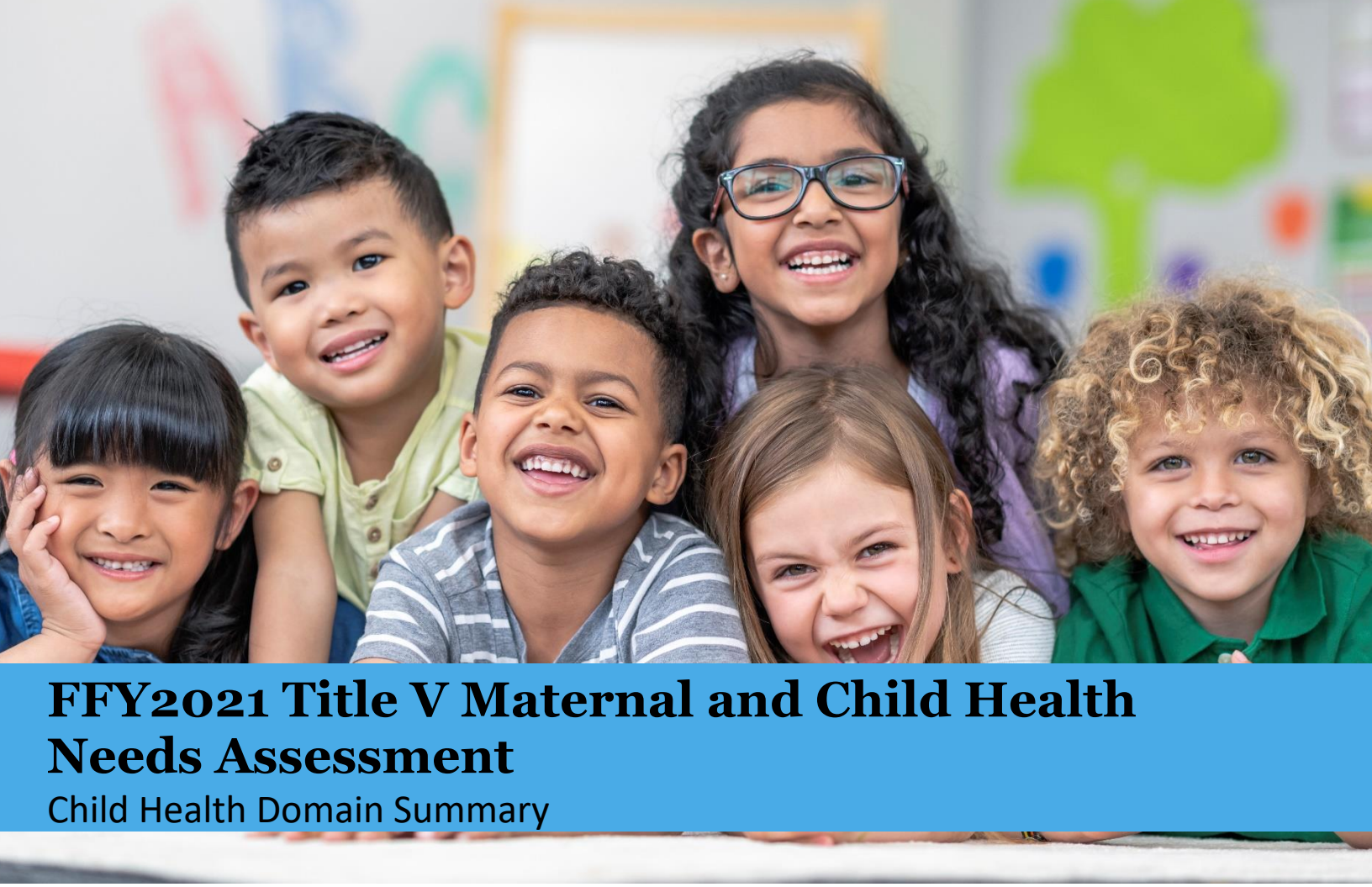

# FFY2021 Title V Maternal and Child Health Needs Assessment

## Child Health Domain Summary

**Bureau of Family Health**
**September 2020**

**Iowa Department of Public Health**
**Protecting and Improving the Health of Iowans**

# Acknowledgements

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# FFY2021 Title V MCH Needs Assessment: Child Health Domain Summary

## Iowa Maternal and Child Health Program Overview

### Iowa Block Grant Description and Structure

Iowa's Title V Maternal and Child Health Block grant 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), a cabinet level agency, 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.

Iowa has approximately 3.1 million people according to United States Census Bureau. In 2018, approximately 35.7% of Iowans live in an area designated as rural in the state. In 2017, there were around 580,000 women of reproductive age (15-44 years) and 38,000 births. Of the 732,000 children under 18 years of age, about 18.8% had special health care needs. CYSHCN are children or youth who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.[i] Although in 2017, 90.6% identified as White, the Hispanic/Latinx population increased from 2.8% in 2000 to 5.7% in 2017. Live births to Hispanic/Latinx women made up 10.9% of all births in 2017.

### Iowa Child Health Population Profile

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.

## Methods

Since early 2019, the Iowa Department of Public Health's (IDPH) Bureau of Family Health (BFH) and the State Oral Health Program, along with partners at the University of Iowa Division of Child and Community Health (DCCH) collaborated to conduct the five-year Needs Assessment (NA) for the FFY2021 Title V Maternal and Child Health Block Grant.

### Framework

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 developed a vision and mission statements to guide the work.

***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) provided overall project guidance and assisted with the recruitment of participation 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 a comprehensive identification of stakeholders for the 2021 Needs Assessment work. The Leadership team 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 as well as survey respondents.

## Data

### *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.

### *Quantitative*

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.

The Child Health Data Snapshots can be found in the Appendix A.

### *Qualitative*

The Title V and MIECHV needs assessments have significant overlap in target populations, predominantly in the population domains of women/maternal health, perinatal/infant health, 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 six Title V regions, participants representing each of the five population domains, Title V recipients and Title V eligible non-recipients, and participants in each of eight underrepresented groups: fathers, People with Disabilities, LGBTQIA+, Refugees/Immigrants, Native American/Alaskan Native, Asian/Pacific Islander, Hispanic/Latinx, and Black/African American.

For the Child Health Domain, IDPH conducted three focus groups, five Title V interviews, and four Key Informant Conversations (KIC) for a total of 45 participants. Focus groups were held in both urban and rural areas and had a set of common questions across all population domains, with specific questions for the Child Health Domain. The focus group and KIC questions are included in Appendix B.

KICs were conducted with 1-5 participants from each of the identified underrepresented populations. 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 upon participant needs. KICs were conducted in MIECHV counties and other communities of interest to Iowa's Title V program. KICs were conducted using interpreters when needed for the following languages: Spanish, Karen, Tigrinya, Vietnamese, Marshallese and Captioning.

The thematic summaries from the Child Health focus groups and KICs can be found in Appendix C.

# Findings

## 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 KICs were available by link within the survey. The following NPMs, SPMs and emerging issues were included in the survey:

- **National Performance Measure 6:** Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
- **National Performance Measure 7:** Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
- **National Performance Measure 8:** Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
- **National Performance Measure 11:** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
- **National Performance Measure 13:** Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- **National Performance Measure 14:** Percent of children, ages 0 through 17, who live in households where someone smokes
- **National Performance Measure 15:** Percent of children, ages 0 through 17, who are continuously and adequately insured
- **State Performance Measure 4:** Percent of early care and education programs that receive Child Care Nurse Consultant services
- **Emergent Issue:**
    - Blood Lead Testing

For the Child Health population domain, survey participants were asked the following questions for each NPM, SPM and emerging issue:

*How important is it for Iowa's Child Health system to address this issue?*

- *Not at all important*
- *Slightly important*
- *Moderately important*
- *Very important*
- *Extremely important*

At the end of the Child Health population domain section of the survey, participants were asked to rank the priorities by importance. Table 1 displays the results of the survey in rank order.

*Table 1 Child Health Population Domain Survey Ranking*

| | Rank: % Ranked as Top 3 Priorities | Importance: % Extremely or Very Important |
|---|---|---|
| Developmental screening among more children (ages 9-35 months) | 62% | 86% |
| Children who are adequately insured (ages 0-17) | 54% | 87% |
| Children with a medical home (ages 0-22) | 54% | 85% |

| | | |
|---|---|---|
| Preventive dental visits (ages 1-17 years) | 32% | 80% |
| Children who are physically active at least 60 minutes each day (ages 6-11) | 25% | 81% |
| Blood lead testing | 22% | 72% |
| Children with payment source for dental care | 19% | 66% |
| Children who live in households where someone smokes | 15% | 64% |
| Percent of early care and education programs that receive child care consultant services | 12% | 69% |
| Injury - related hospital admissions (0-9 years) | 12% | 50% |

Total Survey Participants: 487
Population Group Responses:

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

## 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 the Child Health 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.

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. Based on consensus, the groups indicated the local system's capacity to address the selected measures (Table 2).

*Table 2 Results of Local Capacity Assessment for Child Health Population Domain*

| | **Capacity to Address Priority** | |
|---|---|---|
| | ***Urban*** | ***Rural*** |
| Developmental Screening | High | Medium |
| Medical Home | Medium | Medium |
| Physical Activity | Low | Low |

### *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 (Child Health, 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.

*Table 3 Results of State Level Capacity Assessment for Child Health Population Domain*

| | ***Need*** | ***Capacity*** |
|---|---|---|
| Developmental Screening | High | Medium |
| Lead Screening | High | Medium |
| Physical Activity | Low | Low |
| Child Care Nurse Consultant Services | High | High |
| Oral Health | High | High |

# Priority Selection

## Background

The Title V MCH needs assessment findings are designed to be used to identify priority areas to work on for the next five years. The selection of priority areas is also tied to federal guidance and requirements regarding performance and outcome measurement. The MCHB guidance lists relevant National Performance Measures, and states need to select at least one federal measure for each population group. States are also free to develop State Performance Measures. The National Performance Measures that are directly related to Child Health are:

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

- **National Performance Measure 7:** Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
- **National Performance Measure 8:** Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day
- **National Performance Measure 11:** Percent of children with and without special health care needs, ages 0 through 17, who have a medical home
- **National Performance Measure 13:** Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- **National Performance Measure 14:** Percent of children, ages 0 through 17, who live in households where someone smokes
- **National Performance Measure 15:** Percent of children, ages 0 through 17, who are continuously and adequately insured

The Department determined that health insurance coverage and medical home are foundational to the work that Iowa's Title V project does. With each client service, staff should assess for insurance and medical home.

## Methods for Prioritizing

The findings from the needs assessment were reviewed by the Title V Maternal and Child Health program leadership team for selecting areas to prioritize over the next five years. The review was guided by the needs of communities and for feasibility to address and potential impact. Stakeholder input was provided through the stakeholder survey.

## Final Selected Priorities

The final selected priorities were:

- Infusing Health Equity with in the Title V System
- Access to care for the MCAH Population
- MCAH Systems Coordination
- Dental Delivery Structure of the MCAH Population

The approaches will focus on

- Gap-filling direct and enabling services
- Population-based services
- Workforce development
- Health equity

Progress will be measured through the following performance measures:

- **National Performance Measure 6:** Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
- **National Performance Measure 13:** Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- **State Performance Measure 2:** Percent of children ages 1 and 2, with a blood lead test in the past year.
- **State Performance Measure 3:** Percent of early care and education programs that receive Child Care Nurse Consultant services

- **State Performance Measure 5:** Percent of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider
- **State Performance Measure 6:** Percent of Title V contractors with a plan to identify and address health equity in the populations they serve (cross-cutting)

## Plans to Address Selected Priorities

### 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**

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: 1) 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; 2) collaborating with early care and education providers that encourage developmental screening; and 3) educating families on the importance of developmental screening at recommended age intervals. 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 specifically engage one of the identified 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). Engagement may include building partnerships with alliances who support one or all of these priority 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 provide 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: **Percent of children, ages 1 through 17, who had a preventive dental visit in the past 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 ISmile™, 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 ISmile™ @ 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, which 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 an 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 identified priority populations to promote blood lead testing in more culturally targeted ways. Populations include: 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.

### 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 an application of a health equity lens in services and programs administered at the community level.

The 2021 MCAH RFA requires 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 the 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 data related to the 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.

# Appendix A – Child Health Data Snapshot

## IOWA HEALTH DATA HIGHLIGHTS
## *Child Health*

University of Iowa Stead Family Children's Hospital
Child and Community Health

chsc Child Health Specialty Clinics

IDPH Iowa Department of Public Health

## DEVELOPMENTAL SCREENING

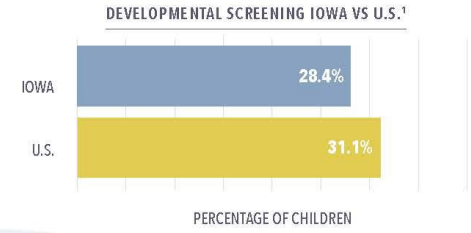
**Development screening allows early identification of signs of delays and therefore early intervention. Early intervention helps children improve their abilities and learn new skills.**

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%).

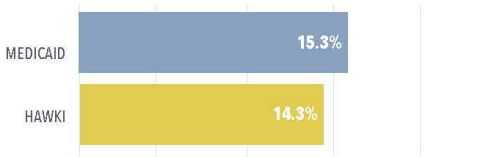
### HEALTH DISPARITY

**In 2017, fewer children on Hawki received developmental screening compared to children on Medicaid.**

DEVELOPMENTAL SCREENING IOWA VS U.S.[1]




HEALTH DISPARITY: CHILDREN SCREENED BY INSURANCE STATUS[1]



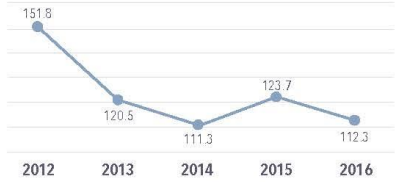

## HOSPITAL ADMISSIONS
### DUE TO INJURY

Injuries are the leading cause of death in the United States for children age 19 years and younger. According to the Centers for Disease Control and Prevention, child injury is one of the most under-recognized public health problems in the US.

**Although there are fluctuations, the rate of hospitalization for non-fatal injuries has decreased from 151.8 in 2012 to 112.3 in 2016.**

INJURY-RELATED HOSPITAL VISITS[2]

*rate per 100,000 children*

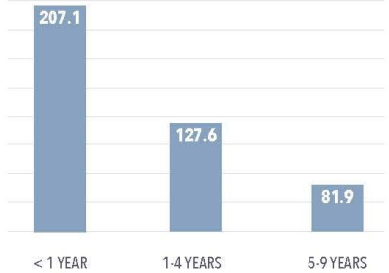



### HEALTH DISPARITY

Infants were noted having a higher rate of hospitalization, followed by children between 1 to 4 years, children between 5 to 9 years were reported to have the least injury related hospitalization in 2016.

RATE OF HOSPITALIZATION DUE TO INJURY[2]

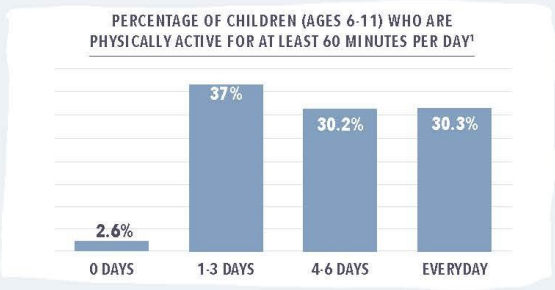
*per 100,000 children*



# PHYSICAL ACTIVITY

**The national recommendation is that children and adolescents aged 6 to 17 years should have 60 minutes (1 hour) or more of physical activity each day.**

About 30% of children were active for either an hour or more every day or at least for 4-6 days a week. 37% of children were active for at least one hour 1-3 days each week. Less than 3% children reported to be inactive.



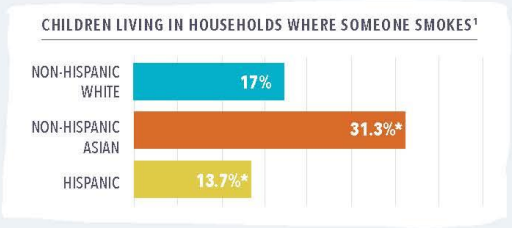

# SMOKING HOUSEHOLDS
## AND CHILDREN'S HEALTH

**Secondhand smoke (SHS) negatively affects children's health.** It increases lower respiratory tract infections and asthma, and decreases pulmonary function. **There is no safe level of exposure to SHS.**[3]

The percent of children living in households where someone smokes decreased from 2011 (29%) to 2016 (17%).


### HEALTH DISPARITY

Smoking was highest in homes with children who were non-Hispanic Asian (31%), followed by non-Hispanic White (17%) and Hispanic (14%) children.

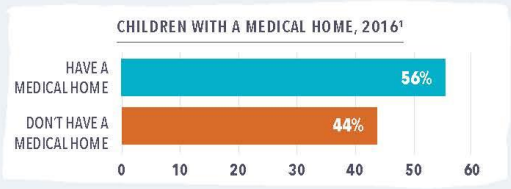



* Data points should be interpreted with caution. Not statistically significant

# MEDICAL HOME

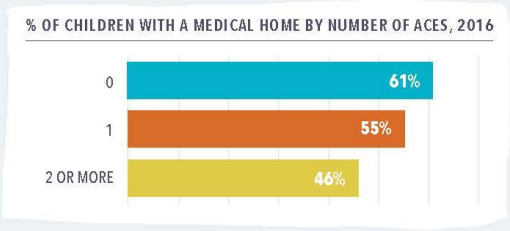
Children with a stable source of health care are more likely to receive preventive care and immunizations, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic conditions.

In 2016, there were more Iowa children with a medical home (56%) than without (44%).




### HEALTH DISPARITY

The higher a child's Adverse Childhood Experiences (ACES) score, the less likely they had a medical home.




Children with special health care needs are less likely to have a medical home (52%) than those without (57%).

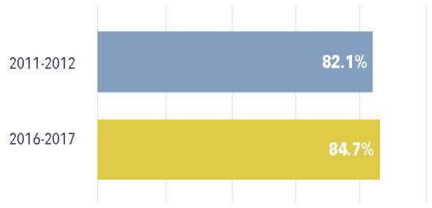
# DENTAL CARE

## PREVENTIVE DENTAL VISIT

**Preventing dental disease and having access to early and regular dental care is critical for good oral health and overall health.**

A slight increase was noted in the percent of children who received a preventive dental visit from 82.1% in 2011 to 84.7% in 2016.

PERCENTAGE OF CHILDREN WITH PREVENTIVE DENTAL VISITS[1]




## PAYMENT SOURCE FOR DENTAL CARE

**Having a way to pay for dental care improves the likelihood that a child will have routine preventive dental visits.** Children need good oral health in order to eat, grow, speak, learn, and maintain positive self-esteem.

The percent of children with a payment source for dental care remained stable from 87.1% in 2016 to 88.7% in 2018, with a dip noticed in 2017.

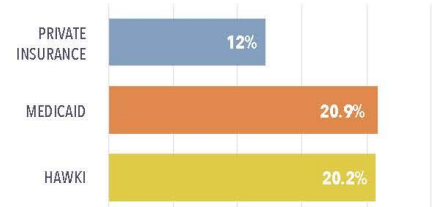
CHILDREN WITH A PAYMENT SOURCE FOR DENTAL CARE[5]


*This dip is due to the data system transition in 2016-2017

## HEALTH DISPARITY

In 2016, third graders on Medicaid and Hawki were more likely to have untreated decay than those with private dental insurance.

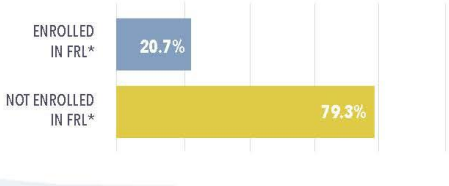
PERCENTAGE OF 3RD GRADERS WITH UNTREATED DECAY BY INSURANCE TYPE, 2016[4]




## HEALTH DISPARITY

A lower percentage (20.7%) of children who were enrolled in free/ reduced school lunches (FRL) had a private payment source versus children who had private payment source for Dental Care.

PERCENTAGE OF CHILDREN WITH A PRIVATE PAYMENT SOURCE FOR DENTAL CARE BY FRL PARTICIPATION[5]

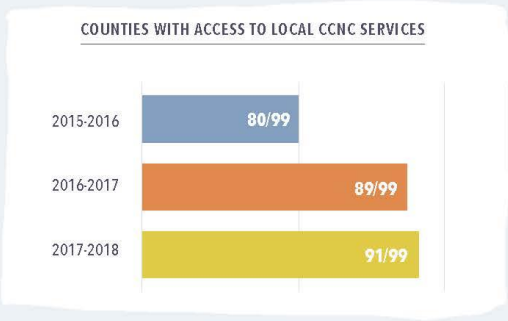



* FRL: free/reduced school lunches

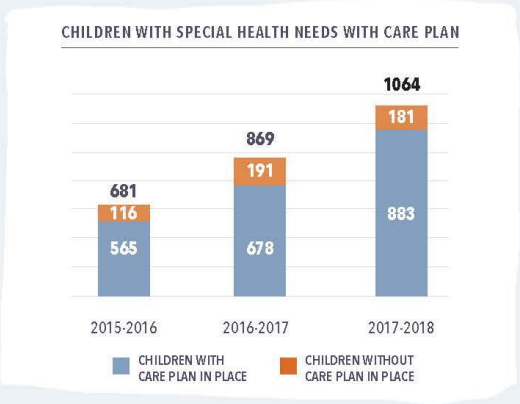
# CHILD CARE NURSE CONSULTANT (CCNC) SERVICES

The counties with access to local Child Care Nurse Consultant (CCNC) Services have increased from 80 in 2015 to 89 in 2016 and to 91 in 2017.

The number of children with special health needs, identified by the CCNC, increased from 681 in 2015 to 1064 in 2017. More than half of those children were found to have a care plan in place.



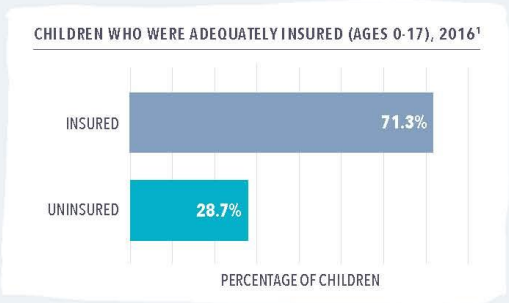

Note: 99 = Total number of counties in Iowa 99.




# ADEQUATE HEALTH INSURANCE

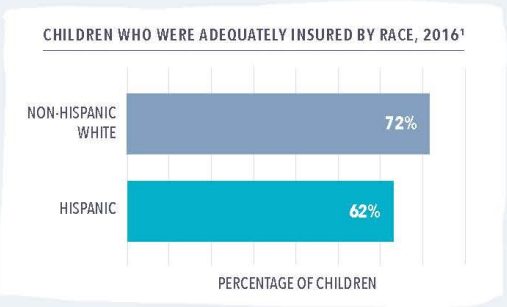
**Health insurance coverage helps provide children with access to preventive and acute care as well as services for chronic conditions. It is also critical to their overall health and well-being.**

In 2016, 71% of children in Iowa have adequate insurance.




## HEALTH DISPARITY

Non-Hispanic White children were more likely to be adequately insured (72%) than Hispanic children (62%).



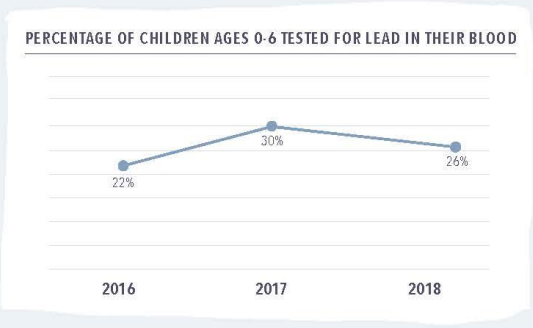
## EMERGENT ISSUE: BLOOD LEAD TESTING

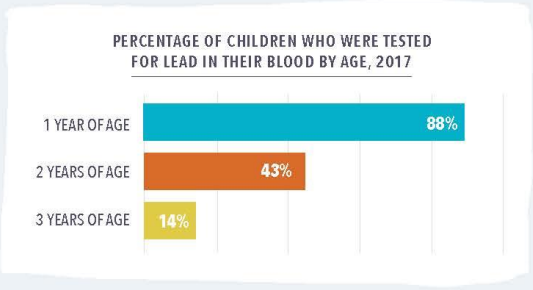
Childhood lead poisoning has been found to be especially harmful to the developing brains and nervous systems of children under the age of six years. **Lead-based paint is the main source of lead poisoning in Iowa.**

The percent of children tested for lead in their blood (ages 0-6) fluctuated from 22% in 2016 to 30% in 2017 down to 26% in 2018.

### HEALTH DISPARITY

The percent of children being tested for lead in their blood 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.




[1] National Survey of Children's Health data [2] State Inpatients Databases (SIDS) [3] U.S. Department of Health and Human Services, 2006 [4] Iowa Third Grade Survey [5] I-Smile@School (TAV)

# Appendix B – Child Health Focus Group and Key Informant Conversation Questions

**Core Questions**

1. What health services does your child receive? I am interested in all the types of health care your child receives.

    *Probe: Mental health care services, health education, health screening, oral health, growth and development, family support programs, or others.*

2. What services that support your child's health are most important to you?

3. Tell me about a time when you have had difficulty obtaining health services that your child needed.

4. Where do you get health information you trust?

5. People are often treated differently based on who they are and what they have. This can be based on race, culture, ethnicity, language, gender, sexual orientation, citizenship status, health care needs, how much money you have, having insurance, or the type of insurance you have, or others. How has this affected your child's health care?

**Home Visiting Questions**

I am going to ask you a few questions about family support home visiting programs. These are programs where a home visitor comes to your home anywhere from once a week to once a month free of charge to provide resources and parenting support for pregnant women and parents with young children.

1. What do you know about home visiting programs available in your community?
2. How interested are you in home visiting services?

    *Probe: How would you want to hear about home visiting programs?*

3. What, if anything, would make it difficult for you to sign up for or receive home visiting services?
4. Who or where do you go to for parenting/child development information?
5. What should we know about why families may decide not to enroll in home visiting programs?

**Population Domain Questions**

1. What do you know about taking care of your child's mouth, teeth and gums?

    *Probe: Cleaning the teeth and mouth, going to the dentist, foods and drinks they consume, or others.*

2. How can daycare providers be supported to include and care for children with health needs?

3. What do you know about lead poisoning?

4. What can your community do to help your child be physically active?

    *Probe: Physical activity is when moving your body to the point your heart rate and breathing increase, things like walking, running, swimming, biking, dancing, or others.*

5. What concerns do you have about the health of children in your community?

**Health Equity Questions**

Community means many things to different people. Community can be your city or town, your neighborhood, people who are similar to you or organizations like your church or mosque, or school.

1. How can your community help with these concerns?

2. How have experiences from your past, like historical racism, gender bias, historical trauma or distrust, influenced your decisions around health care?

3. What are common things people in your culture do to keep their child healthy?

4. How can your community support these cultural practices?

5. Let's talk about someone getting seriously hurt, where they might need to go to the hospital, such as a car accident. What could your community do to prevent these injuries?

# Appendix C – Child Health Focus Group Summary

## IOWA HEALTH DATA HIGHLIGHTS
## *Child Health*

University of Iowa Stead Family Children's Hospital
Child and Community Health

chsc Child Health Specialty Clinics

IDPH Iowa Department of Public Health

*This is a preliminary summary of themes based on focus groups and interviews conducted with Iowa caregivers of children 1 to 11 years old in July and August of 2019.*

### PROVIDER ISSUES

- Not listening to patients
- Dismissing patient concerns
    - Delays in care, inappropriate treatment, and permanent health consequences
- Communication problems including vocabulary used
- Misinformation from doctors
- Discrimination
- Lack of consistent providers and care
- Not taking new patients
- Do not accept Medicaid
- Long waitlist for waivers
- Lots of planning and time necessary to get care
- Poor coordination between primary care and specialists

### SERVICES NEEDED OR DESIRED

- Respite and childcare
- Non-Emergency Medical Transportation
    - Evenings and weekends for urgent care
- School bus monitoring
- More activities and programs
    - Integrated physical/social activities, winter activities, sex education inclusive of trans/non-binary children, suicide prevention
- More information and resources
    - Holistic health and wellness, parenting, child development, mental health
- System navigation support
- Specialized services
    - Play, speech, physical, mental health, occupational and equine therapies, hearing services, postpartum and breastfeeding support, migrant services, ancillary services
- Safe spaces for activities
- More parks
- Supports to maintain insurance coverage across changes/transitions
- Streamlining insurance process
- Support for keeping appointments
- Supports to address stigma associated with medical conditions/diagnoses

## IOWA HEALTH DATA HIGHLIGHTS
## *Child Health*

University of Iowa Stead Family Children's Hospital
Child and Community Health

chsc Child Health Specialty Clinics

IDPH Iowa Department of Public Health

### ACCESS ISSUES

- Cannot find specialized services needed such as mental health or autism services
- No long-term care options
- Cannot get time off work for multiple appointments
- Poor coordination between doctor, insurance, medical companies, and pharmacy
- Lack of transportation
- Caregiver disabilities
- Stigma associated with identity/medical diagnosis
- Authorization requirements to get medically necessary prescriptions
- Unable to purchase medical supplies due to citizenship status
- Untreated mental health disorders
- Winter rural road conditions
- Lack of local pediatric specialists
- Lack of dental care providers
- Don't know services that are available
- Parents unavailable when care is available
- Language barriers
    - Communication through phone interpreter is difficult
    - Medicaid information is unavailable in primary language
- School-based health services (ST, PT, OT) unavailable during summer
- Not enough delay to qualify for primary care provider recommended school-based services
- System fatigue
- Parent personal issues
    - Mental health, substance abuse, GERD, respiratory illness, SPD, ADHD, cerebral palsy, domestic violence, obesity, isolation, hopelessness

### INSURANCE ISSUES

- Limited options
- MCOs/Medicaid
    - Gaps in coverage during transitions
    - Denials