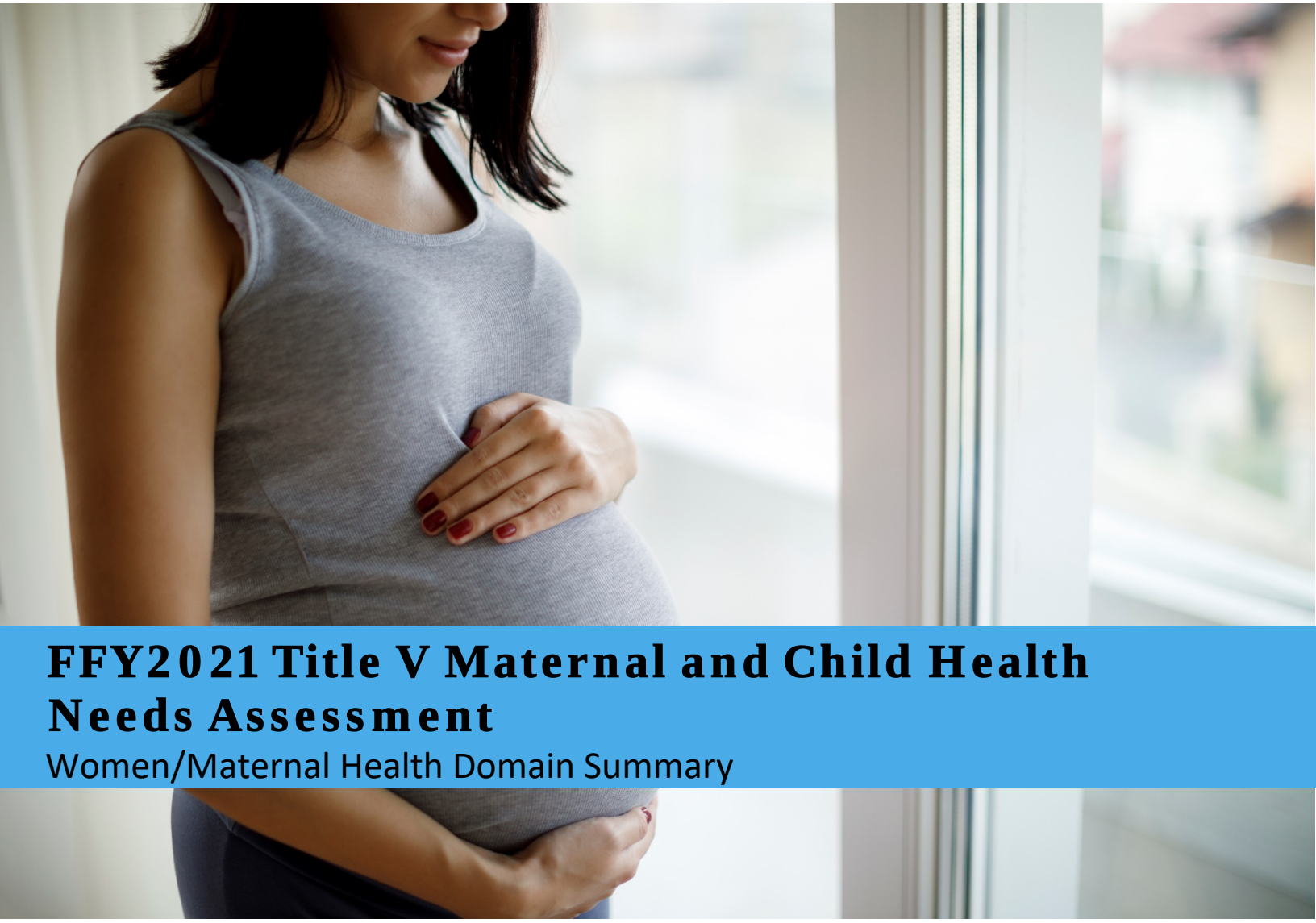

FFY2021 Title V Maternal and Child Health Needs Assessment

Women/Maternal Health Domain Summary

Bureau of Family Health
August 2020

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

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Table of Contents

FFY2021 Title V MCH Needs Assessment: Women/Maternal 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 Maternal Health Population Profile

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 there are significant racial disparities in Iowa's maternal health outcomes and health behaviors. Of mothers who received Medicaid benefits during pregnancy, 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%). 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 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 non-Medicaid 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. 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 four times more likely to die from pregnancy related causes than women in all other categories. Data obtained through

the 2021 needs assessment process reflected similar findings occurring in the national conversation regarding maternal health disparities. 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). Interviews and surveys revealed barriers to obtaining care including language barriers (including difficulty scheduling appointments), other communication issues such as building trust with providers/healthcare team members, feeling judged because of number and spacing of children as well as problems with insurance and payment concerns.

Methods

Since early 2019, the Iowa Department of Public Health's (IDPH) Bureau of Family Health (BFH) and the Oral Health Center (OHC), along with partners at the University of Iowa Division of Child and Community Health (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), and 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 Women/Maternal 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, 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 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 Women/Maternal Health Domain, IDPH conducted four focus groups, two Title V interviews, and four Key Informant Conversations (KIC) for a total of 46 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 Women/Maternal 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 Women/Maternal 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 1:** Percent of women, ages 18 through 44, with a preventive medical visit in the past year.
- **National Performance Measure 2:** Percent of cesarean deliveries among low-risk first births.
- **State Performance Measure 2:** Percent of women served by Title V, who meet Iowa's Title V criteria of having a medical home.
- **National Performance Measure 13A:** Percent of women who had a preventive dental visit during pregnancy.
- **National Performance Measure 14A:** Percent of women who smoke during pregnancy.
- **Emergent Issue:** Maternal Mortality

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

How important is it for Iowa's Women/ Maternal Health system to address this issue?

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

At the end of the Women/Maternal 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 Women/Maternal Health Population Domain Survey Ranking

	Rank: % Ranked as Top 3 Priorities	Importance: % Extremely or Very Important
Maternal mortality rate	77%	93%
Women 18-44 with preventive medical visit in past year	62%	81%
Women who smoke during pregnancy	58%	84%
Women served by Title V who meet Iowa's Title V criteria of having medical home	52%	73%
Preventive dental visit during pregnancy	32%	69%
Cesarean deliveries among low-risk first births	22%	39%

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 Women/Maternal 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 Women/Maternal Health Population Domain

	Capacity to Address Priority	
	Urban	***Rural***
Maternal mortality rate	Medium	Low
Women 18-44 with preventive medical visit in past year	Low	Low
Women who smoke during pregnancy	High	High

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.

Table 3 Results of State Level Capacity Assessment for Women/Maternal Health Population Domain

	Need	***Capacity***
Maternal mortality rate	High	High
Women 18-44 with preventive medical visit in past year	Medium	Medium
Women who smoke during pregnancy	Medium	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 Women/Maternal Health are:

- **National Performance Measure 1:** Percent of women, ages 18 through 44, with a preventive medical visit in the past year.
- **National Performance Measure 2:** Percent of cesarean deliveries among low-risk first births.
- **National Performance Measure 13A:** Percent of women who had a preventive dental visit during pregnancy.
- **National Performance Measure 14A:** Percent of women who smoke during pregnancy.

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 13A:** Percent of women who had a preventive dental visit during pregnancy.
- **National Performance Measure 14A:** Percent of women who smoke during pregnancy.
- **State Performance Measure 1:** Number of pregnancy-related deaths for every 100,000 live births (Maternal Mortality)
- **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 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 trainings 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". In 2021, 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 to 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 which is a standardized assessment and referral tool that 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 Alliance for Innovation on Maternal Health 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, as well as provide cohesive information-sharing between the IMQCC efforts and the work of the Title V program.

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 – Women/Maternal Health Data Snapshot

IOWA HEALTH DATA HIGHLIGHTS
Women & Maternal

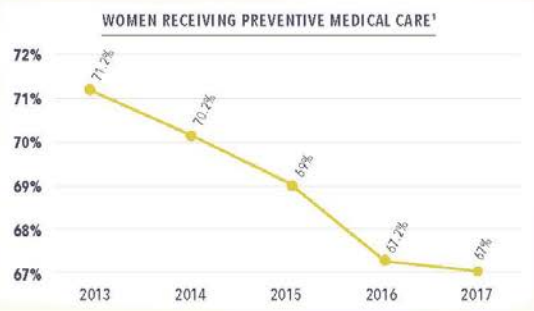
University of Iowa Stead Family Children's Hospital — Child and Community Health
chsc Child Health Specialty Clinics
IDPH Iowa Department of Public Health

PREVENTIVE MEDICAL CARE

In 2017 nearly **one-third of pregnancies** in Iowa were **unplanned.** Preventive visits may be able to reduce unplanned pregnancies.

Women receiving **preventive medical care has decreased in number** in recent years. This may be due to recommendations for less frequent clinical breast exams and pap tests.

WOMEN RECEIVING PREVENTIVE MEDICAL CARE[1]



PREVENTIVE DENTAL CARE
DURING PREGNANCY

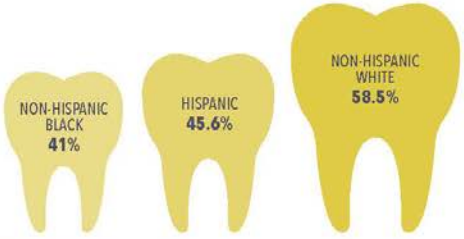
The oral health of a pregnant woman impacts her health and the health of her baby. Pregnancy can cause an increase in cavities due to diet change and additional acidity in the mouth.

HEALTH DISPARITIES

1 in 4 mothers on **Medicaid** were **unable to find a dentist accepting Medicaid** patients.

Non-Hispanic black mothers reported going to **fewer preventive dental visits** than Hispanic and non-Hispanic white mothers.[2]

PERCENTAGE OF WOMEN WITH A PREVENTIVE DENTAL VISIT



MEDICAL HOME
FOR PRENATAL/LABOR/DELIVERY/POSTPARTUM CARE

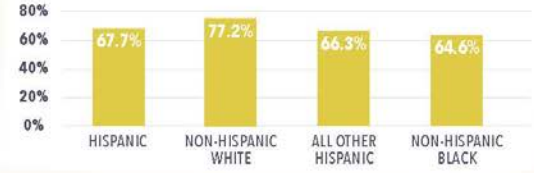
Early and regular **prenatal care,** which provides preventive care guidance for expecting mothers, **improves the chances of healthy pregnancies and newborns.**

Among pregnant women served by Iowa's Title V Maternal Health (MH) agencies, **74% reported having a medical home for their pregnancy.**

HEALTH DISPARITIES

Non-Hispanic black mothers reported the lowest rate of 1st trimester prenatal care initiation compared to other racial/ethic groups.

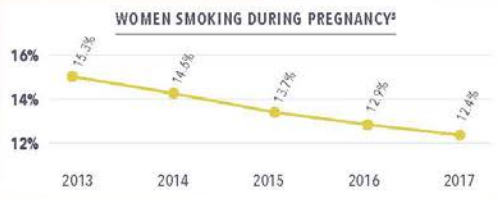
1ST TRIMESTER PRE-NATAL CARE INITIATED BY MOTHERS WITH MEDICAID



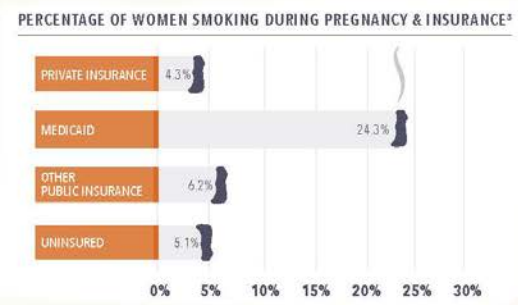
SMOKING DURING PREGNANCY

Smoking during pregnancy **increases risk** for pre-term birth, low birth weights, birth defects of mouth and lips, and sudden infant death syndrome.

The percentage of women **smoking while pregnant consistently dropped** since 2013.



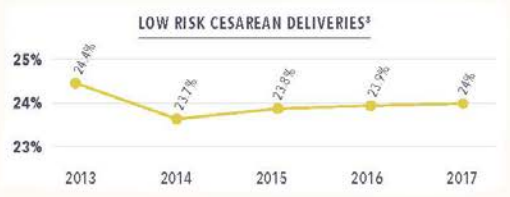
The percentage of **pregnant women who smoked was highest among women with Medicaid**, as compared to other payment sources.



CESAREAN DELIVERIES
AMONG LOW-RISK, FIRST BIRTHS

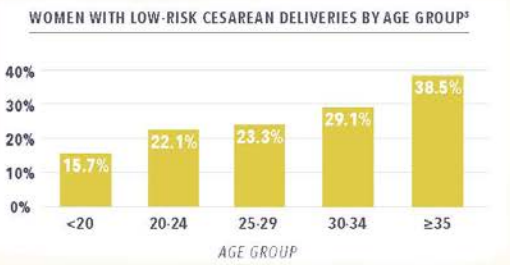
A cesarean delivery **increases the chances** of subsequent cesarean delivery. Multiple cesarean deliveries increases the risk of bladder and bowel injuries, heavy bleeding, and problems with the abnormally adherent placenta (placenta accreta).

The percent of c-sections among low-risk mothers remained stable from 2013 to 2017.



HEALTH DISPARITIES

Women are more likely to have low risk cesarean delivery as they age. This may relate to the fact that older women more often have chronic health conditions.



EMERGENT THEME

In 2014, more women in the US died from pregnancy-related complications than in any other developed country.[4] About 60% of these deaths are preventable.[5]

Non-Hispanic Black women are roughly four times more likely to die from pregnancy related causes than women in all other racial/ethnic groups.[5]

Iowa's maternal mortality rate increased by 55% from 14.7 deaths per 100,000 live births in 2007 to 22.8 in 2015.

[1] Preventive Dental Visit During Pregnancy (PRAMS). [2] The Behavioral Risk Factor Surveillance System (BRFSS). [3] National Vital Statistics System (NVSS). [4] The American College of Obstetricians and Gynecologists [5] CDC, 2019

Appendix B – Women/Maternal Health Focus Group and Key Informant Conversation Questions

Core Questions

1. What Maternal Health Services do you receive? I am interested in all types of health care.

    Probe: Mental health care services, oral health, health education, psychosocial services, interpreter services, transportation, and family support programs.

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

3. Tell me about a time when you have had difficulty obtaining health services that you 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. How has this affected your health care?

    Probe: 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.

Population Domain Questions

We are going to talk about taking care of the health of women specifically women who may become pregnant, are pregnant or are moms. I want to hear about what you think is important for women as they make decisions for their health.

1. What influences you in making decisions about getting an annual well visit/check up?

2. What have you heard about smoking or using tobacco during pregnancy?

3. What about vaping?

4. What concerns do you have about the health of mothers and pregnant women?

5. How do you think the health of your mouth impacts your overall health?

    Probe: ability to eat, chronic diseases

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. What can the community do to help with the concerns you have about the health of mothers and pregnant women?

    Probe: Such as for pregnant women dying during pregnancy, during labor or shortly after)

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

3. What things are important for women, particularly pregnant women, to do for their health in your culture?

4. How can your community support these cultural practices?

5. What do you do when you don't feel like yourself, have serious changes in emotions or stress, or have had thoughts about hurting yourself or others?

Fathers/Men on Women/Maternal Health

1. What Maternal Health Services did your significant other receive? I am interested in all types of health care.

Probe: Mental health care services, oral health, health education, psychosocial services, interpreter services, transportation, and family support programs.

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

3. Tell me about a time when she had difficulty obtaining health services that she 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. How has this affected her health care?

> *Probe: 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.*

Population Domain Questions

We are going to talk about taking care of the health of women specifically women who may become pregnant, are pregnant or are moms. I want to hear about what you think is important for women as they make decisions for their health.

1. What have you heard about smoking, vaping or using tobacco during pregnancy?

2. Can you think of reasons women start smoking, vaping or using nicotine?

3. What helps women stop using tobacco and how can your community help women stop?

4. How do you think the health of your mouth impacts your overall health?

> *Probe: Ability to eat, chronic disease, pregnancy outcomes.*

5. What concerns do you have about the health of mothers and pregnant women?

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. What can the community do to help with the concerns you have about the health of mothers and pregnant women?

Probe: Such as for pregnant women dying during pregnancy, during labor or shortly after)

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

3. What things are important for women, particularly pregnant women, to do for their health in your culture?

4. How can your community support these cultural practices?

5. How can your community involve men/fathers in supporting the health of women?

LGBTQI+ on Women's Health

Core Questions

1. What Maternal Health Services do you receive? I am interested in all types of health care.

Probe: Mental health care services, oral health, health education, psychosocial services, interpreter services, transportation, and family support programs.

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

3. Tell me about a time when you have had difficulty obtaining health services that you 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. How has this affected your health care?

Probe: 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.

Population Domain Questions

We are going to talk about taking care of the health of LGBTQI+ individuals who may become pregnant, are pregnant or are moms. I want to hear about what you think is important for women as they make decisions for their health.

1. What have you heard about smoking, vaping or using tobacco during pregnancy?

2. Can you think of reasons LGBTQI+ women start smoking, vaping or using nicotine?

3. What helps women stop using tobacco and how can your community help women stop?

4. How do you think the health of your mouth impacts your overall health? *Probe: ability to eat, chronic disease, pregnancy outcomes.*

5. What concerns do you have about the health of LGBTQI+ mothers and pregnant women?

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. What can the community do to help with the concerns you have about the health of LGBTQI+ mothers and pregnant women?

Probe: Such as for pregnant women dying during pregnancy, during labor or shortly after)

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

3. What things are important for LGBTQI+ women, particularly pregnant women, to do for their health?

4. How can your community support these things?

5. What do you do when you don't feel like yourself, have serious changes in emotions or stress, or have had thoughts about hurting yourself or others?

Appendix C – Women/Maternal Health Focus Group Summary

IOWA HEALTH DATA HIGHLIGHTS

Women & Maternal

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 pregnant women and mothers of young children in July and August of 2019.

PROVIDER ISSUES

- Judgement/Discrimination
  - Obesity
  - Child-spacing
  - Mental health history
  - Race/ethnicity/country of origin
  - Medicaid/no insurance
- Dismissive of concerns and other provider recommendations
- Lack of medical knowledge
- Unaware of available resources
- Lack of follow-through

SERVICES NEEDED OR DESIRED

- Maternal telehealth
- Transportation assistance
- More maternal follow-up after pregnancy
- In-person interpreters (ASL & spoken languages)
- Specialized care
  - Older mothers, plus-size mothers, mothers of color
- Providers of color
- Training & accountability for providers
- Home-based medical care
- Availability of care in evenings/weekends
- Medicaid coverage for longer after pregnancy
- Resource library
- Ability to make choices for themselves

IOWA HEALTH DATA HIGHLIGHTS

Women & Maternal

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

chsc Child Health Specialty Clinics

IDPH Iowa Department of Public Health

INSURANCE ISSUES

- No insurance
- MCO/Medicaid issues
    - Getting coverage started
    - Transitions and changes
    - Inadequate coverage
        - Mental health care
        - Medications
        - Addiction treatment
        - Limited options for dental care

HEALTH ISSUES

- Back pain
- Numbness in extremities (couldn't hold baby)
- Dental pain
- Allergies
- Asthma
- Obesity
- Long-term addiction care
- Cysts
- Brain injury
- Depression