FFY2023
Title V State Plan
State Performance Measures (SPMs)

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What are State Performance Measures (SPMs)?

Iowa's application for Title V funding reflects national efforts toward a transformed national performance measurement system that is intended to show more clearly the contributions of Title V programs in impacting health outcomes. SPMs are developed by the states to address the priorities identified based on the findings of the Five-Year Needs Assessment and to the extent that a priority need has not been fully address through the selected National Performance Measures (NPMs). SPMs will utilize state-level data to track prevalence rates and work towards demonstrated impact. Collectively, the SPMs represent the five MCH population health domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) CSHCN; and 5) Adolescent Health.

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

Plan for the Coming Year (FFY2023)

From the 2014-2018 data set, Iowa's maternal mortality rate has decreased from 13.9 to 10.4. IDPH anticipates with the increased awareness of elevated maternal mortality rates in the United States, and the disparities among Black/African American pregnant women in Iowa the pregnancy-related death rate will continue to decline from preventable causes. It is unclear what impact the COVID-19 pandemic will have on this measure and IDPH will report on this more in depth when the data become available.

Title V MH staff will provide local agencies training and communication related to the most recent MMRC findings and recommendations. For FFY2023 agencies will begin to form local maternal health coalitions within their region to bring together OB providers, public health, and a variety of other community supports to create a supportive entity to enhance communication about maternal mortality related topics and prevention strategies.

Title V MH agencies will continue to 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. All health education will be tailored to each individual client, with an emphasis on ensuring the education takes into account cultural beliefs and experiences.

IDPH and the local Title V agencies will continue to focus on decreasing health disparities. This will be completed through ongoing educational and workshop opportunities to learn about implicit bias and serving clients with cultural humility.

Title V MH agencies 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.

Conduct annual Maternal Mortality Reviews with a multi-disciplinary review committee and distribute findings and recommendations widely. Findings and recommendations from the Fall 2022 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 participate in the development of the Iowa Maternal Quality Care Collaborative (IMQCC). This work will be funded through the HRSA Maternal Health Innovation grant through FFY2024. Activities for FFY2023 will include maintaining the newly formed IMQCC, 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, in efforts to implement AIM hospital safety bundles. The IDPH director or designee will appoint members and co-chair the IMQCC, and IDPH MH staff will participate in the collaborative to assist in the coordination of meetings, subcommittees, and other needs to ensure success of the IMQCC.

Comments for SPM 1

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

Plan for the Coming Year (FFY2023)

The Title V Program continues to work with the IDPH Childhood Lead Poisoning Prevention Program (CLPPP) to determine the reasons for the decreases in blood lead testing for both one and two year olds for 2020.In recent years the Department has seen a decline in the rate of testing children for lead, especially amongst children under 3 years in age. Overall, 70.8% of Iowa's children 1 year of age received a blood lead test from 2018-2020. However, more than 25% of Iowa's counties have 60% or less of their 1 year old population with a documented blood lead test. There was a 12% decrease in blood lead testing from 2019-2020 for this age group. The number of Iowa's children 2 years of age who received a blood lead test is significantly lower than their 1 year old counterparts. As of 2020, only 35.7% of 2 year old children received a blood lead test, which represents a decrease in coverage from 2019 (38.5%). Currently, both age groups fall below the Department's goal of blood lead tests completed for 75% of Iowa's 2 year old children.

There were two nationwide issues that impacted the blood lead testing rates of children. The first issue was the COVID-19 pandemic and the difficulty in getting routine medical care during this time and then difficulty in doing catch-up routine care once healthcare practices and public health began to re-open doors. The second issue was the recall and subsequent lack of availability of the LeadCare II testing kits by Magellan. Many of the Title V CAH contracting agencies that performed lead testing utilized these tests and there was a lapse of testing due to available supply and pivoting to a different method of testing. In 2021 a deep dive into 2019 and 2020 data was done by CAH staff in collaboration with IDPH CLPPP

staff. Several areas of focus for future work were found, including targeted race/ethnicity in testing and targeted testing efforts for specific counties in Iowa where rates are low and specific types of communities (I.e., micropolitan and rural communities).

In 2023, the CAH Program released a competitive Request for Proposals (RFP) to select new community-based contractors to provide public health services at the community level for Child & Adolescent services. This RFP includes blood lead testing services for children. Through this application process state Title V staff are able to evaluate the applicant's ability to provide quality services for children in the state. Through a deep data dive, it was learned that 8 of Iowa's 99 counties have higher than average rates of children in Title V's Health Equity priority populations, which include Hispanic/Latinx and African American, Black or African, without blood lead tests. Staff are exploring ways to target these identified priority populations, including requiring contract agencies in these 8 counties to focus lead testing efforts on these specific populations. Title V staff will continue to work at the state level to identify and eliminate barriers to testing. Additionally, when looking at the state geographically, there is a discrepancy between counties of residence and blood lead testing at both 1 and 2 years of age. Therefore, through the RFP process a requirement for applicants to provide blood lead testing to 1 year old children in 64 of our 99 counties which had less than the state goal of 75% of children residing in the county with a blood lead test, and for 2 year old children 57 of our 99 counties who had less than the state goal of 40% of children residing in the county with a blood lead test. Title V believes by targeting priority populations and requiring blood lead testing for 1 and 2 year olds in more than half of our counties Iowa will be able to expand testing post-COVID-19 and get more children tested at the proper ages and intervals. Additionally, the RFP requires applicants to set both single year and 5 year goals for both 1 and 2 year old children to increase blood lead testing in their service area. These goals will allow staff to more closely measure each agency's impact on the blood lead testing of children in their area.

Finally, the CAH Program will continue to work collaboratively with the IDPH Children's Lead Prevention Program. The two programs continue to work to determine data sharing and meaningful use of the data collected, targeted interventions for populations, and improved testing strategies for Iowa's children.

Comments for SPM 2

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

Plan for the Coming Year (FFY2023)

Iowa has 3999 regulated child care programs. The COVID-19 pandemic has greatly impacted the need for child care nurse consultant (CCNC) services, increasing the percentage of early care and education (ECE) programs contacting their local CCNC for guidance and services over the past two years. Iowa's Emergency Preparedness Plan for Child Care includes Healthy Child Care Iowa (HCCI) state staff and local CCNCs assisting in communicable disease response. Iowa's COVID-19 guidance for child care has been a collaborative effort between the Iowa Department of Public Health and Iowa Department of Human Services. Local CCNCs have provided assistance to ECE programs regarding COVID-19 health and safety policies; managing positive cases, exposures and outbreaks; and improving quality.

Although COVID-19 cases have decreased in Iowa, requests for CCNC services have continued as many ECE programs who may not have accessed services in the past, have now established a strong partnership with their local CCNC and see the value of the services provided.

Research indicates that CCNCs support healthy and safe early care and education settings and protect and promote the healthy growth and development of children and their families. In Iowa, CCNC services are non-regulatory so 100% of programs receiving services may not be an achievable goal. However this rate will continue to increase due to Iowa's new quality rating system (Iowa Quality For Kids - IQ4K). IQ4K has a continuous quality improvement approach incorporating a focus on health and safety. CCNC services are a requirement for ECE programs applying for IQ4K starting at a level 2.

HCCI state staff will continue to promote 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 limited CCNC coverage, and facilitating meetings with local stakeholders (including Early Childhood Iowa areas) for supports and funding of local CCNC services.

HCCI has and will continue to incorporate health equity language into the CCNC Role Guidance. Health equity is embedded in the Iowa Training Project for Child Care Nurse Consultants (ITPCCNC). ITPCCNC is the required initial training for nurses employed as CCNCs.

HCCI has worked to incorporate the 10 Essential Public Health Services into our HCCI state structure. Staff will continue to assess and ensure these are being utilized when making programmatic decisions.

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 ECI, DHS, MCAH and other partners. HCCI will continue to collaborate with DHS for gap filling support of local CCNC services.

Local CCNC services will be evaluated by state HCCI staff for program fidelity including annual inter-rater reliability visits utilizing the Health and Safety Checklist assessment tool. Fidelity with the tool will be at 90% or higher.

Data from Health and Safety Checklist assessments of ECE programs by local CCNCs will be evaluated by state HCCI staff to assess training needs, resources, fact sheets, and to help drive the work of the CCNC in assessment items falling below national standards where quality improvement is needed.

Comments for SPM 3

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

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Plan for the Coming Year (FFY2023)

From 2018, there has been a significant increase in the percentage of adolescents that report that during the past 12 months they were feeling so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing usual activities. The increase in the percentages is alarming. In the IYS special topics report released in March 2022 the percentage of 6th graders reporting on this measure increased from 19% to 27%. The percentage of 8th graders increased from 24% to 29% and the 11th grade percentage went from 33% to 36%. A reasonable deduction for the increase in percentages can be attributed to the COVID-19 pandemic. It is likely the closure of schools and halt of extracurricular activities may have exacerbated teens feeling lonely and isolated. The COVID-19 pandemic also brought other struggles for families. With the closure of schools and other activities halted, more families were home together. This brings an increase in emotional and physical abuse of children and adolescents as well as other stressors such as job losses and financial stress. Our goal is to maintain this rate for 2023 and reduce the overall percentage across the three grades by .5% each year starting in 2024. It is anticipated that the survey results every two years will remain stable or worse, increase.

Currently, no other state performance measures address adolescent mental health and local Title V agencies have provided minimal services related to adolescent mental health. Iowa was invited to participate in an 18 month Collaborative Improvement and Innovation Network geared toward increasing depression screening in clinical settings and will complete the CoIIN late 2022.

Iowa plans to explore and research collaboration with the Iowa High School boys and girls' athletic unions to promote adding mental health screening questions to

the Iowa Athletic Pre-Participation Physical Examination form.
Historically IDPH has contracted with local Title V agencies to work on all selected NPMs and SPMs across the state. With the 2015 & 2020 MCAH needs assessments demonstrating a need for additional focus on the unique needs of adolescents, many current contractors have struggled to serve such a wide variety of ages. Most contractors have partnered with WIC for several decades, and early care and education programs as primary ways to find and serve pregnant clients, infants, and young children in places they already frequent. Staff with expertise in pregnancy, infant and early childhood care are not typically also experts in adolescent health.

After years of trying to make this model successful, and gathering the feedback of contractors, stakeholders, and families, the Department removed the adolescent well visit and adolescent mental health performance measures from the CAH RFP with the exception of well visit reminders for adolescents enrolled in Title V and Fee-For-Service Medicaid, and outreach during the Informing service.

Local Title V contractors will still have the option to provide direct health care services and screenings as a gap-filling service, with demonstrated need.

Comments for SPM 4

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

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Plan for the Coming Year (FFY2023)

Tooth decay, despite being highly preventable, is the most common chronic disease among children. Research indicates that when fluoride varnish is used early, it can reduce decay by 18-25% in children. The benefits of fluoride varnish for very young children may be demonstrated through Iowa's surveillance data. Based on data showing that too few Medicaid-enrolled children ages 0-2 years see a dentist, I-Smile™ programs have been required to provide preventive services, including fluoride varnish applications, at WIC clinics since 2012. A 2019 survey of WIC children in Iowa found a 4% reduction in untreated decay compared to a 2010 survey.

The Bureau of Oral and Health Delivery Systems (OHDS) staff and I-Smile™ Coordinators will continue to seek ways to increase access to early preventive dental care for children, including use of fluoride varnish by medical providers. OHDS staff will lead the Cavity Free Iowa (CFI) initiative, a workgroup launched in 2017. Recognizing that young children often see their physician more routinely than a dentist, the goal of CFI is to increase the number of young children receiving preventive oral health services like fluoride varnish from their primary

care physician. Using materials developed by OHDS staff, I-Smile™ Coordinators will continue to offer training to medical office staff on the benefits and how to apply fluoride varnish. The medical providers will receive a certificate after training and a plaque after continued use of fluoride for patients. Over the next year, the CFI workgroup plans to add a CFI section to the I-Smile™ website, hosted by OHDS, to connect medical providers to I-Smile™ Coordinators for training. The website will also include specific education about oral health for medical practitioners. The central Iowa pediatrician who has championed CFI was chosen to continue to lead the One Hundred Million Mouths Project. He will continue providing training to medical students in Iowa about oral health and the benefits of fluoride for decay prevention, in hopes that the students will incorporate what they learn when they go into practice. An I-Smile™ Coordinator will assist with the training for medical students.

OHDS will continue to leverage its CFI partnerships in FFY2023. For example, Delta Dental of Iowa Foundation brings experience in public relations and marketing and will provide commemorative plaques and training certificates for medical offices trained by I-Smile™ Coordinators. OHDS staff will work with Medicaid's Dental Program Managers to assure reimbursement to medical offices and troubleshoot any billing issues. OHDS staff will also continue to partner with the CFI pediatrician "champion" and a dentist from a central Iowa dental clinic for the underserved. This partnership works to increase participation in the CFI workgroup by connecting with colleagues and increase the use of physician applied fluoride varnish by helping medical clinics with technical assistance.

OHDS staff also will continue participation in the Oral Health Iowa coalition (OHI). The coalition formed to provide a unified advocacy voice regarding oral health of Iowans; two OHDS staff are on the coalition steering committee. OHI gives OHDS staff access to additional partners who support the goal of physicians incorporating oral health prevention during well-child visits.

As a result of OHDS staff advocating for an expansion of Iowa Medicaid's coverage for physician-applied fluoride to children through age 5 to coincide with Iowa's EPSDT periodicity schedule, Medicaid adopted this policy in December 2021. OHDS staff will assure that flyers, training, and promotional materials are updated to reflect the change so that I-Smile™ Coordinators will have the materials when making required in-person outreach visits to all pediatric medical offices within their service area, emphasizing the importance of early and regular oral health care and parent education. The coordinators will also promote the ability to bill for fluoride varnish applications for children through the age of 59 months with medical clinics when doing their outreach.

Iowa has more than 200 Rural Health Clinics (RHCs). They are federally funded and must meet federal requirements, operating differently than medical clinics that are not designated as RHCs. For example, they receive cost-based reimbursement,

similar to Federally Qualified Health Centers. It is more difficult to integrate use of fluoride varnish within a well-child visit at RHCs due to the cost-based reimbursement. Because of Iowa's large rural population, OHDS staff have met with the State Office of Rural Health staff and the Iowa Association of Rural Health Clinics to identify ways to add use of fluoride varnish applications in RHCs. The collaboration has led to addition of oral health questions on the yearly Iowa Association of Rural Health Clinics needs assessment. In 2023, OHDS staff will use the needs assessment information to determine the interest of Iowa's RHCs for oral health services, linking I-Smile™ Coordinators with those RHCs. OHDS staff will continue working through billing considerations and procedures needed for the RHCs and will seek the assistance of Cavity Free Iowa to determine opportunities to pilot use within selected RHCs.

OHDS staff submitted a HRSA Oral Health Workforce grant with a project period of September 2022 – August 2026. If funded, OHDs would develop a plan to incorporate public health dental hygienists in medical offices. This grant would lead to more medical/dental integration and increased opportunities to reach children ages 0-5 years with preventive dental care.

Comments for SPM 5

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

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Plan for the Coming Year (FFY2023)

The 2022 RFA was a continuation application due to COVID-19. Contractors continued to operate under their work plans submitted and approved for FFY2021 with a few exceptions where plans were updated to reflect changes needed due to COVID-19 or to update with progress made and next steps. All 23 local contractors completed this activity.

Efforts to increase partnerships and collaborations focused specifically on priority populations and family engagement will increase the quality of contractor health equity plans.

In FFY23 continuing to build internal capacity within the State Title V Program is an important strategy in providing programs and services through a health equity lens, and being able to build health equity capacity in local contractors. Title V staff continue to have health equity goals included in their job descriptions, participate in ongoing health equity professional development, and participate in the MCH Workforce Development Health Equity Cohort. The IDPH Health Equity

Coordinator position has been joined with the Iowa Department of Human Services health equity positions to form an Office of Health Equity to serve the soon to be formed Iowa Department of Health & Human Services.

The Health Equity Advisory Committee continues to provide input in planning, implementation, and evaluation of Title V programs and services. Recruitment and retention is an ongoing process. The FFY23 RFP requires local Title V contractors to form a family engagement group, and to recruit one of the members to serve on a statewide family engagement group. Contractors will need the majority of 2023 to recruit and form their local groups, so engaging the local members into a statewide group will likely happen primarily in 2024. Whether these members will join the HEAC or a second group will be formed focused specifically on families will be explored in 2023.

Several requirements for Health Equity and Family Engagement were included in the FFY23 RFP. Providing technical assistance, consultation, and assistance in building capacity to not only meet but thrive with these new requirements will be ongoing, but especially intensive with local contractors in FY2023. The following requirements for Health Equity and Family Engagement were included in the FFY23 RFP:

1. Applicants were asked to focus on two priority populations in 2023. One priority population was predetermined based on 2020 US Census racial and ethnicity population data in the Collaborative Service Area. The applicant will chose one additional population and provide a rationale for chosing the population. The eight priority populations applicants can choose from are:
    a. African American, Black, or African;
    b. Asian, Pacific Islander
    c. Fathers
    d. Hispanic or Latinx
    e. Lesbian, gay, bisexual, transgender, queer, instersex (and emerging terms) (LGBTQI+)
    f. Native American, Alaska Native
    g. Persons with disabilities
    h. Refugees or immigrants

In 2021, when the priority populations were introduced and contractors were required to address these specific population in their RFA, many chose one or two populations to focus on. Some contractors chose all eight. Activities and progress on activities as well as health equity was diminished for contractors choosing too few or too many populations to focus on at a time. Having contractors focus on two populations increases their chances of forming lasting partnerships and strategies to move health equity forward in their CSA. Successful applicants will focus on the two selected populations for activities 2 through 8.

2. Provide health equity training to staff, including subcontractors, approved

by the Department, annually.

3. Collect client/family demographic data to evaluate the effectiveness of programs and services. Staff shall ask demographic questions so clients may self-identify. Staff shall not determine demographics for the client.
4. Provide culturally and linguistically appropriate materials and services for the CAH programs.
    a. Provide information in the preferred language of the client/family. This can be accomplished by use of trained bilingual staff, language lines, and/or hired interpreters. Bilingual staff or interpreters hired shall match the makeup of the service area population and be trained in interpretation, preferably medical interpretation. Track and report all types of interpretation and translation (bilingual staff, language lines translation services and hired interpreters) provided to clients to the Department.
    b. Incorporate clients and people with lived experience in development, review, and distribution plan for materials to assure that the materials are meaningful to the intended audience.
    c. Assess the readability and accessibility of materials, websites and forms, and use plain language whenever possible.
5. Collaborate with organizations, programs or groups led by and/or specifically designed to serve priority populations. See Title V Administrative Manual-draft to determine levels of community engagement/partnership.
6. Recruit and retain staff who represent the population of the CSA as reflected in the 2020 Census data
7. Provide community programs and services with input from clients, family members and members of priority populations
8. Programs, services, and activities shall be designed to improve health outcomes for priority populations

Health equity will be enhanced by engaging clients/families in program planning. Therefore a section on family engagement was added to the RFP.

1. Successful applicants shall engage clients/families of the FE group at the involvement level or higher (see Title V Administrative Manual-draft Policy 605 Community Partnerships) with a minimum of 10 clients/family members in program planning, outreach, implementation, policy development, and evaluation. The required make-up of the group is as follows:
    a. At least one client or parent/primary caregiver from each county of the CSA.
    b. An approximate equal mixture of clients or parents/primary caregivers of clients who are Title V/Medicaid eligible and have used services in the past 2 years, and those eligible in the past 2 years for Title V/Medicaid but have not used services. Clients/primary caregivers shall make up at least 50% of the group.
    c. Include a minimum of 30% clients or parent/primary caregivers

from priority populations.
d. All applicants shall include members who identify as fathers, persons with disabilities, Hispanic/Latin X and LGBTQI+. For data estimates and types of disability by age, sex, race by county see the US Census ACS 2019 5 Year Estimates Table. Specific racial and ethnic priority population members shall be included as predetermined using 2020 US Census Data (table provided to applicants with priority population to include in the CSA).
e. Individuals employed/contracted with the applicant or subcontracted providers may not serve as a client/family member.
f. Relatives or individuals with a close personal or business relationship with an employee or contractor of the applicant are discouraged and shall not exceed 20% of the FE membership. Applicant's may use relatives or personal and business contacts to help recruit members for the FE group.
g. Applicants may use existing groups in their agency or community to satisfy the requirement of having a FE group as long as the membership criteria above are met and sufficient time and resources are available throughout the year to meet the CAH program needs.

2. Successful applicants will recruit a minimum of one client/family member from their FE group to participate in a FE group at the state level. The Department will provide the compensation and coordination for the state level work.
3. At least one meeting of the group will be held in FFY23 for families to give input on service site locations, and days/hours services will be available to families.
4. Creation, maintenance of membership, and ongoing support of the FE group will require dedicated, ongoing staff time, commitment, and resources. Applicants shall prioritize and budget ongoing staff time and resources to ensure success. Describe how the FE group's feedback on service sites and days/hours services will be available, will be incorporated into agency policies.

Applicants had to describe how they would form the group and address their prior experience engaging clients/families in contributing to planning, implementation, evaluation, outreach and policy decisions. Create a contingency plan for if recruitment doesn't go as planned. Describe their compensation for the time and expertise of clients and family members. How they will share power with members of the FE group and partnerships they will engage in to ensure the FE groups success.

In addition to the Health Equity and Family Engagement Component sections of the RFP, health equity and family engagement requirements were also incorporated into other components (NPMs, SPMs, core Title V services) of the RFP. The following are the additional requirements that successful applicants will

address in 2023.

1. Provide specialized care coordination to priority populations as they may need additional care coordination to find a provider that meets their needs.
2. Clients and family members (as defined in Section 2.03B.1.b) shall be included in the development and review of the policies and procedures regarding Informing, call/text scripts, and the contents of the Informing packet. Clients/families shall be engaged to make recommendations for policy/procedures related to connecting with families, providing input in how families are communicated with, how to communicate information, and ensuring processes and information are family-centered.
3. Assist clients/families with health literacy by assessing their needs and then structuring education based on those needs. Provide additional education or assistance in understanding health literacy for priority populations, as needed.
4. Collaborate with specific organizations, programs, or groups that are designed to serve priority populations to promote blood lead poisoning prevention and lead testing throughout the CSA. The Department has selected a priority population(s) for some CSAs based on data demonstrating health inequities in blood lead testing and elevated blood lead levels

For 2023, we requested the target populations for Hawki (SCHIP) Outreach program be amended to change “Special Populations” to the eight priority populations and to remove medical providers and replace with employees without access to employer-sponsored health insurance. We feel these changes will assist in ensuring stronger outreach to populations more in need of health insurance and increase health care access.

A final strategy implemented throughout the RFP was to increase the requirement for services being provided outside M-F 8am-5:30pm, and more equity in activities, partnerships and services being offered in outlying counties of the CSA, versus concentrated in the home county of the applicant. Successful applicants depending on population size must spend a minimum of 25 to 40 hours providing Informing services outside M-F 8-5:30. Hawki outreach is more focused on being out in the community doing the outreach versus at the agency, focusing on families versus professionals, and providing at least 25% of that outreach time outside M-F 8-5:30.

Comments for SPM 6

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

Plan for the Coming Year (FFY2023)

Family support was identified as a significant need for CYSHCN during Iowa's Statewide Needs Assessment process. In FFY2023, DCCH will continue to address this need by 1) providing family-to-family support to Iowa families of CYSHCN; 2) building appreciation for strengths and challenges for families across the state through advocacy and provider workforce development; and 3) building the infrastructure for strengthening family leadership capacity statewide. FFY2023 family support activities include a greater emphasis on building statewide capacity to support families from underrepresented backgrounds.

Family to Family Support

Family to family support activities will continue through DCCH's existing *Family Navigator Network*, which includes 28 family navigators located in all Regional Centers and satellite locations, and available to families of CYSHCN statewide. Family Navigators are all parents or caregivers of CYSHCN, with additional training that enables them to provide emotional support, connections to community resources, and assistance with systems navigation for families of CYSHCN. Family navigators are all encouraged to receive Family Peer Support Services certification through the Iowa Board of Certification. All families of CYSHCN ages 0–21 in Iowa are eligible to receive services from a family navigator. Referrals to CHSC's Family Navigator Network are made through a number of channels including Early Access, Iowa's Regional Autism Assistance Program, primary care and specialty providers, the Integrated Health Home program through Iowa Medicaid, and word of mouth.

The Family Navigator Network will remain flexible in order to respond to challenges from the COVID-19 pandemic. In FFY2023 Family Navigators will receive training on resiliency and mental health, support for families of youth from underrepresented backgrounds, families in crisis, and families who are facing economic instability.

In recognition of the growing population of families from underrepresented backgrounds in Iowa, the Family Navigator Network is working with the DCCH Health Equity Committee to strengthen activities that will identify and support parents from these backgrounds. Activities from the Health Equity Committee's workplan specific to the Family Navigator Network include: 1) developing partnerships within diverse communities and increasing family support services to underserved populations; and 2) recruiting and supporting ethnically diverse staff including cultural liaisons. DCCH has made progress through hiring family navigators from the Marshallese and Spanish-speaking communities who specialize in working with families from the Marshall Islands and families who come from Spanish speaking backgrounds. DCCH is using lessons that were learned from these experiences to strengthen capacity for working with other

underserved communities, recognizing the need for family navigators to provide the highest quality of care through a best-practice, family centered, culturally responsive manner. DCCH also plans to continue building capacity for Family Navigators to support families of LGBTQ+ youth through training and outreach. In order to ensure that family input is received for all initiatives, DCCH's *Family Advisory Council* is supported by the Iowa Title V CYSHCN program. The role of the Family Advisory Council is to provide guidance to all DCCH activities, including family support. In FFY2023, the Family Advisory Council will continue to meet on a bi-monthly basis. DCCH is emphasizing the utilization of the Family Advisory Council to provide early input into all newly planned initiatives, and to receive feedback on existing programs. In addition to acting as advisors to DCCH, the Family Advisory Council will also advocate on behalf of Iowa's families of CYSHCN through a state legislative forum. Designed as a bipartisan effort, the legislative forum will occur in partnership with Iowa's Developmental Disabilities Council (DD Council). This forum is intended to raise awareness about how families of CYSHCN are impacted by policies created by the state legislature.

Advocacy and family support workforce development

Over the past few years, the Iowa CYSHCN program has strengthened capacity for training and workforce development to provide optimal support for families, and now includes a dedicated family training coordinator. In FFY2023, DCCH will continue to build workforce capacity to support families through trainings for providers on family centered care, culturally responsive care, and working with families of LGBTQ+ youth. Trainings will be targeted toward DCCH staff as well as pediatric primary care and specialty care providers. Additionally, leaders in state government will receive information about supporting families of CYSHCN through policies that have a positive impact on families. This will occur through a state Legislative Day on the Hill in Des Moines where legislators will learn about how they can support their CYSHCN constituents. Participants are graduates from the Iowa Family Leadership Training Institute and the DCCH Family Advisory Council.

Family Leadership

Building family leadership skills and statewide capacity has been a focus of DCCH activities for many years. In FFY2023, DCCH will continue to implement programs to strengthen family capacity at all levels (Personal/Family, Community, and Policy). Formal trainings for families such as the Iowa Family Leadership Training Institute, Digital Storytelling, and Storytelling for Family Leaders will continue. The family leadership team is increasing capacity for these trainings by incorporating new trainers across the state. Storytelling is an important skill to help families focus their stories in a way that can provide the best avenues for advocacy and raising awareness. Digital Storytelling workshops will be offered two times during FFY2023. These are free three-day workshops designed to help families build and produce a 2–4 minute digital story. Examples of Digital Stories produced through this training can be found on the Storytelling for Families page of the DCCH-Child Health Specialty Clinics website: https://chsciowa.org/programs/storytelling-

families. DCCH is actively working to identify Spanish speaking families to invite to this training in order to add this perspective to the Digital Storytelling library. DCCH will also work with the Iowa Leadership Education in Neurodevelopmental and Related Disabilities Program (ILEND) to include a digital story highlighting the advocacy needs specific to the African American community.

Additionally, a Storytelling for Family Leaders training will be offered in the fall of 2022. This training is designed to equip families of CYSHCN with the necessary skills to share their stories in a variety of settings and modes of delivery. This is intended to bring awareness and change to Systems of Care for CYSHCN. Participants work with a coach and a cohort of family storytellers to produce 10-minute stories to be used as part of their advocacy efforts.

The Iowa Family Leadership Training Institute was developed to provide parents and caregivers of CYSHCN the opportunity to develop leadership and advocacy skills. Now in its 7th year, the IFLTI leverages Title V block grant funding to train families to work with partners, build their own paths to leadership, advocate for other families, and prepare a community service project. IFLTI delivers this training through five weekend-long sessions. In FFY2023, IFLTI will be offered to parents or primary caregivers of children ages 3 to 19 years with special health care needs living in Iowa.

Family Peer Support Specialist trainings were developed by DCCH, the Iowa Department of Human Services, and the University of Iowa's National Resource Center for Family Centered Practice. Family Peer Support Specialists draw on their own experience as a parent or primary caregiver of a child with special health care needs and may be employed at social service agencies, clinics, residential programs, and other community-based organizations. They may also serve on a variety of advisory boards and committees at local, state, and national levels. This training is one of the requirements to become a certified Family Peer Support Specialist. This year, the program transitioned from being administratively housed with DCCH to the National Resource Center for Family Centered Practice. DCCH is still involved with this program and provides two trainers to the program to facilitate and administer specific aspects of the program. DCCH is also currently working with agency supervisors to work on Family Peer Support Specialist retention and workforce.

Working directly to support families, advocating for family-centered care among the health care workforce, and building family leadership capacity are three strategies that DCCH will continue to implement in the upcoming fiscal year in order to support families and build family leadership capacity. This will be accomplished in partnership with families, and with an emphasis on increasing relationships with underserved and underrepresented families in order to achieve a strengthened System of Care for CYSHCN in Iowa.

Comments for

SPM 7

General Comments