is Director of the Division of Child and Community Health and Director of Community Relations for the Department of Pediatrics. He is board certified in Pediatric Cardiology.

Jessie Marks, MD is Clinical Associate Professor of Pediatrics in the UI Carver College of Medicine. She is the Medical Director for the Division of Child and Community Health. Dr. Marks is board certified in General Pediatrics and Pediatric Hospital Medicine.

Rachel Charlot is a certified Family Peer Support Specialist and has been a Family Navigator since 2008. She has worked in Early ACCESS , Iowa's Early Intervention system, has been an AMCHP family Scholar and is currently Iowa's MCH Title V Family Delegate.

Jean Willard, MPH manages Iowa's Title V CYSHCN Program for the Division of Child and Community Health for the University of Iowa Stead Family Department of Pediatrics.

Alejandra Escoto, MPH coordinates Population Health Programs for the Division of Child and Community Health for the University of Iowa Stead Family Department of Pediatrics.

Promoting and Providing Culturally Appropriate 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. As described in the Needs Assessment Process Title V will continue the HEAC to better serve populations of color.

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

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Partnerships

IDPH and 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; Maternal, Infant, and Early Childhood Home Visiting; Pediatric Mental Health Initiative; Innovations of Care Coordination for Children and Youth with ASD, Early Hearing Detection and Intervention (EHDI) and Maternal Health Innovation. Other projects include participation in the National MCH Workforce Development Center and other TA opportunities.

Other Federal Investments: IDPH and DCCH manage and/or work closely with other federal agency programs that include the PREP, SRAE, Title X Family Planning, Infant and Child Death Review, 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 EHDI. Strong collaborations exist with the US

Department of Agriculture's Special Supplemental Nutrition program for Women, Infants, and Children.

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 Telehealth 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 and I-Smile™ programs are administered through CH contractors. Both projects rely on local coordinators to facilitate partnerships and referrals with medical and dental offices and community organizations. Other state and local partnerships include programs addressing adolescent health, the Child and Youth Psychiatric Consult Project of Iowa and the Regional Autism Assistance program.

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, 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 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 has 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 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 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, 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

DCCH employs a Family Engagement Program Manager. This position requires lived experience caregiving for a CYSHCN. The Program Manager assures family partnership at all levels. In addition, DCCH employs over 25 family members of CYSHCN as Family Navigators (FN) to work in regional centers and satellite locations. FNs work directly with families to

provide family-to-family support and systems navigation. FNs vary in age, urban or rural geographic location, military family status, and special health care needs of their child. DCCH is building a focus on employing FNs from diverse racial and ethnic backgrounds. Additionally, DCCH has an active Family Advisory Council, which was started in 2014. Members of the FAC are compensated for meeting attendance and receive stipends for mileage. Both FNs and members of the FAC receive training on MCH core competencies. In addition DCCH works diligently to expand the workforce for family partnerships through the Family Peer Support program and the Iowa Family Leadership Training Institute.

Nature and substance: 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.

Diversity of members engaged: Family diversity is woven into the fabric of the MCH program. Contractors regularly respond to the changing needs and backgrounds of families using assessments and feedback from those families and incorporating specific outreach to racial and ethnic communities of color.

Number engaged, the degree of engagement, compensation, and 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: 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.

Impact on programs and policies: 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: 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.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Identifying Priority Needs and Linking to Performance Measures

The 5-year needs assessment cycle guides the development of activities, monitoring, and evaluation. These needs are listed below with the NPMs and SPMs that were selected to address them.

Infusing Health Equity within the Title V System

SPM 6: Percent of Title V contractors with a plan to identify and address health equity in the populations they serve

Ensure that all Title V NPMs and SPMs work towards addressing health inequities and disparities within the state and local system. Develop and implement a data analysis plan to assess distribution of Title V resources and services through a health equity lens. Develop partnerships with organizations, agencies or programs and/or those specifically designed to serve priority populations, including communities of color.

Access to care for the MCH population

NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

MCAH Systems Coordination

NPM 14: A) Percent of women who smoke during pregnancy B) Percent of children, ages 0 through 17, who live in households where someone smokes

SPM 1: Number of pregnancy-related deaths for every 100,000 live births

SPM 4: Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities

Dental Delivery Structure of the MCAH Population

NPM 13.1: Percent of women who had a preventive dental visit during pregnancy

NPM 13.2: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

SPM 5: Percent of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider

Safe and Healthy Environments

NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

SPM 2: Percent of children ages 1 and 2, with a blood lead test in the past year

SPM 3: Percent of early care and education programs that receive Child Care Nurse Consultant services

Access to services, pediatric specialty providers, and care coordination

NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Support for making transitions to adulthood

NPM 12: Percent of children with and without special health care needs who receive services necessary to make transitions to adult health care

Support for parenting CYSHCN

SPM 7: Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V

III.D. Financial Narrative

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,503,197	$7,038,530	$6,484,206	$6,768,355
State Funds	$8,107,553	$8,081,135	$6,868,860	$7,035,532
Local Funds	$0	$0	$0	$0
Other Funds	$7,534,907	$6,700,640	$6,801,353	$5,859,807
Program Funds	$480,000	$524,186	$480,000	$480,000
SubTotal	$22,625,657	$22,344,491	$20,634,419	$20,143,694
Other Federal Funds	$9,340,718	$10,283,028	$11,398,041	$10,462,442
Total	$31,966,375	$32,627,519	$32,032,460	$30,606,136

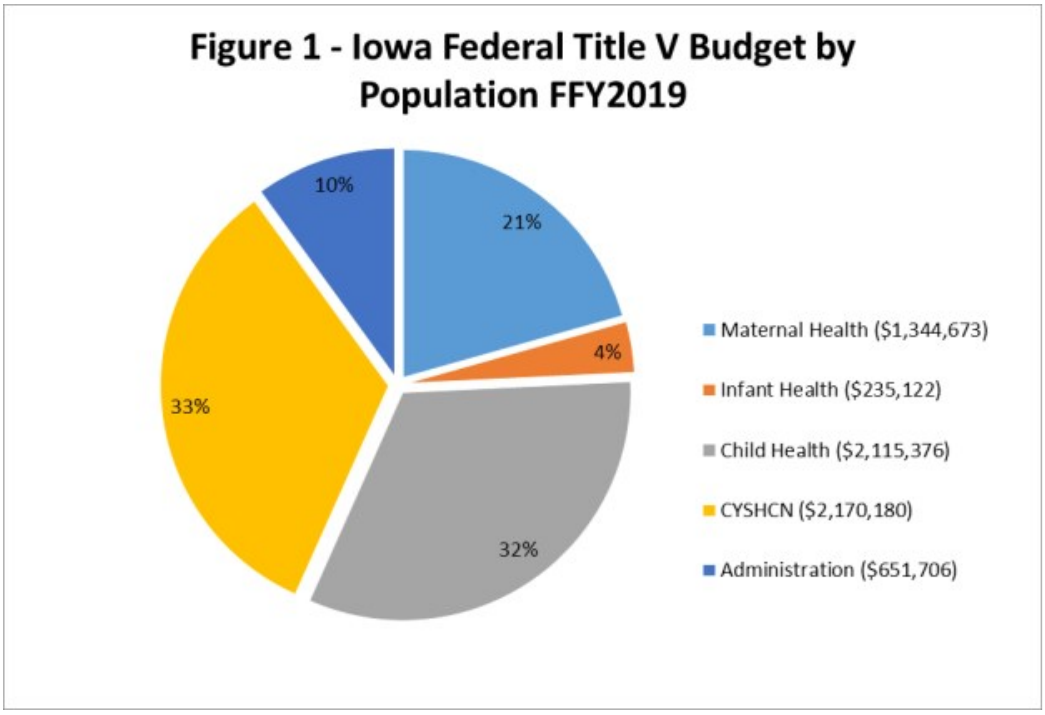
	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,517,057	$6,039,679	$6,502,615	
State Funds	$7,157,773	$7,416,373	$7,038,987	
Local Funds	$0	$0	$0	
Other Funds	$7,155,548	$5,980,879	$8,533,916	
Program Funds	$480,000	$637,056	$480,000	
SubTotal	$21,310,378	$20,073,987	$22,555,518	
Other Federal Funds	$12,313,087	$12,261,235	$8,436,599	
Total	$33,623,465	$32,335,222	$30,992,117	

	2021	
	Budgeted	Expended
Federal Allocation	$6,512,681	
State Funds	$6,334,543	
Local Funds	$0	
Other Funds	$8,847,074	
Program Funds	$480,000	
SubTotal	$22,174,298	
Other Federal Funds	$12,046,998	
Total	$34,221,296	

III.D.1. Expenditures

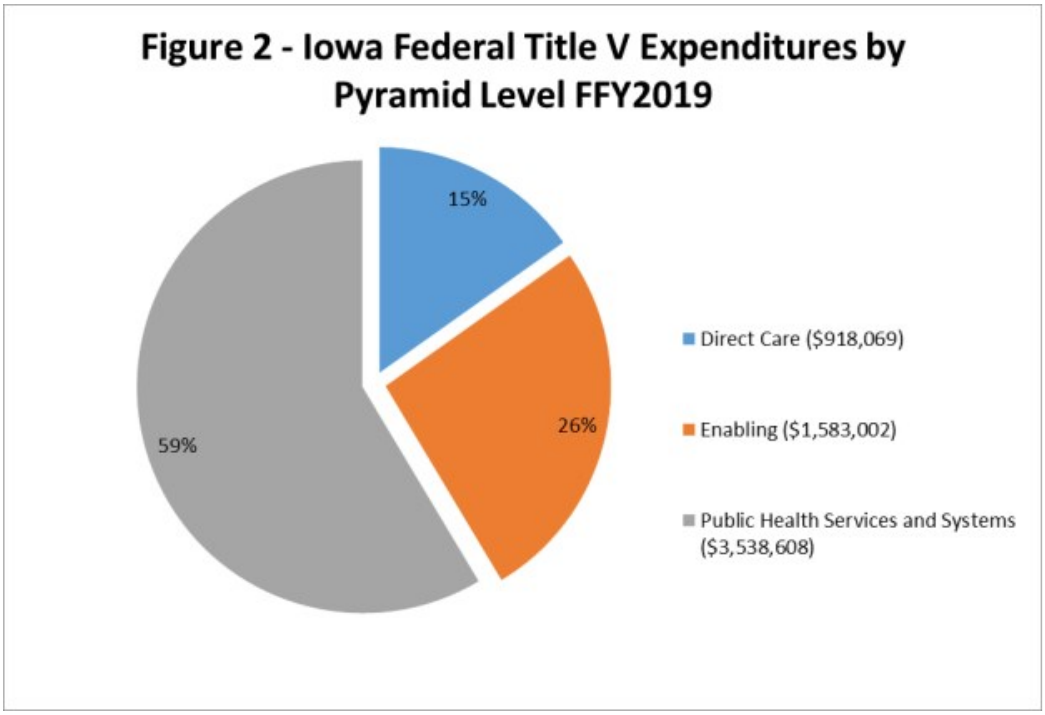
Form 2, MCH Budget/Expenditure Details, shows $6,039,679 in federal Title V fund expenditures. This expenditure report covers the FFY19 calendar year not the necessarily the FFY19 budget period or award and there were two MCH grants running concurrently. When fiscal staff file the FFR for the FFY19 award, expenses/budget periods will match appropriately.

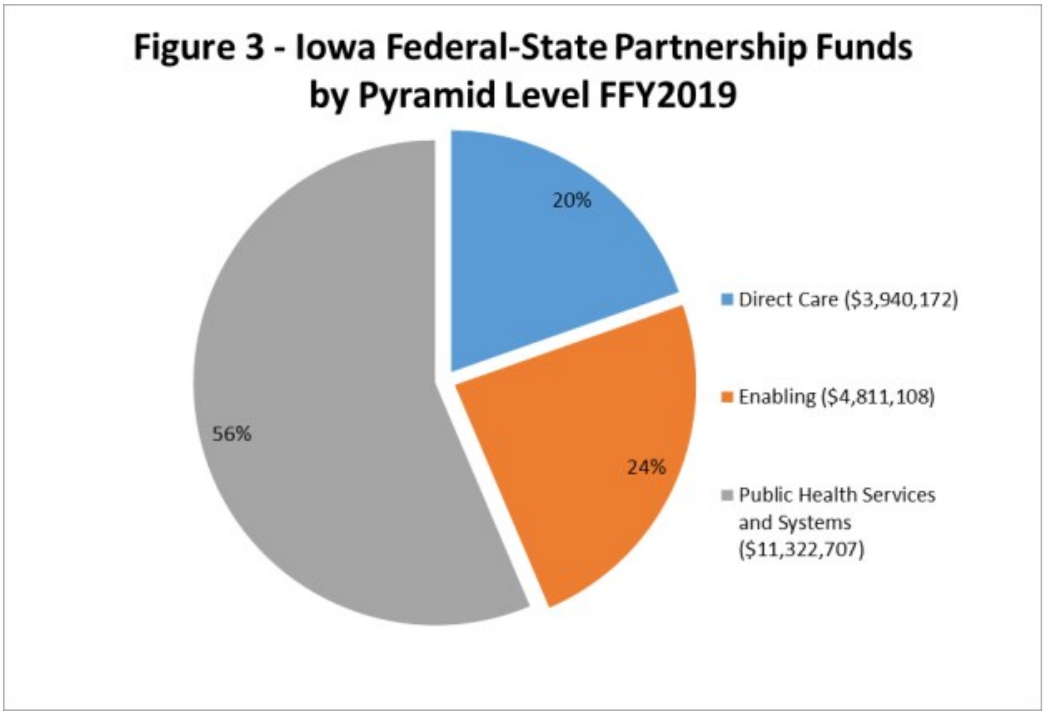
Form 3a, Budget and Expenditures Detail by Types of Individual Served, reports federal-state partnership expenditures for FFY19 in the amount of $19,417,892 excluding admin funds. Of this amount, $5,383,584 was funded by federal Title V. The state match expenditure is reported at $7,416,373. This exceeds both the state match requirement of $4,863,155 and the maintenance of effort requirement of $5,035,775. Figure 1 displays the distribution of Title V expenditures by population served. Federal Title V funds expended for child health primary and preventive care was $1,783,205 or approximately 30 percent of the total Title V expenditures. The federal Title V expenditure for children and youth with special health care needs is reported at $2,106,035 or 35 percent of the federal block grant funds expended for the year. Administration expenditures of $656,095 represent 11 percent of the federal Title V expenditures to date. IDPH expends admin funds in the first year of the funding allocation. When the final FFR is filed this will fall within the allowable limit.



Form 3b, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to Public Health Services and Systems continue to increase for MCH compared to the proportional of funds directed to direct services. Continued improvement has been achieved in reporting on expenditures by pyramid level.

Figure 2 reflects Title V expenditures by pyramid level and Figure 3 illustrates the pyramid level distribution for the combined federal-state partnership.





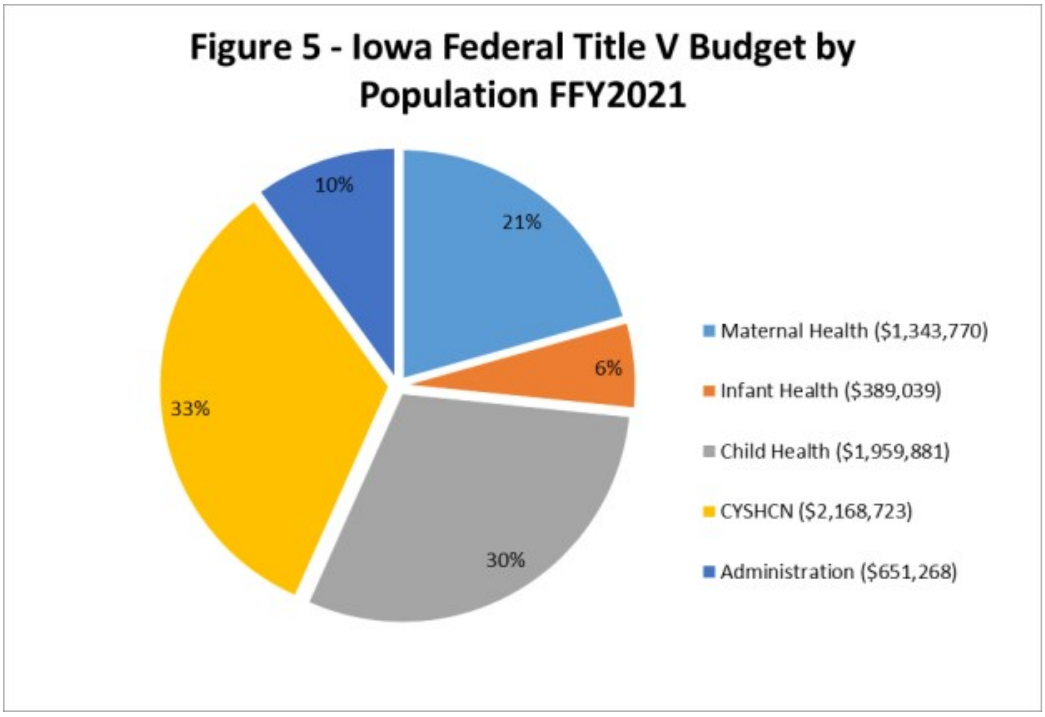
The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with Title 2, US Code of Federal Regulations, Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance). The most recent report is for the period July 1, 2018 to June 30, 2019. The Iowa Department of Public Health had no findings in the 2019 State of Iowa Single Audit Report for the

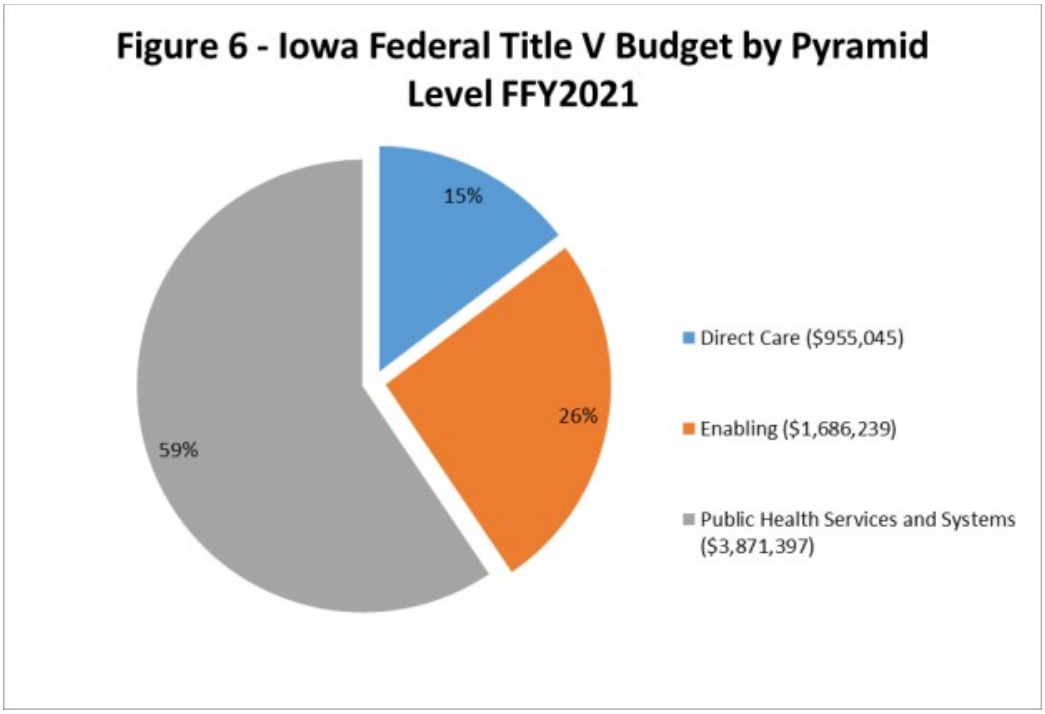
Title V program, CFDA Number 93.994. The report is submitted to the federal clearinghouse by the state Auditor's Office.

III.D.2. Budget

The FFY21 Title V appropriation is projected to be $6,512,681, based on the current Notice of Grant Awards received for FFY20. As itemized in the budget included in the attachments section, this expected allocation is budgeted as follows: $1,343,770 (21%) for maternal health services; $389,039 (6%) for infant health services; $1,959,881 (30%) for child health services; $2,168,723 (33%) for services to children with special health care needs; and $651,268 (10%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. Figure 5 below illustrates the budget plan for Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

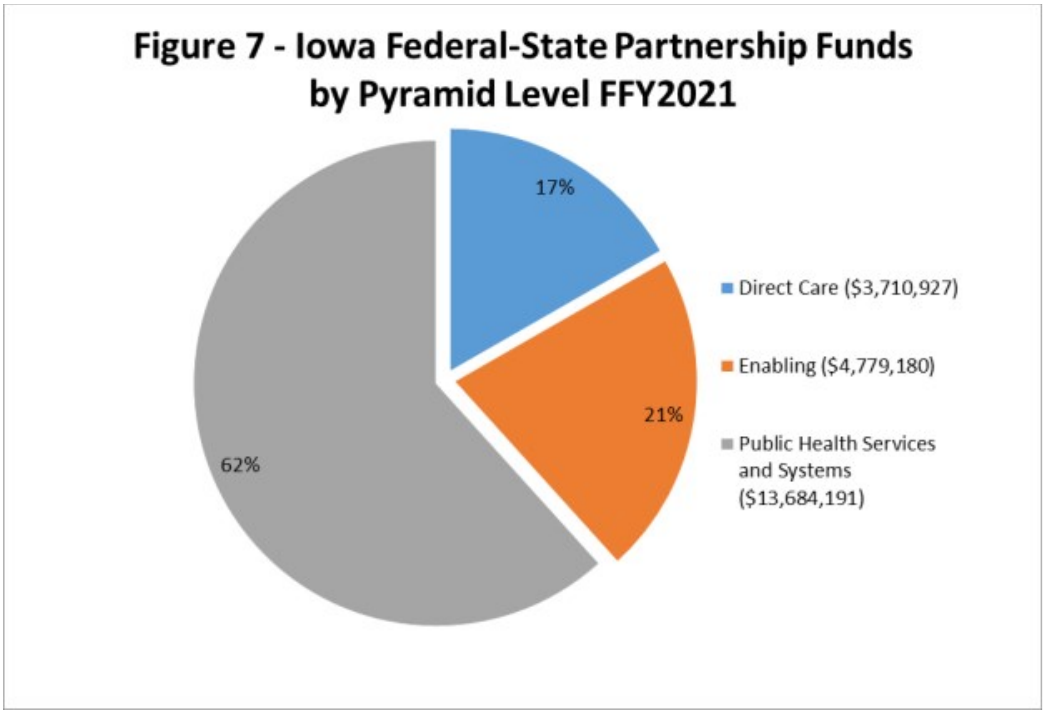
See forms 2, 3a, and 3b and the included budget attachment in supporting documents for detailed information.





The projected state match is $6,334,543. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989 and exceeds the required match of $4,883,780. This amount has decreased from previous years. The Title V program had used Immunization state funding as match, however, due to new match requirements in the Immunization Bureau, these funds were no longer eligible for Title V match.

The total budget for the federal-state partnership is projected to be $22,174,298. Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of service, as well as population group served.



Administrative cost is allocated to each of the pyramid levels and is included in the above partnership amount. Similarly, administrative costs are included in the amount listed for the categories that follow.

Public Health Services and Systems

Estimated budget for continuing development of core public health functions and system development are $13,684,191 or 62 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 36 percent of the funding for local child health agencies and 23 percent of local maternal health funds. In addition, it will include contract services with the University of Iowa, Departments of Pediatrics, Perinatal Review Team, Healthy Child Care Iowa, EPSDT dental and IDPH 1st Five Initiative. CHSC's budget for public health services and systems is estimated at $2,054,031 (37 percent of the CYSHCN budget).

Enabling Services

The federal-state partnership budget for continuation of enabling services are estimated at $4,779,180 representing 22 percent of the partnership budget. This category includes 50 percent of the funding for local child health agencies and 47 percent of local maternal health funds. Healthy Families toll free information and referral line, TEEN Line, Hawki Outreach, EPSDT, STD testing, immunization, lead poisoning prevention, and birth defects and audiological services are included in this category. CHSC's budget for enabling services is estimated at $1,833,676 (33 percent of the CYSHCN budget).CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Direct Health Care Services

The federal-state partnership expenditures for continuation of direct care services are estimated at $3,710,927. This represents approximately 17 percent of the partnership budget. The amount includes 14 percent of the funding for local child health agencies and 30 percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment, and dental sealant projects; and child vision

screening. CHSC projects a direct care budget of $1,627,356 or approximately 30 percent of the CYSHCN budget.

Other federal funds directed toward MCH include:

State Systems Development Initiative (HRSA/MCHB)
Title X Family Planning
Early ACCESS (IDEA, Part C)
Iowa Newborn Screening Surveillance Project (CDC)
Early Hearing Detection and Intervention (CDC and HRSA)
Personal Responsibility Education Program--PREP (ACF)
Maternal, Infant, Early Childhood Home Visiting (HRSA/MCHB)
Pregnancy Risk Assessment Monitoring System (PRAMS) (CDC)
Sexual Risk Avoidance Education Program (ACF)
Care Coordination for ASD/DD (HRSA)
EPSDT – HCBS IS (HRSA)
Peer Support MHDS (HRSA)
Pediatric Mental Health Care Access (HRSA)
Maternal Health Innovation (HRSA)

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Iowa

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Through legislation and Iowa Administrative Code Chapter 641.76 the IDPH is designated as the entity to apply for Title V Block Grant funding and administer Iowa's Maternal and Child Health services. IDPH's BFH is designated as the lead to apply for funding and to enter into contracts with selected private nonprofit or public agencies for the assurance of access to prenatal and postpartum care for women, preventive and primary child health care services, and services to children and youth with special health care needs.

IDPH's Bureau of Oral and Health Delivery Systems (OHDS) collaborates with BFH to develop programs to reduce barriers to oral health care and reduce dental disease through prevention.

The CYSHCN program is administered by Child Health Specialty Clinics (CHSC) in the Division of Child and Community Health (DCCH) at the University of Iowa. IDPH contracts with CHSC to provide services for CYSHCN including infrastructure building activities, clinical services, care coordination, and family support. Iowa legislation requires that 37% of Title V Block Grant funds are allocated to CHSC.

Partnerships and collaborations among these internal groups are essential to working towards the goals and mission of the MCH Block Grant. Iowa also recognizes the importance of having local contract agencies to help meet these goals. With varying needs at the local level, agencies are able to assess the health status and needs of their service area to apply for funding to impact selected NPMs and SPMs that are prevalent needs in their areas of the state.

Maternal, Child, and Adolescent Health (MCAH) Regional Consultants from BFH and OHDS are available to provide technical assistance and consultation to MCAH contract agencies. Consultants are assigned to specific regional contractors to:

- Clarify program requirements and share program expertise and best practice.
- Strengthen the ability of the MCAH contract agency to fulfill the program goals by identifying, exploring, or prioritizing issues.
- Identify or share resources.
- Address funding or billing issues.
- Provide advice and independent, objective perspectives to try to resolve problems or facilitate change.
- Assist with quality assurance and/or quality improvement initiatives.

Iowa's MCAH services are associated with one of the three pyramid levels: Public Health Services and Systems, Enabling Services, and Direct Services. State Title V population domain leads use the State Action Plan Table and narrative to complete the logic models, which are then adapted to a Request for Proposals (RFP) and subsequent Request for Applications (RFA) to help applicants implement local activities to achieve the identified goals.

All activities within Iowa's Title V program locally and statewide connect to selected NPMs, SPMs, ESMs, and or the interagency agreements with other state departments (Medicaid, Education, Human Services).

Iowa's MCH Administrative Manual outlines The Ten Essential Public Health Services to Promote Maternal and Child Health in America. This manual interprets the core public health functions as they relate to MCH and provides the framework for establishing program goals, activities and evaluation. All funded Title V programs in Iowa are expected to follow these core functions. Click here to see the full Administrative Manual.

Iowa's Title V program staff lead multiple stakeholder groups that address both internal and external MCH issues and/or aspects of MCH programming. Following are descriptions of selected MCH focused groups.

Maternal and Child Health Advisory Council

The MCH Advisory Council contributes to the development of the state plans for Title V, WIC and Title X. The council assists with assessment of needs, prioritization of services, establishment of objectives, and encouragement of support for MCH-related programs. The council also advises the director on health and nutrition services for women and children, supports the development of special projects and conferences, and advocates for health and nutrition services for women and children. Members of the council are appointed by the director, including CYSHCN service providers.

Adolescent Health Collaborative

The Adolescent Health Collaborative, established in 2014, is an intra-agency group within IDPH comprised of programs that serve adolescents and young adults. Members include staff from alcohol and substance use, teen pregnancy prevention, family planning, violence and injury prevention, immunizations, STD/HIV prevention, mental health, and suicide prevention.

Iowa Statewide Perinatal Care Program

The Iowa Statewide Perinatal Care Program, established in 1973, provides education, development of standards/guidelines of care, consultation to regional and primary providers, and evaluation of the quality of perinatal care delivered in Iowa with the goal to reduce mortality and morbidity of mothers and infants. Through a contract between IDPH and the University of

Iowa College of Medicine, these services are offered to all Iowa hospitals providing delivery services. As defined in Iowa Code this team's work provides critical support and oversight for Iowa's Regionalized System of Perinatal Care.

Title V MCAH RFP/RFA Work Group

Iowa's Title V MCAH program contracts with local agencies using an RFP process that ensures coverage in all of Iowa's 99 counties. This application process includes services for many MCAH related services including: Maternal, Child and Adolescent Health, Oral Health, Hawki (Iowa's CHIP), Early ACCESS (IDEA, Part C), Child Care Nurse Consultation services and partnerships with other MCH related services (WIC, Childhood Lead Prevention Program, etc). Representatives from these programs participate in the development of this RFP.

Family Advisory Council

In 2014, DCCH created a Family Advisory Council (FAC) to provide feedback regarding the planning, development, and evaluation of programs and policies that will assure a systems-oriented approach to care for Iowa CYSHCN. Members are family members of CYSHCN or self-advocates and represent a broad cross-section of families that CHSC serves across the state. Each February, the FAC participates in a "Day on the Hill" with the Iowa Legislature. A member of the FAC serves on the MCH Advisory Council.

RAP Expert Panel Advisory Committee

The Iowa Regional Autism Assistance Program (RAP) coordinates a statewide committee that helps monitor the System of Care for children and families with Autism Spectrum Disorder (ASD). Meetings provide guidance and input from stakeholders. The Panel provides information to legislators and other stakeholders about successes and barriers children and their families are facing to accessing services and supports statewide.

RAP Family Advisors

In addition to their role on the RAP Expert Panel Advisory Committee, RAP Family Advisors have additional opportunities to share information and advise the Regional Autism Assistance Program.

Partners and collaborators

DCCH staff work with many CYSHCN-focused groups such as the Developmental Disabilities Council, the Iowa Council for Early ACCESS, the Iowa Autism Council, and statewide collaborations focused on issues such as bullying and obesity. The CYSHCN program is co-located and works closely with Iowa's UCEDD and the LEND program.

Iowa's Title V staff are regularly involved in projects at the national level with AMCHP and other MCH organizations. Evidence is utilized to inform program components or activities within Iowa's State Action Plan.

III.E.2.b. Supportive Administrative Systems and Processes

III.E.2.b.i. MCH Workforce Development

Iowa's Title V Maternal and Child Health 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 11.75 FTEs directly funded by Title V. Within the BFH and Bureau of Oral Health Delivery Systems there are 39 professional staff and 4 support staff that work on behalf of the Title V program. Iowa has 24 local MCAH agencies spanning all 99 counties. Local MCAH agencies are chosen through a competitive RFP process. These 24 agencies have a combined workforce of 314.89 FTEs, funded through the federal/state/local partnership. Iowa's Title V workforce is competent in delivering core services, understanding the needs and issues of the vulnerable population they serve and developing partnerships with other community service providers.

A strengthened workforce will lead to improved collaborations and will drive organizational change while enhancing staff competencies. Title V state staff are continually assessing the training needs at both the local and state levels. Once a year Title V MCAH conducts a Fall Seminar to discuss topics that affect the entire system/state and provide professional development programs. Title V staff are planning to conduct a virtual Fall Seminar in 2020 due to COVID-19.

IDPH continues to aim to incorporate health equity into all department functions, including surveillance, planning, implementation, and evaluation. Health equity is defined as supporting opportunities for people to live the healthiest life possible by addressing social, economic and environmental barriers that impact health outcomes.

Specifically, BFH and Title V are working to provide trainings on health equity to state and local staff to expand knowledge on how to better meet the needs of Iowa's changing population. Through Iowa's Needs Assessment process there were many efforts to assess the current health status and needs of disparate populations. The results and current national evidence/best practices are currently being incorporated into state level and local level plans to continue addressing health equity in all levels and populations in Iowa.

In the summer of 2020 Iowa participated in the MCH Workforce Development Center Paired Practicum. The project involved doing a literature review and looking at best practices across the nation as it relates to each of Iowa's selected NPMs and SPMs. An informational one-pager on each of the NPMs and SPMs will be created to easily orientate state and local staff on the activities and the reason behind selecting the respective performance measures.

BFH currently uses the MCH Navigator to assist with new employee orientation. Since Title V is the basis for nearly all of the work in the bureau, it is crucial that new staff have a baseline knowledge of MCH and how their work fits into the MCH system.

DCCH holds an in-person staff meeting for all staff statewide in the fall and regional in-person meetings in the spring. The spring meetings were cancelled this year due to COVID-19. During the COVID-19 period, semi-weekly virtual meetings were held for DCCH's approximately 100 staff members, and then later weekly meetings. The meetings included a variety of topics related to workforce development, including impacts of COVID-19, such as food insecurity. A webinar was recently held to increase staff knowledge of issues related to supported decision making for transition aged-youth. DCCH is also co-located with the Iowa LEND program and provides education for the program and mentorship for family trainees. DCCH staff regularly serve as preceptors for the University of Iowa College of Public Health's MPH students. DCCH and BFH staff provided support for the College of Public Health's successful federal grant application to begin a Maternal and Child Health Training program. Efforts to build the Family leadership workforce have continued, as well as, building capacity to provide services to families from diverse backgrounds.

- The Iowa Family Leadership Training Institute (IFLTI) trains caregivers of CYSHCN who are interested in learning to advocate at the individual, community, and policy levels. This year, the IFLTI worked with the fifth cohort of trainees. The goals for this cohort are to strengthen family capacity to 1) Understand how to work with partners, 2) Become aware of one's own path to leadership, 3) Discover strategies for advocacy, and 4) Prepare a community service project having an impact at the community or systems level.

- The Iowa Peer and Family Peer Support Specialist (FPSS) Training Program provides comprehensive training for Iowa's family peer support workforce including the development of statewide networks and continuing education opportunities. This program is a collaboration among DCCH, the University of Iowa National Resource Center for Family Centered Practice, ASK Resource Center (Iowa's Family Voices affiliate), and the National Alliance on Mental Illness Iowa. A Family Peer Support Specialist is a parent or primary caregiver of a child with an emotional, behavioral, or mental health disorder. They work with families who also have children with serious mental health disorders. The Title V program provides infrastructure support for this Iowa Department of Human Services funded project.

Increasing cultural diversity in the workforce is a need within Iowa's System of Care for CYSHCN. Outreach to family-serving organizations across the state will continue in order to build relationships and share information about the services

that are available through the Title V CYSHCN program. The development of these relationships will also enable DCCH to identify potential staff to help build a workforce that is more reflective of the racial and ethnic composition of the state. In the last year, DCCH has increased outreach efforts and has one Spanish-speaking family navigator, and one who is connected to the Marshallese population. DCCH has interpretation services for most languages available through the University of Iowa Health Care system.

III.E.2.b.ii. Family Partnership

Iowa's Title V program sees the value and need for family and client involvement in the development and implementation of all state MCH activities. While the CYSHCN program has established protocols in place, the other population domains have struggled to successfully involve families and clients. Staff have networked with Region VII and other state Title V Directors to discuss strategies for this involvement, however, this remains a challenge across the region and nation for all populations outside of CYSHCN.

Maternal and Child Health Advisory Council
The MCH Advisory Council allows IDPH and CHSC to connect with families, consumers, and stakeholders. The council assists in the development of the state plan for MCH, including CYSHCN, WIC, and family planning. They also contribute to the assessment of need, prioritization of services, establishment of objectives, and encouragement of public support for MCH, WIC, and family planning programs. In addition, the council advises Iowa's Title V director and advocates for health and nutrition services for women and children and supports the development of special projects and conferences. The Council includes family members and/or consumers of the services provided through Title V.

Health Equity Advisory Committee
The Health Equity Advisory Committee (HEAC) provides guidance to The Bureau of Family Health at the Iowa Department of Public Health for the Maternal, and Child and Adolescent Health (MCAH) programs and the service delivery conducted by contracting agencies across the state of Iowa. Through Iowa's 2021 needs assessment identifying differences in health among ethnic and racial minorities and other population groups with low income or who have historically had less access, power and privilege in Iowa to work on eliminating these disparities was a focus. Priority populations were identified to ensure representation throughout the needs assessment process and an advisory committee was formed. HEAC members representing each of these priority populations provide recommendations on the planning, content, and format of activities conducted by the contracting agencies with a health equity focus. Priority Populations for 2020-2025 include: Black, African American or African Latino, Hispanic, Native American or Alaska Native, Asian or Pacific Islander, Refugee or Immigrant, Persons with Disabilities, Lesbian, gay, bisexual, transgender, queer, intersex plus (LGBTQI+) and Fathers or Men.

CYSHCN
The Title V Program for CYSHCN supports a systems-oriented approach to care for Iowa families including the delivery of comprehensive, coordinated, and family-centered services. DCCH employs a full-time Family Engagement Program Manager who is the parent of a young adult with special health care needs and works to build the family leadership workforce and assure that the family perspective is represented at all levels of DCCH decision-making. Family support and engagement is one of four main goals of the DCCH strategic plan created in 2017, and revised to be called Family Partnership in 2020.

DCCH has a long history of employing family support professionals, now known as Family Navigators. Iowa's first Family Navigator, Julie Beckett, was hired by Child Health Specialty Clinics in 1984. Ms. Beckett worked with state and federal officials to develop the "Katie Beckett Waiver," which was passed into federal law in 1982. Since that time, Iowa has continued to build infrastructure for family-centered care and partnerships.

DCCH has developed a robust, statewide Family Navigator Network. Currently, there are 31 Family Navigators in the Network. All DCCH Regional Centers include at least one trained Family Navigator who is a paid staff member and the parent or primary caregiver of a CYSHCN. Family Navigators provide family support, and assure that the family voice is heard.

In 2014, DCCH created a Family Advisory Council (FAC) to assist with the planning, development, and evaluation of programs and policies that impact the System of Care for Iowa CYSHCN. Members come from areas across the state, both rural, and urban, with primarily mothers, one father and one youth member. Each February, the FAC participates in a "Day on the Hill" with the Iowa Legislature. A member of the FAC serves on the MCH Advisory Council.

In 2016, DCCH created the Iowa Family Leadership Training Institute. The goals of this program are to help parents develop their advocacy and leadership skills and to understand the history and role of families as change agents in the System of Care. Participants are required to complete a Community Service project. Over 50 parents have completed this training in five years. An additional 48 families participated in regional trainings using specific modules from this program. Due to COVID-19, the IFLTI successfully pivoted to an online program in 2020.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

SSDI supports IDPH through the identification of data sources to address and monitor MCH issues including maternal access to prenatal care, birth outcomes by hospital level, and appropriate referrals for care in Iowa's regionalized system of perinatal care. BFH staff regularly submit hospital level information to the Perinatal Team to monitor and provide technical assistance including assurance that very low birth weight infants are born at appropriate level hospitals. SSDI will continue to support IDPH by using available data to evaluate women's access to 17P to prevent preterm delivery, smoking cessation services, and support the efforts of the Iowa Statewide Perinatal Care Program.

BFH has successfully created linkages among multiple data sets, including birth certificate/vital record information to hospital discharge data, and to Medicaid paid claims. Although these data reside in different state departments, these programs maintain 11 regularly scheduled data interfaces. Strategic three-way communication links are established between the Iowa Medicaid Enterprise (and its contractors), the IDPH Bureau of Information Management (BIM), and BFH. As a result, Iowa's MCH community receives important information for program management and policy development. The annual linkage of Iowa's birth records and Medicaid claims files reveals trends in Iowa birth outcomes and potential differences between the Medicaid and non-Medicaid populations. This also allows BFH to evaluate access to prenatal care, tobacco use, and postpartum contraceptive access.

BFH has also linked birth certificate data to hospital discharge data to identify the prevalence of newborn abstinence syndrome (NAS) and severe maternal morbidity. IDPH uses these data linkages to identify risk factors in certain populations, provide information and recommendations to providers, and guide program planning and development. In the next five-year funding period, SSDI will assist to develop strategies that reduce barriers to data linkages and to promote the transformation of data into action.

SSDI staff regularly update the data in the Minimum-Core Dataset Indicator Workbook and the data needed for tracking Title V NPM and SPMs. With the progress of SSDI and the continued push for more streamlined data collection, the process has become less burdensome. Due to a recent shift in focus of goals and objectives, the Title V report has become more robust and includes more user-friendly data.

SSDI supports staffing for the Data Integration project. This project successfully combined databases from BFH programs into a comprehensive system. SSDI will continue to support this data system to help reduce the burden on local contractors to collect data from multiple systems.

III.E.2.b.iv. Health Care Delivery System

The Title V Maternal and Child & Adolescent Health (MCAH) program and the Iowa Medicaid program have a close, mutually beneficial working relationship for over three decades. The foundation for this relationship is the contract established each year between the Iowa Department of Public Health (IDPH) and the Iowa Department of Human Services (DHS) - Iowa Medicaid Enterprise (IME). This agreement is established for a period of six years and renewed annually through an amendment that addresses language and budget updates. This contract - known as the Omnibus Agreement - does not include services for children with special health care needs.

The Omnibus Agreement includes a Cooperative Agreement at its core with four attachments addressing specific program elements. The purpose of each component is as follows:

- The Cooperative Agreement is established for the purpose of mutual cooperation, developing and sustaining a collaborative relationship to promote the availability of comprehensive, cost effective, and quality health services for its beneficiaries. The development of a strong working relationship at the state level helps to prevent duplication of services and assists local human services offices and health agencies to develop cooperative relationships. This core component addresses cooperation between Title V, Title X, WIC, Title XIX, and Title XXI programs. Roles of DHS and IDPH are identified, and program descriptions are included. There is no funding attached to the Cooperative Agreement section.
- Attachment A - Informing and Care Engagement Administrative Services: The purpose of Attachment A is to establish parameters for Title V local contract agencies to provide and receive payment for the following:
    - Informing families of new Medicaid eligible children ages 0 to 21 years of the benefits and services within the EPSDT program.
    - Providing medical care coordination services for pregnant women and children on Medicaid who are not enrolled in a Medicaid Managed Care Organization (MCO). This allows clients to be linked to a medical home and other needed services. The Medicaid MCOs hold the contractual responsibility for providing medical care coordination for MCO enrolled clients.
    - Providing dental care coordination for any Medicaid enrolled pregnant woman or child. This allows clients to be linked to oral health services provided by a dentist and coordinate oral health care services.
    - Providing presumptive eligibility determinations for low income pregnant women without health care coverage. This service is open to the uninsured – both citizens and non-citizens. It allows immediate Medicaid coverage for a limited period of time until a full eligibility determination can be made by Iowa DHS. The pregnant woman is able to receive Medicaid covered maternal health services right away and establish an OB provider.
    - Providing interpretation services, as needed, for the above informing, care coordination, and presumptive eligibility services.

Funding for the above services is paid by Iowa DHS to IDPH. IDPH in turn provides payments to local Title V contract agencies that provide the services for clients in their service area. Because the above are considered Medicaid administrative services, funding is derived from a 50 -50 split of Iowa DHS and Medicaid matching funds. Medicaid data files provided by Iowa DHS, quality review of claims by IDPH, and performance measure reporting to DHS are built into this portion of the agreement.

- Attachment B - EPSDT, Maternal Health, Oral Health, and 1st Five: This attachment defines staffing for program support for the following:
    - EPSDT: Provides IDPH staff support for quality monitoring of EPSDT services provided by Title V contract agencies. Iowa Medicaid established a provider type known as Screening Centers for Title V so that local Title V Child & Adolescent (CAH) Health contract agencies can bill Medicaid (or Medicaid MCOs) for EPSDT screening services. Bureau of Family Health staff provide training, consultation, technical assistance, and quality review of local contract agencies (e.g. chart audits). Typically, the full well child exam is provided by primary care practitioners (the child's medical home). Title V agencies provide limited gap-filling direct care services.
    - Maternal Health: Provides IDPH staff support for quality monitoring of maternal health services provided by Title V contract agencies. Iowa Medicaid established a provider type known as Maternal Health Centers for Title V so that local Title V Maternal Health contract agencies can bill Medicaid (or Medicaid MCOs) for prenatal and postpartum support services. Bureau of Family Health staff provide training, consultation, technical assistance, and quality review of local contract agencies (e.g. chart audits). Prenatal exams are provided by primary care practitioners (OB or other practitioners) in the maternal medical home. Title V agencies provide limited gap-filling direct care services for this important population.

- Oral Health: Provides IDPH staff support for implementation of the I-Smile™ dental home initiative to improve access to Medicaid dental prevention and treatment services for children and pregnant women. It also provides for quality monitoring of oral health services provided by Title V contract agencies. Oral health preventive services are billable by local Title V contract agencies to Iowa Medicaid for pregnant women and children under the Maternal Health Center and Screening Center provider types. IDPH Oral Health Center staff provide training, consultation, technical assistance, and quality review of local contract agencies. Facilitating access to dentists for dental exams is a primary focus.

- 1st Five Children's Healthy Mental Development: Provides IDPH staff support for quality monitoring of 1st Five sites located within Title V contract agencies in 88 of Iowa's 99 counties. Education, consultation, and technical assistance is provided to 1st Five contract agencies to work with local primary care practices to ensure that recommended guidelines for developmental screening, referral processes, and identification of local resources are implemented for Medicaid enrolled children. Funding for 1st Five program evaluation is also included.

Funding to support the above is a blend of IDPH, Iowa DHS, and Medicaid matching funds. Data tracking by IDPH and performance measure reporting to DHS are built into this portion of the agreement. The agreement also includes maintenance and support for signifycommunity (formerly TAVConnect), the integrated data system for documenting services.

- Attachment C – Maternal and Child Health and Hawki Outreach Services: This attachment provides support for the following:
  - Maternal and Child Health Outreach Services: Supports implementation of the toll-free 1-800 phone line so that women, youth, and families can receive information and referral for questions relating to prenatal care and well child services in addition to other services the family may need. IDPH contracts with Iowa State University (ISU) Extension for staffing Iowa's Healthy Families Line and Teen Line for youth. Callers are able to be patched directly into their local Title V contract agency as needed so that local staff can provide assistance. ISU Extension also stores and distributes numerous educational materials used by local Title V contract agencies. Extensive data is reported each month on calls and support activities of the ISU Extension staff.

  - Hawki Outreach: Provides support for a state level Hawki Outreach Coordinator and funding for local Title V CAH contract agencies to conduct Medicaid and Hawki outreach activities to promote enrollment. Hawki is Iowa's SCHIP program. Local outreach activities are conducted with schools, faith-based organizations, medical and dental providers, special populations, and others.

    This component also supports the provision of presumptive eligibility services for children without health care coverage. This service is open to uninsured children who are U.S. citizens. It allows immediate Medicaid coverage for a limited period of time until a full eligibility determination can be made by Iowa DHS. The child is able to receive covered health services right away and establish medical and dental homes.

Maternal and Child Health Outreach is supported by a blend of IDPH and Medicaid matching funds. Hawki Outreach Services are supported by Iowa DHS and Medicaid matching funds. Data is tracked by IDPH, DHS, and/or its contractors. Performance measure reporting to DHS is also built into this portion of the agreement.

- Attachment D – Medicaid and Vital Records Linked Data: Provides support for linking vital records data files and Medicaid paid claims data to evaluate health outcomes to related to Medicaid services provided for pregnant women and children. It provides important information on maternal characteristics and birth outcomes used for policy development and program planning. Funding is a blend of IDPH and Medicaid matching funds. Through this attachment, IDPH funds the MCH Epidemiologist, through an agreement with the CDC. Performance measure reporting to DHS is built into this portion of the agreement.

In February 2020, Iowa's Title V MCH and CYSHCN Directors and Iowa's Medicaid Director were part of HRSA's meeting of six model states to engage in a discussion around promising approaches to promote cross-program collaboration.

Program outreach and enrollment

Promoting outreach and enrollment occurs at a number of levels. Title V supports various websites and the 1-800 Healthy Families Line and Teen Line, and contracts with local community-based public or private non-profit organizations serving all counties in Iowa. Local contractors conduct outreach for Title V, Medicaid, and Hawki by linking with other programs (e.g. WIC), collaborating with local partners, participating in community events such as health fairs or Give Kids A Smile Day, publishing health promotion articles, posters, and brochures, and working with individual families. Presumptive eligibility services for pregnant women and children are provided by Title V MCAH agencies and promote enrollment into Medicaid and Hawki.

IDPH contracts with EveryStep, a non-profit agency in Polk County, to administer the Iowa Family Support Network or IFSN (www.iowafamilysupportnetwork.org). The IFSN serves as a coordinated intake system for home visiting/family support programs statewide, Early ACCESS (IDEA, Part C) and the Children at Home program. The IFSN also houses a statewide resource directory that includes local MCAH agencies, among many other programs.

Health care financing

Beyond Title V grant funding, Medicaid is the primary payer of client based services provided by local Title V MCAH contract agencies. Gap-filling medical direct care services provided by Title V MCAH agencies are billed to Iowa Medicaid for Medicaid fee-for-service clients (approximately 5% of the Medicaid population). Medical direct care services are billed to Iowa's Medicaid MCOs for MCO enrolled clients (approximately 95% of the Medicaid population). The MCOs serving Iowa Medicaid enrollees are Amerigroup and Iowa Total Care.

Medical care coordination is included in the MCO's contract with DHS. As a result, local Title V MCAH contract agencies are not able to bill for medical care coordination services provided for MCO enrolled clients. This has had a significant impact on the continuity of care that Title V contract agencies are able to provide for their population. Agencies are able to bill IME for medical care coordination provided for the Medicaid fee-for-service population (approximately 5%) and for dental care coordination for any Medicaid enrolled MCAH client.

Transportation services provided by local Title V MCAH agencies have also been significantly impacted by the advent of Medicaid MCOs. Historically, Title V agencies have been able to arrange and bill specific types of transportation services for Medicaid clients through their Screening Center or Maternal Health Center provider types. This enabled local staff to assist clients to gain access to Medicaid covered services/appointments. This ability is now limited to only the Medicaid fee-for-service population, as each Medicaid MCO has a transportation broker for handling rides for the MCO enrolled population. Iowa Medicaid also has a transportation broker for serving the Medicaid fee-for-service population. MCAH agencies have experienced many reports from clients regarding difficulties and lack of flexibility of services offered through the transportation brokers.

Waiver Programs

Iowa currently has seven Home and Community Based Services (HCBS) Waivers that provide funding and individualized supports to allow eligible members to live in their own homes and communities. Five of these Waivers apply specifically to Iowa CYSHCN: the Health and Disability Waiver, the Intellectual Disability Waiver, the Brain Injury Waiver, the Physical Disability Waiver, and the Children's Mental Health Waiver. Waivers for CYSHCN currently cover about 16,500 children. Nearly 6,000 children are on waitlists for waiver programs.

DCCH provides consultation, technical assistance, planning and care coordination activities for about 600 individuals who are on the Health and Disability Waiver waiting list and not yet eligible for Medicaid.

Joint Policy Level Decision Making

Over the years, the Bureau Chief of Family Health has experienced many opportunities to meet with Iowa's Medicaid Director on joint policy issues and problem resolution. Examples include working together to plan, pilot, and fully implement the informing and care coordination program; shifting Iowa's care management from 'targeted case management' to 'administrative care coordination' based upon federal clarification; including interpretation for PE, informing, and care coordination as a service paid by IDPH to local MCAH agencies through DHS funding; increasing Medicaid's reimbursement rate for certain services based upon Cost Analyses completed by local Title V MCAH contract agencies; establishing third party billing policies; and resolving some instances of lack of payment to local contract agencies from the MCOs.

Approximately thirteen staff from various programs within the Bureau of Family Health and Oral Health Center meet monthly with the IME Maternal Health Center & Screening Center Project Manager, IME Oral Health Project Manager, and IME Contract Manager. The meetings provide an opportunity for staff to pose questions and concerns, provide input, and receive guidance and updates from IME on Medicaid policy and current issues. Challenges that local MCAH agency contractors have experienced with the April 1, 2016 transition to Medicaid Managed Care are presented and discussed. IDPH staff share information on progress within Title V MCAH and other programs of mutual interest.

III.E.2.c State Action Plan Narrative by Domain

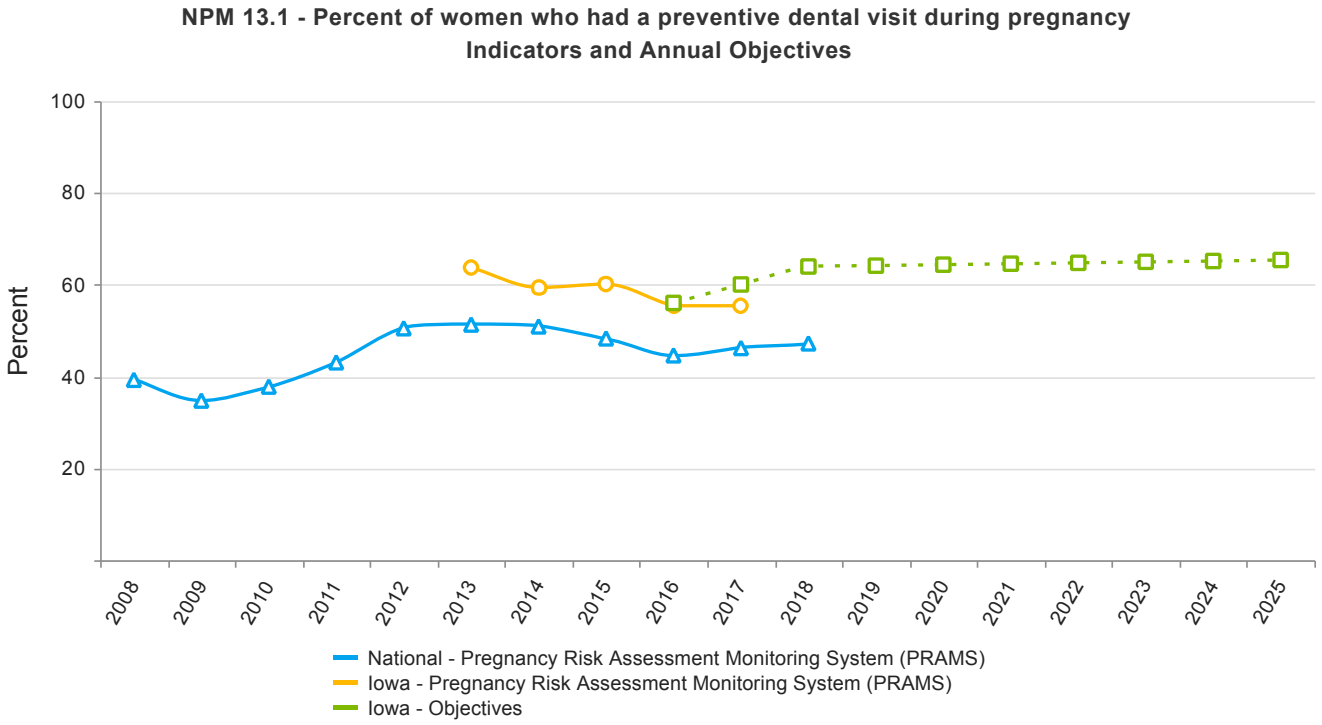
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2017	54.7	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2014_2018	13.9	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2018	6.9 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2018	9.9 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2018	25.3 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2017	4.9	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.3	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2017	3.3	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.0	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2017	130.1	NPM 1 NPM 14.1
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	98.9	NPM 14.1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	5.7 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2017	2.7	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	9.3 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	89.0 %	NPM 13.1 NPM 14.1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	15.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2017	7.4 %	NPM 1

National Performance Measures



Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	56	60	63.9	64.1
Annual Indicator	59.2	60.2	55.3	55.3
Numerator	21,739	21,891	19,796	19,796
Denominator	36,708	36,352	35,811	35,811
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	64.3	64.5	64.7	64.9	65.1	65.3

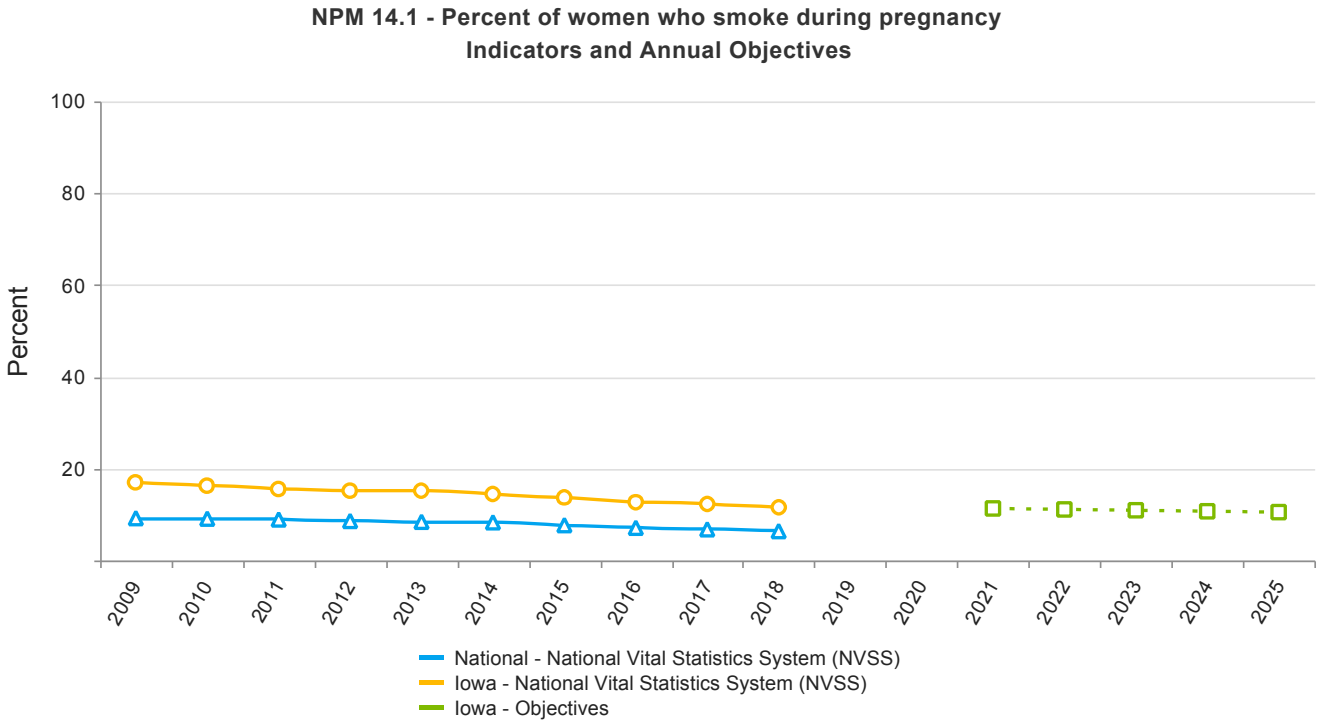
Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			355
Annual Indicator			397
Numerator			
Denominator			
Data Source			Local Title V MCAH Year End Report
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0



Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2019
Annual Objective	
Annual Indicator	11.6
Numerator	4,388
Denominator	37,751
Data Source	NVSS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	11.4	11.2	11.0	10.8	10.6

Evidence-Based or –Informed Strategy Measures

ESM 14.1.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	55.0	60.0	65.0	70.0

State Performance Measures

SPM 1 - Number of pregnancy-related deaths for every 100,000 live births

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	9.0	8.9	8.8	8.7	8.6

State Action Plan Table

State Action Plan Table (Iowa) - Women/Maternal Health - Entry 1

Priority Need
Dental Delivery Structure of the MCAH Population

NPM
NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives
By 2025, increase the percent of women who had a preventive dental visit during pregnancy to 65.3%

Strategies
Build partnerships with organizations and health care providers
Outreach to dental and medical providers
Oral health promotion
Care coordination and referrals
Gap-filling preventive services

ESMs	Status
ESM 13.1.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator	Active

NOMs
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Iowa) - Women/Maternal Health - Entry 2

Priority Need

MCAH Systems Coordination

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

By 2025, decrease the percent of women who smoke during pregnancy to 10.6%

Strategies

Local Title V agencies utilize standardized screening tool for tobacco use (Ask Advise Refer) and motivational interviewing techniques with trained staff

Local Title V agencies collaborate with their local tobacco coalitions to provide community education and outreach specific to tobacco use in pregnant women

Collaborate with IDPH Tobacco Division to implement an incentive program for pregnant women accessing the Iowa Quitline pregnancy program

Provide opportunities for local Title V agencies to receive training and technical assistance on tobacco cessation

Provide opportunities for local Title V agencies to receive training and technical assistance on tobacco cessation

MH agency staff providing health education will do so in a way that recognizes cultural beliefs and experiences

ESMs	Status
ESM 14.1.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Iowa) - Women/Maternal Health - Entry 3

Priority Need

MCAH Systems Coordination

SPM

SPM 1 - Number of pregnancy-related deaths for every 100,000 live births

Objectives

By 2025, decrease the number of pregnancy-related deaths for every 100,000 live births to 8.6

Strategies

Title V MH agencies will be provided training and communication related to the most recent MMRC findings and recommendations

Title V MH agencies provide screenings and education on topics specific to preventing maternal mortality

MH agency staff providing health education will do so in a culturally and linguistically appropriate way. Specific maternal mortality topics will be tailored to reflect cultural beliefs and experiences, particularly related to minority women impacted by maternal mortality at a higher rate.

Title V MH agencies provide postpartum home visits to clients. Clients who decline receive a follow up phone call.

Conduct annual Maternal Mortality Reviews with a multi-disciplinary review committee and distribute findings and recommendations widely

Title V MH staff, in collaboration with the University of Iowa Department of Obstetrics and Gynecology, will develop the Iowa Maternal Quality Care Collaborative (IMQCC)

Title V MH staff will assist the IMQCC in joining the Alliance on Innovation in Maternal Health (AIM) and implementing hospital safety bundles

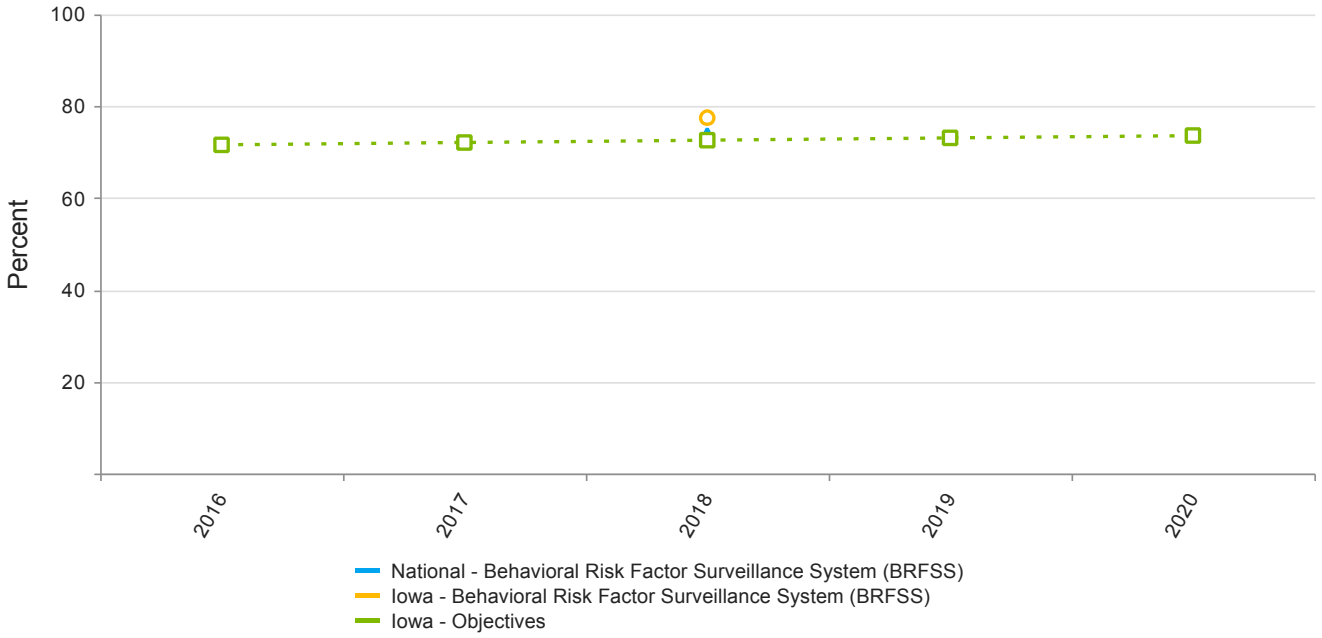
Maternal Mortality Committee will recruit multidisciplinary members to participate in the review process

All Maternal Mortality Case Summaries will be entered into MMRIA and the de-identified data shared with the CDC

The Maternal Mortality Review Committee will be trained on and begin using the Committee Decision form designed by the CDC in MMRIA.

2016-2020: National Performance Measures

2016-2020: NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	71.5	72	72.5	73
Annual Indicator	69.0	67.2	67.0	77.3
Numerator	359,806	353,545	353,700	407,591
Denominator	521,137	525,862	527,557	527,210
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 1.1 - Percent of Title V maternal health participants that received education on continuing their health care coverage.

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		65	35	54
Annual Indicator	64	27.2	48.6	51.8
Numerator	5,478	296	1,357	1,842
Denominator	8,560	1,090	2,794	3,559
Data Source	WHIS	TAV Connect	TAV Connect	Signifycommunity
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: State Performance Measures

2016-2020: SPM 2 - A)Percent of children 0-21 served by Title V who meet Iowa's Title V criteria as having a medical home B)Percent of women served by Title V who meet Iowa's Title V criteria as having a medical home

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		91	84.5	88
Annual Indicator	90.5	84	87	86.2
Numerator				
Denominator				
Data Source	CAReS and WHIS	TAV Connect	TAV Connect	Signifycommunity
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

NPM 1: Percent of women with a past year preventive medical visit

All new Title V MH staff received education on Iowa's State Family Planning Program, either through in person training or by viewing a recorded webinar. In July of 2017 Iowa's State Family Program replaced the Family Planning Medicaid 1115 Waiver which provides coverage for birth control for low income women. The program was shifted from a Federal Waiver through Iowa Medicaid to a State funded program through direct state appropriation. In FFY19, ongoing education was provided to local Title V agencies to ensure agency staff understood the program and were able to help eligible women access free or reduced cost birth control.

In Iowa, income eligibility for Medicaid decreases after pregnancy; many women lose Medicaid eligibility 60 days postpartum. To address this potential loss of insurance coverage the Title V MH program continued to evaluate insurance coverage after delivery and helped women re-establish insurance coverage if needed. Local MH staff were required to provide postpartum follow up to all clients, either through home visits, clinic visits, or phone calls. Title V MH staff provided appointment reminders for clients' postpartum visit with their health care provider and provided health education on methods of birth control.

Title V agency staff evaluated client's medical home status and see if the health care provider for their pregnancy would continue to provide medical care or if the client needed help finding a new health care provider. Local Title V MH agencies were required to work with community partners including Title X clinics, FQHC's, free clinics, and local providers to increase the number of women served and the quality of their visit. Two MH Title V agencies will continue to integrate services within private provider clinics.

NPM 13: A) Percent of women who had a dental visit during pregnancy

In 2019, OHC maintained the successful oversight and technical assistance for I-Smile™ and the MCAH contractors. OHC also addressed challenges, such as access to dentists for the MCAH population. Although OHC has limited impact regarding dental offices that accept Medicaid, we required I-Smile coordinators to make outreach visits to all general and pediatric dental offices within each service area. Developing and improving relationships with the offices is important to build stronger referral networks. In addition, the dental director communicated with the dental association's new director, identifying areas of common ground and methods to improve the public-private link. The dental director also continued discussions with the Iowa Dental Board regarding services provided by I-Smile dental hygienists within hospital systems/medical offices. OHC staff expanded partnerships with state stakeholders who have investments in oral health for underserved Iowans, including Iowa Medicaid and Delta Dental of Iowa Foundation.

OHC staff led the Cavity Free Iowa initiative, monitoring activities with the Mercy Des Moines health system and providing technical assistance to I-Smile coordinators around the state to implement similar projects in their areas. Coordinators oversaw the school dental screening requirement and were required to make outreach visits to all pediatric medical offices in their service areas to continue to build awareness about gaps in dental care for at-risk children. Additional outreach occurred with child care providers, using oral health training and setting up tooth brushing protocols to assist centers with Quality Rating System requirements. Oral health promotion continued through updates to the I-Smile website (ismile.idph.iowa.gov) and sharing education through the I-Smile Facebook page, targeting parents. (https://www.facebook.com/ISmileDentalHomeInitiative/?ref=bookmarks).

OHC received approval by the Iowa Dental Board for use of silver diamine fluoride (SDF) by dental hygienists using public health supervision. This secondary preventive measure can arrest some tooth decay, potentially reducing pain and costs for restorative care. OHC incorporated use of SDF within I-Smile, to include education for hygienists, recommended outreach to dentists, assurance of available training, and development of materials such as consents with photographs of teeth treated with SDF. SDF was offered and used, when appropriate, for MCAH participants receiving gap-filling preventive services through I-Smile.

SPM 2: B) Percent of women served by Title V who report a medical home

IDPH staff monitored data for the percent of women with a past year preventive visit and the pregnant women served who report a medical home. This was accomplished through reports from the signifycommunity Maternal Health module. Local MH contract agencies assessed medical home status within each episode as they provide preventive services for pregnant women. Medical home determinations will continue to be based upon those women with a 'yes' response to 'Do you have a medical home?' Local contract agencies monitored local medical home data. IDPH staff also monitored Barriers to Prenatal Care data for any barriers identified for women accessing

prenatal or delivery care.

Title V MH agencies assisted low income women who are not citizens and have no insurance in finding a medical home for their pregnancy. Most of these women accessed care through a local Federally Qualified Health Center or local health care providers that may provide care on a sliding fee scale or a reasonable payment plan. Local Title V MH agencies promoted well woman preventive visits. They were required to work with community partners including Title X clinics, FQHC's, free clinics, and local providers to increase the number of women served and the quality of their visit. Two MH Title V agencies continued to integrate services within private provider clinics.

The Medicaid Maternal Health Task Force met quarterly with the MCO medical directors and MCO maternal health program leadership to discuss quality prenatal care for Medicaid members including access to prenatal care.

Women/Maternal Health - Application Year

NPM 13: A) Percent of women who had a dental visit during pregnancy

I-Smile™ is the oral health component of Iowa's Title V Maternal, Child, and Adolescent Health (MCAH) program. Staff with the Iowa Department of Public Health's Bureau of Oral and Health Delivery Systems (OHDS) manages I-Smile™, which includes I-Smile™ @ School (school-based sealant program). I-Smile™ connects children, pregnant women, and families with dental, medical, and community resources to ensure a lifetime of health and wellness. OHDS staff provide oversight and technical assistance for I-Smile™. Each Child and Adolescent Health contractor is required to have a dental hygienist who serves as the local I-Smile™ Coordinator. OHDS and I-Smile™ Coordinators have a strong relationship and strive to improve the oral health of Iowans. I-Smile™ Coordinators must spend at least 20 hours a week on public health services and systems-building and enabling services. I-Smile™ Coordinators also serve the MH population. In agencies where the MH and CAH agencies are separate coordination is required to ensure MH clients have access to oral health services.

OHDS staff use data to determine focus areas within I-Smile™. Data sources include the MCAH data system, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Dental Services Reports, and oral health screening surveys. Data is analyzed by the bureau's epidemiology consultant, who also facilitates quarterly quality assurance reviews of MCAH data with OHDS consultants to identify service gaps, data entry errors, and troubleshoot areas of concerns. Similarly, local I-Smile™ activities are determined using a needs assessment, updated each year using community data and information from the MCAH service area.

OHDS staff will hold quarterly I-Smile™ Coordinator trainings, to ensure program consistency, share best practices, develop leadership skills, and promote current standards and procedures. These training often include continuing education on current oral health topics and an open forum for sharing from the I-Smile™ Coordinators. OHDS staff will make a site visit to each contractor to discuss local work plans, review data, and troubleshoot concerns. OHDS staff will also participate in yearly chart audits to ensure documentation of services is accurate and provide technical assistance to each contractor.

Assuring good oral health for underserved children and pregnant women relies upon the strength of partnerships, both at the state and local levels. OHDS staff will maintain important partnerships with entities such as WIC and the 5210 project, Head Start, Healthy Child Care Iowa, Delta Dental of Iowa Foundation, Iowa Primary Care Association, Iowa Medicaid Enterprise, and the University of Iowa College of Dentistry. Partnership activities in FY21 will include training of local WIC staff; networking meetings with Head Start health Coordinators; providing support to sealant programs that are not administered by MCAH contractors, to assure maximum benefit for children statewide; and collaborating on oral health promotion campaigns, such as "Rethink Your Drink". Next year, OHDS plans to work with a new partner, Count the Kicks, to incorporate oral health into its program, which uses best practices and evidence-based strategies to save babies and prevent stillbirths. OHDS staff will provide assistance to Count the Kicks regarding oral health education and resources to keep moms and babies healthy. I-Smile™ Coordinators will work to educate and distribute Count the Kicks educational materials while doing outreach to medical and dental offices.

OHDS staff will maintain strong partnerships with Iowa Medicaid Enterprises (IME) and the Dental Prepaid Pre-Ambulatory Health Plan (PAHP) carriers for Medicaid in Iowa – Delta Dental of Iowa and Managed Care of North America. Partners are discussing the potential for children to be covered by PAHP in the future and strategizing how to work together for the health of Iowa Medicaid members.

OHDS staff also facilitate advisory workgroups for I-Smile™ @ School and community water fluoridation (CWF). In addition to partners already mentioned, workgroup members include: Iowa State Education Association, Iowa School Nurse Organization, Iowa Department of Education, local MCAH contractor staff, American Water Works Association, Iowa Department of Natural Resources, Iowa Public Health Association, Iowa State Hygienic Lab, and Iowa Association of Water Agencies. Another important collaboration is Cavity Free Iowa, a workgroup focused on increasing training for medical office staff to apply fluoride varnish for children at well-child exams. Trainings are provided by I-Smile™ coordinators.

I-Smile™ Coordinators are also responsible for maintaining local partnerships. In FY21, I-Smile™ Coordinators are required to develop at least one new local partnership as well as improving and expanding partnerships with a minimum of four existing partners to benefit families served through I-Smile™. I-Smile™ Coordinators are holding medical/dental summits and facilitating and creating local coalitions to educate communities about oral health. Next year, I-Smile™ Coordinators will make face-to-face outreach visits with all general and pediatric dental offices within their service areas, outreach visits to family practice medical offices and/or pediatric medical offices, provide trainings for medical office staff as requested, and conduct oral health promotion at community events.

I-Smile™ Coordinators will train MCAH staff about oral health, ensuring staff is competent regarding oral health as it pertains to the informing process and care coordination; about oral health in accordance with the EPSDT periodicity schedule; and about proper techniques for direct preventive dental services (e.g., screenings, fluoride applications) and most current guidance for oral health education and anticipatory guidance. OHDS will maintain its stock of promotional materials that can be used for new moms as part of outreach to hospitals as well as for children and

families. The I-Smile™ Facebook page will target parents/guardians with information and education about good oral health for children as well as during pregnancy.

I-Smile™ Coordinators will work with MCAH staff to continue focus on referrals to dentists and improved access to resources that address social determinants of health through individualized care coordination for those who need it. OHDS staff will offer technical assistance to MCAH contractors regarding best practices for providing care coordination. An online training is available for all local MCAH staff who provide care coordination, including information about proper documentation requirements. OHDS staff will work with Bureau of Family Health staff to assure proper documentation within the MCAH data system by completing service note review and working with Iowa Medicaid Enterprise to assure funding for dental care coordination is continued. In addition, the 2019 oral health survey of children at WIC found that children in racial/ethnic populations of color are more likely to experience decay but not restorative dental treatment. OHDS staff are identifying outreach and care coordination plans to use with MCAH contractors that will help ensure populations of color receive the care needed.

Access to dentists for Iowa's Medicaid-enrolled and under/uninsured families continues to be difficult. In 2019, 1,842 fewer Medicaid-enrolled children received care from a dentist than in 2018, demonstrating the need for MCAH contractors to continue to provide gap-filling preventive services. In FY21, dental hygienists and registered nurses will provide gap filling preventive services, such as dental screenings and fluoride varnish treatments at WIC clinics. Dental hygienists will also provide services as needed at child care centers, Head Start centers, and preschools. Dental hygienists will offer dental screenings, fluoride varnish applications, individual and classroom oral health education, and sealants to children in elementary schools with 40% or greater free/reduced lunch rates through the I-Smile™ @ School program. Oral health screenings are made available to maternal health clients during WIC clinics, and every client receives oral health education. Referrals and care coordination are provided as needed, following provision of all services.

As part of a HRSA oral health workforce grant, OHDS staff will work with I-Smile™ Coordinators to incorporate silver diamine fluoride applications for children within preventive services offered at WIC. When applied to tooth decay, silver diamine fluoride stops the decay process. In addition to reducing bacterial infection, use of silver diamine fluoride stops cavities from getting larger and can sometimes prevent the need for a restoration. Another component of the HRSA workforce grant is to work with I-Smile™ Coordinators to facilitate community-driven approaches to recruit dentists to towns that may be experiencing or will soon experience a shortage of dentists.

The full impact of the COVID-19 pandemic on the I-Smile™ program is not yet known. OHDS staff anticipate changes to infection control requirements for dental services in the future and have also heard that more dental offices have already declined accepting any Medicaid referrals due to upcoming anticipated backlog of dental care.

NPM 14: A) Percent of women who smoke during pregnancy B) Percent of children, ages 0 through 17, who live in households where someone smokes

IDPH MH staff will actively collaborate with staff from the Division of Tobacco Use and Prevention. This will include attending regular meetings to discuss collaborative projects, providing Iowa Quitline materials to local MH agencies, inviting subject matter experts to provide training and/or presentations at the MCAH fall conference and other in-person training events. Local MH agencies will be required to collaborate with their local tobacco coalition, funded by the Division of Tobacco Use and Prevention, and technical assistance will be provided by IDPH staff to facilitate collaboration as needed.

IDPH MH staff will also support staff in the Division of Tobacco Use and Prevention in implementing an incentive

program for pregnant women who smoke to participate in the Quitline maternal tobacco use program. This will include providing outreach and educational materials to local MH agencies to provide to clients related to the incentive program and educating statewide partners, such as the Iowa Maternal Quality Care Collaborative, the Iowa Neonatal Quality Care Collaborative, and the Iowa Statewide Perinatal Care Program, on the incentive program.

IDPH MH staff will provide training resources to all MH agencies, including online access to the Ask, Advise, Refer training. This is a standardized assessment and referral tool all agencies will be required to use with pregnant women who use tobacco. IDPH staff will share resources and events related to maternal tobacco use to agencies on a regular basis.

All local MH agencies providing direct services to pregnant women in Iowa will provide individualized health education on the importance of tobacco use cessation and refer interested clients to the Quitline. Local MH agencies providing direct services will receive training on providing education in a culturally and linguistically appropriate manner. This will be reviewed by IDPH MH staff during direct service chart audits.

SPM 1: Number of pregnancy-related deaths for every 100,000 live births

Title V MH staff will provide local agencies training and communication related to the most recent MMRC findings and recommendations. For FFY 2021 agencies will receive specific resources related to the importance of seatbelt safety and chronic disease management. Agencies will also receive training and resources from the AWHONN POST-BIRTH Warning Signs to improve client recognition and earlier access to care where there are life threatening emergencies.

Title V MH agencies provide screenings and education on topics specific to preventing maternal mortality. MH agencies are required to conduct depression screens, substance abuse screens, domestic violence screens, and tobacco screens on all MH clients receiving direct services. Clients also receive health education which includes specific topics related to recommendations from the maternal mortality review committee recommendations such as the importance of chronic disease management, nutrition, and physical activity.

Title V MH agencies will be required to identify gaps and needs for staff training on providing services with cultural humility. MH agency staff will receive training based on identified gaps and needs. All health education will be tailored to each individual client, with an emphasis on ensuring the education takes into account cultural beliefs and experiences.

Title V MH agencies in counties serving the highest number of Medicaid-eligible pregnant women will be required to offer postpartum home visits to MH clients receiving direct care services, with clients who decline receiving a follow up phone call. Postpartum home visits are conducted by a nurse and include depression screening and a physical assessment of the mother and infant.

IDPH will begin conducting annual Maternal Mortality Reviews with a multi-disciplinary review committee and distribute findings and recommendations widely. Previously Iowa's MMRC met every three years with a medical team only. Findings and recommendations from the June 2019 review will be distributed to local agencies, birthing hospitals, and other stakeholders working with pregnant and postpartum women. IDPH MH staff will work with the statewide perinatal care team to share findings and best practice recommendations with all birthing hospitals in Iowa.

IDPH MH staff are participating in the development of the Iowa Maternal Quality Care Collaborative (IMQCC). This

work is funded through the HRSA Maternal Health Innovation grant through FFY2024. Activities for FFY2021 will include development of the IMQCC, selection of membership, development and maintenance of the website, leadership and participation in meetings, and development of a strategic plan. Beyond 2024 this work will be supported by Title V.

IDPH staff will support the IMQCC, once developed, in efforts to join AIM and implement hospital safety bundles. The IDPH director or designee will appoint members and co-chair the IMQCC, and IDPH MH staff will participate in the collaborative to assist in the coordination of meetings, subcommittees, and other needs to ensure success of the IMQCC.

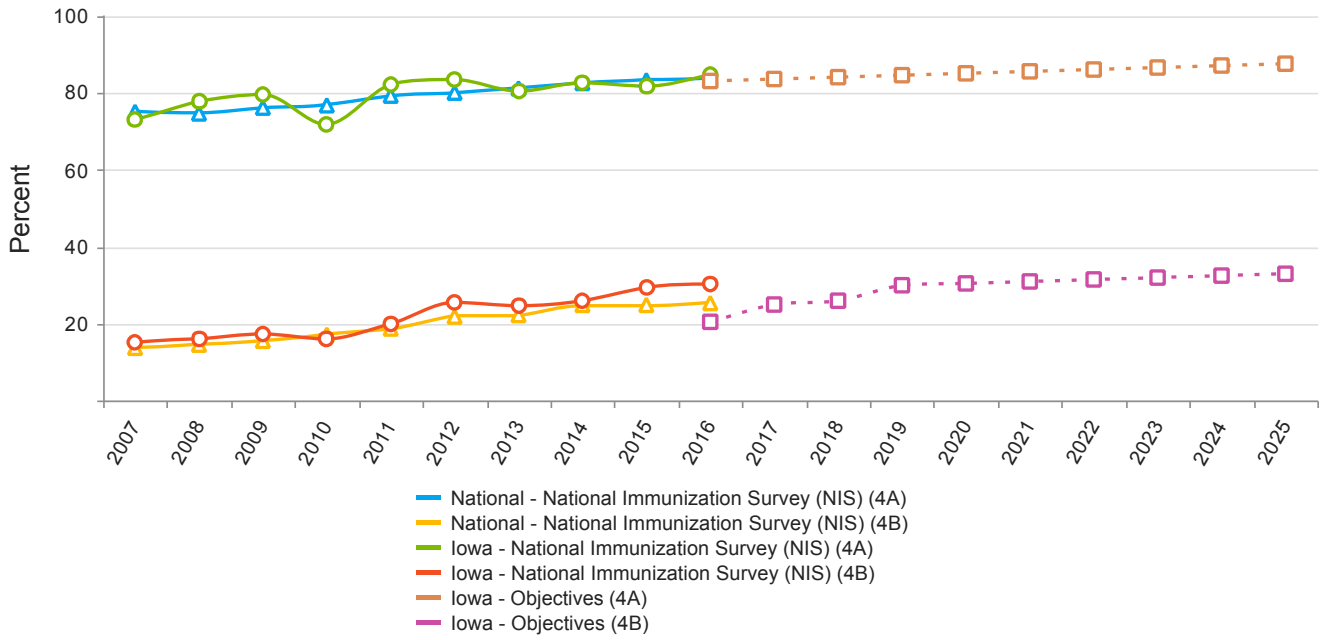
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2017	5.3	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2017	2.0	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2017	98.9	NPM 4 NPM 5

National Performance Measures

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	83	83.5	84	84.5
Annual Indicator	80.5	82.7	81.5	84.5
Numerator	26,118	31,692	29,306	27,589
Denominator	32,462	38,306	35,951	32,646
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	85.0	85.5	86.0	86.5	87.0	87.5

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20.5	25	26	30
Annual Indicator	24.9	26.1	29.5	30.5
Numerator	7,875	9,655	10,092	9,785
Denominator	31,681	36,965	34,193	32,069
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	30.5	31.0	31.5	32.0	32.5	33.0

Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	23.0	46.0	69.0	92.0	112.0

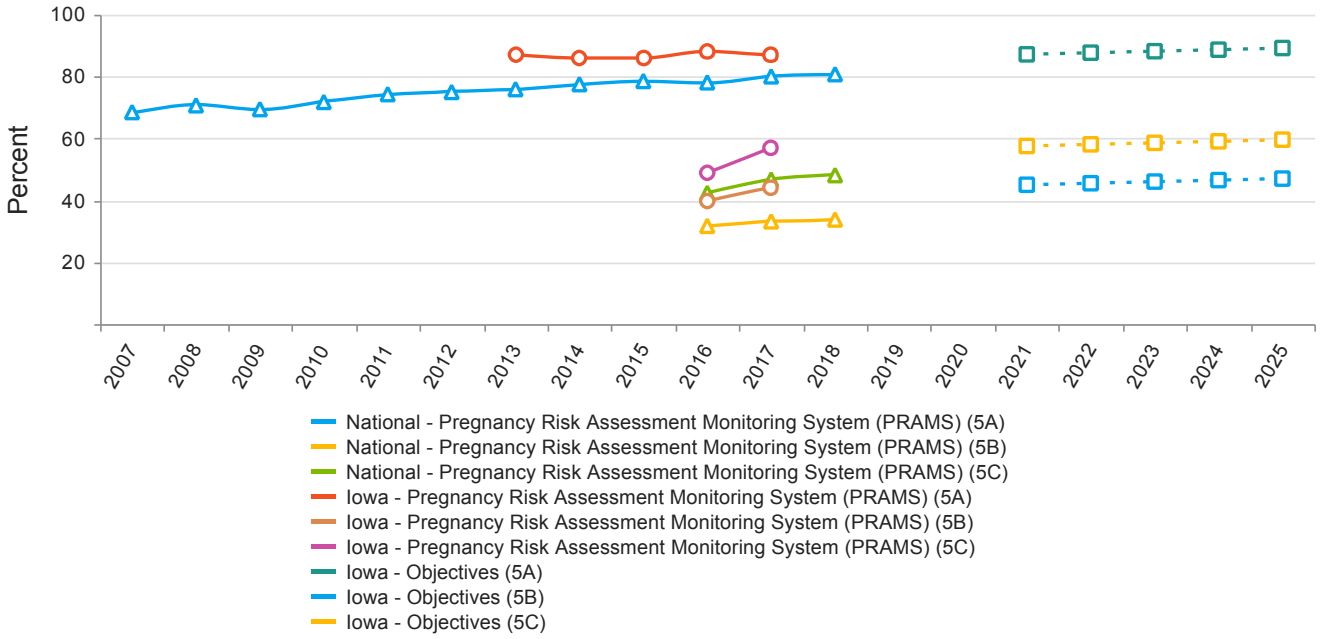
ESM 4.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	30.0	32.0	34.0	36.0	38.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	86.7
Numerator	30,649
Denominator	35,356
Data Source	PRAMS
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	87.0	87.5	88.0	88.5	89.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	44.2
Numerator	15,044
Denominator	34,022
Data Source	PRAMS
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	45.0	45.5	46.0	46.5	47.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	57.0
Numerator	19,594
Denominator	34,396
Data Source	PRAMS
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	57.5	58.0	58.5	59.0	59.5

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	14.0	16.0	18.0	20.0

State Action Plan Table

State Action Plan Table (Iowa) - Perinatal/Infant Health - Entry 1

Priority Need

Access to care for the MCAH Population

NPM

NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Objectives

By 2025, increase the percent of infants breastfed exclusively for 6 months to 33%

Strategies

Title V agency will collaborate with the hospital lactation consultant in their service area to ensure mutual referrals

Title V agency staff will join their local breastfeeding coalition

Title V agencies will work with a minimum of 1 local employer with a minimum of 50 employees per year to educate on breast pumping policy, laws and best practice

Title V agencies will ensure their staff are appropriately trained on current breastfeeding best practice through continued education

Title V agencies will link their clients to a WIC peer counselor when one is available

Title V agencies will maintain a list or directory of local breastfeeding resources to share with clients and the community

Title V agencies will refer clients to a lactation counselor when appropriate

TItle V agencies will provide breastfeeding educational materials to all clients

Title V agencies will provide health education on breastfeeding when providing direct care services

Title V agencies with develop individualized breastfeeding education that is tailored to each client’s needs, and will take into account cultural beliefs and experiences that may impact breastfeeding

Some Title V agencies will provide breast feeding classes for women in their service area if other classes are not available

ESMs	Status
ESM 4.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age	Active
ESM 4.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

State Action Plan Table (Iowa) - Perinatal/Infant Health - Entry 2

Priority Need

Safe and Healthy Environments

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

By 2025, increase the percent of infants placed to sleep on their backs to 89%

By 2025, increase the percent of infants placed to sleep on a separate approved sleep surface to 47%

By 2025, increase the percent of infants placed to sleep without soft objects or loose bedding to 59.5%

Strategies

Title V agencies will provide education about safe sleep environments to at least one community organization or retailer in their service area per year

Title V agencies will develop, and then provide each woman they serve with, a safe sleep resources directory

Women who need a free or low cost crib will be referred to that community service if one is available in the Title V service area

Women who receive direct care health education services will be provided safe sleep education based on the assessed needs of the mother

Minority women, who are clients of a Title V agency, will receive individualized education on safe sleep best practices that emphasizes the recommendations in a culturally appropriate way to meet the client where she is

A flyer on safe sleep will be distributed with each birth certificate on an annual basis to every new mom in Iowa

IDPH will work with Iowa birthing hospitals to encourage them to conduct safe sleep audits. IDPH will share an audit tool with all of Iowa's birthing hospitals and encourage them to use the tool to increase staff awareness of the sleep environment of newborns in the hospital post delivery

ESMs	Status
ESM 5.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year	Active

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

2016-2020: National Performance Measures

NPM 4: A) Percent of infants who are ever breastfed; B) Percent of infants breastfed exclusively through 6 months

MH Title V agencies developed and strengthened partnerships with local birthing hospitals to promote breastfeeding. Title V agencies connected clients to lactation consultants during the postpartum follow up visit to provide consultation and support, especially if there was a breastfeeding issue. Relationships with WIC breastfeeding peer counselors continued to develop; MH Title V agencies without peer counselors continued to collaborate with other local breastfeeding resources.

MH Title V agencies provided education to clients about the benefits of breastfeeding and provided resources as necessary. Title V MH nurses helped empower women to ask their healthcare provider or WIC staff about getting a breast pump before they get ready to return to work or school.

Title V MH staff provided leadership for the Children's Healthy Weight COIIN, coordinated by ASPHN and supported by AMCHP. The focus of this initiative was to make systems-level improvements to increase capacity for health equity by developing a standard WIC breast pump policy, improve Medicaid lactation coverage for breast pumps, and normalizing breastfeeding and promote breastfeeding communities.

Activities included establishing new policies or practices that address social, ecological barriers to breastfeeding. Primary drivers for the CoIIN work included:

1. Capacity building for health equity by providing funding support for recruitment of one African American staff member from WIC/Title V MCH/Birthing Hospital to complete training as Certified Lactation Counselor (CLC) and seeking education and support from ASPHN and other states in the CoIIN regarding the most effective practices to provide breastfeeding support to African American Women.

2. Technical Assistance Training on Policy and Practice by training women attending WIC/Title V on their work place rights – place to pump during work day and break time to pump, partnering with Healthy Child Care Iowa to develop a statewide policy for child care providers, assisting with development of online training in methods to support breastfeeding for infants and children in daycare, developing statewide standard breast pump policy for WIC, exploring Iowa Medicaid Policy changes to support Lactation Services through discussion of CMS Issue Brief "Medicaid Coverage of Lactation Services" at the Medicaid Maternal Health Task Force meeting.

3. Normalizing Breastfeeding/Breastfeeding Friendly Community by increasing the number of Title V MCAH agencies/birthing hospitals that offer breastfeeding classes, seeking education and support from ASPHN and other states in the CoIIN regarding the most effective practices to provide breastfeeding support to African American Women, and expanding the current role of Health Families line counselors to include providing support and referral lactation service statewide.

NPM 4: A) Percent of infants who are ever breastfed; B) Percent of infants breastfed exclusively through 6 months

IDPH will work with the 23 maternal health agencies in Iowa to ensure women in their service receive the support they need to continue breastfeeding their infants through 6 months. This will be done through successful collaborations and referrals to lactation consultants both in hospitals where available and within the community when not, through mutually supportive collaborations with WIC agencies in the area, and individual, community and group breastfeeding education opportunities.

Women will be connected to lactation consultants in a variety of ways, one of which is through the collaboration between the Title V agencies and the birthing hospitals, and the Title V agency and the local WIC and breastfeeding coalitions. The intention of these collaborations is to ensure that the hospital staff, WIC staff and peer counselors, and any other breastfeeding support service providers in the service area are aware of the services Title V agencies are able to provide. These collaborations will help to meet women where they are at and when they need the support.

The Title V agencies across the state will also be working with one business per year in their service area to educate them on breastfeeding laws and policies, and how to create a supportive environment for women who choose to breastfeed. This will build a stronger relationship for the Title V agency and the business community which could lead to productive relationships in the future.

All Title V agencies working with women in a direct service capacity, or one on one educational opportunity, will provide culturally and linguistically competent educational information or teaching on breastfeeding. For women receiving direct services, specific health education will be provided to meet her individual needs. Additionally, some Title V agencies may provide group breastfeeding classes to women they provide services to, if other opportunities are not available in their service area.

NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

IDPH will work with the 23 Title V agencies across the state to reach women in Iowa in a variety of ways to educate them about the importance of safe sleep practices and refer them to resources for safe sleep options if necessary.

The Title V agencies in Iowa will each reach out to at least community organization per year who work with anyone who puts a baby down to sleep to provide education about safe sleep environments. This education will cover topics such as: back to sleep, safe sleep environment, no co-sleeping, no extra items in the crib and any other recommendations from the Child Death Review team. Additionally, this can potentially open a line of communication between the agency and retailer for future collaborative purposes.

Each Title V agency will develop a list of safe sleep resources to distribute to women and families they reach through an enabling service, or community outreach capacity. Additionally, women will be referred to resources to obtain a free or low cost crib if needed, if that resource is available in the area.

Women who are receiving Title V direct care services will receive safe sleep education based on the mother's needs, taking into account any personal or cultural beliefs the mom or family express, on the following topics: back to

sleep, safe sleep environment (crib), no co-sleeping, no extra items in the crib and other recommendations from the AAP and the report from the Child Death review team as applicable. MH agency staff will receive education and specific TA on addressing cultural beliefs related to safe sleep practices.

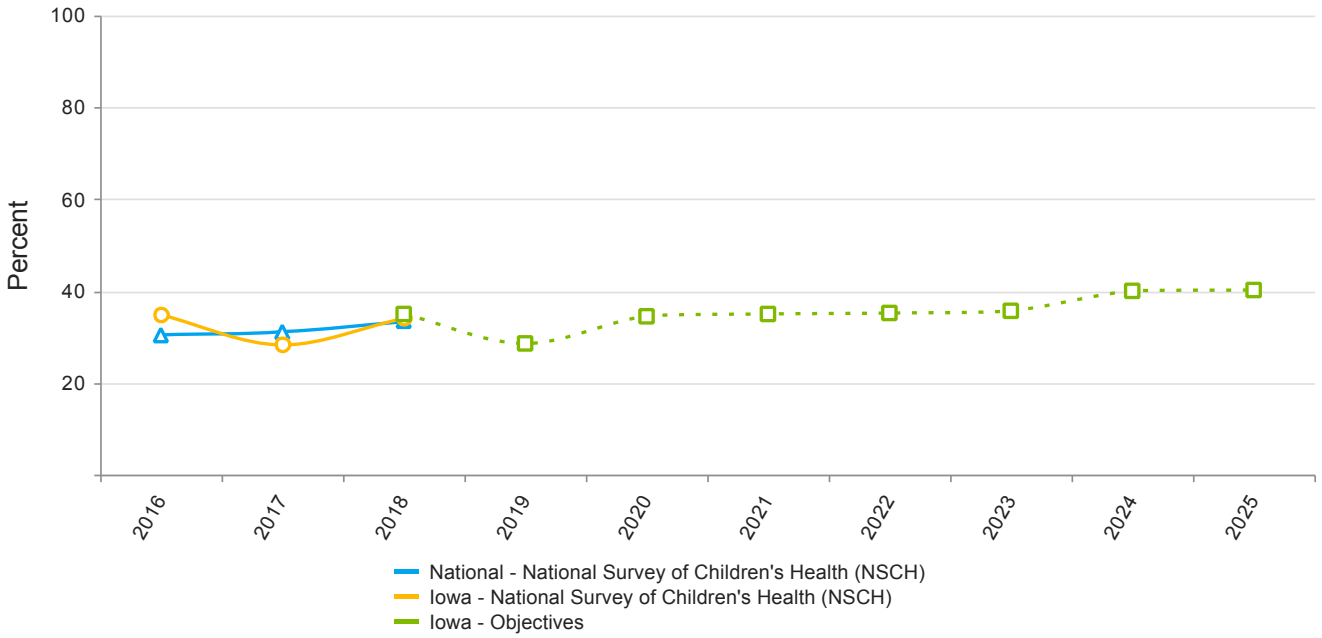
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2017_2018	9.3 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	89.0 %	NPM 6 NPM 13.2

National Performance Measures

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			35	28.6
Annual Indicator		34.8	28.4	34.2
Numerator		31,438	27,467	32,539
Denominator		90,233	96,650	95,266
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.5	35.0	35.2	35.7	40.0	40.2

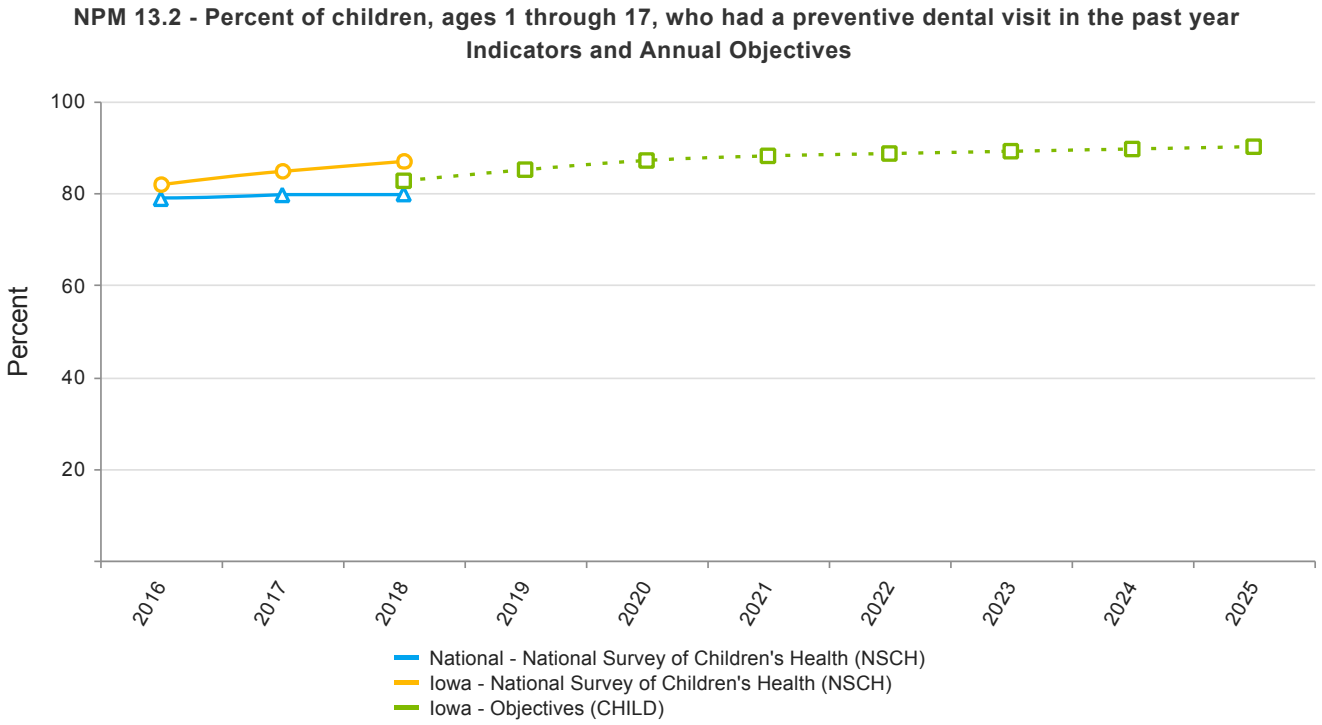
Evidence-Based or –Informed Strategy Measures

ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		1.5	2	2
Annual Indicator	0.9	1.6	1.9	1.9
Numerator	971	1,744	1,076	1,076
Denominator	110,608	110,577	56,307	56,307
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2016	2017	2018	2018
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	2.5	3.0	3.5	4.0	4.5	5.0



NPM 13.2 - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			82.6	85
Annual Indicator		81.7	84.7	86.7
Numerator		563,970	573,272	585,814
Denominator		690,337	676,624	675,638
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	87.0	88.0	88.5	89.0	89.5	90.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective			350	385
Annual Indicator	93	341	380	397
Numerator				
Denominator				
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

State Performance Measures

SPM 2 - Percent of children ages 1 and 2, with a blood lead test in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	45.0	50.0	55.0	65.0	75.0

SPM 3 - Percent of early care and education programs that receive Child Care Nurse Consultant services.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		30	32	36
Annual Indicator	28.5	25.6	34.6	37.2
Numerator	1,512	1,347	1,558	1,563
Denominator	5,299	5,265	4,507	4,201
Data Source	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	38.0	40.0	42.0	44.0	46.0	48.0

SPM 5 - Number of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	904.0	949.0	997.0	1,046.0	1,049.0

State Action Plan Table

State Action Plan Table (Iowa) - Child Health - Entry 1

Priority Need

Access to care for the MCAH Population

NPM

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Objectives

By 2025, increase the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year to 24.5%

Strategies

Provide System Coordination of development screens with local providers. This includes child care providers, home visiting programs, primary care providers, CCNC, Head Start to assess for gaps, assure access and avoid duplication

Community Partnerships with Children's Mental Health System Regions throughout the state

Promotion of screening to Early Childhood Education Programs (ECE)

Priority Population Partnerships. Partner with specific organizations, programs or groups that address priority populations to increase culturally appropriate access, outreach and education on developmental screening and emotional behavioral assessments

Educate parents on developmental milestones in their children's lives and promote the Iowa Family Support Network and Early Access

Developmental Monitoring for required Early ACCESS Activity - infants and toddlers ages 0-3 found not be eligible for Early ACCESS services

ASQ or ASQ: SE Referrals - First Five

CFPC evaluation of First Five

ESMs	Status
ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.	Active

NOMs
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Iowa) - Child Health - Entry 2

Priority Need

Dental Delivery Structure of the MCAH Population

NPM

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Objectives

By 2025, increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year to 90%

Strategies

Building partnerships with organizations and health care providers

Outreach to dental and medical providers

Oral health promotion

Care coordination and referrals

Gap-filling preventive services

ESMs	Status
ESM 13.2.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Iowa) - Child Health - Entry 3

Priority Need

Safe and Healthy Environments

SPM

SPM 2 - Percent of children ages 1 and 2, with a blood lead test in the past year

Objectives

By 2025, increase the percent of children ages 1 and 2 with a blood lead test in the past year to 75%

Strategies

Title V Agencies must assure children in their service area receive age and interval appropriate blood lead testing through the provision of testing, referral to another agency, or referral to the child's primary care provider

Coordinate the provision of blood lead tests in the service area to assess for gaps, assure access and avoid duplication

Conduct an environmental scan in FFY2021 of practitioners in Iowa and document which providers are conducting blood lead tests and at what ages

Educate families on the importance of blood lead testing at recommended age intervals (e.g. informing scripts, initial inform mailing, social media platforms)

Partner with specific organizations, programs or groups that address priority populations to increase culturally appropriate access, outreach and education on lead poisoning prevention and lead testing

IDPH will provide training to Title V agencies on blood lead testing guidelines, CLPPP and strategies for engaging health care providers and families

BFH and Childhood Lead Poisoning Prevention Program collaboration and coordination of programming

Collaborate with different state agencies to obtain increased access to data sources and strengthen partnerships to increase data sharing

Prioritize sustainable funding sources for lead screening. Work collaboratively with Iowa Medicaid Enterprise and private insurers to promote appropriate reimbursement for blood lead screening for Child Health Screening Centers

State Action Plan Table (Iowa) - Child Health - Entry 4

Priority Need

Safe and Healthy Environments

SPM

SPM 3 - Percent of early care and education programs that receive Child Care Nurse Consultant services.

Objectives

By 2025, increase the percent of early care and education programs that receive child care nurse consultant services to 48%

Strategies

Development of partnerships between Title V Child Health agencies and CCNC programs

Provide annual updates on CCNC services, performance measure data, and information on child care health/nurse consultation nationally and impact on quality child care to state Early Childhood Iowa (ECI) and DHS

Collaborate with state ECI Professional Development and DHS for support of CCNC services

Provide quarterly training to CCNCs on performance measure data collection

CCNC agencies will be evaluated by State HCCI staff for program fidelity including a review of child care provider outreach activities, performance measure data collection methods, comparison of local data with statewide averages, and local partnerships/collaboration

State Action Plan Table (Iowa) - Child Health - Entry 5

Priority Need

Dental Delivery Structure of the MCAH Population

SPM

SPM 5 - Number of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider

Objectives

By 2025, increase the number of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider to 1,049

Strategies

Maintain and develop state and local partnerships

Outreach and training for medical providers

Outreach to dentists

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 2 - A)Percent of children 0-21 served by Title V who meet Iowa's Title V criteria as having a medical home B)Percent of women served by Title V who meet Iowa's Title V criteria as having a medical home

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		91	84.5	88
Annual Indicator	90.5	84	87	86.2
Numerator				
Denominator				
Data Source	CAReS and WHIS	TAV Connect	TAV Connect	Signifycommunity
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SPM 3 - Percent of children with a payment source for dental care

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		88	89	82.5
Annual Indicator	87.1	82	82	89.8
Numerator	14,141	15,385	15,385	
Denominator	16,244	18,773	18,773	
Data Source	I-Smile@School	I-Smile@School TAVConnect	I-Smile@School TAVConnect	I-Smile@School signifycommunity data
Data Source Year	2016	2017	2017-2018	2019
Provisional or Final ?	Final	Final	Final	Final

NPM 6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool

Title V Child and Adolescent Health (CAH) agencies continued to reinforce the importance of developmental screening through the informing process for newly enrolled Medicaid families. Bureau of Family Health (BFH) provided Title V CAH agencies with needed information and resources. Title V CAH agencies also continued to offer gap-filling developmental screenings (Ages and Stages Questionnaire (ASQ)) and emotional-behavioral screenings (Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)).

In the Title V MCAH RFA application process and resulting contract, the Bureau of Family Health continued the requirement for provision of developmental screening services, including maintaining the working relationship with the Area Education Agencies (AEAs) regarding developmental screening and developmental monitoring under Early ACCESS.

BFH staff maintained the strong working relationship between Title V MCAH and Iowa Medicaid Enterprise (IME). BFH staff worked with Medicaid's project manager to continue payable developmental screening services under the Screening Center provider status within the Iowa Medicaid and Medicaid Managed Care Organization (MCO) payment structure.

As part of the federal-state partnership, Iowa's state funded 1st Five program engages health care providers in supporting the use of developmental surveillance and screening tools. The 1st Five program continued to support primary care providers in administering standardized developmental screening utilizing a validated instrument. The partnership between providers and 1st Five staff was established for care coordination through developmental support, referral, and follow up services.

Local 1st Five site coordinators (currently engaged with 88 Iowa counties) worked on outreach to medical front desk office staff. Outreach included screening information displayed in newsletters, trainings, and guide books. Incentives promoting the 1st Five logo were provided in some locations as well.

Local 1st Five site coordinators will work with 1st Five Medical Consultants on providing developmental screening trainings to office staff and engaged healthcare partners.

BFH continued to enhance collaboration between Title V CAH programs and 1st Five, Early ACCESS, early care and education, home visiting providers, and CHSC to encourage developmental screening. BFH staff continued to share aggregated developmental screening data with the Children's Justice Leadership Team related to its work regarding the health and well being of pregnant women, infants, and children.

NPM 13: B) Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year

In 2019, OHC maintained the successful oversight and technical assistance for I-Smile™ and the MCAH contractors. OHC also addressed challenges, such as access to dentists for the MCAH population. Although OHC has limited impact regarding dental offices that accept Medicaid, we required I-Smile coordinators to make outreach visits to all general and pediatric dental offices within each service area. Developing and improving relationships with the offices is important to build stronger referral networks. In addition, the dental director continued communicating with the dental association's new director, identifying areas of common ground and methods to improve the public-private link. The dental director also continued discussions with the Iowa Dental Board regarding services provided by I-Smile dental hygienists within hospital systems/medical offices. OHC staff expanded partnerships with state

stakeholders who have investments in oral health for underserved Iowans, including Iowa Medicaid and Delta Dental of Iowa Foundation.

OHC staff led the Cavity Free Iowa initiative, monitoring activities with the Mercy Des Moines health system and providing technical assistance to I-Smile coordinators around the state to implement similar projects in their areas. Coordinators oversaw the school dental screening requirement and were required to make outreach visits to all pediatric medical offices in their service areas to continue to build awareness about gaps in dental care for at-risk children. Additional outreach occurred with child care providers, using oral health training and setting up toothbrushing protocols to assist centers with Quality Rating System requirements. Oral health promotion continued through updates to the I-Smile website (ismile.idph.iowa.gov) and sharing education through the I-Smile Facebook page, targeting parents. (https://www.facebook.com/ISmileDentalHomeInitiative/?ref=bookmarks).

OHC received approval by the Iowa Dental Board for use of silver diamine fluoride (SDF) by dental hygienists using public health supervision. This secondary preventive measure can arrest some tooth decay, potentially reducing pain and costs for restorative care. OHC incorporated use of SDF within I-Smile, to include education for hygienists, recommended outreach to dentists, assurance of available training, and development of materials such as consents with photographs of teeth treated with SDF. SDF was offered and used, when appropriate, for MCAH participants receiving gap-filling preventive services through I-Smile.

SPM 2: A) Percent of children 0-21 served by Title V who report a medical home

BFH staff continued to monitor data for the percent of children and adolescents served with a medical home. This was accomplished through reports from the **signify**community - CAH module. Local CAH contract agencies continued to assess a child's medical home status regularly when providing presumptive eligibility, informing for new Medicaid eligibles, care coordination, and gap-filling direct care health services through completion of the Intake Assessment. A medical home was identified for those children with a 'yes' response to three questions:

1. Does the client have a usual source of medical care?
2. Is the usual source of medical care available 24/7?
3. Does the source of medical care maintain the child's record?

Statewide medical home percentages were tracked on the Child Health Program Profile and the IDPH Executive Scorecard.

Medical homes were established for uninsured or underinsured children as well as those on Medicaid. Presumptive eligibility services for children continued to be provided, offering a window of Medicaid coverage while a full determination of eligibility for Medicaid or Hawki is made. Local Title V CAH agencies continued to assist families with understanding their Medicaid or Hawki coverage. For Medicaid enrolled children, they assisted families to connect with primary care providers within their child's Medicaid status. Local CAH agency staff promoted health literacy by striving to assure that families understood their health insurance coverage, knew how to use it to access health care, and assisted with needed transitions to new providers or alternate types of health care coverage.

Local CAH agencies advanced public-private partnerships with local medical providers of preventive health care services, including educating practitioners on the CAH agency's role in assuring medical homes and serving children in the EPSDT program. This work was especially strong among CAH agencies that also held a contract for Iowa's 1st Five Healthy Mental Development Initiative.

Local CAH contract agencies with a FFY 2019 RFA adolescent well visit plan worked with primary care practitioners in the area of adolescent health, with a goal to increase the number of adolescents served and

enhance the quality of the well visit. These agencies partnered with school districts and other adolescent serving organizations to promote adolescent well visits in an established medical home. Addressing annual adolescent well visits per Iowa's revised EPSDT Periodicity Schedule remained a priority.

At the state level, BFH staff worked with Iowa Medicaid and MCOs to address challenges regarding provision and payment of services for the EPSDT population provided by Title V CAH agencies (Medicaid Screening Centers). Monthly Medicaid Team meetings continued to be held. Local CAH agencies continued to strive to work effectively with the MCOs to maintain access to care that meets the needs of the families they serve.

BFH staff will work with Child Health Specialty Clinics regarding efforts to promote medical homes for children with special health care needs to support NPM #11 and assure appropriate resources for referral from CAH agencies.

SPM 3: Percent of children with a payment source for dental care

OHC continued to monitor the climate in Iowa for a possible transition to managed care for dental services for children through regular communication and face-to-face meetings with Iowa Medicaid Enterprise, Delta Dental of Iowa and Managed Care of North America (MCNA), a carrier for Medicaid's adult dental services. The dental director continued his role as a leader in the state through his work on the Hawki board, with stakeholder groups, and with national organizations with insight to other state's policies.

I-Smile coordinators were required to make outreach visits to all pediatric medical offices as well as general and pediatric dental offices, intended to build the referral network for I-Smile and in the end increase not only access to dental care but also assistance for families to receive care. Coordinators provided oral health training and implemented tooth brushing protocols for child care centers to help meet child care Quality Rating System requirements. Enrollment information about Medicaid and Hawki were shared with child care providers through this outreach. In addition, through the regular contacts with families via the services provided by I-Smile at WIC, Head Start, schools, and other public health sites, children found to have no payment source for dental care were screened for presumptive eligibility.

SPM 4: Percent of early care and education programs that receive Child Care Nurse Consultant Services

Iowa's Healthy Child Care Iowa Coordinator was involved in the development of Iowa's Quality Rating System (IQ4K). In the new system there are new requirements that programs must utilize CCNC services:

- Professional Development Category - Medication Administration Skills Competency training and skills "test-out" requirement for all home providers and center director/staff who administer medications.
- Environment Category - Onsite assessment using the *Health and Safety Checklist* a nationally recognized research based assessment tool developed by the California Childcare Health Program, UCSF School of Nursing. This tool is being used by nurse (health) consultants in 4 states to evaluate health and safety in early care and education environments. Iowa will be the 5th state to utilize this tool.

Additional areas that Child Care Nurse Consultants help support providers in quality:

- Nutrition and Physical Activity Category – Providers will complete a self- assessment and develop a quality action plan in both nutrition and physical activity. NAP SACC and Let's Move Child Care are two resources that CCNCs currently utilize in training/consultation and will be helpful to providers in this category.
- Teaching and Learning Category- This category promotes developmental screening and inclusive environments. CCNCs can assist providers with developmental screening resources and are knowledgeable

in policies/procedures for inclusive care.
- Health Policies: Safe sleep; playground equipment stability, fall surfacing, and inspection; strangulation prevention; Tobacco Free/Nicotine Free environment (aligning with IDPH policy guidelines); oral health.
- Positive Behavioral Interventions and Supports (PBIS) training/coaching

While the IQ4K framework and criteria are finalized, the Iowa Department of Human Services has not implemented the updated QRS.

Title V staff and HCCI staff continued researching potential partnerships to increase funding for gap filling services throughout the state. Through the MCAH RFA, Title V was able to support each child health agency with funding to ensure a minimum level of service was available in all areas.

Child Health - Application Year

NPM 6: Percent of children, ages 9 through 71 months, receiving a developmental screening using a parent-completed screening tool

Each of Iowa's 23 Title V Child and Adolescent Health (CAH) contract agencies are approved Medicaid Screening Centers. They are enrolled with the IME and two MCOs operating in Iowa are (Amerigroup and Iowa Total Care). Developmental screenings and emotional/behavioral assessments are provided by CAH agencies using the ASQ and ASQ:SE tools. Contract agencies are able to receive payment from the IME for services provided for Medicaid fee-for-service clients and from the Medicaid MCO for children enrolled in an MCO.

The FFY 2021 Request for Application will require all CAH applicants to continue to develop plans to address NPM #6. Agencies will continue coordinating developmental screening with local providers such as child care providers, home visiting programs, and primary care practitioners to assess need, assure access, and avoid duplication; collaborating with early care and education providers that encourage developmental screening; and educating families on the importance of developmental screening at recommended age intervals. Moreover, IDPH will contract with an outside entity to do a state-wide environmental scan to assure coordination of the provision of developmental screens and social/emotional assessments. It will assist in identifying where screening/assessment occurs and the tools used within the following environments: child care providers, home-visiting programs, primary care providers, CCNC, ECI, MIECHV and Head Start.

Agencies will continue to educate parents on their child's developmental milestones and promote and utilize the toll-free central referral line and/or website for the Iowa Support Network (www.iafamilysupportnetwork.org) to provide resources to parents. Promoting developmental screening will continue to be a part of the age-specific informing scripts. Agencies will ensure that age appropriate developmental screening is provided by trained staff, results are communicated with primary care practitioners, and related education and follow-up services are provided.

In FFY2021, Title V agencies will be asked to engage with the Children's Behavioral Health Coordinator in their Children's Mental Health System Region in system building to advance universal, periodic behavioral health screening and assessments, education, prevention and access to mental health consultation services in collaboration with the Children's Mental Health Systems Region covering all counties their service area. Detecting early signs of mental health conditions in children, will circumvent issues later. If children can be referred to mental health professionals (counselors, therapists, psychologists, etc) earlier in life, long-term benefits will result.

Title V agencies will also be asked to write to one of the priority populations in the FFY 2021 RFA. This includes- African Americans/Black American, Alaska Native/Native Americans, Asian/Pacific Islanders, Fathers, Hispanic/Latinx, Immigrants/Refugees, LGBTQ+ and Persons with Disabilities. Other populations may be addressed in addition to the priority populations, based on the service area (e.g. Amish, families involved with the correctional system, children in foster care). This includes building partnerships with alliances who support one or all of these priority populations. It can include joining the Refugee and Immigrant Alliance in a local community, educating and training local public health staff on annual cultural competency training that serves one of these populations.

Partnerships will continue with 1st Five, early care and education programs, home visiting (MIECHV), family support and CHSC to promote developmental screening. BFH monthly meetings with Iowa Medicaid staff provided an avenue to discuss contracting, coding, and billing issues pertaining to developmental services.

BFH staff continue to meet with MIECHV program staff to discuss opportunities for collaboration including coordination of developmental screening promoted by CAH, 1st Five, and home visiting programs and the need to avoid duplication. Since 2015, BFH staff have participated on a state-wide (stakeholder) Leadership Team coordinated by Iowa Children's Justice to address the impact of substance use/abuse on pregnant women, infants,

and children. Promoting children's healthy growth and development is an inherent component of this work. Aggregated data reports of results of ASQ and ASQ:SE screening provided by Title V CAH contract agencies have been of particular interest to this workgroup.

At the state level, IDPH will continue to provide technical assistance where needed particularly to agencies (providing direct services) who will be providing ongoing developing screening (ASQ) and emotional /behavioral assessments (ASQ-SE) to infants and toddlers ages 0-3 years found not be eligible for Early ACCESS services. The state will continue to enhance our partnership with our other Title V partner (CHSC) Child Health Specialty Clinics from the University of Iowa Stead Family Children's Hospital; serving those children with special healthcare needs.

IDPH will begin exploring more resources for Title V agencies specifically around culturally appropriate developmental screening tools for parents and children of different cultures and backgrounds. In addition, the state will explore the abundant parental apps to assist parents in their child's development.

Title V Child and Adolescent Health (CAH) agencies will continue to reinforce the importance of developmental screening through the informing process for newly enrolled Medicaid families. Bureau of Family Health (BFH) will provide Title V CAH agencies with needed information and resources. Title V CAH agencies will continue to offer gap-filling developmental screenings (Ages and Stages Questionnaire (ASQ)) and emotional-behavioral screenings (Ages and Stages Questionnaire: Social- Emotional (ASQ:SE)). Some local agencies also administer the Modified Checklist for Autism in Toddlers (M-CHAT) for toddlers between 16 and 30 months of age.

Iowa's 1st Five program engages healthcare providers in supporting the use of developmental surveillance and standardized developmental screening tools. A partnership between providers and 1st Five staff is established for developmental support services (an enhanced form of referral and follow up services). 1st Five is funded through a state appropriation and was built upon Iowa's Title V infrastructure at the local level.

Local 1st Five site coordinators will work on outreach to primary care practices to encourage their consistent and universal use of screening tools. Outreach may include, but is not limited to, newsletters, trainings, and personal contacts through phone, email and meetings. Local 1st Five site coordinators will work with 1st Five Medical Consultants on providing developmental screening trainings to office staff and engaged healthcare partners.

Contracts with local 1st Five sites will build on the recent performance measure to increase the percentage of referrals that follow results of a standardized developmental screen. The measure will continue to tier the expectations so that lower performing sites will need to make greater progress to achieve the measure.

1st Five's IDPH staffing has increased, adding a staff member with more direct experience working with care coordination and services for families. Through this staffing, technical assistance for local sites will include enhanced assistance with planning, preparation, and skill-building to better prepare local staff for providing developmental support services and documenting services. 1st Five also expects continued improvements and enhancements to training and support for 1st Five site coordinators for their work with primary care practices.

NPM 13: B) Percent of infants and children, ages 1 through 17 years, who had a preventive dental visit in the last year

I-Smile™ is the oral health component of Iowa's Title V Maternal, Child, and Adolescent Health (MCAH) program. Staff with the Iowa Department of Public Health's Bureau of Oral and Health Delivery Systems (OHDS) manages I-Smile™, which includes I-Smile™ @ School (school-based sealant program). I-Smile™ connects children, pregnant women, and families with dental, medical, and community resources to ensure a lifetime of health and wellness. OHDS staff provide oversight and technical assistance for I-Smile™. Each Child and Adolescent Health contractor is required to have a dental hygienist who serves as the local I-Smile™ Coordinator. OHDS and I-Smile™ Coordinators have a strong relationship and strive to improve the oral health of Iowans. I-Smile™ Coordinators must spend at least 20 hours a week on public health services and systems-building and enabling services.

OHDS staff use data to determine focus areas within I-Smile™. Data sources include the MCAH data system, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Dental Services Reports, and oral health screening surveys. Data is analyzed by the bureau's epidemiology consultant, who also facilitates quarterly quality assurance reviews of MCAH data with OHDS consultants to identify service gaps, data entry errors, and troubleshoot areas of concerns. Similarly, local I-Smile™ activities are determined using a needs assessment, updated each year using community data and information from the MCAH service area.

OHDS staff will hold quarterly I-Smile™ Coordinator trainings, to ensure program consistency, share best practices, develop leadership skills, and promote current standards and procedures. These training often include continuing education on current oral health topics and an open forum for sharing from the I-Smile™ Coordinators. OHDS staff will make a site visit to each contractor to discuss local work plans, review data, and troubleshoot concerns. OHDS staff will also participate in yearly chart audits to ensure documentation of services is accurate and provide technical assistance to each contractor.

Assuring good oral health for underserved children and pregnant women relies upon the strength of partnerships, both at the state and local levels. OHDS staff will maintain important partnerships with entities such as WIC and the 5210 project, Head Start, Healthy Child Care Iowa, Delta Dental of Iowa Foundation, Iowa Primary Care Association, Iowa Medicaid Enterprise, and the University of Iowa College of Dentistry. Partnership activities in FY21 will include training of local WIC staff; networking meetings with Head Start health Coordinators; providing support to sealant programs that are not administered by MCAH contractors, to assure maximum benefit for children statewide; and collaborating on oral health promotion campaigns, such as "Rethink Your Drink". Next year, OHDS plans to work with a new partner, Count the Kicks, to incorporate oral health into its program, which uses best practices and evidence-based strategies to save babies and prevent stillbirths. OHDS staff will provide assistance to Count the Kicks regarding oral health education and resources to keep moms and babies healthy. I-Smile™ Coordinators will work to educate and distribute Count the Kicks educational materials while doing outreach to medical and dental offices.

OHDS staff will maintain strong partnerships with Iowa Medicaid Enterprises (IME) and the Dental Prepaid Pre-Ambulatory Health Plan (PAHP) carriers for Medicaid in Iowa – Delta Dental of Iowa and Managed Care of North America. Partners are discussing the potential for children to be covered by PAHP in the future and strategizing how to work together for the health of Iowa Medicaid members.

OHDS staff also facilitate advisory workgroups for I-Smile™ @ School and community water fluoridation (CWF). In addition to partners already mentioned, workgroup members include: Iowa State Education Association, Iowa School Nurse Organization, Iowa Department of Education, local MCAH contractor staff, American Water Works Association, Iowa Department of Natural Resources, Iowa Public Health Association, Iowa State Hygienic Lab, and Iowa Association of Water Agencies. Another important collaboration is Cavity Free Iowa, a workgroup focused on increasing training for medical office staff to apply fluoride varnish for children at well-child exams. Trainings are provided by I-Smile™ coordinators.

I-Smile™ Coordinators are also responsible for maintaining local partnerships. In FY21, I-Smile™ Coordinators are required to develop at least one new local partnership as well as improving and expanding partnerships with a minimum of four existing partners to benefit families served through I-Smile™. I-Smile™ Coordinators are holding medical/dental summits and facilitating and creating local coalitions to educate communities about oral health. Next year, I-Smile™ Coordinators will make face-to-face outreach visits with all general and pediatric dental offices within their service areas, outreach visits to family practice medical offices and/or pediatric medical offices, provide trainings for medical office staff as requested, and conduct oral health promotion at community events.

I-Smile™ Coordinators will train MCAH staff about oral health, ensuring staff is competent regarding oral health as it pertains to the informing process and care coordination; about oral health in accordance with the EPSDT periodicity schedule; and about proper techniques for direct preventive dental services (e.g., screenings, fluoride applications) and most current guidance for oral health education and anticipatory guidance. OHDS will maintain its stock of promotional materials that can be used for new moms as part of outreach to hospitals as well as for children and families. The I-Smile™ Facebook page will target parents/guardians with information and education about good oral health for children as well as during pregnancy.

I-Smile™ Coordinators will work with MCAH staff to continue focus on referrals to dentists and improved access to resources that address social determinants of health through individualized care coordination for those who need it. OHDS staff will offer technical assistance to MCAH contractors regarding best practices for providing care coordination. An online training is available for all local MCAH staff who provide care coordination, including information about proper documentation requirements. OHDS staff will work with Bureau of Family Health staff to assure proper documentation within the MCAH data system by completing service note review and working with Iowa Medicaid Enterprise to assure funding for dental care coordination is continued. In addition, the 2019 oral health survey of children at WIC found that children of minority racial groups are more likely to experience decay but not restorative dental treatment. OHDS staff are identifying outreach and care coordination plans to use with MCAH contractors that will help ensure minority populations receive the care needed.

Access to dentists for Iowa's Medicaid-enrolled and under/uninsured families continues to be difficult. In 2019, 1,842 fewer Medicaid-enrolled children received care from a dentist than in 2018, demonstrating the need for MCAH contractors to continue to provide gap-filling preventive services. In FY21, dental hygienists and registered nurses will provide gap filling preventive services, such as dental screenings and fluoride varnish treatments at WIC clinics. Dental hygienists will also provide services as needed at child care centers, Head Start centers, and preschools. Dental hygienists will offer dental screenings, fluoride varnish applications, individual and classroom oral health education, and sealants to children in elementary schools with 40% or greater free/reduced lunch rates through the I-Smile™ @ School program. Oral health screenings are made available to maternal health clients during WIC clinics, and every client receives oral health education. Referrals and care coordination are provided as needed, following provision of all services.

As part of a HRSA oral health workforce grant, OHDS staff will work with I-Smile™ Coordinators to incorporate silver diamine fluoride applications for children within preventive services offered at WIC. When applied to tooth decay, silver diamine fluoride stops the decay process. In addition to reducing bacterial infection, use of silver diamine fluoride stops cavities from getting larger and can sometimes prevent the need for a restoration. Another component of the HRSA workforce grant is to work with I-Smile™ Coordinators to facilitate community-driven approaches to recruit dentists to towns that may be experiencing or will soon experience a shortage of dentists.

The full impact of the COVID-19 pandemic on the I-Smile™ program is not yet known. OHDS staff anticipate changes to infection control requirements for dental services in the future and have also heard that more dental offices have already declined accepting any Medicaid referrals due to upcoming anticipated backlog of dental care.

SPM 2: Percent of children ages 1 and 2, with a blood lead test in the past year

Historically, the Childhood Lead Poisoning Prevention Program (CLPPP) has measured testing rates by birth cohort at 0-6 years. Through a collaboration between Title V and CLPPP through involvement in the Maternal and Child Environmental Health Lead Poisoning Prevention Collaboration Innovation and Implementation Network (CoIIN), Title V and CLPPP have been sharing more annual testing rates per age. Birth cohort information is typically close to 100% giving providers and stakeholders a false/inflated sense of testing. While most children will have a test by the time they are 6 years old, that does not mean they are being tested per recommendations. Annual testing rates per age really highlighted for Title V, the CLPPP, providers and stakeholders that Iowa is not testing children at two years of age as recommended and when they may be most at risk to exposure, developmentally.

With the state prioritizing blood lead testing of one and two year olds, increasing publicity of the need and partnerships with primary care providers, the rate should go up. The CLPPP goal for blood lead testing of one and

two year olds is 75%. The goal is to maintain the current rate for one year olds at 78%, but to steadily increase the rate for two year olds over the next five years.

Some contributing factors to the current rate from surveying and meeting with primary care providers are the belief that a low test at one year of age is predictive of future tests being low, and hesitancy to test if parent states a test has already been done.

Each of Iowa's 23 Title V Child and Adolescent Health (CAH) contract agencies are approved Medicaid Screening Centers. Blood Lead testing is an approved gap-filling Screening Center activity. Contractors with counties that do not meet the goal for testing one year olds (75%) or with counties below the state average for number of two year olds tested (40%) will be required to provide testing for one and/or two year olds in the counties with low testing rates.

The FFY 2021 Request for Application will require all CAH contractors to develop plans to address SPM #2. Contractors will coordinate blood lead screening with primary care providers, local public health agencies, local CLPPPs and others providing blood lead testing in the community. CAH contractors will be conducting a environmental scans to assure coordination of the provision of blood lead testing to identify if and where the contractor should provide gap-filling screening and at what ages.

Contractors will educate parents on the importance of blood lead testing at appropriate intervals. Contractors providing blood lead testing must provide related education, anticipatory guidance and follow-up. Follow blood lead testing guidelines established by the IDPH Childhood Lead Poisoning Prevention Program. Provide results of all blood lead tests to the primary care provider, regardless of results. Provide all results to the IDPH Childhood Lead Poisoning Prevention Program.

Title V contractors are encouraged to partner with an agency or group serving one of the priority populations to promote blood lead testing in more culturally targeted ways. This includes: African Americans/Black/African, Alaska Native/Native Americans, Asian/Pacific Islanders, Fathers, Hispanic/Latinx, immigrants/Refugees, LGBTQ+ and Persons with Disabilities. Other populations may be addressed in addition to the priority populations, based on the service area (e.g. Amish, families involved with the correctional system, children in foster care).
IDPH will provide training and resources to Title V agencies on blood lead testing guidelines, CLPPP and strategies for engaging health care providers and families. The Department has updated lead testing brochures and website information with 69,000 brochures being printed to support the new agency work FFY2021.

The Department will work with the University of Iowa through the EPSDT Training contract on a lead poisoning prevention initiative for increasing EPSDT lead screening compliance in response to the federal report on lack of testing in the Medicaid population in Iowa. This will include an EPSDT Newsletter article that is distributed to all primary care providers enrolled in Iowa Medicaid.

The Department will begin looking into priority population specific strategies for promoting lead testing, and family education. Additional strategies will be explored for assuring racial and ethnic demographic information is included in testing reporting from LPHAs, providers, and labs.

The Department will support the ongoing collaboration and coordination of programming between Title V and the Childhood Lead Poisoning Prevention Program. Department staff and local contractor participation in the Childhood Lead Advisory Workgroup. Department will support the signifyCommunity data feed of HHLPPSS lead testing data.

Title V staff will collaborate with different state programs and agencies to obtain increased access to data sources

and strengthen partnerships to increase data sharing.

Title V staff will work collaboratively with Iowa Medicaid Enterprise and private insurers to promote appropriate reimbursement for blood lead screening for Child Health Screening Centers.

SPM 3: Percent of early care and education programs that receive Child Care Nurse Consultant services

Child Care Nurse Consultant (CCNC) services focus on health and safety in the early care and education (ECE) environment. In FY19, 96 out of the 99 counties in Iowa had access to local CCNC services with a 2% increase in the number of ECE programs receiving services. CCNC services are non-regulated and are optional for ECE providers in Iowa's Quality Rating System (QRS). Often licensed centers request CCNC services for onsite health and safety visits, policy development and care planning for children with special health needs. Many home providers do not request CCNC services. In Iowa, approximately 30% of ECE providers participate in QRS and both homes and centers request CCNC services when applying for QRS levels 3, 4 and 5. This past year Iowa saw an increase in the number of ECE providers participating in QRS however the largest increase was in the number of providers entering the QRS system at a level 1 or 2. There was also an increase in the number of centers moving up in QRS levels 4 and 5; however, these centers would have probably already been receiving CCNC services for other requests.

Iowa will continue to see an increase in the number of ECE programs receiving CCNC services as statewide coverage is achieved, as CCNCs prioritize outreaching to home providers, and when Iowa's new quality rating system (Iowa Quality For Kids - IQ4K) is released. IQ4K will have a continuous quality improvement approach incorporating a focus on health and safety as well as medication administration. CCNC services will be a requirement for both homes and centers in IQ4K starting at a level 2.

HCCI State staff will continue to help in the development of partnerships between Title V Child Health agencies and CCNC programs by providing annual local and statewide CCNC performance measure data to partners, outreaching to agencies with no or limited CCNC coverage and by facilitating meetings with local agencies and other local stakeholders (including Early Childhood Iowa areas) for statewide expansion of local CCNC services.

HCCI State staff will provide annual updates on CCNC services, performance measure data, and information on child care health/nurse consultation nationally and impact on quality child care to state Early Childhood Iowa (ECI) and DHS. HCCI will continue to collaborate with state ECI Professional Development and DHS for support of CCNC services.

HCCI State staff will provide quarterly training to CCNCs on performance measure data collection. Data collection tools will be provided to CCNC agencies by HCCI for consistent/reliable collection and reporting.

CCNC agencies will be evaluated by State HCCI staff for program fidelity including a review of child care provider outreach activities, performance measure data collection methods, comparison of local data with statewide averages, and local partnerships/collaboration. HCCI CCNC TA Team will conduct annual fidelity visits with local CCNCs utilizing the Health and Safety Checklist assessment tool. Fidelity with the tool will be at 90% or higher.

Annual HCCI CCNC Program presentation by HCCI State staff to Early Childhood Iowa Area Directors. HCCI CCNC program updates will be included in MCAH regional meetings with an annual program overview including CCNC statewide performance data with Title V Child Health agencies.

SPM 5: Percent of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider

Children are recommended to see a dentist before their first birthday. However, many dentists are not comfortable seeing children this young. Cavity Free Iowa is an initiative focused on increasing the number of children who receive preventive fluoride varnish at well-child medical appointments and dental referral. In 2019, 61% more Medicaid-enrolled children ages 0-3 years received a fluoride varnish application from a medical provider than in 2018. As more medical offices participate around the state, the number of children receiving fluoride varnish is expected to increase over the next 5 years and the National Outcome Measure (decay experience) to decline.

Tooth decay is the most common chronic disease in children, five time more common than asthma. Left untreated, children with active tooth decay may experience mouth pain, difficulty learning and concentrating, impaired eating leading to growth delays, and delayed speech development. Children see a physician up to 11 times by their third birthday, yet in 2018 only one in five children saw a dentist before turning 3. Recognizing the need to prevent dental disease, Iowa's Medicaid program adopted a policy several years ago to reimburse physicians for application of topical fluoride varnish during well-child visits for children up to 36 months of age. And although I-Smile™ Coordinators have provided trainings for medical offices for many years on how to apply the fluoride, very few offices have incorporated the service as part of routine care.

In 2017, the American Academy of Pediatrics /Bright Futures added fluoride varnish applications to their recommendations for all well child visits from age 6 months to 5 years. In response, Iowa's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) periodicity schedule was updated to reflect that change. A central Iowa pediatrician noticed the change in the periodicity schedule and began investigating how to incorporate use of fluoride varnish into his practice. The result became a collaboration between the Iowa Department of Public Health's Bureau of Oral and Health Delivery Systems (OHDS), Delta Dental of Iowa Foundation, local I-Smile™ Coordinators, Medicaid, hospitals, dental clinics, and the interested pediatrician known today as Cavity Free Iowa (CFI). CFI is an initiative focused on increasing the number of children ages 0-35 months receiving preventive fluoride varnish applications in the primary care setting. Currently Medicaid-enrolled children have an easier time finding a primary care physician than a dentist that accepts their insurance. Since low income children are more likely to suffer from dental decease, this initiative serves to improve this health disparity. Initial implementation was in the Des Moines area and the project has expanded to target medical offices statewide. Thirty-two of Iowa's 99 counties have medical practices participating in CFI.

Much of the success of CFI can be attributed to the pediatrician who has become a champion for the cause. Another key factor to the success of CFI has been the work of I-Smile™ Coordinators (working for Maternal, Child, and Adolescent Health contractors) who have provided trainings and follow up for medical office staff. In 2019, 61% more Medicaid-enrolled Iowa children (904) received a fluoride application from a physician's office than in 2018 (562), likely due to the efforts of Cavity Free Iowa.

During FY21, I-Smile™ Coordinators are required to visit all pediatric medical offices to promote the age one dental visit; offer training on oral screenings and fluoride varnish applications; and provide oral health educational and promotional materials. (Coordinators will make visits to all family practice medical offices in counties with no pediatrician.) I-Smile™ Coordinators will provide onsite training (developed by OHDS staff) for offices interested in becoming a "Cavity Free Iowa" participant and assist with referrals to local dentists for care. OHDS staff is researching options to offer continuing education credits for medical staff who participate in the fluoride varnish training.

OHDS staff will continue to facilitate quarterly Cavity Free Iowa workgroup meetings, bringing medical and dental stakeholders together to discuss how to grow the initiative and address barriers. In 2020, OHDS mailed letters to

pediatric and general dentists describing Cavity Free Iowa, seeking the interest of dentists to accept referrals from local physicians and to refer children to a physician if they do not have one already. The letter also sought dentists to join the Cavity Free Iowa initiative. Similar letters will be mailed to pediatric and family practice physicians. Partnerships with workgroup members will continue in FY21 to leverage contributions. For example, Delta Dental of Iowa Foundation brings experience in public relations and marketing and provides commemorative plaques and training certificates for medical offices trained by I-Smile™ Coordinators. OHDS staff will work with Medicaid's Dental Program Manager to assure reimbursement to medical offices and troubleshoot any billing issues.

OHDS staff will provide technical assistance for I-Smile™ Coordinators regarding planning of local medical-dental collaboration events. Two events are being planned by I-Smile™ Coordinators for Fall 2020 in eastern and central Iowa. OHDS staff and I-Smile™ Coordinators will also look at how to use local and state coalitions to enhance how oral health can be integrated within medical practice for the benefit of children and women of child-bearing age.

It is difficult to know how or if the COVID-19 pandemic will impact outreach visits to medical and dental offices and trainings for medical providers. During Spring of 2020, medical offices in Iowa have continued providing well-child visits, while dental offices have only been available for emergencies. This is an example of prime example of how young children may still obtain preventive dental care, even in a health crisis.

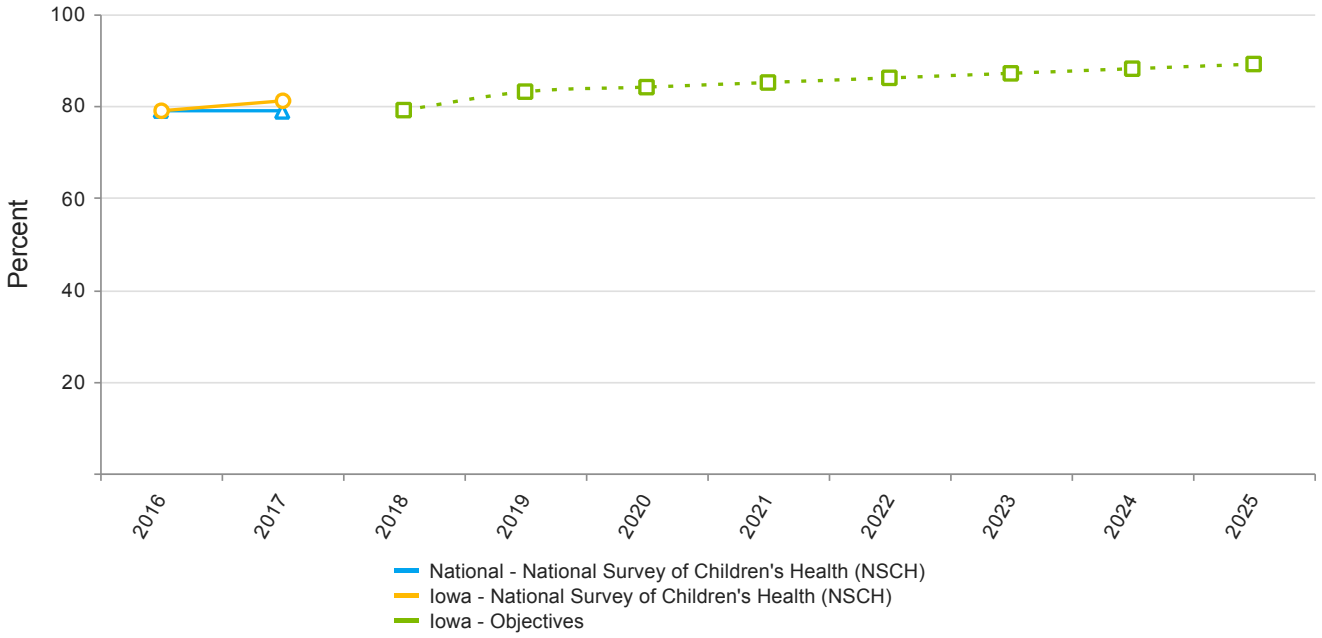
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2018	31.9	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2016_2018	13.7	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2016_2018	12.6	NPM 9 NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	61.8 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	89.0 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2017_2018	16.4 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2016	15.2 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2017	15.3 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2018_2019	65.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2018	73.4 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2018	94.0 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2018	89.2 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2018	15.3	NPM 10

National Performance Measures

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Indicators and Annual Objectives



Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			79	83
Annual Indicator		78.8	81.1	81.1
Numerator		202,051	191,475	191,475
Denominator		256,527	236,185	236,185
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.0	85.0	86.0	87.0	88.0	89.0

Evidence-Based or –Informed Strategy Measures

ESM 10.1 - Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	46.0	92.0	138.0	161.0	184.0

State Performance Measures

SPM 4 - Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	24.5	24.0	23.5

State Action Plan Table

State Action Plan Table (Iowa) - Adolescent Health - Entry 1

Priority Need

Access to care for the MCAH Population

NPM

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Objectives

By 2025, increase the percent of adolescents ages 12 through 17 with a preventive medical visit in the past year to 85%

Strategies

Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, universities, and/or community colleges to promote adolescent well visits to parents/guardians

Local Title V agencies will educate parents of adolescents on the importance of annual well visits during the Informing process

Provide culturally and linguistically appropriate annual well visit reminders for adolescents who are Title V clients and for adolescents enrolled in Medicaid Fee For Service

Bureau of Family Health will utilize Every Age Even Teenage promotions and social media platforms to promote the adolescent well visit

Conduct an environmental scan(s) to identify which providers are conducting adolescent well visits, what hours well visits are available and ages they are routinely offered

Bureau of Family Health staff will explore possible collaborations with Iowa Medicaid Enterprise, Department of Human Services, local Managed Care Organizations, the University of Iowa EPSDT physician group, and provider associations, to assure adolescents receive annual well visits

ESMs	Status
ESM 10.1 - Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well	Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

State Action Plan Table (Iowa) - Adolescent Health - Entry 2

Priority Need

MCAH Systems Coordination

SPM

SPM 4 - Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities

Objectives

By 2025, decrease the percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities to 23.5%

Strategies

Explore the use of psychosocial assessments for Adolescents in primary care settings and billing options for local Title V agencies to provide gap filling services

Provide adolescent mental health training for local Title V agencies

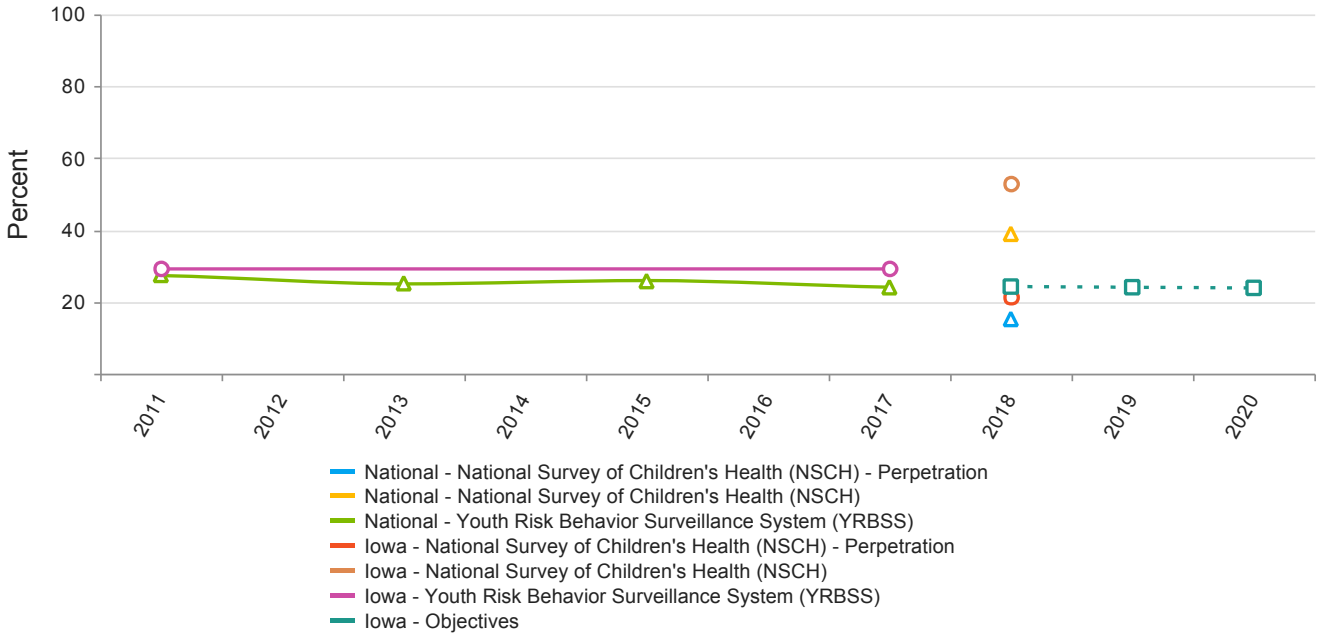
Collaborate with the Iowa Department of Education and local school districts in assessing gaps or barriers to adolescent mental health services in local communities

Assist in the advancement of the efforts ordered by the Governor of Iowa in the establishment and implementation of Iowa's Children's Behavioral Health System State Board (Children's Board) and promote state and local Title V agency level participation

Continue to maintain partnerships with organizations that support LGBTQI youth and collaborate in the development of evidence based strategies improving the mental well being of adolescents

2016-2020: National Performance Measures

2016-2020: NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Indicators and Annual Objectives



Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	14.8	14.6	24.3	24.1
Annual Indicator	29.1	29.1	29.3	29.3
Numerator	43,459	43,459	41,460	41,460
Denominator	149,221	149,221	141,691	141,691
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2011	2011	2017	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2017	**2018**	**2019**
Annual Objective			24.1
Annual Indicator			21.2
Numerator			52,515
Denominator			248,081
Data Source			NSCHP
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2017	**2018**	**2019**
Annual Objective			24.1
Annual Indicator			52.7
Numerator			130,850
Denominator			248,281
Data Source			NSCHV
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 9.2 - Convene a Bullying Prevention Task Force

Measure Status:	Active

Baseline data was not available/provided.

2016-2020: State Performance Measures

2016-2020: SPM 2 - A)Percent of children 0-21 served by Title V who meet Iowa's Title V criteria as having a medical home B)Percent of women served by Title V who meet Iowa's Title V criteria as having a medical home

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		91	84.5	88
Annual Indicator	90.5	84	87	86.2
Numerator				
Denominator				
Data Source	CAReS and WHIS	TAV Connect	TAV Connect	Signifycommunity
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

2016-2020: SPM 5 - Percent of adults aged 18-24 who report being physically active

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		85.8	86	86.2
Annual Indicator	85.6	88.3	85.5	83.4
Numerator				
Denominator				
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

NPM 9: Percent of adolescents, ages 12 through 17, who are bullied or who bully others

The Adolescent Health Coordinators continued to coordinate and meet with the Adolescent Health Collaborative on a quarterly basis. The collaborative discusses several topics and events specific to adolescents which includes bullying, suicide, and mental health. The collaborative brings together programs from across IDPH that work in adolescent program. Participants include the Division of Tobacco Use and Prevention, substance abuse, domestic violence, immunizations, I-Smile, family planning, and others.

The BFH Adolescent Health staff continued to maintain an interactive tool for school nurses in Iowa related to adolescent health issues that includes bullying and suicide information and resources with state-specific data as a way to address the life course indicators.

PREP grantees addressed mental health and suicide prevention through programming with Iowa youth as part of the Adulthood Preparation Subjects requirements through the federal grant.

BFH was accepted to the Maternal and Child Health Workforce Development Center through University of North Carolina at Chapel Hill. Through this opportunity Iowa's Title V staff began planning a cross-sector workgroup to advance Iowa's bullying prevention efforts through a public health approach.

Using the HRSA Maternal & Child Health "Bullying Prevention, Change Package and Driver Diagram" Iowa's Title V staff team identified two primary and secondary drivers that would advance state-level work in Iowa's bullying prevention program. Iowa's project focused on:

- Creating strong partnerships across agencies and other programs and organizations to support the development of statewide activities to address bullying prevention.

- Partnering with Iowa's Child Death Review Team (CDRT) to ensure that bullying is considered during the initial death investigation across all law enforcement and emergency first responder units and during the subsequent review of child deaths. It is necessary that team members are aware of evidence-based bullying prevention strategies. This partnership will address the need for additional investigation information from law enforcement (questioning friends and acquaintances) when working a child/adolescent suicide scene. The child death intake/summary booklet identifies both "bullying as a perpetrator" and bullying as a victim" as options to report upon intake. However, if there is no mention of bullying in the medical and law enforcement records reviewed, those options are left blank. The CDRT used to send a questionnaire to schools to complete when a school aged child committed suicide. However, the information returned from the schools lacked information related directly to bullying. As a result, the CDRT stopped sending the questionnaire.

- Actively engage health care professionals in bullying prevention to reduce the adverse health outcomes (physical and psychosocial) associated with bullying.

- Collaborating with state chapters and professional associations of healthcare providers (Iowa Chapter of the American Academy of Pediatrics) to develop and provide information and continuing education on bullying prevention to their members.

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive visit in the past year

The Adolescent Health team will continue to provide materials and education through venues such as conferences and at grantee meetings. Facilitators will be encouraged to continue to incorporate materials and education into their programming.

The Adolescent Health team will continue to provide materials to key staff at Kirkwood Community College, Indian Hills Community College and Des Moines Area Community College to disseminate throughout campus, through Navigators and at family campus events.

State Title V staff created and disseminated marketing materials for MCAH agencies to use in the promotion of the well-visit at the local level. A social media campaign, “Every Age, Even Teenage, ” was developed including Facebook and Twitter posts. IDPH also hosted a green screen photo booth opportunity at state athletic tournaments with the “Every Age, Even Teenage” messaging. When students and parents submitted their picture, they received an email back with messaging on the importance of the adolescent well visit.

State Title V staff partnered with school nurses, local Title V maternal, child and Adolescent health (MCAH) agencies, managed care organizations, providers and other youth serving organizations in the state to increase awareness about the importance of the adolescent well-visit. The group discussed opportunities for co-branding of materials for distribution.

SPM 5: Percent of adults aged 18-24 who report being physically active

State Title V staff monitored and contributed to the IDPH strategic plan around the topic of obesity and physical activity.

State Title V staff worked with the Iowa Department of Education to identify existing programs or initiatives to collaborate on and expand upon. This information will be shared with MCAH agencies that select the option to address physical activity.

State Title V staff with worked with the Bureau of Nutrition and Health Promotion to identify resources on effective programing or strategies to impact physical activity in selected populations.

State Title V staff has representation on the 5-2-1-0 initiative. 5-2-1-0 Healthy Choices Count provides a framework to create healthy environments for kids and to teach kids how to make healthy choices. It is based on a nationally recognized model that provides evidence-based strategies and hands-on support at places where kids spend a lot of time. IDPH partners with the Healthiest State Initiative, a nonpartisan, nonprofit organization driven by the goal to make Iowa the healthiest state in the nation. For more information on 5-2-1-0 go to https://idph.iowa.gov/5210.

Resources were distributed to Local MCAH agencies that have selected this performance measure. Physical activity for adolescents was an optional activity for local MCAH agencies to select. Nearly one third of the agencies selected this NPM to address.

Adolescent Health - Application Year

NPM 10: Percent of adolescents, ages 12 through 17, with a preventive visit in the past year

Adolescence is a period of major physical, psychological, and social development. Receiving health care services, including annual adolescent preventive well visits, helps adolescents adopt or maintain healthy habits and behaviors, avoid health damaging behaviors, manage chronic conditions, and prevent disease. Assuring that adolescents receive annual well visits will help prepare adolescents to manage their health.

IDPH contracts with 23 CAH agencies with service provision in all of Iowa's 99 counties. Title V Child and Adolescent Health agencies will work with local primary care practitioners and other providers serving adolescents to increase the numbers served and enhance the quality of the visit.

Local CAH agencies will work on partnering with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well visits to parents/guardians. Agencies will document a description of the groups, organizations or programs that they will be partnered with, history of prior experience with the organization/program (if any), the goals of the partnership, roles and responsibilities of the applicant and organization/program in the partnership, and timeline for activities.

CAH agencies are encouraged to communicate with and share resources with the school nurse designee from each school district within the applicant's service area to promote adolescent well visits to parents/guardians. They will include narrative describing the school districts they are partnering with, history or prior experience with the nurse (if any), goals of the partnership, roles and responsibilities of the applicant and the nurse activities.

Iowa's Title V RFA has taken a health equity lens in working on eliminating health disparities among ethnic and racial populations of color and other population groups with low income or who have historically had less access, power and privilege in Iowa. Priority populations that are known to experience significant levels of health disparity in child and adolescent health and must be addressed are African Americans/Black/African, Alaska Native/Native Americans, Asian/Pacific Islanders, fathers, Hispanic/Latinx, immigrants/refugees, people identifying as Lesbian, Gay, Bisexual, Transsexual, Queer, Intersex, plus (LGBTQI+), and persons with disabilities. Other populations may be addressed based on needs in the service area (e.g. Amish, families involved with the correctional system, pregnant women and adolescents experiencing homelessness, etc.) IDPH has maintained that our agencies should partner with specific organizations, programs or groups that address priority populations to increase culturally appropriate access, outreach and education on adolescent well visits.

The Informing Process is the process by which staff at the Title V Child and Adolescent Health agency contact newly eligible clients to explain the EPSDT Care for Kids program and its benefits. The discussion with the family addresses the benefits available, importance of preventive health care services, location of services, support services, and local resources available to help the clients. For FFY21 an emphasis has been placed on the education of parents/guardians of adolescents on the importance of the annual well visit.

Title V Child and Adolescent Health agencies will provide culturally and linguistically appropriate annual well visit reminders for adolescents who are Title V clients and adolescents enrolled in Medicaid Fee For Service. The agencies will describe the activities to assure well visit reminders are linguistically and culturally appropriate, the partners involved, and how the reminders are conducted.

Title V MCAH Agencies may provide gap-filling direct care services for adolescents based upon an assessment of

need within the service area. (e.g. nutritional counseling, preventive medicine counseling, nursing assessments). Agencies are able to provide these services under their Screening Center provider status and are to be reimbursed by both Iowa Medicaid and the Medicaid Managed Care Organizations (MCOs). The Bureau of Family Health staff continues their communication and working relationship between Title V MCAH and Iowa Medicaid Enterprise (IME). BFH monthly meetings with Iowa Medicaid staff provided an avenue to discuss contracting, coding, and billing issues pertaining to these gap filling services.

The Bureau of Family Health staff will develop social media posts during International Adolescent Health Week (IAHW) 2021. IAHW is a grass-roots initiative for young people, their health care providers, their teachers, their parents, their advocates and their communities to come together and celebrate young people and with an ultimate goal of working collectively towards improving.

IDPH will continue collaboration with the Iowa Department of Education to promote and manage the Iowa Adolescents: Let's Talk Health google site and update content as requested.

The Bureau of Family Health staff will measure NPM10 by utilizing CMS416 Reports for ages 10-14, 15-18, and 19-20 years and signifycommunity™. In addition, MCAH Regional Consultants will analyze Mid-Year and Year End Reports, and review with agencies during their annual Site Visits.

IDPH will subcontract with an outside entity to conduct an environmental scan (e.g. electronic survey, face to face) in the first six months of FFY2021 to identify which providers are conducting adolescent well visits, what hours well visits are available and the ages they are routinely offered. Narrative documentation will detail their work with the providers as well as the staff roles and responsibilities, partnerships and roles/responsibilities of the partners. The documentation of the results of the environmental scan will be shared with the local providers, community stakeholders and the Regional MCAH Consultants.

SPM 4: Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities

In the last project period, Iowa focused on the NPM attempting to reduce the occurrence of bullying or bullying of others. The most recent Iowa Title V needs assessment suggested that although preventing bullying is a component of adolescent well-being, broader strategies related to improving overall mental well-being among adolescents may prove to be more impactful. The focus of this new SPM will address adolescent well-being and adolescent mental health. Currently, no other state performance measures address adolescent mental health and local Title V agencies have provided minimal services related to adolescent mental health.

Iowa plans to explore and research the use of psychosocial assessments provided to adolescents in primary care settings across the state. If gaps in services are identified, Iowa will partner with the Iowa Medicaid Enterprise (IME) to identify billing codes (non home visit codes) that local Title V agencies can pursue under their purview of their child screening center designation. In addition to these strategies, Iowa will explore the use of telehealth medicine in primary care settings and the availability to local Title V agencies. Iowa will also promote the use of telehealth medicine with adolescent mental health providers.

Iowa's Title V program has a strong infrastructure that is conducive to hosting a solid training network available to local Title V agencies. Iowa plans to host a wide array of statewide adolescent mental health trainings such as: adult mental health training, youth mental health first aid, youth peer to peer training, training for parents of adolescents, and training for local Title V agencies. Iowa will explore partnering with the Iowa Academy of Pediatrics to provide training to primary care physicians on the use of motivational interviewing with adolescents.

Iowa's Title V program has historically maintained a solid partnership with the Iowa Department of Education (DE) and their network of school nurses. Iowa will continue to partner with the DE and solicit the assistance of local school districts and school nurses in identifying service gaps related to adolescent mental health. A resource sponsored by DE and Iowa school nurses is the Iowa Adolescents: Let's Talk Health. Iowa's Title V program will continue to collaborate with DE and Iowa school nurses to promote access and content via this resource.

Iowa's Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need, including children and youth with special health care needs (CYSHCN). Iowa's Title V program is committed to partnering with this statewide effort and linking local Title V agencies with the mental health systems developed in their region of the state. The state Title V program plans to provide education to local Title V agencies about the state's advancements in building the Children's Behavioral Health System and how the local Title V agency might interface their MCAH programming with the new children's mental health regional system to provide gap filling services. Additionally, Title V will explore collaboration with the State of Iowa Youth Advisory Council (SIYAC) to gain the youth perspective on adolescent mental health. SIYAC is a non-partisan policy advising organization comprised of young people from across Iowa between the ages of 14 and 20. The IDPH Director serves on the Children's Board and the title V Director serves on several workgroups of the Children's Board.

In previous work related to NPM 9 and the prevention of bullying or those that bully among adolescents, Iowa was successful in establishing a pilot project and utilizing an evidence based bullying prevention curriculum with local LGBTQI youth Gay Straight Alliances (GSAs). Iowa's Title V program has an established partnership with Iowa Safe Schools. Iowa Safe Schools provides comprehensive support, victim services, resources, and events for LGBTQ and Allied youth. Iowa will continue to collaborate with Iowa Safe Schools in providing training for adolescents and training for parents/community members on mental health issues facing LGBTQI youth and how youth can be supported with access to services.

Iowa will facilitate the work of the sub awardees of the Personal Responsibility Education Program (PREP) to implement adult preparation subjects within the program that may include topics such as addressing adolescent mental health. Iowa Title V program will work with local Title V contractors to identify content and provide program support in content sharing with PREP program participants.

Iowa will work towards addressing health equity issues that arise around this SPM. For each of the 4 strategies listed above technical assistance provided to local Title V agencies will focus on social determinants of health and health equity strategies. Specifically, in Iowa, many disparities exist that encompass people of color, ESL, LGBTQI, immigrants/refugees and people with disabilities. Being able to locate providers that look like them, are culturally competent in addressing their unique issues and speak their language near where they live is an important aspect of overall health. In rural areas, health care, specifically mental health care access (for adults and adolescents) is disparate in comparison to urban settings. We will explore, with our Title V agencies, how they can play a role in the children's mental health regional system and, where appropriate, consider gap-filling services.

Children with Special Health Care Needs

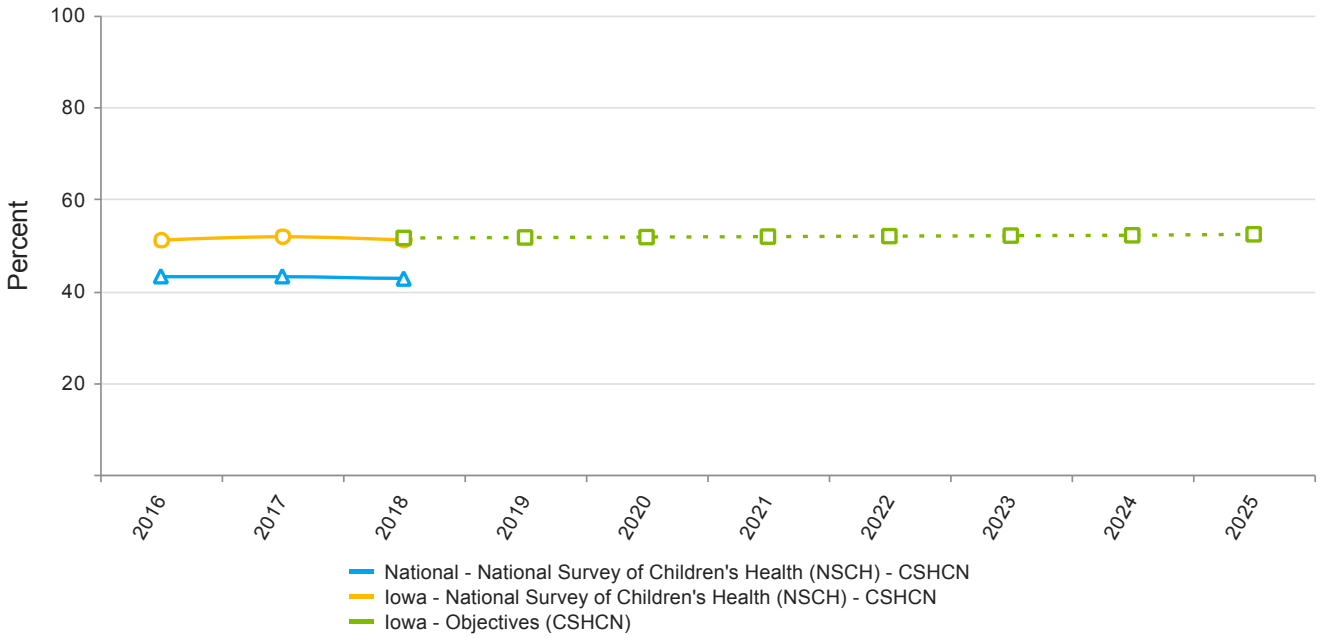
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2017_2018	24.1 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2017_2018	61.8 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2017_2018	89.0 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2017_2018	1.2 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			51.5	51.6
Annual Indicator		50.9	51.9	51.0
Numerator		65,262	70,636	74,037
Denominator		128,218	136,125	145,140
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	51.7	51.8	51.9	52.0	52.1	52.3

Evidence-Based or –Informed Strategy Measures

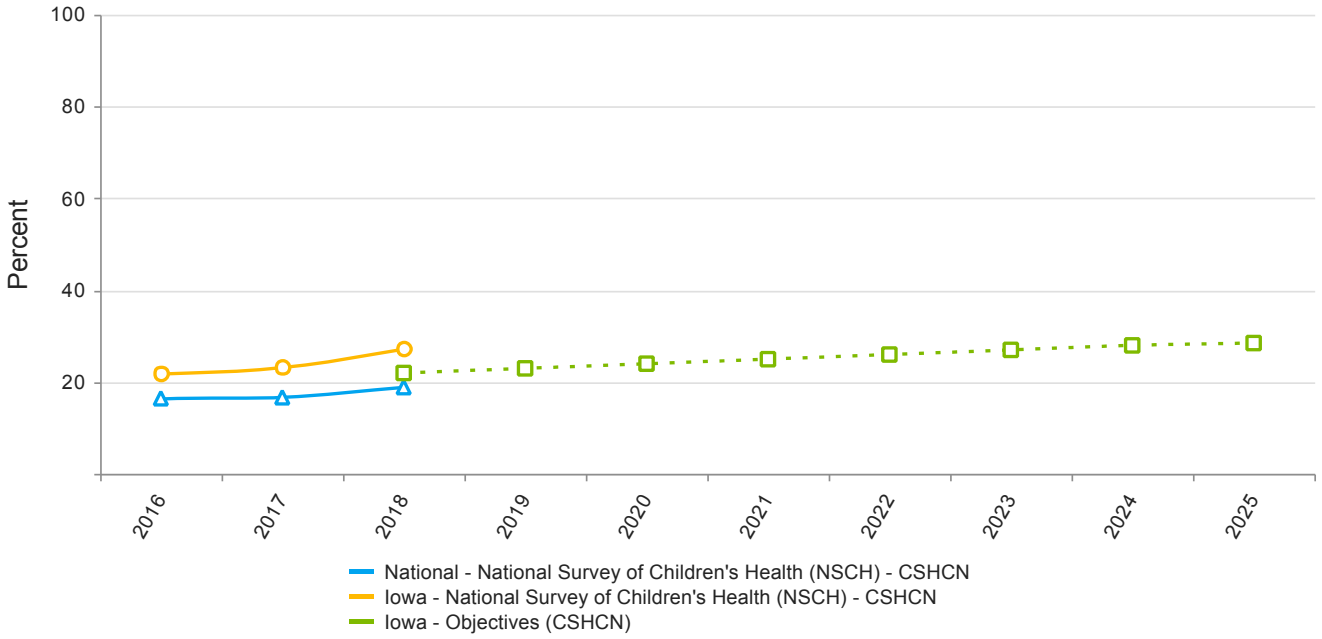
ESM 11.1 - Number of telehealth visits through Child Health Specialty Clinics

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	3,115
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3,150.0	3,185.0	3,215.0	3,245.0	3,275.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			22	23
Annual Indicator		21.9	23.1	27.2
Numerator		13,904	16,833	20,601
Denominator		63,445	72,960	75,605
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	24.0	25.0	26.0	27.0	28.0	28.5

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	62.1
Numerator	218
Denominator	351
Data Source	Electronic Medical Record
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	64.0	66.0	68.0	70.0	72.0

State Performance Measures

SPM 7 - Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	88.3
Numerator	98
Denominator	111
Data Source	Youth Services Survey for Families
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	88.0	88.5	89.0	89.5	90.0

State Action Plan Table

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 1

Priority Need
Access to community-based services and supports, pediatric specialty providers, and coordination of care

NPM
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives
By 2025, increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home to 53.4%

Strategies
Provide access to specialty care through Child Health Specialty Clinics (CHSC), including attention to culturally and linguistically appropriate care
Strengthen infrastructure and increase opportunities for pediatric specialty care through Telehealth
Increase Primary Care capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities

ESMs	Status
ESM 11.1 - Number of telehealth visits through Child Health Specialty Clinics	Active

NOMs
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 2

Priority Need

Access to support for making necessary transitions to adulthood

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

By 2025, increase the percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care to 24.6%

Strategies

Work with youth and families in the transition to adult health care

Assure appropriate transition resources for families accessing CHSC Regional Center services

Assure appropriate resources for youth and families from underrepresented backgrounds who are transitioning from pediatric to adult health care

ESMs	Status
ESM 12.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist	Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 3

Priority Need

Support for parenting Children and Youth with Special Health Care Needs

SPM

SPM 7 - Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V

Objectives

By 2025, increase the percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V to 90%

Strategies

Provide family support services to Iowa families of CYSHCN, including recruiting and supporting ethnically diverse staff including cultural liaisons

Increase appreciation of strengths and understanding of barriers to family participation and care for direct services staff statewide

Assure caregiver confidence and capacity to advocate for CYSHCN on all levels (personal/family, community, and policy), including family training to underserved/underrepresented populations

2016-2020: National Performance Measures

2016-2020: State Performance Measures

2016-2020: SPM 6 - Percent of CYSHCN with parents who are very satisfied with the communication among doctors and other health care providers

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			69
Annual Indicator			70.2
Numerator			82,857
Denominator			117,950
Data Source			NSCH
Data Source Year			2017-2018
Provisional or Final ?			Final

Children with Special Health Care Needs - Annual Report

Children with Special Health Care Needs – Annual Report FFY19

In FFY19, the Division of Child and Community Health (DCCH) supported coordinated, comprehensive and family-centered Systems of Care, including implementing and enhancing the National Consensus Standards for Systems of Care for CYSHCN 2.0. The plan included emphases on the Foundational Standards of 1) Health Equity and 2) Family Partnership (Family Participation and Engagement).This effort was designed to align with the DCCH vision to assure a systems-oriented approach to care through: 1) Integration of Services, including enhanced infrastructure for quality care coordination and telehealth; 2) Medical/Health Home Approach; and 3) Transition to Adult Health Care. Specifically, DCCH focused on assuring family-centered care through goal setting approaches; expanding access to care through telehealth; documenting impacts of health inequity and providing recommendations for improvement; building family leadership capacity; expanding access through primary care capacity for treating CYSHCN; and building systems to support transition to adult health care.

Priority Need

Integration of Services (October 1, 2018-September 30, 2019)

This arm of the Integration of Services priority area was built on the Access to Care domain from the Standards for Systems of Care 2.0. Pertinent standards include Access to Care standard number 1*: CYSHCN have geographic and timely access to primary and specialty services"* and number 4: *"Satellite programs, electronic communications, and telemedicine are used to enhance access to specialty care."*

SPM 6: Percent of CYSHCN with parents who are very satisfied with the communication among doctors and other health care providers

In FFY19, the Integration of Services priority area focused on two arms: improving staff capacity to provide quality *care coordination* and improving access to pediatric specialty care through a *telehealth* infrastructure.

Access to Care: Care Coordination

Communication and trainings for implementation of goal setting and Shared Plans of Care (SPoC)

To increase the quality of care coordination, a focus of FFY19 was on refining the process of implementation for the Shared Plan of Care (SPoC), building on lessons learned from Iowa's 2014 HRSA-funded D70 grant program, "Enhancing the System of Services for CYSHCN through Systems Integration." Efforts focused on goalsetting for all families seen in Child Health Specialty Clinic Regional Centers. A full-time Program Coordinator and dedicated time from a Family Navigator led Iowa's care coordination efforts in order to assure the spread of the highest quality services through a family-centered care team approach. Bi-monthly emails provided staff with updates, reminders, and announcements concerning the SPoC as well as the ACT.md platform. ACT.md is a cloud-based platform, compliant with the Health Insurance Portability and Accountability Act (HIPAA), to promote care coordination through online plans of care. ACT.md connects care teams, promotes family-professional partnerships, enables collaborative care planning, and drives action across Systems of Care for CYSHCN.

Expand the use of the ACT.md platform

ACT.md was used as a platform for centralized care coordination and goal setting until September 30, 2019. DCCH's contract with ACT.md was cancelled for several reasons, including barriers for staff entering data into the platform, an extremely low family participation rate with the ACT.md interface, and limited outside provider participation.

In preparation for this transition, a similar workflow was built within the DCCH Electronic Medical Record. This produced efficiencies by 1) reducing double documentation of goals by staff 2) allowing families to more easily access their information within their existing University of Iowa Health Care account, 3) increasing cost effectiveness, and 4) allowing for more efficient data collection for goal setting and transition program initiatives.

Access to Care: Telehealth

This arm of the Integration of Services priority area was built on the Access to Care domain from the Standards for Systems of Care 2.0. Pertinent standards include Access to Care standard number 1:

CYSHCN have geographic and timely access to primary and specialty services" and number 4: *"Satellite programs, electronic communications, and telemedicine are used to enhance access to specialty care."*

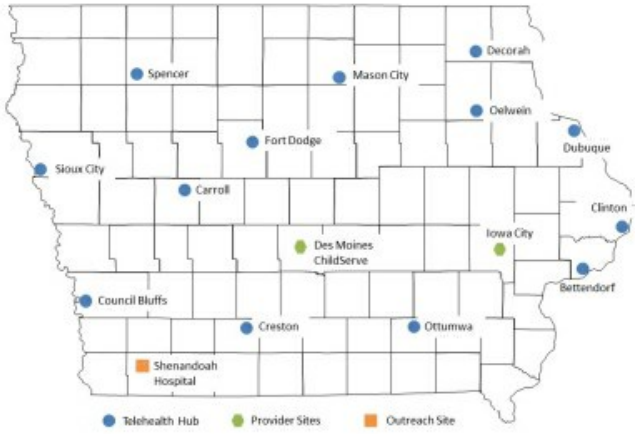
Access to pediatric specialty services through telehealth

A full-time Program Coordinator led the Iowa MCH Title V CYSHCN telehealth effort to assure that CYSHCN have timely access to specialty services through telemedicine. Regional Center locations in communities across the state allowed families, especially those living in rural areas, to access many pediatric specialty services without having to travel long distances. Using HIPAA-compliant live videoconferencing, families were connected with specialists from the University of Iowa Stead Family Children's Hospital in the areas of psychiatry, developmental and behavioral pediatrics, neurology, genetics, neonatology, Intellectual Disability-Mental Illness (IDMI) services, nutrition, and psychology. DCCH expanded into two additional areas for telehealth during FY19: Hematology/Oncology and some CHSC ARNP clinical services. The following table shows the number of appointments by specialty:

Telehealth Appointments by Specialty 10/1/18- 9/30/19	
Psychiatry	1613
CHSC ARNP	765
Dietitian	651
Behavioral Pediatrics	49
Genetics	12
Neurology	9
Neonatology	6
Endocrinology	2
Hematology/Oncology	3
IDMI	5

During FFY19, except for nutrition services, telehealth services were all delivered to families through CHSC Regional Centers, with the support of staff including registered nurses, family navigators, and clerical staff at each center. Some visits were also supported by nurse practitioners or social workers. The table below shows the location of the telehealth patient and provider sites. Most services provided by dietitians were delivered directly to patients in their homes.

Telehealth patient and provider sites, CHSC FFY19



Investigate and document health equity issues in the context of telehealth services

DCCH worked with an MD/MPH trainee from Iowa's LEND program on a research project that focused on reviewing existing literature related to health equity issues that might be addressed through telehealth. Although there is limited information on this topic for pediatric populations, several potential areas were identified where telehealth could benefit individuals from a health equity perspective: increased access to subspecialty service in non-traditional places; decreased cost for families due to less travel and lost work time; reduced ED or urgent care service utilization; increased quality of care through coordination with primary care providers; and addressing stigma in seeking care. This trainee also completed a practicum project through DCCH for the University of Iowa College of Public Health's MPH program that addressed health equity and the delivery of pediatric mental health services. This project is further described in the Medical Home section of this report.

Priority Need

Care Coordination for CYSHCN

NPM 11: Percent of children with and without special health care needs having a medical home

Iowa's Title V CYSHCN program focused medical home efforts on goal-setting initiatives with families and on the dissemination of information about the use of evidence-based screening tools for primary care providers (PCPs). For FFY19, efforts also included two additional areas of focus: the development of family leadership capacity to strengthen family advocacy efforts within Iowa in working with the health care systems; and the development of training and education activities to build the capacity of PCPs to treat CYSHCN within their practices.

Strengthen care coordination for DCCH families by using the ACT.md platform to collect and disseminate goals

Patients and families receiving care coordination or clinical services through Regional Centers were introduced to ACT.md, a

HIPAA compliant, cloud-based platform to capture the goals of families and their healthcare team. Staff worked with families to develop and enter goals into ACT.md and invited them to log into the platform to review and share these goals with other providers. In FFY19, DCCH staff entered new goals for 1336 patients. ACT.md was used until September 30, 2019. Patient goals were added to the platform and regularly updated. Other entities involved in a child's care were often invited to the platform, but outside provider interaction with the platform was found to be relatively low. As noted in the *Integration of Services* section previously, the contract with ACT.md was cancelled at the end of FFY19 and goal setting initiatives are now documented directly in the patient's Electronic Medical Record.

Strengthen programs to enhance CYSHCN family leadership capacity and workforce

In FFY19, DCCH strengthened Iowa's family leadership capacity and workforce through the expansion of the Iowa Family Leadership Training Institute (IFLTI). This program provides training to parents and caregivers of CYSHCN. The goals of this training are to: understand how to work with partners; develop a path to leadership; and discover strategies for advocacy. All training participants are also required to complete a Community Service Project.

In FFY19, there were 13 training participants, including two members of the DCCH Family Navigator Network. Community Services Projects completed by this cohort are listed below:

- Formed the Southwest Iowa Autism Support Group, which planned a sensory-friendly holiday event.
- Researched caregiver resilience and advocated with several providers to implement a caregiver resilience screening tool.
- Created a social media group for gender nonconforming children on the autism spectrum.
- Formed a support, empowerment, and advocacy group for families of children with disabilities living in the participant's area.
- Developed a "Places to Play" list, recreational areas accessible to children with special needs and their families.
- Developed a Facebook page for families of children with Cerebral Palsy, filling a gap in Iowa.
- Created a resource guide for parents whose premature children are being discharged from a hospital Neonatal Intensive Care Unit.
- Created a plan to provide guidance to school districts on how to consider a student's IEP when administering a good conduct violation in extracurricular activities.
- Created a plan to make the Home- and Community-Based Services waiver application process more understandable for families who may apply for them on behalf of their children with special needs.

In summer 2019, interviews were conducted to determine the level of growth in leadership and advocacy among previous participants. Pre/post assessment data were analyzed, and a poster was developed and accepted to the AMCHP 2020 conference. Conclusions from this study were:

- Participants learned to recognize and develop their own leadership skills and expertise as parents of CYSHCN.
- Participants gained the confidence and skills to develop community and system-level partnerships. The IFLTI encouraged continuing connectedness among cohorts.
- While family training positively impacts the System of Care for CYSHCN, more research is needed to measure impact over time.

This program also sponsored a series of evening trainings that were held at or in conjunction with CHSC Regional Centers and partnering organizations. The table below shows information about the IFLTI Regional Trainings:

IFLTI Regional Trainings, FFY19

Date	Location	Number of trainees	Topics	Partners
October-18	Spencer	12 trainees, 3 Regional Center staff, 2 Iowa City staff	Family Centered Care, Good Communication	Sponsored by RAP
November-18	Oelwein	14 trainees, 2 Regional Center staff	Family Professional Partnerships, Good Communication	Sponsored by RAP
March-19	Clinton	15 trainees, 3 Regional Center staff, 2 Iowa City staff	Family Centered Care, Good Communication	Sponsored by RAP
September-18--May-19	Coralville	Varied	El Grupo Manantial Trainings, various topics	Partnered with ChildServe to provide monthly trainings to Spanish-speaking parents.
September-19	Independence	12 trainees, 3 staff	Good Communication, Alternatives to Legal Guardianship	MHDS training: Collaboration with East Central MHDS Region and CDD
November-18	Iowa City	20 trainees in three trainings	Various topics	Family Peer Support Specialist Trainings
April-19	West Des Moines			
August-19	Coralville			

Another component of the Care Coordination strategy was the continuation of the Family Peer Support Specialist Training Program (FPSS) that provides comprehensive training for Iowa's family peer support workforce including the development of statewide networks and continuing education opportunities. This program is a collaboration among DCCH, the University of Iowa National Resource Center for Family Centered Practice, ASK Resource Center (Iowa's Family Voices affiliate), and the National Alliance on Mental Illness Iowa. A Family Peer Support Specialist is a parent or primary caregiver of a child with an emotional, behavioral, or mental health disorder. They work with families who also have children with serious mental health disorders. The Title V program provides the infrastructure for this Iowa Department of Human Services funded project as part of a broader Peer Support Specialist training program.

In FFY19, program staff developed a credentialing process through the Iowa Board of Certification based on the training curriculum in collaboration with the Midwestern Public Health Training Center. A comprehensive exam was developed and approved by the Iowa Board of Certification as part of this credentialing for the new FPSS certification in the state of Iowa. Other components of this process include the completion of online and in-person training sessions, including assigned homework, a score of 70% or higher on the exam, and completion of an eight-hour Youth Mental Health First Aid training.

In FFY19, FPSS trained 20 Family Peer Support Specialists and developed a protocol for all DCCH Family Navigators to complete the FPSS certification process. The Family Navigator Network includes 31 DCCH Family Navigators located in Regional Centers around the state. The Network Coordinator facilitates monthly trainings, securing speakers and arranging for FPSS continuing education certificates. To date, 22 Family Navigators have received FPSS certification through the Iowa Board of Certification.

Three in-person training sessions were completed in FFY19 in November 2018 (Iowa City), April 2019 (West Des Moines), and August 2019 (Coralville). Prior to being admitted to this training, participants were required to complete 30 hours of online training including homework and a final exam. Topics included the System of Care for CYSHCN, the FPSS role, laws and regulations, ethics and professionalism, overview of childhood diagnoses and typical treatment protocols, communication, cultural competency, advocacy, special education, goalsetting and change theory, and wellness and trauma-informed care.

Conduct outreach to organizations statewide that serve families from underrepresented populations

CHSC Regional Center staff have been working to create and enhance relationships with community-based organizations serving underrepresented populations in Iowa. For example, the Sioux City Regional Center strengthened partnerships with two agencies that serve underrepresented populations: Mary Treglia Community House, serving families new to the Sioux City area, including immigrants and refugees; the Crittendon Center, a multi-disciplinary agency designed to give children and families the support they need to feel cared for, nurtured, healthy, safe, and to lead successful self-sufficient lives. The Dubuque Regional Center staff have partnered with the Crescent Center FQHC to support efforts to hire a family navigator to assist with serving Marshallese families. Iowa City staff began conversations with EMBARC after EMBARC requested family navigation for a Burmese family. EMBARC is an organization that was started by refugees in Iowa to serve refugee families.

Provide access for CYSHCN and their families to care coordination

All families who receive services through DCCH have access to care teams that include Family Navigators, RNs ARNPs, Dietitians, and specialty providers. Some teams also include Social Workers and Program Coordinators. The DCCH System of Care approach includes gap-filling clinical services; care coordination; and family to family support. In FFY19, families of 7405 CYSHCN were directly served through this model.

Develop a program to enhance Primary Care Provider capacity to treat CYSHCN with mild- to- moderate special health care needs

Most of Iowa's children have a community-based primary care provider (PCP). In FFY19, DCCH received funding from HRSA for the Pediatric Mental Health Care Access Program to develop the Iowa Pediatric Mental Health Collaborative. This program builds on foundational support from Title V and aligns with DCCH's Title V goal to enhance the capacity of PCPs to treat CYSHCN with mild- to- moderate special healthcare needs within their medical home. This enables greater availability of pediatric specialty providers to treat patients with more complex healthcare needs. The program's advisory board met three times in FFY19 and includes representatives from the Iowa Chapter of the American Academy of Pediatrics (IA-AAP) and the Iowa Association of Nurse Practitioners (IANP), the Director of the University of Iowa Physician Assistants Program, primary care providers, a family representative, and staff from state programs such as 1st Five. In FFY19, three in-person conferences were held for primary care providers with a total of 173 participants. The table below lists the locations, dates, and attendees present at each conference.

Pediatric Mental Health Primary Care conferences

Conference	Date	Attendees
Ottumwa Critical Conversations	4/24/19	49
Fayette Critical Conversations	5/8/19	67
Spencer Critical Conversations	8/28/19	57
Total		173

Topics presented at the conferences varied by location and included:

- Introduction to the Iowa Pediatric Mental Health Collaborative
- Treatment of anxiety disorders
- Understanding disruptive behaviors
- ADHD in children and adolescents
- Learning disorders in children and adolescents
- Depression management in children and adolescents
- Suicide risk assessment
- Caring for the health of LGBTQ+ youth
- Infant and early childhood mental health
- Evaluation and behavior management of severe self-injurious behaviors
- Bipolar disorder in children and adolescents
- Transition to adulthood for individuals with an intellectual disability

The program also hosted six webinars with a total of 213 participants. The following table lists the webinar topics and number of attendees at each:

Pediatric Mental Health Primary Care Webinars

Webinar	Presenter	Date	Attendees
Orthorexia: From Research to DSM-6	Susan Pike, MD	2/2/19	32
Integrative Approaches for the Autism Spectrum	Suzanne Bartlett-Hackenmiller, MD and Todd Kopelman, PhD	4/17/19	68
Cultural Humility in Pediatric Mental Health Care	Tanzeh Metzger, MD/MPH Candidate	5/29/19	20
IoWA-PCIT: Integration of Working Models of Attachment into Parent-Child Interaction Therapy	Beth Troutman, PhD, ABPP	6/19/19	38
Behavioral Interventions in Primary Care	Erin Olufs, PhD	8/13/19	31
Affirmative Care: Working with Teens who are Transgender and Gender Non-Conforming	Caroline Woods, MS, PA-C	9/18/19	24
Total			213

An online resource and referral database were also developed that includes information for primary care providers and families. An MD/MPH trainee practicum student worked with program staff to complete a project focused on issues of Health Equity when providing training and education to PCPs. Among other activities, the student facilitated the following health equity trainings for PCPs as part of the webinar series listed above:

- *Cultural Humility in Care: Addressing Health Disparities in Pediatric Mental Health Care*
- *Affirmative Care: Practicing Cultural Humility and Working with Teens who are Transgender and Gender-Nonconforming*

Collaborate with Iowa's public health programs that support the use of evidence based preventive health assessments

DCCH has a longstanding relationship with the Iowa Department of Public Health (IDPH) 1st Five Healthy Mental Development Initiative. The role of DCCH in this contractual relationship builds on the foundational support of the Title V funding. DCCH worked with IDPH and 1st Five sites at local public health agencies to complete 17 training events. These included presentations, webinars, and peer-to-peer consultations with PCPs across the state. Primary care focused events were on issues relevant to early childhood development including developmental screening and surveillance, Adverse Childhood Experiences, the implementation of Ages and Stages Questionnaires (ASQ), and the Modified Checklist for Autism in Toddlers (M-CHAT). DCCH offered CME and CEU credits for many of these events.

DCCH activities during FFY19 also included service coordination for Iowa's Early Intervention program, Early ACCESS, continued support of Iowa's Act Early Ambassador, and collaboration with Iowa's Regional Autism Assistance Program (RAP). The RAP program provides a broad array of services to improve systems of care for children and youth with autism spectrum disorder. RAP supports CHSC providers in administering the *Screening Tool for Autism in Toddlers and Young Children* (STAT) and supports community providers in administering the Autism Diagnostic Observation Schedule for diagnosing and assessing autism.

Priority area:

Transition to Adult Health Care (October 1, 2018-September 30, 2019)

NPM 12: Percent of children with and without special health care needs who received services necessary to make transitions to adult health care

Transition to Adulthood Planning Tools.

Transition to Adulthood Planning Tools were developed using a transition workgroup and went through several rounds of

revisions. In FFY18, DCCH created tools utilized in CHSC Regional Centers to support transition planning for youth with special health care needs (YSHCN) and their families. In FFY19, DCCH enhanced these tools and added additional resources. Youth and families received an introductory transition checklist to assess family and adolescent preferences for topics to initiate the transition planning process. Staff members continued to work with youth and families over time to make progress on goals, overcome obstacles, and identify new priorities. A protocol for implementing the Transition Checklist was last edited in March 2019. This included information about how to introduce the transition checklist to families seen in CHSC Regional Centers and the roles of Regional Center staff when discussing transition with families. This protocol also included information about how to document transition goals within the patient's Electronic Medical Record and ACT.md and how to follow up discussions about transition with patients and their families. This protocol was re-evaluated in September 2019 and ways of more efficiently documenting transition to adult health care were discussed with DCCH staff. The transition to adulthood checklist is now available on DCCH electronic welcome tablets for all patients who are 12 years of age and older who are seen at a Regional Center. During the clinic visit, the patient, patient's family, or both are invited to complete the transition checklist on the welcome tablet. This information is then stored in the patient's medical record and is available to the provider to discuss specific concerns during the appointment. This tool is also now available electronically for staff to send to patients prior to their appointment, if desired.

Data are regularly collated and reported back to staff to assure compliance with the developed transition protocol. In FFY19, 62% of youth over age 12 years served by CHSC had an initiated transition plan.

State plan to coordinate transition efforts

Multiple state, regional, and local agencies have developed policies and programs that impact YSHCN and their families during the transition to adulthood, yet these organizations are often unaware of the needs in the community and the services offered by other organizations. This results in a duplication of some services, gaps in others, and no comprehensive state plan to coordinate efforts to assist YSHCN in the transition to all areas of adult life. In FFY2019, the Transition to Adulthood Program Coordinator took another position and broader plans to expand DCCH transition efforts were put on hold. The position was filled in May 2019.

Regionally based resource directory of transition services

In FFY18, content was added to the DCCH website to assist YSHCN and their families in preparing for adult health care. This included a list of Frequently Asked Questions, information about making the most of a visit with a health care provider, and guidelines to determine if a YSHCN will need support making decisions as an adult. In FFY19, this content was expanded to include information about understanding health insurance, guardianship and alternatives for decision-making support, transition and education, and planning for a health emergency. The following link is where this information can be found:

https://chsciowa.org/programs/health-care-transition-adulthood

Health equity issues in the context of transition to adulthood.

Inequities exist in all aspects of health care, including transition to adulthood. Factors related to health insurance, community resources, and socioeconomic factors can all contribute to inequities in preparation and outcomes for transition to adulthood. In FFY19, DCCH compiled information about the influence of race, ethnicity, geography, and diagnoses on the preparation for transition to adult health care.

Findings from this investigation showed disproportionate poverty and subsequent lack of resources; gaps in preventive primary care; disproportionate levels of health literacy exacerbated by complexity associated with special health care needs; language barriers including reports by Spanish-speaking families that their provider did not adequately teach them about diagnosis and management of their child's care; few online resources in languages other than English; cultural gaps at all levels of health care delivery; stigma and misconceptions about culture/religious traditions and values; implicit biases among providers; and lack of a culturally diverse workforce. The concept of a medical home is a valuable and effective approach for care and transition, but many black and Hispanic CYSHCN have never had this System of Care. Among all CYSHCN: 56.7% receive medical home transition services, with 59% among non-Hispanic white children, 45.5% of black children, and 44.6% of Hispanic children. Recommendations from this study included incorporating equity-based interventions transition to adulthood; early education on transition to adulthood services for all CYSHCN and particularly for traditionally underserved populations; cultural humility education for providers; advocacy for the medical home model; promoting the use of telehealth services; and encouraging more research on the topics of disparities within transition to adulthood and telehealth services in the CYSHCN populations.

Share Transition-related resources outside of DCCH as appropriate.

In June 2019, DCCH Title V and Regional Autism Assistance Program (RAP) staff partnered with Iowa's UCEDD to sponsor a retreat for families of transition-age youth. UCEDD funding was available to cover most costs for families, including registration, meals, and an overnight hotel stay. The agenda included a young adult and parent panel, Life after High School and Leaving Home, Legal and Financial Rules of the Road, a Caregiver and Parent Café, and a keynote speaker. Forty-eight parents and caregivers of transition aged CYSHCN attended the retreat. Evaluation data showed that participants most appreciated the young adult panel, the opportunity to be with other parents with similar challenges, and an increased understanding of the resources that are available for transition-aged youth.

Children with Special Health Care Needs - Application Year

Children with Special Health Care Needs – Action Plan FFY21

Priority areas identified through the FFY21 Needs Assessment process included 1) access to community-based services and supports, pediatric specialty providers, especially mental health providers, and coordination of care; 2) access to support for making necessary transitions to adulthood; and 3) support for parenting CYSHCN. While DCCH is open to serving all CYSHCN in Iowa, populations of special focus are children with behavioral or mental health challenges, chronic and complex health needs, or developmental and intellectual disability.

Priority area: *Access to care*

To address barriers to access to care for Children and Youth with Special Health Care Needs, the University of Iowa Division of Child and Community Health (DCCH) will focus on 1) providing access to specialty care through Child Health Specialty Clinics (CHSC) Regional Centers, 2) strengthening infrastructure and increasing opportunities for specialty care through telehealth, and 3) increasing Primary Care capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities.

DCCH will provide statewide care coordination, family support, systems navigation, and gap-filling clinical services through the existing regional network of CHSC Regional Centers. This will include marketing of services through a collaboration with the University of Iowa Stead Family Children's Hospital Continuity of Care program for children with special health care needs. DCCH staff will also define best practices for care coordination, including for telehealth, for children with medical complexity, mental health diagnoses, developmental and intellectual disabilities. This will include and emphasis on trauma informed care and culturally responsive best practices. CHSC Regional Centers are currently equipped to be hubs for telehealth services. In the upcoming fiscal year, DCCH will assure appropriate staffing and updated equipment when appropriate for delivery of all services, including telehealth. DCCH will assess how CHSC Regional Centers can best align with community needs, create succession plans for CHSC Regional Center Nurse Practitioners, and assure appropriate equipment such as additional welcome tablets if a need is identified. DCCH will ensure a linguistically and culturally appropriate approach to care by evaluating which linguistically appropriate forms should be included on welcome tablets, and working with staff to build relationships with diverse populations in CHSC Regional Center Communities.

In order to strengthen infrastructure and increase opportunities for pediatric specialty care through telehealth, DCCH will build partnerships with specialty providers including those from other states and institutions, investigate mechanisms for funding and reimbursement of facility and staff time for telehealth, and evaluate staffing needs to prepare for increasing telehealth opportunities. Appropriate staffing needs for telehealth will be identified, and enhanced training to CHSC Regional Center Registered Nurses for physical assessment under guidance of telehealth providers will be provided. DCCH is committed to ensuring access to interpretation services to support telehealth visits. DCCH is currently adjusting approaches to telehealth to better accommodate changes to practice patterns related to the healthcare environment changes associated with COVID-19. This includes at-home vs. in Regional Center telehealth visits, and family-to-family support provided through video and telephone visits.

DCCH is committed to increasing access for Children and Youth with Special Health Care Needs to medical home approaches to care. To this end DCCH will work with primary care practices to increase their capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities. This will be accomplished through enhanced workforce development initiatives for primary care providers (PCPs) in Iowa. DCCH will streamline existing communication and marketing approaches to outreach and engaging PCPs; create working relationships with professional organizations; enhance resources for provider access to information about treating CYSHCN, including medical home approaches, family partnerships, culturally and linguistically appropriate care; and provide primary care focused regional and state-wide conferences and webinar trainings. DCCH will educate on and market the 24/7 Psychiatry Consultation line to PCPs utilizing resources enabled through the Health Resources Services Administration (HRSA) funded Pediatric Mental Health Care Access Program. DCCH will also work to integrate Family Peer/Family-to-Family Support within primary care settings for systems navigation/care coordination.

Priority area: *Transition to adulthood*

During the upcoming and subsequent fiscal years, DCCH plans to continue existing initiatives and implement new strategies to address needs for youth ages 12 - 21 years who are in the process of transitioning to adulthood and adult health care. A 3-pronged approach will assure that goals are met: 1) continuing direct services to youth with special health care needs and their families; 2) updating transition-to-adulthood resources for youth, families and those who work with them, 3) special attention to creation and implementation of transition-to-adulthood resources that directly address issues for youth with special health care needs from underrepresented backgrounds.

To assure high quality direct services to transition age youth, DCCH staff will receive enhanced training for working with families of transition-age youth. Plans are underway to implement new trainings for staff, assure that staff are properly trained to utilize resources that have already been developed, and review processes for delivering care. Additionally, DCCH staff will assess feasibility and create a plan to implement a Youth Advisory Council.

DCCH currently utilizes a number of resources to assist youth and families through the process of transition to adulthood. A review of these resources will take place in order to assure appropriate literacy levels and accessibility. An evaluation of these resources from the family and youth perspectives will be conducted. Additionally, DCCH staff utilize the University of Iowa Health Care System Electronic Medical Record, EPIC in order to document health care utilization, diagnoses, and treatment. The current system for documenting activities related to transition to adulthood will be reviewed and streamlined in order to assure that all providers including nurse practitioners, family navigators, registered nurses, and social workers have access to the existing documentation resources. DCCH staff recognize that there are many youth with special health care needs who do not receive direct services from the organization. In the upcoming fiscal year, DCCH will create a plan for making transition to adulthood resources to broader audiences.

There is limited information regarding specific issues and best practices associated with transition to adulthood for youth with special health care needs from underrepresented backgrounds. Research from a student trainee in 2019 highlighted some of the issues related to transition to adulthood for families who may get left out of policy and planning conversations. In the upcoming fiscal year, special attention will focus on youth with complex health needs, mental health challenges, and intellectual and developmental disabilities from underrepresented backgrounds and their families. DCCH will examine workflows to assure a streamlined process for all families, including those for whom providers will need additional support for addressing cultural or linguistic needs. DCCH will also investigate the utilization of cultural brokers in reviewing resources and approaches to care. DCCH will share findings and resources stemming from these efforts to providers and organizations statewide.

Priority area: Support for families

The need for family support was identified during the Iowa Statewide Needs Assessment process. DCCH plans to address this need by 1) providing family-to-family support to Iowa families of children and youth with special health care needs, 2) building appreciation for strengths and barriers for families across the state, and 3) building the infrastructure for strengthening family leadership capacity statewide.

DCCH will provide family-to-family support through the existing Child Health Specialty Clinics (CHSC) Regional Center Family Navigator Network. During the upcoming fiscal year, efforts will focus on assuring recruitment of and support for staff from a diverse range of ethnic, racial, and cultural backgrounds. Family Navigator training will focus on identified needs including enhanced understanding of trauma-informed and culturally responsive care. The Family Advisory Council is an existing mechanism for receiving feedback from the family perspective for the Division. This Council will continue to operate through the next fiscal year to assure that DCCH adheres to principles of Family Centered Care. Furthermore, recognizing that there are many family-serving organizations statewide who are not aware of the DCCH Family Navigator Network, efforts will focus on strengthening awareness and understanding of DCCH family support services to new and existing partners including Iowa's Early Intervention program (Early ACCESS), and the University of Iowa Center for Disabilities and Development. DCCH strategies will promote the value of peer-to-peer support provided through organizations and programs such as the National Alliance for Mental Illness, the Family and Peer Support Specialist training programs, and Child Health Specialty Clinics. DCCH outreach to families will include an emphasis on building partnerships within diverse communities and increased family support services to traditionally underserved populations.

Families of children and youth with special health care needs often face challenges associated with access to care, financial barriers, and isolation. During the upcoming fiscal year, DCCH will continue to build awareness for general populations of some of the strengths and challenges families face. DCCH will provide family storytelling workshops including Digital Storytelling for sharing family stories with direct service providers in a variety of ways including videos, parent panels, and academic presentations. The Iowa Family Photo Story Project was created in 2018 and highlights a number of Iowa families of children and young adults with special healthcare needs. DCCH will continue to present this project in new venues such as the Iowa Learning Academy, CHSC Regional Centers, healthcare provider conferences and the Iowa State Capitol. CHSC will continue to educate direct service providers, families, and staff about the need for family-to-family support and educate about the importance of Shared Decision Making. DCCH will also work to improve methods and processes to help identify families that need added emotional support and incorporate screening tools and screening processes into workflows.

Building family capacity to advocate for Children and Youth with Special Health Care Needs on all levels (Personal/Family, Community, and Policy) is a strategy that DCCH will continue to implement in the upcoming fiscal year. Through formal trainings for families through programs such as the Iowa Family Leadership Training Institute, trainings in CHSC Regional Center communities, and Family Peer Support Specialist trainings, the family advocacy workforce will be strengthened in Iowa. Additionally, the CHSC Regional Center staff will use high quality information and resources to help build family capacity to advocate for their child. A specific focus on family leadership capacity will be on increasing relationships and family support trainings to underserved and underrepresented populations to reduce isolation and increase knowledge.

Cross-Cutting/Systems Building

State Performance Measures

SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	20.0	90.0	95.0	99.0

State Action Plan Table

State Action Plan Table (Iowa) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Infusing Health Equity with in the Title V System

SPM

SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve

Objectives

By 2025, 99% of all Title V contractors will have developed a plan to identify and address health equity in the populations they serve

Strategies

Inclusion of health equity plan requirement language in BFH grant agreements

Increase the percent of contractors that demonstrate application of health equity strategies

Utilize Health Equity Advisory Committee (HEAC) to provide input into the health equity strategies for each NPM and SPM and local contractors

Inclusion of health equity activities in all Title V funded BFH Staff positions

Increase the percentage of Title V Contractors that engage diverse participant voices in program planning, decision making and implementation

Build internal capacity within the Bureau of Family Health/Title V Program Health Equity Team; completion of an organizational assessment of equity practices, and facilitation of staff professional development and technical assistance

Develop and implement a data analysis plan to assess distribution of Title V resources and services through a health equity lens

Cross-Cutting/Systems Builiding - Annual Report

Performance Measures previously addressed in Cross-Cutting/Life Course Domain have been incorporated in to the appropriate Population Domains.

Cross-Cutting/Systems Building - Application Year

SPM 6: Percent of Title V contractors with a plan to identify and address health equity in the populations they serve

The Bureau of Family, including Title V staff, have been incrementally increasing internal understanding and capacity to address health equity in programs and services. The Bureau/Title V is ready to expand capacity internally and to engage contractors in assuring health equity in services and programs administered at the community level.

The 2021 MCAH RFA is requiring contractors to address strategies and activities to demonstrate application of health equity strategies and engage diverse participant voices in program planning, decision making and implementation, and demonstrate inclusion of evidence-based/-informed community engagement and collective impact strategies. These are beginning steps to assist contractors in being prepared to comply with the inclusion of a health equity plan requirement in the next RFP.

An environmental scan of current contractors will be conducted to assess the presence of health equity plans, current engagement in health equity strategies and partnerships, and assess the support needed by Title V contractors. Title V plans to utilize the Health Equity Advisory Committee (HEAC) developed as part of the Title V Needs Assessment to provide input, technical assistance and content expertise on the health equity strategies being developed at the state and contractor level. The HEAC is comprised of members of or service providers with expertise in working with the state identified priority populations: African American/Black/African, Asian/Pacific Islander, fathers, Hispanic/Latinx, immigrants/refugees, LGBTQI+, Native American, and persons with disabilities.

The 2021 MCAH RFA outlines roles for Title V Contractors to engage diverse participant voices in program planning, decision making and implementation. Contractors shall incorporate strategies for family, youth, and community member participation into programming. Contractors will have access to the HEAC for consultation. Title V will increase membership of the state identified priority populations affected by health inequities on MCH Advisory Committee to assure adequate representation.

Continuing to build internal capacity within the Bureau of Family Health/Title V Program is an important strategy in providing programs and services through a health equity lens. Strategies to build capacity include the development of a Health Equity Team; Identification and completion of ongoing assessments/analyses of health equity of Iowa Title V program, development and implementation of a data analysis plan to assess distribution of Title V resources and services through a health equity lens, and facilitation of staff professional development and technical assistance.

III.F. Public Input

During FFY20, the Iowa MCH Advisory Council provided input into the proposed goals and activities as well as during the public comment period. The Council approved and endorsed the proposed priority needs, goals, and activities during the June 2020 meeting.

Iowa continued to utilize the IDPH website to post the proposed plans for the NPMs and SPMs. IDPH allowed a three-week period for interested MCH stakeholders and partners to provide feedback on Iowa's state priorities, proposed activities and performance measures through an online survey. The survey link and ask for responses was posted to the IDPH Facebook and Twitter. The Title V Director sent the survey with an ask to many partners to forward it on to their distribution lists including Early Childhood Iowa and local Title V agencies.

During the public input period, 148 individuals completed the online feedback survey. Nearly all of those that completed the survey supported the proposed performance measure activities. Comments received mostly encouraged the expansion of performance measures to include larger populations and ideas that could help move the needle on many performance measures. All feedback was shared with program staff to include updates, as necessary, into the FFY21 plan.

Public Input during Title V Needs Assessment

Focus Groups/ Key Informant Conversations

In total, Iowa conducted 7 MIECHV and 15 Title V focus groups, 9 Title V interviews, and 25 Key Informant Conversations (KICs). Focus groups were held for each population domain and had a set of common questions across all groups, with specific domain questions. Focus groups were held in both urban and rural areas. The intention was to conduct at least one KIC with each underrepresented population for each population domain. The advantages were that staff could gather targeted information from families and from each population domain to sample. This precision limited our ability to look in-depth to compare across specific underrepresented populations, because each underrepresented population was asked different question sets beyond the general Title V questions. However; this approach allowed underrepresented voices to be incorporated into each of the Title V population domains examined in the Needs Assessment.

Conducted KICs with 1-5 participants from each of the underrepresented populations identified. Utilized trained community champions as facilitators; also acted as recruiters. These were conducted either in-person or through teleconferencing based participant needs. KIC were conducted in MIECHV counties and other communities of interest to Iowa's Title V program. KIC were conducted using interpreters, other than spoken English languages: Spanish, Karen, Tigrinya, Vietnamese, Marshallese and Captioning.

Participation Summary

- 158 focus group/ key informant interviews participants
- 55 targeted Health Equity Voices (35%)
- 59% of the sample was urban
- 41% of the sample was rural
- 12 counties and the Meskwaki Settlement

Non Participant Survey

While Focus Groups and Key Informant Conversations provided insight to the families that received Title V Services, it was important to engage potentially eligible individuals that are not part of Iowa's Title V system of care. A paper survey was sent to over 200 WIC recipients eligible for Title V services, but have not received Title V services. The paper survey contained the same 5 main questions used in Focus Groups and Key Informant Conversations, collected demographics, and a few questions related to not accessing available services and referrals. Over 30 responses were received. The survey results depicted that the respondents were unsure of Title V services and were not aware that they were eligible for these services. This gives staff the opportunity to work with WIC to discuss ways to cross promotion of services.

Stakeholder Survey

A survey was conducted to seek input about the greatest health needs and challenges for Iowa's families, with a focus on the following populations: women/maternal, infants, children, adolescents, and children and youth with special health care needs. A brief video was created to describe the intent and background for the survey. Each population group included a set of questions relating to different national and state priorities. General data about each of the priority areas was embedded into the survey. Consideration of respondents' professional, personal, and community experience was used to answer

survey questions. For additional information on each population domain, the data snapshots and themes from Focus Groups and KIC were available by link within the survey.

The survey had one section for each population domain. Participants were asked to rank the importance of issues within each population domain. There was an option to answer questions for one or more of these groups.

Total Participants: 487
Population Group Responses:

- Women/ Maternal Health 172
- Child Health 172
- Perinatal/Infant Health 127
- Adolescent Health 116
- CYSHCN 110

III.G. Technical Assistance

Health Equity will be a large focus for Iowa's Title V program in the next year and five year cycle. Technical assistance opportunities for trainings at the state and local level will be explored to better equip the workforce to work with priority populations identified in the Needs Assessment process. Iowa would like to work with experts who have had success in program planning and administration when it comes to serving disparate populations. This could be an opportunity to work with other state's Title V programs across the nation or within Region VII to better pool our resources and share the best practices widely.

Iowa is in the early stages of implementation of the Iowa Maternal Quality Care Collaborative (IMQCC) to enhance the quality of care provided to Iowa's pregnant and postpartum mothers. Early plans of the IMQCC include implementation of AIM safety bundles. Iowa will identify states with similar demographics and structure that have implemented AIM bundles to identify success, challenges, barriers and lessons learned.

A primary and ongoing concern for CYSHCN is transition to adulthood and the adult health care system. DCCH will seek technical assistance opportunities to assist with the development of a robust training program for health care providers who are assisting families in the transition to the adult system. Trainings will focus on workforce including DCCH Family Navigators, Registered Nurses, Social Workers, and Nurse Practitioners. Additionally, DCCH will seek training for developing the workforce for pediatric primary and specialty care beyond DCCH providers.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V Medicaid MOU 2021.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - FY21 Maps.pdf

Supporting Document #02 - FFY21 Budget Side by Side Population.pdf

Supporting Document #03 - FFY21 Budget Side by Side Pyramid.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Combined Org Charts.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Iowa

	FY 21 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,512,681	
A. Preventive and Primary Care for Children	$ 1,959,881	(30%)
B. Children with Special Health Care Needs	$ 2,168,723	(33.3%)
C. Title V Administrative Costs	$ 651,268	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 4,779,872	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,334,543	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 8,847,074	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 480,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 15,661,617	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,035,775		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 22,174,298	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 12,046,998	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 34,221,296	

OTHER FEDERAL FUNDS	FY 21 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 401,978
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 520,729
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 414,420
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 5,772,883
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) and Other Developmental Disabilities	$ 154,393
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 115,706
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,134,389

	FY 19 Annual Report Budgeted		FY 19 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,517,057		$ 6,039,679	
A. Preventive and Primary Care for Children	$ 2,115,377	(32.5%)	$ 1,783,205	(29.5%)
B. Children with Special Health Care Needs	$ 2,170,180	(33.3%)	$ 2,106,035	(34.8%)
C. Title V Administrative Costs	$ 651,705	(10%)	$ 656,095	(10.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 4,937,262		$ 4,545,335	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,157,773		$ 7,416,373	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 7,155,548		$ 5,980,879	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 480,000		$ 637,056	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 14,793,321		$ 14,034,308	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,035,775				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 21,310,378		$ 20,073,987	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 12,313,087		$ 12,261,235	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 33,623,465		$ 32,335,222	

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 408,440	$ 412,573
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 514,313	$ 562,255
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500	$ 157,500
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 115,706	$ 115,706
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 260,063	$ 260,063
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) and Other Developmental Disabilities	$ 154,970	$ 154,545
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 6,097,921	$ 6,096,921
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 2,273,174	$ 2,182,517
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 250,000	$ 238,155
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,331,000	$ 1,331,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000	$ 150,000

OTHER FEDERAL FUNDS	FY 19 Annual Report Budgeted	FY 19 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Peer Support MHDS	$ 500,000	$ 500,000

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: This expenditure report covers the FFY19 calendar year not necessarily the FFY19 budget period or award. There were two MCH grants running concurrently.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: At the time of submission, expenditures remain to be claimed in the Preventive and Primary Care for Children budget category; this category is fully obligated. IDPH anticipates this budget category to be fully expended by the end of the budget period and will meet the minimum 30% requirement.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The Administrative Costs percentage is a point-in-time variance above the limit. Title V Administrative Costs will not exceed the 10% maximum once all Title V expenditures are accounted for.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: The FY19 expenditures for the 1st Five Healthy Mental Development were lower than anticipated.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Hired a new ARNP during FY19 that lead to an increase of telehealth visits. Overall ARNP visits increased for FY19 that lead to greater program income than what was budgeted.	

6.	**Field Name:**	**Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: IDPH: $260,027 CHSC: $154,393	

Data Alerts:

- The value in Line 1A, Preventive and Primary Care for Children, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater than 10% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Iowa

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 1,343,770	$ 1,319,105
2. Infants < 1 year	$ 389,039	$ 175,239
3. Children 1 through 21 Years	$ 1,959,881	$ 1,783,205
4. CSHCN	$ 2,168,723	$ 2,106,035
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 5,861,413	$ 5,383,584

IB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Pregnant Women	$ 444,565	$ 287,316
2. Infants < 1 year	$ 63,041	$ 89,151
3. Children 1 through 21 Years	$ 11,807,671	$ 10,234,093
4. CSHCN	$ 3,346,340	$ 3,423,748
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 15,661,617	$ 14,034,308
Federal State MCH Block Grant Partnership Total	$ 21,523,030	$ 19,417,892

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Iowa

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 955,045	$ 918,069
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 284,127	$ 312,658
B. Preventive and Primary Care Services for Children	$ 345,610	$ 289,506
C. Services for CSHCN	$ 325,308	$ 315,905
2. Enabling Services	$ 1,686,239	$ 1,583,002
3. Public Health Services and Systems	$ 3,871,397	$ 3,538,608
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 315,905
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 472,692
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 17,075
Other		
Gap Filling Services		$ 112,397
Direct Services Line 4 Expended Total		$ 918,069
Federal Total	$ 6,512,681	$ 6,039,679

IIB. Non-Federal MCH Block Grant	FY 21 Application Budgeted	FY 19 Annual Report Expended
1. Direct Services	$ 2,755,882	$ 3,022,103
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 86,226	$ 43,932
B. Preventive and Primary Care Services for Children	$ 1,367,608	$ 1,566,530
C. Services for CSHCN	$ 1,302,048	$ 1,411,641
2. Enabling Services	$ 3,092,940	$ 3,228,106
3. Public Health Services and Systems	$ 9,812,794	$ 7,784,098
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,411,641
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,264,195
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 45,666
Other		
Gap Filling Services		$ 300,601
Direct Services Line 4 Expended Total		$ 3,022,103
Non-Federal Total	$ 15,661,616	$ 14,034,307

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2021**
	Column Name:	**Application Budgeted**
	Field Note: Includes $91,178 of Admin funds	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2019**
	Column Name:	**Annual Report Expended**
	Field Note: Includes $91,853 in Admin funds.	
3.	**Field Name:**	**IIA. - Other - Gap Filling Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**
	Field Note: Gap Filling Services NOT provided in a physician office which include: Developmental testing Domestic violence screen Evaluation and Management (E&M) Health history Hearing Immunizations Mental health screenings Nursing assessments Nutrition assessments Preventive medicine counseling Social assessments Social Work assessments Substance abuse screenings Vision screenings	
4.	**Field Name:**	**IIB. - Other - Gap Filling Services**
	Fiscal Year:	**2021**
	Column Name:	**Annual Report Expended**

Field Note:
Gap Filling Services NOT provided in a physician office which include:
Developmental testing
Domestic violence screen
Evaluation and Management (E&M)
Health history
Hearing
Immunizations
Mental health screenings
Nursing assessments
Nutrition assessments
Preventive medicine counseling
Social assessments
Social Work assessments
Substance abuse screenings
Vision screenings

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Iowa

Total Births by Occurrence: 37,557 **Data Source Year: 2019**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	37,318 (99.4%)	2,716	119	119 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Hearing Loss	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency				

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Newborns with a confirmed diagnosis are referred to subspecialty care for long-term follow-up through the newborn's PCP. The Iowa Newborn Screening Program does not monitor newborns long-term.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Iowa

Annual Report Year 2019

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	5,402	80.3	0.1	7.7	11.9	0.0
2. Infants < 1 Year of Age	3,595	78.4	0.0	6.0	15.6	0.0
3. Children 1 through 21 Years of Age	103,780	71.5	0.5	0.8	27.2	0.0
3a. Children with Special Health Care Needs	7,574	38.0	10.0	28.0	10.0	14.0
4. Others	0					
Total	112,777					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	37,785	Yes	37,785	100	37,785	5,402
2. Infants < 1 Year of Age	37,641	Yes	37,641	100	37,641	3,595
3. Children 1 through 21 Years of Age	878,657	Yes	878,657	100	878,657	103,780
3a. Children with Special Health Care Needs	185,924	Yes	185,924	100	185,924	7,574
4. Others	2,239,197	Yes	2,239,197	0	0	0

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2019**
	Field Note: Data was pulled from SignifyConnect, Iowa's Title V program data system. This count includes women served through the Maternal Health program. Services include: maternal health risk assessment, health education, psychosocial services, oral health services, care coordination, and presumptive eligibility.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2019**
	Field Note: Data was pulled from SignifyConnect, Iowa's Title V program data system. This count includes infants served through the Child Health program. Services include: informing, care coordination, and gap filling direct care services.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Data was pulled from SignifyConnect, Iowa's Title V program data system. This count includes children served through the Child Health program. Services include: informing, care coordination, and gap filling direct care services.	
4.	**Field Name:**	**Children with Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: Data was derived through review of the electronic medical record. Some organizations that refer CYSHCN to DCCH do not provide primary source of coverage upon referral, which reflects the high "unknown" percentage. Some of the "unknowns" may have no insurance, though DCCH is unable to discriminate between these two categories	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: All individuals served by Title V are accounted for in the previous categories.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2019**
	Field Note: The Statewide Perinatal Care Team, funded by Title V, visits all birthing hospitals to provide training and technical assistance.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2019**
	Field Note: All infants born in Iowa receive new born metabolic and hearing screening, which are part of the Title V federal/state partnership.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2019**
	Field Note: Iowa's Title V program has the potential reach of all children in Iowa because of activities that fall within the Public Health Services and Systems level of the MCH Pyramid. Activities included promotion of the AAP recommended screenings to primary care providers, statewide promotional campaigns, and statewide data collection and dissemination of ACEs.	
4.	**Field Name:**	**Children With Special Health Care Needs**
	Fiscal Year:	**2019**
	Field Note: Policy, infrastructure, and workforce development activities are designed to impact all CYSHCN in Iowa.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2019**
	Field Note: All individuals served by Title V are accounted for in the previous categories.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Iowa

Annual Report Year 2019

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	40,665	30,277	2,783	3,657	193	1,116	175	695	1,769
Title V Served	6,745	4,166	757	1,007	16	152	80	153	414
Eligible for Title XIX	16,152	9,842	2,121	2,165	155	387	110	468	904
2. Total Infants in State	41,298	30,758	2,844	3,694	196	1,127	175	712	1,792
Title V Served	4,163	2,671	457	568	6	103	52	88	218
Eligible for Title XIX	16,376	9,965	2,174	2,186	157	390	110	481	913

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Iowa

A. State MCH Toll-Free Telephone Lines	2021 Application Year	2019 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 369-2229	(800) 369-2229
2. State MCH Toll-Free "Hotline" Name	Iowa Healthy Families Line	Healthy Families Line
3. Name of Contact Person for State MCH "Hotline"	Tammy Jacobs	Tammy Jacobs
4. Contact Person's Telephone Number	(515) 727-0656	(515) 727-0656
5. Number of Calls Received on the State MCH "Hotline"		700

B. Other Appropriate Methods	2021 Application Year	2019 Annual Report Year
1. Other Toll-Free "Hotline" Names	Teen Line	Teen Line
2. Number of Calls on Other Toll-Free "Hotlines"		645
3. State Title V Program Website Address	http://idph.iowa.gov/familyhealth and http://chsciowa.org	http://idph.iowa.gov/familyhealth and http://chsciowa.org
4. Number of Hits to the State Title V Program Website		39,626
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Iowa

1. Title V Maternal and Child Health (MCH) Director	
Name	Marcus Johnson-Miller
Title	Title V Director
Address 1	321 E 12th St
Address 2	
City/State/Zip	Des Moines / IA / 50319
Telephone	(515) 281-4911
Extension	
Email	marcus.johnson-miller@idph.iowa.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Dr. Thomas Scholz
Title	CYSHCN Title V Director
Address 1	100 Hawkins Dr.
Address 2	
City/State/Zip	Iowa City / IA / 52242
Telephone	(319) 467-5009
Extension	
Email	thomas-scholz@uiowa.edu

3. State Family or Youth Leader (Optional)	
Name	Rachel Charlot
Title	Program Coordinator
Address 1	100 Hawkins Drive
Address 2	
City/State/Zip	Iowa City / IA / 52242
Telephone	(712) 792-5530
Extension	
Email	rachel-charlot@uiowa.edu

Form Notes for Form 8:

None

Form 9
State Priorities – Needs Assessment Year

State: Iowa

Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Infusing Health Equity with in the Title V System	New
2.	Access to care for the MCAH Population	Continued
3.	MCAH Systems Coordination	Continued
4.	Dental Delivery Structure of the MCAH Population	Continued
5.	Safe and Healthy Environments	New
6.	Access to community-based services and supports, pediatric specialty providers, and coordination of care	Continued
7.	Access to support for making necessary transitions to adulthood	Continued
8.	Support for parenting Children and Youth with Special Health Care Needs	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Iowa

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	81.5 %	0.2 %	30,619	37,568
2017	80.9 %	0.2 %	30,922	38,217
2016	81.1 %	0.2 %	31,801	39,213
2015	80.2 %	0.2 %	31,516	39,275
2014	80.2 %	0.2 %	31,680	39,516
2013	76.7 %	0.2 %	29,902	38,967
2012	76.6 %	0.2 %	29,528	38,556
2011	77.1 %	0.2 %	29,310	38,017
2010	76.4 %	0.2 %	29,210	38,212
2009	75.3 %	0.2 %	29,296	38,917

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	54.7	3.8	204	37,275
2016	52.4	3.7	198	37,808
2015	53.0	4.3	152	28,702
2014	44.6	3.4	170	38,095
2013	57.2	3.9	215	37,605
2012	48.3	3.6	180	37,229
2011	49.9	3.7	185	37,045
2010	49.0	3.6	184	37,530
2009	45.8	3.5	176	38,435
2008	44.8	3.4	172	38,415

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2018	13.9	2.7	27	194,787

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	6.9 %	0.1 %	2,608	37,768
2017	6.6 %	0.1 %	2,526	38,418
2016	6.8 %	0.1 %	2,661	39,385
2015	6.7 %	0.1 %	2,663	39,471
2014	6.7 %	0.1 %	2,675	39,667
2013	6.6 %	0.1 %	2,561	39,080
2012	6.7 %	0.1 %	2,579	38,689
2011	6.5 %	0.1 %	2,495	38,196
2010	7.0 %	0.1 %	2,700	38,695
2009	6.7 %	0.1 %	2,671	39,683

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	9.9 %	0.2 %	3,745	37,774
2017	9.2 %	0.2 %	3,524	38,421
2016	9.3 %	0.2 %	3,652	39,393
2015	9.0 %	0.1 %	3,565	39,470
2014	9.3 %	0.2 %	3,677	39,676
2013	9.0 %	0.1 %	3,512	39,070
2012	9.5 %	0.2 %	3,690	38,668
2011	9.2 %	0.2 %	3,505	38,166
2010	9.6 %	0.2 %	3,728	38,674
2009	9.4 %	0.2 %	3,720	39,662

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	25.3 %	0.2 %	9,575	37,774
2017	24.3 %	0.2 %	9,344	38,421
2016	23.1 %	0.2 %	9,104	39,393
2015	22.5 %	0.2 %	8,878	39,470
2014	22.7 %	0.2 %	9,003	39,676
2013	22.3 %	0.2 %	8,708	39,070
2012	23.2 %	0.2 %	8,976	38,668
2011	23.1 %	0.2 %	8,835	38,166
2010	23.7 %	0.2 %	9,151	38,674
2009	23.7 %	0.2 %	9,403	39,662

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	4.9	0.4	188	38,527
2016	5.4	0.4	215	39,504
2015	3.9	0.3	154	39,564
2014	5.1	0.4	204	39,788
2013	4.7	0.4	185	39,190
2012	5.1	0.4	197	38,801
2011	4.9	0.4	189	38,312
2010	4.6	0.3	177	38,818
2009	4.8	0.4	191	39,805

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	5.3	0.4	204	38,430
2016	6.0	0.4	235	39,403
2015	4.2	0.3	167	39,482
2014	4.8	0.4	189	39,687
2013	4.2	0.3	166	39,094
2012	5.3	0.4	206	38,702
2011	4.7	0.4	181	38,214
2010	4.9	0.4	188	38,719
2009	4.6	0.3	183	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	3.3	0.3	126	38,430
2016	3.7	0.3	146	39,403
2015	2.5	0.3	99	39,482
2014	3.1	0.3	125	39,687
2013	2.7	0.3	105	39,094
2012	3.3	0.3	128	38,702
2011	2.9	0.3	110	38,214
2010	2.6	0.3	101	38,719
2009	2.6	0.3	105	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	2.0	0.2	78	38,430
2016	2.3	0.2	89	39,403
2015	1.7	0.2	68	39,482
2014	1.6	0.2	64	39,687
2013	1.6	0.2	61	39,094
2012	2.0	0.2	78	38,702
2011	1.9	0.2	71	38,214
2010	2.2	0.2	87	38,719
2009	2.0	0.2	78	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	130.1	18.4	50	38,430
2016	172.6	21.0	68	39,403
2015	103.8	16.2	41	39,482
2014	148.7	19.4	59	39,687
2013	120.2	17.6	47	39,094
2012	121.4	17.7	47	38,702
2011	149.2	19.8	57	38,214
2010	134.3	18.6	52	38,719
2009	115.9	17.1	46	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	98.9	16.1	38	38,430
2016	101.5	16.1	40	39,403
2015	88.6	15.0	35	39,482
2014	58.0	12.1	23	39,687
2013	89.5	15.1	35	39,094
2012	80.1	14.4	31	38,702
2011	83.7	14.8	32	38,214
2010	108.5	16.8	42	38,719
2009	80.6	14.3	32	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.7 %	1.1 %	2,061	36,451
2014	4.6 %	1.0 %	1,686	36,813
2013	5.5 %	1.0 %	1,979	36,123

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	2.7	0.3	101	37,481
2016	2.6	0.3	101	38,132
2015	2.9	0.3	84	28,917
2014	2.8	0.3	109	38,603
2013	2.2	0.2	84	38,016
2012	2.0	0.2	74	37,690
2011	1.4	0.2	52	37,533
2010	1.1	0.2	42	37,987
2009	0.8	0.1	30	38,906
2008	0.7	0.1	27	38,936

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	9.3 %	1.2 %	63,400	678,171
2016_2017	8.6 %	1.0 %	57,913	677,227
2016	7.7 %	1.1 %	52,833	685,398

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	16.9	2.2	61	361,042
2017	16.8	2.2	61	362,719
2016	17.6	2.2	64	363,753
2015	18.5	2.3	67	362,852
2014	18.2	2.3	66	361,818
2013	16.6	2.1	60	361,652
2012	17.4	2.2	63	361,686
2011	19.6	2.3	71	361,834
2010	13.5	1.9	49	363,614
2009	18.9	2.3	68	360,733

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	31.9	2.8	135	422,686
2017	35.8	2.9	151	421,448
2016	30.6	2.7	128	418,789
2015	31.6	2.8	132	417,513
2014	26.5	2.5	110	415,812
2013	26.8	2.5	111	414,779
2012	29.6	2.7	123	415,083
2011	35.5	2.9	148	417,468
2010	32.3	2.8	135	417,741
2009	28.8	2.6	121	419,835

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	13.7	1.5	88	644,088
2015_2017	13.0	1.4	84	644,325
2014_2016	11.7	1.4	75	642,181
2013_2015	10.9	1.3	70	639,567
2012_2014	11.1	1.3	71	638,549
2011_2013	14.0	1.5	90	641,683
2010_2012	16.3	1.6	105	646,012
2009_2011	16.3	1.6	106	651,930
2008_2010	14.6	1.5	96	657,062
2007_2009	18.0	1.7	119	661,090

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2018	12.6	1.4	81	644,088
2015_2017	13.7	1.5	88	644,325
2014_2016	11.4	1.3	73	642,181
2013_2015	11.7	1.4	75	639,567
2012_2014	10.5	1.3	67	638,549
2011_2013	11.7	1.4	75	641,683
2010_2012	11.8	1.4	76	646,012
2009_2011	11.2	1.3	73	651,930
2008_2010	11.4	1.3	75	657,062
2007_2009	10.9	1.3	72	661,090

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	20.0 %	1.6 %	145,140	725,207
2016_2017	18.8 %	1.4 %	136,250	725,205
2016	17.7 %	1.5 %	128,468	725,960

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	24.1 %	3.7 %	34,928	145,140
2016_2017	24.1 %	3.4 %	32,873	136,250
2016	23.5 %	3.7 %	30,239	128,468

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	2.6 %	0.6 %	15,747	600,776
2016_2017	2.7 %	0.6 %	16,257	599,933
2016	3.1 %	0.8 %	18,652	611,443

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	10.9 %	1.4 %	65,074	597,558
2016_2017	9.0 %	1.2 %	53,855	596,935
2016	7.7 %	1.2 %	47,120	608,745

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	61.8 %	5.6 %	60,985	98,742
2016_2017	60.7 %	5.9 %	55,010	90,571
2016	62.8 %	6.2 %	47,665	75,958

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	89.0 %	1.5 %	645,018	725,056
2016_2017	91.1 %	1.2 %	659,928	724,068
2016	92.4 %	1.1 %	668,504	723,687

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	15.2 %	0.2 %	3,724	24,427
2014	14.7 %	0.2 %	3,656	24,835
2012	15.1 %	0.2 %	4,033	26,722
2010	15.6 %	0.2 %	4,590	29,481
2008	15.7 %	0.2 %	4,089	26,103

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	15.3 %	1.7 %	21,043	137,135
2011	13.3 %	1.5 %	18,381	138,231
2007	11.1 %	1.4 %	15,748	141,310
2005	12.2 %	1.4 %	17,896	146,287

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	16.4 %	2.3 %	50,171	306,093
2016_2017	17.7 %	2.1 %	53,104	299,529
2016	17.5 %	2.3 %	55,364	315,462

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.1 %	0.5 %	22,513	731,105
2017	2.6 %	0.4 %	19,135	730,569
2016	2.2 %	0.3 %	15,817	723,558
2015	3.3 %	0.4 %	23,663	724,960
2014	3.2 %	0.4 %	22,951	724,668
2013	4.8 %	0.5 %	34,835	724,105
2012	4.3 %	0.5 %	31,251	721,858
2011	4.6 %	0.5 %	33,041	722,389
2010	4.3 %	0.4 %	31,080	722,835
2009	4.4 %	0.4 %	31,347	708,602

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	74.4 %	3.7 %	41,994	56,468
2017	72.8 %	3.4 %	41,158	56,512
2016	73.5 %	2.9 %	41,046	55,848
2015	77.9 %	2.8 %	43,061	55,273
2014	71.3 %	4.2 %	38,980	54,643
2013	78.3 %	3.4 %	42,641	54,441
2012	74.8 %	3.2 %	42,342	56,587
2011	71.6 %	3.5 %	41,820	58,405
2010	57.7 %	3.7 %	34,602	59,956
2009	42.5 %	3.6 %	24,602	57,903

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) - Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	65.8 %	1.9 %	452,825	688,184
2017_2018	58.9 %	2.1 %	404,858	687,676
2016_2017	58.7 %	2.1 %	401,512	683,774
2015_2016	59.1 %	1.7 %	401,179	679,043
2014_2015	57.5 %	2.0 %	391,098	680,763
2013_2014	54.4 %	2.2 %	373,587	687,152
2012_2013	52.6 %	2.2 %	361,225	686,646
2011_2012	50.1 %	2.2 %	336,614	672,137
2010_2011	50.6 %	2.6 %	342,515	676,908
2009_2010	46.6 %	2.2 %	306,473	657,668

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	73.4 %	3.1 %	149,228	203,329
2017	71.4 %	2.8 %	144,996	203,089
2016	60.7 %	3.0 %	123,186	202,834
2015	57.2 %	3.1 %	116,137	203,164

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	94.0 %	1.5 %	191,105	203,329
2017	93.4 %	1.5 %	189,740	203,089
2016	89.2 %	1.8 %	180,848	202,834
2015	85.5 %	2.4 %	173,608	203,164
2014	76.7 %	3.3 %	156,645	204,263
2013	79.6 %	2.6 %	161,155	202,457
2012	77.8 %	3.0 %	157,505	202,458
2011	74.8 %	3.0 %	152,366	203,835
2010	64.2 %	3.3 %	131,182	204,220
2009	61.2 %	3.1 %	124,745	203,850

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	89.2 %	2.3 %	181,356	203,329
2017	83.6 %	2.4 %	169,737	203,089
2016	74.9 %	2.6 %	151,976	202,834
2015	75.0 %	2.7 %	152,339	203,164
2014	64.4 %	3.5 %	131,631	204,263
2013	63.7 %	3.0 %	128,863	202,457
2012	64.4 %	3.4 %	130,376	202,458
2011	60.5 %	3.4 %	123,342	203,835
2010	53.7 %	3.4 %	109,756	204,220
2009	46.4 %	3.1 %	94,649	203,850

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	15.3	0.4	1,603	104,650
2017	16.0	0.4	1,678	104,979
2016	17.2	0.4	1,804	105,029
2015	18.6	0.4	1,943	104,477
2014	19.7	0.4	2,048	104,065
2013	22.1	0.5	2,289	103,809
2012	24.1	0.5	2,498	103,716
2011	25.3	0.5	2,665	105,140
2010	28.6	0.5	3,017	105,526
2009	32.1	0.6	3,421	106,721

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	7.4 %	1.2 %	2,615	35,459
2016	12.1 %	1.5 %	4,376	36,319
2015	8.8 %	1.4 %	3,205	36,438
2014	10.1 %	1.4 %	3,709	36,666
2013	9.3 %	1.3 %	3,287	35,512

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2018	1.2 %	0.4 %	8,961	724,471
2016_2017	2.0 %	0.5 %	14,326	724,356
2016	2.5 %	0.8 %	18,460	724,262

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Iowa

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	83	83.5	84	84.5
Annual Indicator	80.5	82.7	81.5	84.5
Numerator	26,118	31,692	29,306	27,589
Denominator	32,462	38,306	35,951	32,646
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	85.0	85.5	86.0	86.5	87.0	87.5

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data				
Data Source: National Immunization Survey (NIS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	20.5	25	26	30
Annual Indicator	24.9	26.1	29.5	30.5
Numerator	7,875	9,655	10,092	9,785
Denominator	31,681	36,965	34,193	32,069
Data Source	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	30.5	31.0	31.5	32.0	32.5	33.0

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	86.7
Numerator	30,649
Denominator	35,356
Data Source	PRAMS
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	87.0	87.5	88.0	88.5	89.0

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	44.2
Numerator	15,044
Denominator	34,022
Data Source	PRAMS
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	45.0	45.5	46.0	46.5	47.0

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2019
Annual Objective	
Annual Indicator	57.0
Numerator	19,594
Denominator	34,396
Data Source	PRAMS
Data Source Year	2017

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	57.5	58.0	58.5	59.0	59.5

Field Level Notes for Form 10 NPMs:

None

NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			35	28.6
Annual Indicator		34.8	28.4	34.2
Numerator		31,438	27,467	32,539
Denominator		90,233	96,650	95,266
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	34.5	35.0	35.2	35.7	40.0	40.2

Field Level Notes for Form 10 NPMs:

None

NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			79	83
Annual Indicator		78.8	81.1	81.1
Numerator		202,051	191,475	191,475
Denominator		256,527	236,185	236,185
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	84.0	85.0	86.0	87.0	88.0	89.0

Field Level Notes for Form 10 NPMs:

None

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			51.5	51.6
Annual Indicator		50.9	51.9	51.0
Numerator		65,262	70,636	74,037
Denominator		128,218	136,125	145,140
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	51.7	51.8	51.9	52.0	52.1	52.3

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2016	**2017**	**2018**	**2019**
Annual Objective			22	23
Annual Indicator		21.9	23.1	27.2
Numerator		13,904	16,833	20,601
Denominator		63,445	72,960	75,605
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	24.0	25.0	26.0	27.0	28.0	28.5

Field Level Notes for Form 10 NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data				
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	56	60	63.9	64.1
Annual Indicator	59.2	60.2	55.3	55.3
Numerator	21,739	21,891	19,796	19,796
Denominator	36,708	36,352	35,811	35,811
Data Source	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	64.3	64.5	64.7	64.9	65.1	65.3

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH)				
	2016	**2017**	**2018**	**2019**
Annual Objective			82.6	85
Annual Indicator		81.7	84.7	86.7
Numerator		563,970	573,272	585,814
Denominator		690,337	676,624	675,638
Data Source		NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2020	**2021**	**2022**	**2023**	**2024**	**2025**
Annual Objective	87.0	88.0	88.5	89.0	89.5	90.0

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2019
Annual Objective	
Annual Indicator	11.6
Numerator	4,388
Denominator	37,751
Data Source	NVSS
Data Source Year	2018

Annual Objectives					
	2021	**2022**	**2023**	**2024**	**2025**
Annual Objective	11.4	11.2	11.0	10.8	10.6

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Iowa

2016-2020: NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data				
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	71.5	72	72.5	73
Annual Indicator	69.0	67.2	67.0	77.3
Numerator	359,806	353,545	353,700	407,591
Denominator	521,137	525,862	527,557	527,210
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018

Field Level Notes for Form 10 NPMs:

None

2016-2020: NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2016	**2017**	**2018**	**2019**
Annual Objective	14.8	14.6	24.3	24.1
Annual Indicator	29.1	29.1	29.3	29.3
Numerator	43,459	43,459	41,460	41,460
Denominator	149,221	149,221	141,691	141,691
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2011	2011	2017	2017

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - Perpetration			
	2017	**2018**	**2019**
Annual Objective			24.1
Annual Indicator			21.2
Numerator			52,515
Denominator			248,081
Data Source			NSCHP
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2017	**2018**	**2019**
Annual Objective			24.1
Annual Indicator			52.7
Numerator			130,850
Denominator			248,281
Data Source			NSCHV
Data Source Year			2018

Previous NPM-9 NSCH data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable to 2018 survey data given major wording and response option changes.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Iowa

SPM 1 - Number of pregnancy-related deaths for every 100,000 live births

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	9.0	8.9	8.8	8.7	8.6

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of children ages 1 and 2, with a blood lead test in the past year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	45.0	50.0	55.0	65.0	75.0

Field Level Notes for Form 10 SPMs:

None

SPM 3 - Percent of early care and education programs that receive Child Care Nurse Consultant services.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		30	32	36
Annual Indicator	28.5	25.6	34.6	37.2
Numerator	1,512	1,347	1,558	1,563
Denominator	5,299	5,265	4,507	4,201
Data Source	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	38.0	40.0	42.0	44.0	46.0	48.0

Field Level Notes for Form 10 SPMs:

None

SPM 4 - Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	25.0	25.0	24.5	24.0	23.5

Field Level Notes for Form 10 SPMs:

None

SPM 5 - Number of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	904.0	949.0	997.0	1,046.0	1,049.0

Field Level Notes for Form 10 SPMs:

None

SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	5.0	20.0	90.0	95.0	99.0

Field Level Notes for Form 10 SPMs:

None

SPM 7 - Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	88.3
Numerator	98
Denominator	111
Data Source	Youth Services Survey for Families
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	88.0	88.5	89.0	89.5	90.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - A)Percent of children 0-21 served by Title V who meet Iowa's Title V criteria as having a medical home B)Percent of women served by Title V who meet Iowa's Title V criteria as having a medical home

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		91	84.5	88
Annual Indicator	90.5	84	87	86.2
Numerator				
Denominator				
Data Source	CAReS and WHIS	TAV Connect	TAV Connect	Signifycommunity
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: a) 90.5% b) 91.5%	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: A) 84% B) 80%	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: A) 87% B) 74%	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: A) 86.2% B) 74%	

2016-2020: SPM 3 - Percent of children with a payment source for dental care

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		88	89	82.5
Annual Indicator	87.1	82	82	89.8
Numerator	14,141	15,385	15,385	
Denominator	16,244	18,773	18,773	
Data Source	I-Smile@School	I-Smile@School TAVConnect	I-Smile@School TAVConnect	I-Smile@School signifycommunity data
Data Source Year	2016	2017	2017-2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
With the transition to TAVConnect there are some inconsistencies throughout the 2017 school-based sealant program data in TAV. Staff will continue to provide TA to ensure this is being documented correctly.

2016-2020: SPM 5 - Percent of adults aged 18-24 who report being physically active

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		85.8	86	86.2
Annual Indicator	85.6	88.3	85.5	83.4
Numerator				
Denominator				
Data Source	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 6 - Percent of CYSHCN with parents who are very satisfied with the communication among doctors and other health care providers

Measure Status:			**Active**
State Provided Data			
	2017	**2018**	**2019**
Annual Objective			69
Annual Indicator			70.2
Numerator			82,857
Denominator			117,950
Data Source			NSCH
Data Source Year			2017-2018
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measure (ESM)

State: Iowa

ESM 4.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	23.0	46.0	69.0	92.0	112.0

Field Level Notes for Form 10 ESMs:

None

ESM 4.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	30.0	32.0	34.0	36.0	38.0

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective		1.5	2	2
Annual Indicator	0.9	1.6	1.9	1.9
Numerator	971	1,744	1,076	1,076
Denominator	110,608	110,577	56,307	56,307
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2016	2017	2018	2018
Provisional or Final ?	Final	Final	Final	Provisional

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	2.5	3.0	3.5	4.0	4.5	5.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Data for ESM has been adjusted to match the NPM age ranges.

ESM 10.1 - Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	46.0	92.0	138.0	161.0	184.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Number of telehealth visits through Child Health Specialty Clinics

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	3,115
Numerator	
Denominator	
Data Source	Program Data
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	3,150.0	3,185.0	3,215.0	3,245.0	3,275.0

Field Level Notes for Form 10 ESMs:

None

ESM 12.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist

Measure Status:	Active

State Provided Data	
	2019
Annual Objective	
Annual Indicator	62.1
Numerator	218
Denominator	351
Data Source	Electronic Medical Record
Data Source Year	2019
Provisional or Final ?	Final

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	64.0	66.0	68.0	70.0	72.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.1.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator

Measure Status:	Active

State Provided Data			
	2017	2018	2019
Annual Objective			355
Annual Indicator			397
Numerator			
Denominator			
Data Source			Local Title V MCAH Year End Report
Data Source Year			2019
Provisional or Final ?			Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

Field Level Notes for Form 10 ESMs:

None

ESM 13.2.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.

Measure Status:	Active

State Provided Data				
	2016	2017	2018	2019
Annual Objective			350	385
Annual Indicator	93	341	380	397
Numerator				
Denominator				
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Annual Objectives						
	2020	2021	2022	2023	2024	2025
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: I-Smile Coordinators are required to provide visit all pediatric medical offices in each county of the service area. Data includes the number of pediatric medical offices in the state. In Iowa there are 93 pediatric medical practices and 511 family medicine practices. When this ESM was developed a tracking form was developed for the I-Smile Coordinators to collect this data.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: In Iowa there are 93 pediatric medical practices and 511 family medicine practices.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: In Iowa there are 93 pediatric medical practices and 511 family medicine practices.	

ESM 14.1.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2021	2022	2023	2024	2025
Annual Objective	50.0	55.0	60.0	65.0	70.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Percent of Title V maternal health participants that received education on continuing their health care coverage.

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		65	35	54
Annual Indicator	64	27.2	48.6	51.8
Numerator	5,478	296	1,357	1,842
Denominator	8,560	1,090	2,794	3,559
Data Source	WHIS	TAV Connect	TAV Connect	Signifycommunity
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: With the transition to the new integrated data system this question has been added as a data point.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Iowa's Title V programs have transitioned to a new database for documenting discharge of clients. There is not a set protocol for discharge, each agency is able to establish their own process. Technical assistance will be provided on the importance of educating women on continuing health care coverage after discharge from Maternal Health Program.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: There is not a set protocol for discharge, each agency is able to establish their own process. Technical assistance will be provided on the importance of educating women on continuing health care coverage after discharge from Maternal Health Program	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: There is not a set protocol for discharge, each agency is able to establish their own process. Technical assistance will be provided on the importance of educating women on continuing health care coverage after discharge from Maternal Health Program	

2016-2020: ESM 4.1 - Percent of women educated on the importance of breastfeeding to ensure that the feeding decision is fully-informed.

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		87	80	54
Annual Indicator	86.7	6.6	48.7	45
Numerator	938	167	1,362	1,600
Denominator	1,082	2,548	2,794	3,559
Data Source	WHIS	TAV Connect	TAV Connect	Signifycommunity
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
While the ESM data shows a low number of MH clients receiving breastfeeding education this could be due to a data entry error. Iowa's Title V programs have transitioned to a new database for documenting health education there is a drop down option to list to select critical topics covered. The staff may have not been selecting all topics covered. This will be included in TA provided over the next year. All Title V agencies are required to provide education on the benefits of breastfeeding to clients and provided resources and referrals during postpartum visits when appropriate. IDPH provide copies of "My 9 months" a guide to a healthy pregnancy published by the March of Dimes which is given to each pregnant mom this educational magazine is offered in English and Spanish and has four pages of education on breastfeeding.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
This count is for clients who received health education. MH agencies are required to address breastfeeding at one of the health education visits for all clients. Agencies are currently in the process of collecting specific health education topics addressed, however there have been data entry issues with this data collection field. Title V staff have provided training and reminders to agencies and conduct regular QA checks on this measure..

2016-2020: ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a developmental screen using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		13.5	14	30
Annual Indicator	12.9	13.9	29.4	29.4
Numerator	14,315	15,381	16,529	16,529
Denominator	110,608	110,577	56,307	56,307
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2016	2017	2018	2018
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Medicaid data pulled has been adjust to match the age ranges specified in NPM.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Waiting on 2019 data.	

2016-2020: ESM 9.2 - Convene a Bullying Prevention Task Force

Measure Status:	Active

Baseline data was not available/provided.

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 10.1 - Number of school districts and other adolescent serving organizations with whom Title V CAH agencies partner with and/or educate on the promotion of preventive medical visits among adolescents ages 12-17.

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		84	105	90
Annual Indicator	88	88	88	88
Numerator				
Denominator				
Data Source	Local Title V MCAH Application	Local Title V MCAH Application	Local Title V MCAH Application	Local Title V MCAH Application
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2017 RFP 22 agencies selected NPM 10.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2018 RFA 22 agencies selected NPM 10.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2018 RFA 22 agencies selected NPM 10.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2019 RFA 22 agencies selected NPM 10.	

2016-2020: ESM 11.1 - The percent of CYSHCN served by DCCH Regional Centers who have a Shared Plan of Care

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		0	5	10
Annual Indicator	0	1.5	1.3	84.5
Numerator	0	105	96	4,857
Denominator	100	7,061	7,500	5,746
Data Source	Chart review and program data	Chart review and program data	Chart review and program data	Chart review and program data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.2 - The number of care coordinators serving CYSHCN who received trainings about the Shared Plan of Care.

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective			20	23
Annual Indicator	0	29	23	34
Numerator				
Denominator				
Data Source	Program Data	Program Data	Program Data	Program Data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.1 - Percent of YSHCN served by DCCH Regional Centers with an initiated transition plan

Measure Status:			Active	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		0	15	30
Annual Indicator	6	6.2	42.5	62.1
Numerator	5	15	144	218
Denominator	83	242	339	351
Data Source	Program data	Program data	Program Data	Program Data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.2 - Percent of YSHCN served by DCCH Regional Centers with at least annual transition reviews

Measure Status:			**Active**	
State Provided Data				
	2016	**2017**	**2018**	**2019**
Annual Objective		0	15	30
Annual Indicator	0	0	0	88
Numerator	0	0	0	477
Denominator	83	242	339	542
Data Source	Program data	Program data	Program Data	Program Data
Data Source Year	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: No data regarding annual reviews of transition plans because the new transition planning protocol had not been implemented for a full year at the end of FFY17.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: No data regarding annual reviews of transition plans because the new transition planning protocol had not been implemented for a full year at the end of FFY18.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Iowa

SPM 1 - Number of pregnancy-related deaths for every 100,000 live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce preventable maternal mortality through modifiable actions based on recommendations from the Maternal Mortality Review Committee
Definition:	**Numerator:** Number of maternal deaths **Denominator:** 100,000 live births **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Reduce the rate of maternal mortality from 12.7 to 11.4/100,000 live births
Data Sources and Data Issues:	Iowa Maternal Mortality Review Committee report and Viral Records. In the current Maternal Mortality Review Committee report there is 3 years worth of data. Vital Records data is based on 1 calendar year. Occasionally, this causes an incongruity between reported data.
Significance:	Maternal mortality rates are continuing to rise in the United States and Iowa, while all other Countries reporting data are seeing a decline in maternal mortality rates. The Maternal Mortality Review Committee has seen an increase in the rate of women dying due to pregnancy-related complications.

SPM 2 - Percent of children ages 1 and 2, with a blood lead test in the past year
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percent of Iowa children ages 1 and 2 with a blood lead test.
Definition:	**Numerator:** Number of children ages 1 and 2 (12-35 months) with a blood lead test **Denominator:** Number of children ages 1 and 2 (12-35 months) **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	EH-8 Reduce blood lead levels in children
Data Sources and Data Issues:	Healthy Homes & Lead Poisoning Surveillance System (HHLPSS) database and Annual Estimated Census Data by County
Significance:	Statewide in 2017, 88% of one year olds were tested for blood lead, compared to 43% of two year olds and 14% of three year olds. The typical development of toddlers increases their risk to environmental lead exposure during their second and third year of life through hand to mouth behavior and increased mobility. There is a significant need to test increase testing of 2 year olds, while maintaining the high rate of one year olds being tested.

SPM 3 - Percent of early care and education programs that receive Child Care Nurse Consultant services.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of early care and education programs receiving Child Care Nurse Consultant services.
Definition:	**Numerator:** Number of early care and education programs receiving Child Care Nurse Consultant services. **Denominator:** Total number of early care and education programs. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Early and Middle Childhood EMC-1(Developmental) Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social-emotional development, approaches to learning, language, and cognitive development.
Data Sources and Data Issues:	Healthy Child Care Iowa and Early Childhood Iowa
Significance:	Improving the quality of child care allows Iowa to address cross-cutting MCH needs such as nutrition and physical activity, breastfeeding support, developmental screenings, and safe sleep environments. Families of CYSHCN also reported difficulties finding childcare providers that are qualified and comfortable caring for their children. Iowa has a history in working with registered day care providers, both centers and in-home, through the Healthy Child Care Iowa program. The role of child care nurse consultants (CCNCs) is based on the Blueprint for Action from the Healthy Child Care America campaign. The CCNC program has the ability to reach a wide range of settings and provide support to day care providers in establishing practices that are medically sound and meet the objectives of Title V programs.

SPM 4 - Percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Decrease the percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities
Definition:	**Numerator:** Number reporting during the past 12 months that they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities **Denominator:** Total number of 6th, 8th and 11th graders completing Question B62 of the Iowa Youth Survey. **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	Mental Health Status Improvement MHMD-1 Reduce the suicide rate MHMD-2 Reduce suicide attempts by adolescents MHMD-3 Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight MHMD-4 Reduce the proportion of persons who experience major depressive episodes (MDEs) MHMD-4.1 Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs) MHMD-4.2 Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs) MHMD-5 Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral MHMD-6 Increase the proportion of children with mental health problems who receive treatment
Data Sources and Data Issues:	Iowa Youth Survey
Significance:	This measure is significant as it is a direct result of the qualitative and quantitative data gathered during the needs assessment, in addition to emerging legislation creating a children's regional mental health system structure statewide in response to what has been a child/adolescent mental health crisis in the state. Title V in Iowa has not played a significant role in adolescent mental health previously, therefore an exploratory phase is required to better understand the gap filling role for Title V.

SPM 5 - Number of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the number of children 0-35 months who have had fluoride varnish during a well visit with physician/health care provider
Definition:	**Numerator:** Children 0-35 months enrolled in Iowa Medicaid who received a fluoride varnish application from a medical provider **Denominator:** NA **Unit Type:** Count **Unit Number:** 1,500
Healthy People 2020 Objective:	OH-8 Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year
Data Sources and Data Issues:	Medicaid paid claims – requested by the Bureau of Oral and Health Delivery Systems annually
Significance:	Medicaid-enrolled children are more likely to receive routine care from a primary care or pediatric physician than a dentist, particularly for those younger than 3 years of age. Since low income children are more likely to suffer from dental decease, receiving fluoride varnish from physicians addresses this disparity.

SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Ensure the local Title V contractors have a plan to identify and address health equity in the populations they serve
Definition:	**Numerator:** Number of local Title V contractors with a plan to identify and address health equity **Denominator:** Total local Title V contractors **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	There is a social determinants of health objective but it doesn't really fit. There are measures for specific diseases/conditions but no general broad health equity one.
Data Sources and Data Issues:	Local Title V RFA/RFP action plans
Significance:	To make progress in health equity, our local contractors delivering Title V services need to be planful and intentional about addressing health equity. Contractors need partnerships and knowledge of their community and to be engaged with priority populations in their community, to develop and implement a plan.

SPM 7 - Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the satisfaction with support services received through Title V
Definition:	**Numerator:** Number of families who report overall satisfaction with services received **Denominator:** Total Families receiving CYSHCN services through DCCH **Unit Type:** Percentage **Unit Number:** 100
Healthy People 2020 Objective:	MICH-31Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive, and coordinated systems
Data Sources and Data Issues:	Youth Services Survey for Families. DCCH will administer this survey annually
Significance:	CYSHCN whose parents receive needed support have better health outcomes

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - A)Percent of children 0-21 served by Title V who meet Iowa's Title V criteria as having a medical home B)Percent of women served by Title V who meet Iowa's Title V criteria as having a medical home
Population Domain(s) – Women/Maternal Health, Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the percent of children 0-21 and percent of women served by Title V who meet Iowa's criteria as having a medical home.
Definition:	**Numerator:** Number of children 0-21 who report a medical home Number of women who report a medical home **Denominator:** Total number of children 0-21 served by Title V Total number of women served by Title V **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	TAV Connect
Significance:	A medical home provides a family-centered approach to comprehensive primary care that values the whole person, communication with patients and families, and coordination of care. Women and children with a medical home are significantly less likely to have an unmet medical need and are more likely to have received preventive medical care in the last year. Women and children with a medical home are more likely to have improved functional health outcomes and increased family engagement than those without a medical home. Establishing a medical home has also resulted in reduced morbidity and mortality, hospitalizations, readmissions, and emergency room visits. "Served by Title V" is defined as individuals that receive direct or enabling services from local CAH and MH agencies.

2016-2020: SPM 3 - Percent of children with a payment source for dental care
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of children with a payment source for dental care
Definition:	**Numerator:** Number of Title V Child Health clients reporting a payment source for dental care **Denominator:** Total number of Title V Child Health clients. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	TAV Connect
Significance:	In the Iowa health insurance marketplace dental insurance is an additional policy and cost. Individuals are able to opt-out of purchasing dental insurance.

2016-2020: SPM 5 - Percent of adults aged 18-24 who report being physically active
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the percent of adults aged 18-24 who report being physically active.
Definition:	**Numerator:** Number of adults aged 18-24 who report being physically active. **Denominator:** Total number of adults aged 18-24. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System
Significance:	The implications for engaging in physical activity cut across the lifespan for all MCH populations. Iowa's women of reproductive age suffer from a range of chronic conditions, including obesity. Additionally, minority women are less likely to engage in the recommended amount of physical activity than non-Hispanic white women. Increasing physical activity would help to address issues of obesity and other chronic conditions that can lead to more complications during pregnancy. Additionally, CYSHCN may not perform the recommended amount of physical activity per day. CYSHCN often experience unique barriers to physical activity, such as functional limitations, medication side effects that cause weight gain and make physical activity difficult, the high cost of specialized programs and equipment, and a lack of nearby facilities or programs. When CYSHCN exercise safely and regularly, socialization increases, weight status and overall health are improved, and the progression of chronic disease and functional decline decreases.

2016-2020: SPM 6 - Percent of CYSHCN with parents who are very satisfied with the communication among doctors and other health care providers
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase communication between health care providers
Definition:	**Numerator:** Number of CYSHCN with parents who are satisfied with the communication among doctors and other health care providers **Denominator:** Total number of CYSCHN in Iowa **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	The National Survey of Children's Health (2016 NSCH). This is an updated State Performance Measure for FFY19. Our original Quality of Care indicator is no longer available through the Data Resource Center.
Significance:	Communication among health care providers is an important component of service integration. Communication between providers is a standard within The Standards for Systems of Care for CYSHCN 2.0: The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Iowa

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Iowa

ESM 4.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the education of businesses and organizations on the importance of strong policies to support employees to continue to breastfeed through or beyond 6 months of age.
Definition:	**Numerator:** Number of businesses or organizations who were provided education by Title V agencies **Denominator:** N/A **Unit Type:** Count **Unit Number:** 150
Data Sources and Data Issues:	RFA/RFP documentation from Local Title V Agencies
Significance:	Educating businesses and/or organizations on best practices and policies to implement within their practices will help ensure employees are able to continue to breastfeed when returning to work.

ESM 4.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of Maternal Health clients who receive education about breastfeeding through 6 months and information on pumping at work
Definition:	**Numerator:** Number of Maternal Health clients who receive education **Denominator:** Total number of Maternal Health clients served **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Title V data system report. Ensuring agencies are aware of how to document the this activity in the data system
Significance:	Educating women on the benefits of breastfeeding through 6 months and their rights and best methods on pumping at work will help increase the rate on initiation and breastfeeding through 6 months.

ESM 5.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Provide evidence based training opportunities for state and local partners/contractors on the importance and best practices on the topic of safe sleep.
Definition:	**Numerator:** Number of training opportunities provided on the topic of safe sleep **Denominator:** NA **Unit Type:** Count **Unit Number:** 50
Data Sources and Data Issues:	Title V state and local reporting
Significance:	Increasing the knowledge of staff on the importance and best practices of safe sleep will ensure the education being provided to maternal health clients is up to date and evidence based.

ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the percentage of children with Medicaid coverage receiving a brief emotional behavioral assessment using a standardized tool.
Definition:	**Numerator:** Medicaid claims data for children ages 9 through 71 months for whom CPT code 96127 was billed. **Denominator:** All children ages 9 through 71 months with Medicaid coverage. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid claims data.
Significance:	Emotional/behavioral assessments are important to detect delays early and link the families to services needed.

ESM 10.1 - Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the number of partnerships with adolescent serving organizations who are able to provide promotion of the importance of adolescent well visits.
Definition:	**Numerator:** Number of organizations or agencies partnering with local agencies **Denominator:** NA **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Local RFA/RFP reporting. Ensure agencies track and document new and existing partnerships.
Significance:	Partnering with adolescent serving organizations will increase the instances education on well visits can be provided to clients.

ESM 11.1 - Number of telehealth visits through Child Health Specialty Clinics
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the number of telehealth visits conducted for CYSCHN in the state
Definition:	**Numerator:** Number of telehealth visits conducted **Denominator:** NA **Unit Type:** Count **Unit Number:** 10,000
Data Sources and Data Issues:	University of Iowa Health Care Electronic Medical Record
Significance:	Telehealth visits are an important component of access to pediatric specialty care in rural areas where there are few providers.

ESM 12.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
ESM Subgroup(s):	CSHCN
Goal:	Increase the percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
Definition:	**Numerator:** Number of clients served who have a transition checklist documented **Denominator:** Total number of clients served **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	University of Iowa Health Care Electronic Medical Record
Significance:	The transition checklist is the tool that initiates transition services for youth served by Child Health Specialty Clinics

ESM 13.1.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the number of medical practices receiving an outreach visit from an I-Smile Coordinator
Definition:	**Numerator:** Number of medical practices received an outreach visit from an I-Smile Coordinator **Denominator:** Total number of medical practices **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Year end reports from local Title V agencies
Significance:	Partnering with local medical providers to do continued education for pregnant women on the importance of a dental visit will ensure the information is coming from a trusted source and will increase the number of patients with a dental visit in the past year.

ESM 13.2.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of medical practices receiving an outreach visit from an I-Smile Coordinator.
Definition:	**Numerator:** Number of medical practices who received an outreach visit from an I-Smile Coordinator **Denominator:** Total number of medical practices **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Year End Reports from local Title V agencies.
Significance:	Partnering with local medical providers to do continued education for pregnant women and children (1-17) on the importance of a dental visit will ensure information is coming from a trusted source and will increase the number of patients with a dental visit in the past year.

ESM 14.1.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
ESM Subgroup(s):	Pregnant Women
Goal:	Increase the percent of Maternal Health clients who are screened for tobacco use with Ask, Advise, Refer
Definition:	**Numerator:** Number of maternal health clients who have been screened for tobacco use using the Ask, Advise, Refer **Denominator:** Total number of maternal health clients served **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Title V data system. Ensure agencies are documenting the screening and education appropriately.
Significance:	Ask, Advise, Refer is an evidence based product to screen for tobacco use with women. This will ensure Title V staff are appropriately screening and referring clients who need tobacco cessation services.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Percent of Title V maternal health participants that received education on continuing their health care coverage.
2016-2020: NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active
Goal:	Increase Title V maternal health participants' knowledge on the topic of continuing their health insurance coverage.
Definition:	**Numerator:** New field in WHIS collecting number of women educated about how to get help for how to receive health insurance coverage. **Denominator:** Total number of women who receive direct or enabling services from a MH agency **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Will need to add a field in WHIS (Maternal Health data system) to capture if a maternal health client received education on the topic of continuing health insurance coverage.
Significance:	Health insurance plays an important role because women with insurance are more likely to obtain preventive health care. Women are more vulnerable to loose their coverage as they may depend coverage through their partners job, so if he looses his job or they are divorced or widowed they may have no insurance. Also income eligibility decreases after pregnancy so many women lose Medicaid eligibility 60 days post partum.

2016-2020: ESM 4.1 - Percent of women educated on the importance of breastfeeding to ensure that the feeding decision is fully-informed.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase knowledge of importance of breastfeeding to ensure that the feeding decision is fully-informed.
Definition:	**Numerator:** Number of maternal health clients who receive education on breastfeeding. **Denominator:** Total number of women who receive direct or enabling services from a MH agency **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Data field will need to be added to WHIS to capture if maternal health clients received breastfeeding education.
Significance:	Education of the importance of breastfeeding has been shown to increase the initiation and continuation of breastfeeding in mothers.

2016-2020: ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a developmental screen using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of Title V Child Health clients and Medicaid enrolled receiving a developmental screening using a standardized tool.
Definition:	**Numerator:** Medicaid claims data for children ages 9 through 71 months for whom CPT code 96110 or HCPCS code G0451 was billed. **Denominator:** All children ages 9 through 71 months with Medicaid coverage. **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Medicaid claims data.
Significance:	Earlier detection of social-emotional and developmental delays and family risk-related factors in children will increase the needed referrals, interventions and follow-up.

2016-2020: ESM 9.2 - Convene a Bullying Prevention Task Force
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Convene a task force comprised of state level leaders to coordinate anti-bullying efforts at least 4 meetings a year.
Definition:	**Numerator:** Number of meetings conducted **Denominator:** Number of possible meetings **Unit Type:** Count **Unit Number:** 4
Data Sources and Data Issues:	Program data
Significance:	Better coordination of bullying prevention efforts across systems within the state will enable collaboration and sharing of best practices.

2016-2020: ESM 10.1 - Number of school districts and other adolescent serving organizations with whom Title V CAH agencies partner with and/or educate on the promotion of preventive medical visits among adolescents ages 12-17.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the knowledge of school districts and other adolescent serving organizations on the topic of strategies to increase preventive medical visits among adolescents ages 12 through 17.
Definition:	**Numerator:** Number of school districts and other adolescent serving organizations educated and/or partnered with to increase preventive medical visits among adolescents ages 12-17. **Denominator:** Not Applicable **Unit Type:** Count **Unit Number:** 200
Data Sources and Data Issues:	Year End Reports from local Title V Child Health agencies. A foreseeable issue for the first year is that this is a new measure and activity for the agencies to be collecting on and coordinating.
Significance:	Increasing the knowledge of school officials, adolescent serving community agencies, and adolescents on the importance of preventive medical visits will likely increase the participation rate.

2016-2020: ESM 11.1 - The percent of CYSHCN served by DCCH Regional Centers who have a Shared Plan of Care
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, 20% of CYSHCN served by DCCH Regional Centers have a Shared Plan of Care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number of CYSHCN served by DCCH who have a Shared Plan of Care</td></tr>
<tr><td>Denominator:</td><td>Total number of CYSHCN served by DCCH Regional Centers</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Epic/Record Review</td></tr>
<tr><td>Significance:</td><td>The SPoC template and protocol recommendations will allow medical homes to easily collaborate and communicate with multiple stakeholders and the family in Iowa’s System of Care.

The Lucile Packard Standards for Systems of Care for Children and Youth with Special Health Care Needs describes a SPoC as including information necessary to assure issues affecting a child’s health and health care are identified and accessible across systems and that activities. The SPoC also documents the person accountable for addressing those activities. The SPoC results from a process of family-centered, team-based care coordination and is developed jointly among families, clinicians and coordinators. Research has shown that care plans centralize care, enhance information exchange and strengthen relationships between providers and families, and improve perceived quality of care outcomes including; enhanced patient safety, caregiver health and well-being, patient- and family-centered care, efficient and timely care, care coordination, and continuity of care.

This ESM focuses on scaling up the SPoC to eventually reach all Iowa CYSHCN with moderate or greater health care needs, beginning with families served within DCCH.</td></tr>
</table>

2016-2020: ESM 11.2 - The number of care coordinators serving CYSHCN who received trainings about the Shared Plan of Care.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	By 2020, at least 25 people employed as care coordinators for CYSHCN will have received trainings about the use and implementation of Shared Plans of Care.
Definition:	**Numerator:** The number of care coordinators serving CYSHCN who received trainings about the Shared Plan of Care. **Denominator:** Not applicable **Unit Type:** Count **Unit Number:** 1,000
Data Sources and Data Issues:	Title V DCCH program data
Significance:	This ESM will disseminate Shared Plans of Care (SPoCs) to CYSHCN and their families across Iowa. SPoCs are a mechanism that allows CYSHCN to receive services through a coordinated medical/health home approach to care.

2016-2020: ESM 12.1 - Percent of YSHCN served by DCCH Regional Centers with an initiated transition plan
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Measure Status:	Active
Goal:	By 2020, 60% of Youth with Special Health Care Needs (YSHCN) served by DCCH Regional Centers will have an initiated transition readiness assessment and Shared Plan of Care, including a medical summary and emergency care plan by age 14 years
Definition:	**Numerator:** Number of YSHCN ages 14-21 years served by DCCH Regional Centers with an initiated transition plan **Denominator:** Number of YSHCN ages 14-21 years served by DCCH Regional Centers **Unit Type:** Percentage **Unit Number:** 100
Data Sources and Data Issues:	Internal chart review
Significance:	The transition plan will help ensure that YSHCN receive services necessary to make transitions to adult health care. This ESM will allow DCCH to monitor the engagement of YSHCN and their families in the development of transition plans.

2016-2020: ESM 12.2 - Percent of YSHCN served by DCCH Regional Centers with at least annual transition reviews NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, 60% of Youth with Special Health Care Needs (YSHCN) served by DCCH Regional Centers will have an annual review of their transition readiness assessment until age 21 years.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Numerator:</td><td>Number YSHCN served by DCCH Regional Centers with at least an annual review of transition readiness plan</td></tr>
<tr><td>Denominator:</td><td>Number YSHCN served by DCCH Regional Centers ages 14-21 with a transition readiness plan</td></tr>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Internal chart review</td></tr>
<tr><td>Significance:</td><td>The transition plan will help ensure that YSHCN receive services necessary to make transitions to adult health care. This ESM will allow DCCH to monitor the engagement of YSHCN and their families in the development and continual review of the transition plan.</td></tr>
</table>

Form 11
Other State Data

State: Iowa

The Form 11 data are available for review via the link below.

Form 11 Data