Maternal and Child Health Services Title V Block Grant

Iowa

FY 2022 Application/ FY 2020 Annual Report

Created on 8/31/2021 at 12:47 PM

Table of Contents

I. General Requirements

I.A. Letter of Transmittal

IDPH IOWA Department of PUBLIC HEALTH

Protecting and Improving the Health of Iowans

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

August 27, 2021

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

RE: Title V Maternal and Child Health (MCH) Block Grant Application for FFY2022 and Annual Report for FFY2020

Dear Mr. Dykton:

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

Thank you.

Sincerely,

Nalo Johnson, PhD

Digitally signed by Nalo Johnson, PhD
Date: 2021.08.30 11:53:40 -05'00'

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

Lucas State Office Building • 321 East 12th Street • Des Moines, IA 50319 • 515.281.7689 • www.idph.iowa.gov
DEAF RELAY (Hearing or Speech Impaired) 711 or 1.800.735.2942

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

The State of Iowa is primarily rural, with approximately 3.2 million people according to United States Census Bureau. In 2019, there were around 595,000 women of reproductive age (15-44 years). $28,610 was the median family income for female householders, no husband with own children under 18 in 2018. The median income for married-couple families was $97,993. The median income for male householder, no wife present was $45,828.

In 2020, the total number of deliveries in the state totaled 35,418 this is a decrease from 37,557 deliveries in 2019. Of the 733,000 children under 18 years of age, about 128,000 were CYSHCN. Of Iowa's population, 18% is covered by Medicaid and/or Hawki. In 2019, 90.6% identified as white, the Hispanic population increased from 2.8% in 2000 to 6.3% in 2019, which is consistent with data showing that Iowa is becoming more diverse. Live births to Hispanic women made up 19.5% of all births in 2019.

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

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

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

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

Access to care for the MCH population
NPM 4: A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Provide education to maternal health clients on the benefits and methods of breastfeeding. Ensure maternal health nursing

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

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

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

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

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

MCAH Systems Coordination

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

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

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

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

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

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

Dental Delivery Structure of the MCAH Population

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

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

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

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

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

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

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

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

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

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

Access to services, pediatric specialty providers, and care coordination
NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

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

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

DCCH is continuing with existing initiatives and implementing new strategies to address needs for youth ages 12 - 21 years who are in the process of transitioning to adulthood and adult health care. A 3-pronged approach ensures that goals are met: 1) Continuing direct services to YSHCN (youth with special health care needs) and families; 2) Providing up-to-date transition-to-adulthood resources for youth and families; 3) Creating and implementing transition-to-adulthood resources that directly address issues for YSHCN from underrepresented backgrounds.

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

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

Family centered services

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

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

Established partnerships

Title XIX

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

Early ACCESS

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

1st Five Healthy Mental Development

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

Mobile Regional Child Health Specialty Clinics

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

The Regional Autism Assistance Program (RAP)

The Iowa Department of Education (DE) has contracted with DCCH for over 30 years to support the statewide Regional Autism Assistance Program (RAP). RAP aligns with authorizing legislation, Iowa Code 256.35, to "coordinate educational, medical, and other human services for persons with autism, their parents, and providers of services to persons with

autism.” DCCH combines Title V resources with support from DE and IDPH to provide a comprehensive System of Care for children and youth with Autism Spectrum Disorder (ASD) and their families.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

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

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

III.A.3. MCH Success Story

Statewide Policy Change began as an Iowa Family Leadership Training Institute Community Service Project

While parents and caregivers of CYSHCN have significant life experience, they may need to build skills that will help them partner with professionals at all levels. Family leadership training increases the capacity of caregivers to communicate better with providers, work with community partners, and make health care systems more family-centered and culturally-responsive. The Iowa Family Leadership Training Institute (IFLTI) receives foundational support through the Title V Block grant, and is family-led by CHSC Family-Partnership staff. IFLTI provides training to Iowa parents and primary caregivers of children and youth with special health care needs to develop their leadership skills and become strong advocates. Through four-sessions, in-person training teaches participants: 1) how to work with partners, 2) individual paths to leadership, 3) strategies for advocacy, and 4) how to impact communities and systems. Participants work individually with seasoned family leadership mentors to create Community Service Projects, encouraging growth in leadership and providing real-world experience.

In 2021, one 2019 IFLTI graduate saw her hard work and advocacy succeed. This mother of a child with a number of health and developmental challenges recognized the need for changing stations that would accommodate older children, teens, and adults in public restroom facilities. For her IFLTI Community Service Project, she worked with her state legislator to introduce a bill that would require changing tables that can accommodate larger children, teens, and adults to be installed in all of Iowa's Interstate Rest Areas. The bill, co-authored by the IFLTI graduate, was introduced during the 2020 and the 2021 legislative session, and made it through committee in 2021, but never made it to the floor. However, due to the advocacy from the mother and her Changing Spaces Iowa organization, along with the assistance of the bill's sponsor, the Iowa Department of Transportation (IDOT) voluntarily added provisions for larger changing tables into their budget. IDOT plans to add this feature to all new rest areas going forward, as well as retrofitting all of the modern style rest areas over the next four years.

This project also laid the groundwork for a Community Service Project for a 2021 IFLTI graduate who used the Changing Spaces message for an awareness raising campaign. This advocacy led to a request from the US Department of Transportation (USDOT) to provide input into efforts to prioritize equity at the DOT.

IFLTI provides mentorship through seasoned family leaders for all program participants throughout and after the IFLTI sessions. Foundational support for IFLTI through the Iowa Title V program helped build capacity for family-led advocacy for the benefit of all families of CYSHCN with a need for family-friendly changing spaces who travel through Iowa, and even has the potential to lead to changes at the federal level.

III.B. Overview of the State

Principal Demographics and Geography of Iowa

Iowa is a rural state with approximately 3.2 million people according to the United States Census Bureau. Iowa typically has had a healthy economy with an unemployment rate of 2.8% (Feb. 2020, Iowa Workforce Development), a figure significantly below the national average. The unemployment rate during the COVID-19 pandemic rose to 8% (June 2020, Iowa Workforce Development). June 2021 the unemployment rate has reduced to 4% with more Iowans reentering the labor force (July 2021, Iowa Workforce Development). While agriculture and related industries contribute significantly to Iowa's economy, other industries are pivotal as well, such as, advanced manufacturing, biosciences, insurance, and financial services. While the unemployment rate is low, 2019 data shows the percentage of Iowans living below the federal poverty level was 11.2% this is a slight increase from the 2017 data.

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

Providing access to maternity care is a challenge in rural communities. According to 2017 data from Rayburn and colleagues, the United States has a rate of 4.5 obstetricians/gynecologists per 10,000 women of reproductive age. In the same publication, Rayburn reported that there were 3.3 obstetricians/gynecologists per 10,000 women of reproductive age in Iowa. Between the years 2000 and 2020, forty community level hospitals have discontinued their maternity services. IDPH in partnership with University of Iowa-Carver College of Medicine-Office of Statewide Clinical Education Programs (OSCEP) and the University of Iowa Department of Obstetrics and Gynecology (UI) has begun to examine Iowans' access to maternity and prenatal care. Provisional results suggest that women's prenatal care access is generally preserved and a high proportion of women have obtained adequate prenatal care, based on an index of prenatal care adequacy. Of concern is a rising number of rural-residing women at risk to deliver outside of a labor and delivery unit and the high rates of maternal transfers. We will continue to monitor these trends and develop strategies to address the trends. Additionally, Iowa is one of the the most inclusive state in the US in terms of Medicaid income eligibility for pregnant women and infants (up to 375% FPL). However, undocumented women rely on Emergency Medicaid for Non-Qualified Immigrants for delivery when their presumptive eligibility expires.

Overall, Iowa children are in good health. According to the Iowa Children's Health Care Report Card from Georgetown University, 2.9% of children under the age of 19 were uninsured in 2019. This rate places Iowa in 7th in the nation for lowest rates of uninsured children. According to the US Census Bureau, the 2019 estimates show 6.2% of Iowa's total population is under the age of five. In 2018, the percent of families with related children under 18 years old living below the poverty level was 11.2%. According to the 2016 National Survey of Children's Health, it is estimated that 128,000 Iowa children and youth have, or are at risk of having, a special health care need. Access to pediatric specialty health care services remains a challenge for children and youth with special health care needs and their families, especially in rural areas.

The state is 90.6% White (American Community Survey, 2019); however, racial and cultural diversity is increasing. The Hispanic population increased from 2.8% in 2000 to 6.3% in 2019. Live births to Hispanic women made up 3,877 which is a rate of 19.5 of all births (2019 Vital Statistics of Iowa). Other key demographic data that paint the picture of Iowa includes 31.7% of families are single parent families. In 2019, the percentage of children in families where the head of household lacks a high school diploma was 7 percent; this is better than the 2010 rate of 9 percent.

Iowa's MCAH Population

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

Women/Maternal/Prenatal/Infant Health:

In FFY20, 23 local maternal health agencies provided maternal health services to approximately 4,493 low-income pregnant women. A wide range of health education and support services are available to low-income pregnant women, such as risk assessment, psychosocial screening, oral health screening, delivery planning and presumptive eligibility. The maternal health agencies also provide care coordination to promote early entry into care.

Women/Maternal Health Agency Service Areas*:

Child and Adolescent Health:

In FFY20, 23 local child health (CH) agencies provided child health services to approximately 94,276 children, ages 0 to 22 years. Through dental care coordination services, the child health programs help families access dental education and referral through Iowa's I-Smile™ program. CH agencies may also provide gap filling services, such as immunizations; developmental, nutrition and psychosocial screenings; and laboratory tests including blood lead testing. Child health agencies also provide informing and care coordination services for the Medicaid population.

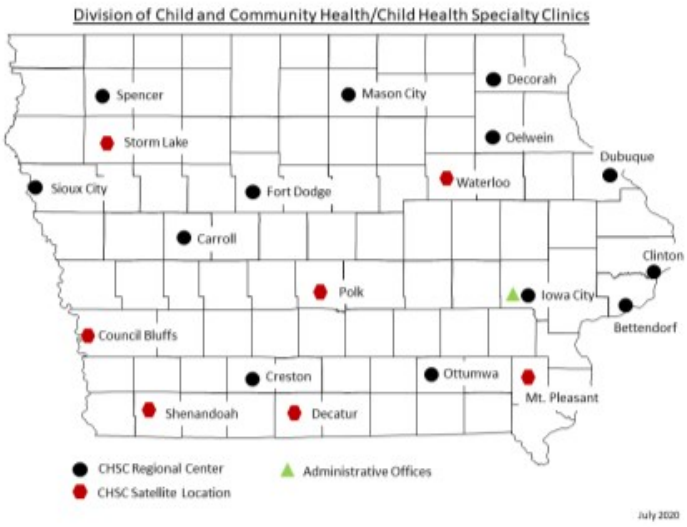
Child and Adolescent Health Agency Service Areas*:

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

Children and Youth with Special Health Care Needs:

The University of Iowa Division of Child and Community Health (DCCH) administers Iowa's Title V program for Children and Youth with Special Health Care Needs (CYSHCN), overseeing systems building, enabling, and direct services. DCCH has administrative offices in Iowa City, a network of 13 Child Health Specialty Clinics (CHSC) Regional Centers, and 7 satellite locations across Iowa, employing nearly 100 public health professionals, clinical providers, and Family Navigators. DCCH provides direct clinical care (in-person and via telehealth), care coordination, and family-to-family support to CYSHCN ages 0-21 and their families. In FFY20, DCCH provided services and supports to over 6,500 Iowa CYSHCN and their families.

DCCH Regional Center Locations:



DCCH's vision is to ensure a systems-oriented approach to care for Iowa's children and youth with special health care needs and their families, and is guided by the Standards for Systems of Care for CYSHCN 2.0. The mission is to improve the health, development, and well-being of children and youth with special health care needs in

partnership with families, service providers, communities, and policymakers. The current priorities for Iowa's CYSHCN program are Access to Care, Transition to Adulthood, and Family Support. In addition to administering the MCH Title V program for CYSHCN, DCCH provides services and supports to Iowa CYSHCN and their families through a number of programs including the Pediatric Integrated Health Home program, the Community Circle of Care, the Iowa Regional Autism Assistance Program, the Iowa Pediatric Mental Health Care Collaborative, and Iowa's Early Intervention program-- Early ACCESS.

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

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

Iowa has seven Home and Community Based Services (HCBS) Waivers that provide funding for services and supports so that people who would otherwise require care in a medical institution can live in their own homes and communities. Five of these waivers apply to Iowa CYSHCN: The Health and Disability Waiver, the Intellectual Disability Waiver, the Brain Injury Waiver, the Physical Disability Waiver, and the Children's Mental Health Waiver. Waivers for CYSHCN currently cover about 16,500 children. Nearly 6,000 children are on waitlists for waiver programs. DCCH also provides consultation, technical assistance, planning, and care coordination for approximately 600 individuals under the age of 21, with complex and special health care needs who are applying for the Health and Disability (HD) Waiver, are on the waiting list for the HD Waiver, or currently enrolled with the HD Waiver.

Medicaid In Iowa

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

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

- Amerigroup Iowa, Inc.
- Iowa Total Care

IDPH has had a collaborative relationship with the Iowa Department of Human Services – Iowa Medicaid Enterprise (IME) – for more than 30 years. Medicaid's work with the Title V Maternal and Child & Adolescent Health program began with a systems change initiative to decrease barriers and assure that pregnant women and children have access to services to which they were entitled. The relationship offered a comprehensive system of care that

included outreach, informing of newly eligible families of EPSDT services, and care coordination services. Although linkage with established medical and dental homes is a program priority, local Title V contract agencies are also able to bill Medicaid for direct care maternal and EPSDT services through specific provider packages established by Iowa Medicaid. Title V agencies provide EPSDT gap-filling services under Iowa Medicaid's Screening Center provider status, and Title V agencies provide Maternal Health gap-filling services under Medicaid's Maternal Health Center provider status.

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

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

Iowa Health and Wellness Plan

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

Data Integration

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

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

IDPH implemented a system to document screening, further testing, and follow-up/referrals for newborn screening programs. The system name is Iowa Newborn Screening Information System (INSIS). IDPH contracts with Optimization Zorn (OZ Systems, Inc.) for its web-based surveillance software system, eScreener Plus (eSP™). The data system was built to integrate three newborn screening databases (Early Hearing Detection and Intervention [EHDI], Dried Bloodspot [DBS] and Critical Congenital Heart Disease [CCHD]) into one system. INSIS hearing

screening and CCHD modules went live in June 2016. The blood spot screening module is scheduled to go live in 2022; implementation is delayed due to the State Hygienic Laboratory switching to a new data system.

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

As an entity of the University of Iowa Health Care System, DCCH integrates data through the Epic electronic health record (EHR). This allows families and health care providers to access information and allows for timely communication. DCCH has been involved in adapting the EHR to accommodate Title V priorities. For example buttons and pull down menus have been created that allow practitioners to review and document family goals, the transition to adulthood checklist, and care plan templates. Through the EHR, DCCH is able to extract data for measuring progress toward block grant strategies. Families are able to access their child's health information through MyChart software that is part of the Epic EHR. An additional feature of this integrated data system is that community-based primary care providers/medical home have web-based access to their patients' records through the Epic application CareLink. CareLink provides complete access to clinical data, care plans, and medical and community referrals.

Public Health Accreditation Board

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

Strengths and Challenges Impacting the MCH Population

Challenges

Rural

The rural nature of Iowa presents unique challenges for clients to access services throughout the state. Local Title V MCAH agencies work to ensure needed health services are provided in the rural counties. This is accomplished through building partnerships with health providers and community resources. Likewise, DCCH provides services for families of CYSHCN in many rural areas. In 2019, the Iowa Legislature eliminated the Rural Health and Primary Care Advisory Committee. BFH staff is currently exploring other ways to ensure involvement of rural populations in the development and implementation of Title V activities in all 99 counties.

An initiative in Iowa to incentivize providers to practice in underserved areas is the Primary Care Recruitment and

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

Medicaid

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

- Shifting MCO enrollment for individuals has caused difficulties when serving clients. Initially in April 2016, there were three MCOs established – AmeriHealth Caritas, Amerigroup, and UnitedHealthcare. As of November 30, 2017, AmeriHealth Caritas withdrew from Iowa. This resulted in these clients shifting either to Iowa Medicaid (fee-for-service) or UnitedHealthcare. Several months later, once Amerigroup was able to handle greater capacity, some of the clients were shifted to Amerigroup. In March 2019, it was announced that UnitedHealthcare would be leaving the state on June 30, 2019; and on July 1, 2019, a new MCO (Centene's Iowa Total Care) began coverage of services. As a result, effective July 1, 2019 Iowa had two Medicaid MCOs in the state -- Amerigroup and Iowa Total Care. This series of changes in MCO providers has caused significant challenges for both Medicaid members and providers. Title V agencies work to stay abreast of the changes and assist clients in understanding the shifts in MCO assignment.
- Numerous challenges related to payment of certain services allowed under Maternal Health Center and Screening Center provider types have occurred, including inconsistencies in payment and denials of payment. Policies established for payment may vary from one MCO to another. Reasons provided for non-payment may include 'lack of medical necessity,' declaring some services are an 'add on code' requiring another primary procedure, third party liability, stating services are 'not covered,' and limitations on the number of services -- all that did not formerly exist. Bureau of Family Health staff continue to work with Iowa Medicaid staff to try to resolve difficulties as they arise.
- Fiscal challenges have created a burden in working with the MCOs. Submitting claims among multiple MCO providers who have differing processes is not a small undertaking. Handling claim resubmissions, denials, and appeals has taken significantly greater staff time and therefore cost. In addition, tracking payments and recoupments to assure fiscal accountability is not always straight-forward. In some cases, payments are made and subsequently recouped at a later date and at times from a completely different provider type.

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

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

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

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

Strengths

Health Insurance Coverage

In 2019 it was reported that 97.1% of children, 19 years and under, in Iowa had some form of medical insurance. It is estimated that 96.2% of all uninsured eligible children participate in Medicaid or Hawki. Since 2010, children eligible for Hawki and Medicaid have been able to obtain immediate, temporary Medicaid coverage through the Presumptive Eligibility for Children program. All Title V agencies are able to assist families in applying for Medicaid and presumptive eligibility. Iowa's Hawki program also has a dental-only option to increase access to oral health services for families that have medical coverage but lack dental coverage.

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

Maternal Mortality Enhancement

Iowa is working towards significant improvements to the maternal mortality review process. Beginning in 2020, Iowa began to develop a multidisciplinary Maternal Mortality Review Committee (MMRC); previously Iowa's MMRC only included physicians. IDPH will identify pregnancy-associated deaths within one year of the death and abstract available data to support multidisciplinary review of each death. The comprehensive de-identified information about all deaths related to pregnancy will be entered into a standard data system [Maternal Mortality Review Information Application (MMRIA)]. Annual reviews of the maternal deaths will be done and summaries of the committee decisions will also be entered into MMRIA within 2 years of the maternal death. Previously our MMRC only reviewed maternal deaths once every three years. All de-identified data entered into MMRIA will be shared with the Center for Disease Control (CDC). Quality assurance processes, in partnership with CDC, will be used for improving data quality, completeness, and timeliness. IDPH and the CDC will analyze data and share findings with a broad range of stakeholders to inform policy and prevention strategies to reduce maternal deaths. To accomplish this work, 0.5 FTE for an RN to do data abstraction and oversee the review of maternal deaths was created. Job responsibilities also include oversight of Iowa's Regionalized System of Perinatal Care.

In 2019, Iowa's MMRC found that 18% of Iowa maternal deaths were the result of motor vehicle accidents in the last three years; 71% of the women were not wearing a seatbelt and frequently were ejected from the vehicle. Deaths to these young women occurred during pregnancy and the postpartum period. Iowa's Title V program, in partnership

with the newly formed IMQCC, the Governor's Traffic Safety Bureau, the Iowa Department of Transportation- Zero Fatalities, and Safe Kids Iowa at Blank Children's Hospital, is developing a social media campaign on seatbelt use during pregnancy. For more information on safe seat belt use during pregnancy go to the following link: https://www.nhtsa.gov/sites/nhtsa.dot.gov/files/documents/pregnant-seat-belt-use.pdf

The Iowa Maternal Quality Care Collaborative (IMQCC) was developed through the HRSA Maternal Health Innovation grant that was received by IDPH in 2019. The IMQCC's first quality improvement project was to implement statewide the Association of Women's Health Obstetrical and Neonatal Nurse's (AWHONN) POST-BIRTH Warning Signs program. This was based on data from our Maternal Mortality Review Committee report that showed 56% of Iowa pregnancy associated death occurred postpartum. The strategies in the program focuses on a standard approach to empower postpartum parents to recognize and act on warning signs of potential life threatening postpartum emergencies. The goal of the education is to prevent pregnancy complications and death that can occur during pregnancy and postpartum. Iowa would like healthcare providers to communicate with patients about warning signs, and use tools to help patients and families identify warning signs early to ensure women can receive timely treatment. It is important for women and their families to communicate their pregnancy history any time care is received in the year after their pregnancy has ended and to know when and who to call for help. Iowa will use AWHONN's POST- BIRTH warning signs to postpartum women in Iowa's Birthing Hospitals and by education provided by Title V Maternal Health nurses in local communities. For more information on AWHONN's POST-BIRTH warning signs go to https://awhonn.org/education/hospital-products/post-birth-warning-signs-education-program/

Iowa has received a grant from the CDC titled Preventing Iowa Maternal Deaths: Maternal Mortality Review Committee. This is a three (3) year award which starts October 1, 2021. This grant will support the work of the Maternal Mortality Review Committee and staffing responsibilities of IDPH.

I-Smile

The I-Smile program began in December 2006 when child health contractors began to receive funding to administer the program in their communities. Each contractor is required to maintain a dental hygienist as I-Smile coordinator, responsible for strategies that include: developing local partnerships to increase awareness about oral health; working with dental offices to encourage acceptance of referrals of underserved families needing dental care; promoting oral health through participation in community events and presentations at meetings; training medical providers how to apply fluoride and do oral screenings to build the safety net; and assuring care coordination and gap-filling preventive services (e.g., fluoride applications) are provided for at-risk families.

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

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

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

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

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

Division of Child and Community Health Strategic Plan and Title V's role

The DCCH program at the University of Iowa implemented a revised strategic plan in 2017, and this was updated in 2021. Funding through the Title V program serves as foundational support for all activities that take place within DCCH. The DCCH strategic plan includes the following goals:

- Care Coordination and Clinical Services
    - Title V funding supports the regional center structure and allows resources to be combined so services can be provided through a community-based approach, even in the most rural areas of the state.
- Family Professional Partnerships
    - Title V funding is combined with other state and federal funding sources to build a robust system of family-centered care and shared decision making at all levels.
- Advocacy and Policy
    - Strengthened by the designation as Iowa's Title V program for CYSHCN, DCCH provides a leadership role in pediatric advocacy and policy efforts and the local, state, and national levels to better support children and youth with special health care needs.
- Health Equity
    - The promotion of health equity and honoring diversity among Iowa children and youth with special health care needs and their families is a primary goal in DCCH's strategic plan. Leadership support is funded through the Title V CYSHCN program.

Other State Statutes and Regulations that Impact Title V Programs:

Iowa Administrative Code Chapter 641.76 Summary

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

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

Other sections of Iowa Code that impact Title V:

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

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

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Ongoing needs assessment activities

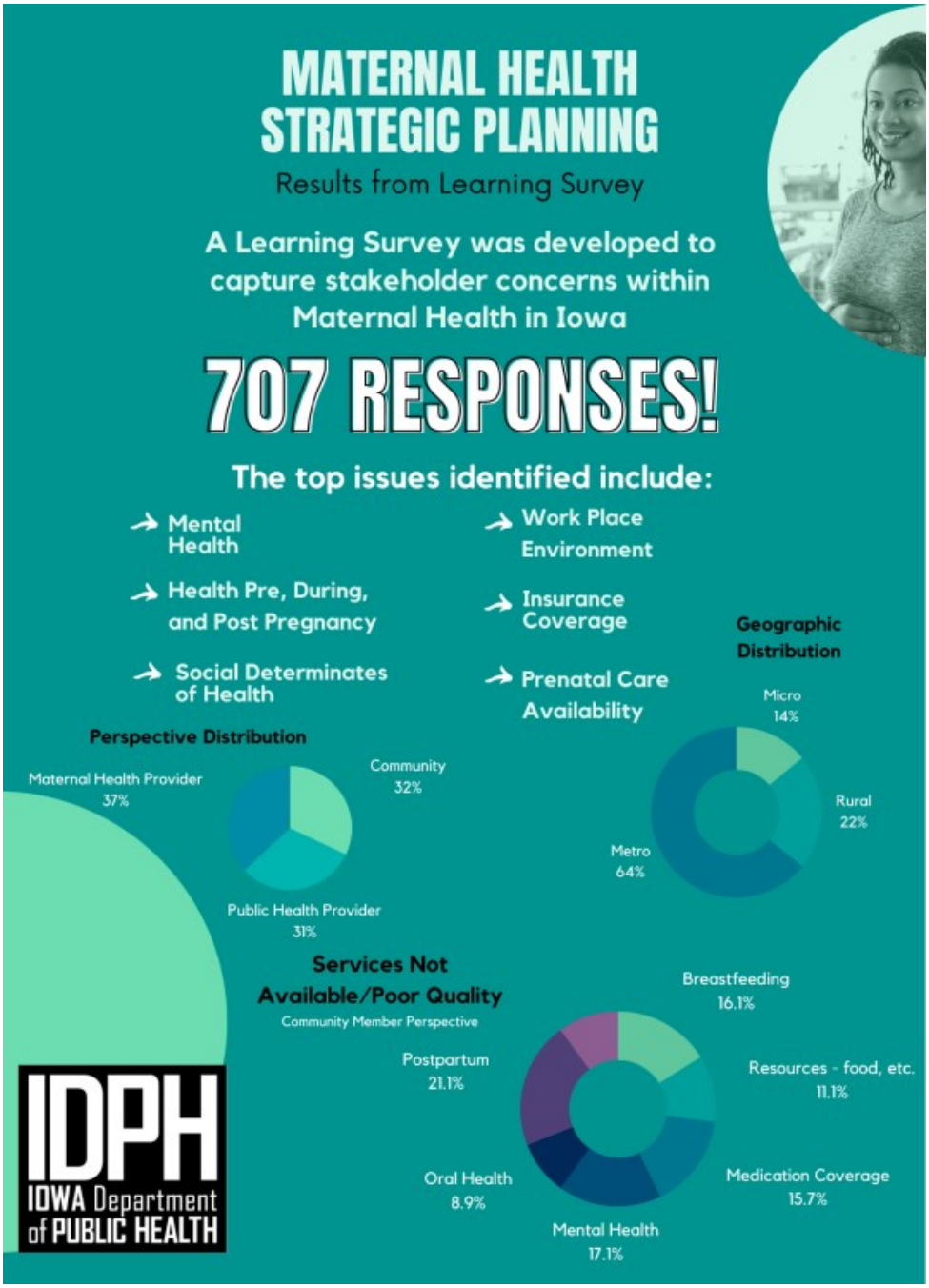
Iowa's Title V program continues to evaluate programs and processes, and strives to include family input into all activities, including the assessment of needs and priorities. Iowa's Title V Family Delegate was a core member of the Needs Assessment team. The Title V plans and Needs Assessment process are presented for feedback from the Maternal, Child, and Adolescent Health Advisory Council (MCAH Advisory Council) which includes multiple youth and family representatives. Additionally, the DCCH Family and Professional Partnership Program Manager is intentional about providing regular feedback and ensuring that the strategic plans for the Family Partnership program and the Title V CYSHCN program are aligned with the needs articulated by Iowa families. The Family Advisory Council (FAC) provides review of the Title V Block Grant initiatives and members of DCCH and FAC leadership are developing plans to strengthen their role in advising all DCCH programs.

This year the Maternal Health Program undertook a strategic planning process utilizing a Learning Survey and focus group methodologies. Below are infographics with the process and selected results.

Learning Survey:

The purpose of the learning survey was to capture feedback from individual perspectives with regard to strengths, challenges and areas of focus you believe are critical regarding the state's maternal health needs. Utilized Survey Monkey, an electronic survey consisting of ten (10) questions and was shared broadly using multiple forms of communication.

The goal of the survey was to reach first and foremost individual perspectives, providers, staff of community based organizations, other community programs, engaged stakeholders, and associations across the state. The survey was open for eleven (11) days with a reminder sent on the seventh day it was available. Below is an infographic depicting the results of the survey.



A full report detailing the Learning Survey and the Focus Groups is in development with the Maternal Health team and the contractor selected to assist with this project.

The National Survey of Children's Health is an ongoing source of population-based, family-reported data for Iowa's Title V CYSHCN program. Noticeable differences were not observed between the 2016-2017 data set and the 2018-2019 data set. Small numbers in the CYSHCN category may have limited Iowa's ability to observe meaningful changes in these data.

A newly reinstated family survey is part of the annual process for many DCCH programs. The Youth Services Survey for Families is a questionnaire that includes 26 questions with a 5-level Likert-type response scale ranging from 'Strongly Agree' to Strongly Disagree.' Respondents were also given the option 'Does not apply.' The items in the

questionnaire are grouped into 6 domains: Access, Participation in Treatment, Cultural Sensitivity, Satisfaction, Outcomes, and Social Connectedness. Domains contain between 2 and 6 questions, combined into a Mean score. Additional questions were added to cover basic demographic information: Gender, age-category, and race/ethnicity. Additionally, there were 3 open-ended questions, asking 1) What has been the most helpful thing about the services you and your child received as a result of DCCH Family Navigation; 2) What would improve the services for families who need family navigation support; and 3) Any other comments. The needs assessment update for next year will provide comparative data, allowing a more thorough assessment of needs.

In the spring of 2021, the Youth Services Survey for Families (YSS-F) was administered to parents of a sample of children who received direct services from the Iowa Title V CYSHCN program in calendar year 2020. These data were primarily intended to provide baseline data. These baseline results will be incorporated into programmatic decisions and will be tracked over time to monitor overall family perceptions of DCCH services and gain a stronger understanding of service and support needs for families.

The survey elicited valid responses from 150 families who received direct services from DCCH (response rate: 9%). Overall results are shown in the table below. The overall mean score was 4.3 on a 5-point scale, and 90% of families reported positive results overall. The distribution of respondents by race and ethnicity did not allow us to evaluate any specific non-White or Hispanic/Latino populations separately. There is some indication of disparities between respondents from Hispanic or non-White backgrounds when compared with White non-Hispanic respondents. DCCH is currently investigating methods for increasing overall response rates. A process is currently underway to develop appropriate assessment activities that will provide insight into experiences with our services for a wider range of racial and ethnic populations.

Table: Youth Services Survey for Families results for 2021 DCCH, weighted by program

	Spring 2021 (N=150)	
Domain	Mean (5-point scale)	% Positive (mean domain score is over 3.5)
Access	4.4	89%
Participation in treatment	4.4	88%
Cultural Sensitivity	4.7	98%
Satisfaction	4.4	87%
Outcomes	3.8	76%
Overall (above domains)	4.3	90%
Social Connectedness	4.4	90%

As part of the University of Iowa Health Care (UIHC) system, clinical health care services are provided through DCCH's Child Health Specialty Clinics Regional Centers. For health care direct services, UIHC's Office of the Patient Experience uses Press Ganey systems to measure family perceptions of care through DCCH. Press Ganey covers a number of areas of patient satisfaction. One area of particular interest to UIHC is the "Likelihood of Recommending" score, or how likely the family is to recommend the service to friends or family who are facing a similar health concern. DCCH has consistently ranked above the 90th percentile over the past 6 quarters for this score.

The CYSHCN program has an established relationship with the University of Iowa College of Public Health and frequently provides mentorship to students during practicum (MPH) experiences and experiential internships (Undergraduate). These learning opportunities provide additional resources for DCCH to assess the needs of CYSHCN and families while helping to build the future MCH workforce. Students have worked with the CYSHCN program recently to evaluate food insecurity (Public Health Quantitative Methods student), study telehealth access and policy (Public Health Policy student), and identify gaps and areas of opportunity in services based on racial and ethnic demographic data (Public Health undergraduate experience). The Family Advisory Council provided guidance in order to receive family input for student projects.

The food insecurity data analysis project was completed by an MPH Quantitative Methods student in the spring of 2020. Using the National Survey of Children's Health data from 2016-2018 for Region 7 (Iowa, Kansas, Missouri, and Nebraska), the project revealed that after controlling for a number of factors, children with medical complexity had 1.5 times greater odds of living in a household with food insecurity. A 10 minute video summarizing this project can be found here: Food Insecurity Among Iowa Children and Youth with Special Health Care Needs - YouTube (https://www.youtube.com/watch?v=TfLOzyBmy2g). As a result of this work, staff were encouraged to screen all families of CYSHCN receiving services, refer them to supplemental food programs when appropriate, and advocate for supplemental food programs for families of CYSHCN. This project was shared as part of the MCHB Region VII AMCHP Quarterly call on July 14, 2020.

Changes in health status and need

The top priority needs for Iowa's Title V program were identified in the 2020 needs assessment as:

- Infusing Health Equity in the Title V System
- Access to care for the MCH population
- Maternal, Child, and Adolescent Health systems coordination
- Dental Delivery Structure
- Safe and Healthy Environments
- Access to community-based services and supports, pediatric specialty providers, and coordination of care
- Access to support for making necessary transitions to adulthood
- Support for parenting CYSHCN with mental health or complex health needs.

COVID-19 exacerbated the need to address all of these priority areas, especially access and parent support. Iowa's Title V program including CYSHCN continued to provide support in all of these areas, including expanded access to in-home telehealth direct services and supports for families. For a large portion of 2020, many Title V local and state program staff provided this care while working from home, or in reduced density work environments.

Due to the COVID-19 pandemic, circumstances were difficult for almost everyone nationally (and worldwide) in 2020. Challenges for Iowa families including those with CYSHCN included difficulty accessing childcare, respite care, direct services staff, and even school. Many families of CYSHCN were concerned that their children may have been especially vulnerable to long term health effects or even death from COVID-19. Although Iowa Title V did not systematically collect data about the difficulties experienced by families, staff and agencies across the state such as the Iowa Developmental Disabilities Council and Maternal Infant Early Childhood Home Visitation indicated that it was difficult for many families to access direct care staff. This included nursing staff and respite care despite the ongoing needs of their children including those with medical complexity. Other feedback indicated that it was hard for families that well-child visits, screenings, evaluations, and therapies were either on hold or stopped and others weren't comfortable with telehealth options.

Families of children with developmental disabilities worried about regressions without in-person school and therapy. For families with CYSHCN who are less severely affected and therefore receive fewer services at school, there were some families who found home or online school less stressful since some children have more stressors that impact behavior at school.

Temporary changes to insurance coverage due to the pandemic benefitted many families. Having insurance cover the telehealth mode of delivery enabled greater access to careand would have a lasting impact if it continued. For Autism Spectrum Disorder (ASD) specifically, telehealth coverage of Applied Behavioral Analysis (ABA) has been an ongoing discussion with Managed Care Organizations. In previous years, ABA had been covered by Medicaid and that changed, so having this period where it was again covered by Medicaid and other insurers was beneficial to families who may not have otherwise had access to that therapy. The same is true for the ASD evaluations that happened via telehealth as a benefit to rural families. There were educational opportunities offered to providers to help make this a viable option.

Phones for Families

The impacts of the COVID-19 pandemic has been vast, with families who are already more vulnerable due to low-income or family risk status, such as those served by Maternal, Infant, and Early Childhood Home Visiting (MIECHV) and other state-funded family support programs, disproportionately impacted by loss of income, mental health inequality, higher exposure to health risks, and higher rates of COVID19 infection and death. In addition to the health

and economic risks, requirements for social isolation to curb COVID-19 transmission created substantial barriers to the provision of family support services. In response to these outcomes, the Iowa Department of Public Health, with support from the Association of Maternal & Child Health Programs, implemented the Phones for Families program to try to help address social isolation and continue provision of services virtually by providing loaner smartphones to families during the pandemic.

Title V staff partnered with MIECHV staff who had developed and implemented the Phones for Families program. In April 2020, IDPH announced the Phones for Families program and 216 phones had been purchased for distribution to families by mid-May 2020. The purpose of these phones was to facilitate virtual visits between family support programs and group parent education programs while in-person visits and groups were suspended due to COVID-19. Eligible families needed to be enrolled in either a family support program or group parent education program in the state of Iowa, including federal (MIECHV) and state funded programs. Directors from eligible programs were asked to complete a survey indicating the number of families they had currently enrolled in programming that did not have a cell phone or device to participate in virtual visits/groups. Survey results were compiled and IDPH worked with US Cellular to ship the phones directly to the programs which then organized distribution to families. IDPH partnered with Lutheran Services of Iowa (LSI) for procurement and distribution of the phones as well as management of the phones (handling damaged devices, movement of phones between programs that needed them, managing phone contract with US Cellular).

Additional phones were procured through a maternal child health grant provided by AMCHP. Phones were mailed to “partner organizations” and flyers were sent to programs that requested phones in early February 2021. A total of 265 additional phones were ordered for a total contract of 6 months. Once the initial 6 months expire the phones will be disconnected. These phones expanded access to families beyond home visiting programs, and were available to programs that provided the following services: Early Intervention, Maternal Child Health programs, Child Health Specialty Clinics (CHSC), Early Hearing Detection, and Newborn Screening. Family support programs and group parent education programs were also included in this phase of phone distribution. Fewer phones than expected were needed by Area Education Agencies (AEA) for Early Intervention programs and CHSC families, so AMCHP availability was expanded to include families receiving services from Women, Infants and Children (WIC) and state supported lactation consultations.

An evaluation was conducted by a collaborative group which was led by Iowa’s Integrated Data System for Decision-Making (i2d2). This is Iowa’s integrated early childhood data system which has been an ongoing project through Early Childhood Iowa. IDPH has been heavily involved in the development and governance of the system.

The goal of the current evaluation was to assess the utility and impact of the Phones for Families program. Clients were asked about their usage of the phone, its impact on their receipt of family support services, and their feedback on virtual home visits. Family support providers were asked how the phones have helped their clients, their job satisfaction with virtual visits, and how provision of services was impacted throughout the pandemic.

Surveys were administered via text message to 162 families who had an active phone number through the Phones for Families program at the time of the survey, with a response rate of 21% (33 mostly completed surveys). Providers received surveys via the family support email distribution list. The provider results include 30 completed responses from providers who had at least 1 family participating in the Phones for Families program. Families were overwhelmingly positive regarding the Phones for Families program with 78% of respondents saying they were “very satisfied” and none saying they were at all dissatisfied. Over 80% of families and providers responded that they would prefer a combination of virtual and in-person visits going forward, though slightly more families would prefer all in-person compared to providers (11% vs. 10%). Providers noted somewhat less job satisfaction overall since the pandemic began (mean of -0.59 on a -5 to 5 scale), though 28% indicated higher job satisfaction and 70% responded that the quality of their home visits had increased with the addition of virtual options. Finally, providers reported about the same or more visit cancellations overall with 30% saying they had fewer cancellations. Open text responses indicated mixed responses on cancellations though a few noted it was easier to reschedule when necessary. Findings from this evaluation are being shared with executive leadership and program staff to help inform future home visiting practice with the possibility of implementing virtual home visiting and overcoming service barriers. Areas of opportunity for the advancement of the practice include training for virtual coaching skills and technical support.

Changes in capacity and MCH systems of care

The Iowa legislature had an active session in 2020-21 with a number of provisions that could have an impact on access to essential services for the priority populations. These provisions included additional funding to the

Medicaid budget in order to increase provider rates for Home and Community Based Services (HCBS); increasing reimbursement for Home Health providers; providing more funding for Psychiatric Medical Institutions for Children (PMIC) reimbursement; additional funding to reduce or eliminate the Children's Mental Health (CMH) Waiver waiting list (currently over 1100 children are waitlisted for the CMH waiver); and ensuring that administrative rules for pediatric health services for Medicaid-eligible children are consistent with EPSDT requirements, including occupational therapy, physical therapy, speech language pathology, and applied behavior analysis. Additionally, there is now parity for reimbursement for mental health services delivered via telehealth and in-person.

Breadth of Partnerships with other entities that serve the MCH population

Iowa's Title V program works extensively with organizations such as the Iowa Departments of Management, Education, and Humans Services. Coordination of services and ensuring Iowa's most vulnerable families are receiving the needed services to succeed has been a cornerstone of these collaborations. The MCH program, including CYSHCN, has strong linkages within IDPH Bureaus of Immunizations, Oral and Health Delivery Systems, Chronic Disease Prevention and Management, as well as Vital Records & Health Statistics, and Substance Abuse Prevention and Treatment programs. IDPH's Office of Disability, Injury & Violence Prevention supports state and local efforts to improve services for victims of domestic and sexual violence. IDPH and DCCH appreciate many public-private partnerships with organizations such as Delta Dental of Iowa Foundation, the Iowa AAP, ChildServe, Blank Children's Hospital, the Iowa Primary Care Association, the National Alliance on Mental Illness Iowa Chapter, Common Good Iowa (formerly known as the Child and Family Policy Center), ASK Resource (Family Voices affiliate), the Autism Society of Iowa, Blank Children's Hospital, and a number of other health care providers and systems. Opportunities range from funding for school-based dental sealant programs, participation on health advisory councils, and evaluating program data.

The CYSHCN section of Title V also works with the Iowa Developmental Disabilities Council (DD Council) and is co-located and meets regularly with the University Center for Development and Disability (UCEDD), and the Iowa Leadership Education in Neurodevelopmental and Related Disabilities Project (LEND) programs. The Iowa Title V CYSHCN program has active collaborations within the University of Iowa Department of Pediatrics, including the Division of Developmental and Behavioral Pediatrics and the Division of General Pediatrics. Other University of Iowa programs that Title V actively collaborates with include the Departments of Psychiatry and Family Medicine, and the College of Public Health.

Operationalizing the 2020 Needs Assessment

BFH is currently in the process of developing the FFY2023 RFP. The Title V Block Grant State Action Plans directly effect and dictate the development of requirements and activities outlined in the funding opportunity. Staff continue to use and update the 2020 Needs Assessment to ensure the needs of Iowa's population are continuing to be met and continue to reduce barriers faced by families.

In order to further operationalize the Needs Assessment state Title V staff are planning to convene the Maternal and Child Health Advisory Council and the Health Equity Advisory Committee in joint planning meetings to there are multiple aspects shared (professional and personal). IDPH will host facilitated conversations with the two advisory groups in order to help with development and feedback on Title V activities. Staff are working with the IDPH Quality Improvement Coordinator to develop the process and conduct the facilitation.

The facilitations will be conducted based on population domains outlined as the priority populations within the Title V federal guidance. Individuals on the advisory groups will self-select the population domain where their expertise lies. Members are able to attend multiple conversations if they desire. The facilitators have been selected and are either outside of the Title V program or are closely related. Population domain lead staff will attend their respective conversation to serve as subject matter experts. In having the population domain staff as a resource rather than participants or facilitators is intentional to put the participants mind at ease that there are not right or wrong answers when it comes to providing feedback or developing new plans to better serve women, children, and their families.

The updated DCCH strategic plan aligns the needs of CYSHCN and families and the work that is carried out by DCCH. Small work groups that include family representation create activities associated with each strategy that will be carried out in the following years. Additionally, priority areas are used to advocate with other organizations with shared goals. For example, the team lead for DCCH's Transition efforts participated in a grant development and writing process with the Iowa UCEDD and the Department of Psychiatry.

Changes in organizational leadership

Iowa's Title V MCH program has not experienced any organizational leadership changes in the past year. While there haven't been changes, the IDPH Interim Director Kelly Garcia has a strong interest in Iowa's Maternal Health Program and its connection to The Department of Human Services programs. The Title V Director and HPCDP Division Director have been involved in systems level discussions related to the development of a statewide Maternal Health plan.

Iowa's Title V CYSHCN program experienced few changes in organizational structure and leadership during the past year. One noteworthy change is that DCCH's Program Manager for Family Engagement retired in July, 2020. The working title of the position was changed to Program Manager for Family and Professional Partnership, and a new staff member was hired for this position. A requirement of this position is that the person hired must have experience as a caregiver of a CYSHCN. The new program manager has significant managerial experience and is currently focusing on strategic planning and leadership for the DCCH Family Navigator Network to provide high quality and consistent services for families.

Another recent change is that the DCCH Director of Policy and Advocacy was recently asked to concurrently serve as a primary advocacy liaison to the Iowa State Legislature and other governing state and federal organizations for the University of Iowa Stead Family Children's Hospital and the Stead Family Department of Pediatrics.

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

III.C.2.a. Process Description

Process

Goals, Framework, Methodology

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

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

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

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

Leadership Team

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

Health Equity Advisory Committee

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

Stakeholder Involvement

IDPH, DCCH and KU program leadership met to identify stakeholders to provide guidance and input throughout the needs assessment process. A network analysis was conducted by over 30 leaders to identify current stakeholders and needed stakeholders. After conducting the network analysis, an initial list was compiled for the overall for the identification of stakeholders for the 2021 Needs Assessment work. Leadership team then conducted a second round of consideration through a health equity lens to broaden the stakeholder base to include nontraditional partners. Stakeholders that were identified included individuals, community organizations, professional organizations, faith based groups, institutions of higher education, philanthropic organizations, advocacy groups, consumers, providers and governmental entities. Stakeholders were then analyzed and sorted into data collection activities such as focus group and key informant conversation participants and survey respondents.

Quantitative and Qualitative Methods

Data Snapshots

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

Qualitative Data Collection

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

Focus Groups and Key Informant Conversations

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

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

Participation Summary

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

Non Participant Survey

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

Stakeholder Survey

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

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

Total Participants: 487
Population Group Responses:

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

MCAH Capacity Assessment

Local Capacity

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

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

State Level Capacity

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

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

- Low Need: Another bureau or program within IDPH or state agency is addressing the issue, Title V is already a partner or could be a partner in the work, but don't see Title V as the leader in the work.
- Medium Need: There is work happening in the state, but not a clear leader. Title V could take on the leadership role, but may be better for others to.
- High Need: There is no coordination of the work in the state, or lacks clear vision of the work. Title V is positioned to be the convener/leader of the work.

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

- Low Capacity: Iowa's Title V program could not identify strategies to address the priority.
- Medium Capacity: Iowa's Title V program identified a small number or weak strategies to address the priority.

- High Capacity: There were multiple evidence-based strategies the state Title V program could identify to address the priority.

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

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

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

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

MCH Population Findings

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

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

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

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

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

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

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

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

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

Programmatic Approaches

Efforts to be Continued

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

Oral health care is integrated into Title V program activities throughout the state. Iowa's Title V funded agencies are able to provide oral health services to clients, including establishing a dental home for women.

Areas of Opportunity for New Activities

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

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

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

Infant and Perinatal Health

The areas of breastfeeding initiation and duration through 6 months of life, the importance of safe sleep environments, and access to appropriate care for infants born preterm continue to top the list of important health factors for infants in Iowa. Breastfeeding is one of the most important things a mother can do to provide lifelong health benefits to her child. Overall, women in Iowa have increased rates of ever having breastfed their infant. There have been some fluctuations, from 2011

(82.1%) to 2015 (81.5%) with a high in 2012 of (83.4%). The rates of women who breastfeed exclusively for the first 6 months of their child's life has increased greatly from 2011 (20.1%) to 2015 (29.5%). Unfortunately, women who receive Medicaid benefits report breastfeeding in the hospital at lower rates (72.6%), than women with private insurance (88%). Additionally, a racial disparity in breastfeeding rates is also present. Women who identify as Non-Hispanic Black breastfed in the hospital at a rate of 66.8% while women who identify as Non-Hispanic White, Hispanic and Non-Hispanic other breastfeed at rates of 82.8% to 83.1%.

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

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

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

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

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

Promoting a safe sleep environment was one of the highest ranked topics in the stakeholder survey in terms of priority (90%) and importance (93%). Given the number of infant deaths reported in 2016 that were due to unsafe sleep situations and the statewide and local capacity to address these issues.

Programmatic Approaches

Efforts to be Continued

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

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

Areas of Opportunity for New Activities

IDPH will work with Title V agencies across the state to implement educational efforts and create community connections to

support the health of everyone.

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

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

Child Health (CH)

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

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

- NPM 6: Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year
- SPM 2: Percent of children ages 1 and 2, with a blood lead test in the past year
- SPM 3: Percent of early care and education programs that receive child care nurse consultant services
- SPM 5: Percent of children 0-35 Months who have had fluoride varnish during a well visit with physician/health care provider

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

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

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

SPM 3, in 2019, 75% of working families with children under the age of 6 utilize child care. Iowa has over 4,200 regulated child care providers (centers, preschools and homes) with 169,945 available child care slots. Currently there are not enough child care spaces to meet the needs of working families and almost one-fourth of Iowans live in areas that have an

undersupply of regulated child care options. That number is even higher when looking for infant and toddler child care. Nationwide there has been an increase in childhood chronic health conditions and allergies. Child Care Nurse Consultants (CCNC) provide best practice guidance, assessment visits, medication administration training and care planning for children with special health needs to improve child care quality. In 2019, 37% of child care programs participated with child care nurse consultant services including 4,322 on-site child care visits completed, 6,227 technical assistance provided, 217 group trainings, and 698 children with special health needs identified, 92% with a care plan in place at the child care program.

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

Programmatic Approaches

Efforts to be Continued

Gap filling developmental testing by contractors and partnership with Iowa's 1st Five program to encourage providers to include developmental screening as part of the well visit. Provide gap filling blood lead testing by contractors. Sustain and enhance partnership between the Childhood Lead Poisoning Prevention Program and Title V at the state level. CCNC visits, technical assistance, quality improvement tools, trainings and special needs child care planning with child care providers in Iowa will also continue. Oral health care is integrated into Title V program activities throughout the state. Iowa's Title V funded agencies are able to provide oral health services to clients, including establishing a dental home for women and children. The UI College of Dentistry operates a dental clinic where dental students gain first-hand experience in working with CYSHCN, utilizing a multi-disciplinary care team approach.

Areas of Opportunity for new activities

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

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

Adolescent Health (AH)

Iowa adolescents receive well visits at a high rate relative to the national average, with 81.1% of all Iowa adolescents reporting having a preventive medical visit in the last year. However, Iowa still needs to improve the quality of the well visits and address disparities among youth covered by Medicaid. Iowa adolescents have critical mental health needs that are not always addressed, and access to mental health professionals is difficult throughout Iowa. 94% of adolescents ages 12 - 17 received a preventive dental visit in 2016-2017. About 9% of children (ages 0 - 17) in Iowa were reported to have ongoing emotional, developmental, or behavioral conditions that require treatment or counseling. This is true for about 17% of adolescents ages 12-17. Vaping continues to increase in teens in Iowa. When asked if they had done "any vaping" in the

last 12 months, 37.3% of 12th graders reported that they had, compared to only 27.8% in 2017.

Two performance measures were selected for the Adolescent population domain:

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

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

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

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

Programmatic Approaches

Efforts to be Continued

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

Areas of Opportunity for new activities

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

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

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

Children and Youth with Special Health Care Needs (CYSHCN)

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

children. Iowa's adolescent population has a higher proportion with special health care needs than nationwide.

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

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

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

In Iowa, 23.1% of CYSHCN received services necessary to transition to adult health care. When looking specifically at children with more complex health needs, it was 15.1%. Among focus group participants, many stated that they are not prepared to help their child navigate this transition. Many families interviewed stated that they predict that preparing for their child's transition to adult health care will be challenging.

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

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

Three performance measures were selected for the CYSHCN population domain:

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

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

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

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

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

Programmatic Approaches

Efforts to be Continued

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

Areas of Opportunity for new activities

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

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

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

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

Organizational Structure

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

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

Agency Capacity

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

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

MCH Workforce Development and Capacity

Iowa's Title V MCH System is implemented through a community utility model and strives to improve access to care for pregnant women, children, and families. At the state level there are a total of 11.75 FTEs directly funded by Title V. Within BFH there are 39 professional staff and 4 support staff that work (directly and indirectly) on behalf of the Title V program. Iowa has 24 local MCH agencies with a combined workforce of 314.89 FTEs covering Iowa's 99 counties. Local and state

MCH partners focus on fostering integration within the public health system and across organizational boundaries/sectors.

Key MCH Leadership Staff

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

Marcus Johnson-Miller has served as Iowa's Title V MCH Director and Bureau Chief of the Bureau of Family Health at the Iowa Department of Public Health since September 2014, but has been involved in Title V coordination and implementation for over 18 years.

Bob Russell, DDS, MPH has been the Public Health Dental Director at the Iowa Department of Public Health for 15 years. Dr. Russell assures the Title V program is infusing dental practices in all aspects of the programs.

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

CYSHCN Workforce Development and Capacity

DCCH administers Iowa's Title V program for CYSHCN. DCCH delivers its public health, systems building, enabling and direct services through 13 community-based Regional Centers and 7 satellite locations across Iowa. The total number of DCCH employees is 95, with 73.08 FTEs. MCHB Title V funds support 64 employees, equating to 20.07 FTEs.

Key CYSHCN Leadership Staff

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

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

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

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

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

Promoting and Providing Culturally Appropriate Delivery of Services

Although Iowa is less racially diverse than some states, its diversity is increasing. Iowa's Asian and Hispanic communities are the fastest growing population groups. Key informants noted there has been an increase in immigrant and refugee populations, resulting in small groups of people from several different countries, residing within a single community. As described in the Needs Assessment Process Title V will continue the HEAC to better serve populations of color.

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

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

Partnerships

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

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

Other Federal Investments: IDPH and DCCH manage and/or work closely with other federal agency programs that include the PREP, SRAE, Title X Family Planning, Infant and Child Death Review, and Head Start. Projects through the Centers for Disease Control and Prevention include an Oral Disease Prevention grant, a MCH Epidemiologist (CDC assignee), the Pregnancy Risk Assessment Monitoring System, and EHDI. Strong collaborations exist with the US Department of Agriculture's Special Supplemental Nutrition program for Women, Infants, and Children.

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

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

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

Other Governmental Agencies: A Medicaid policy specialist at DHS provides technical assistance and support to state and local MCH staff. Interagency contracts between IDPH and DHS cover quality service provision for MCH, 1st Five, and I-Smile™; Hawk-i outreach and PE; data sharing; and care coordination reimbursement. Collaborations also include the Healthy Child Care Iowa program, work with the Autism Support Program, and training and certification for adults with serious persistent mental illness and families of children with SED. Early Childhood Iowa and the Department of Education's Early ACCESS (IDEA, Part C), Regional Autism Assistance, Head Start State Collaboration Office, and School Nurse Consultant are also partners.

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

Family/Consumer Partnership and Leadership Programs: Some of the ways that IDPH and DCCH hear family and

consumer viewpoints are through focus groups, advisory councils, the Access for Special Kids Resource Center, and Family Voices.

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

Family/Consumer Partnerships

DCCH employs a Family Engagement Program Manager. This position requires lived experience caregiving for a CYSHCN. The Program Manager assures family partnership at all levels. In addition, DCCH employs over 25 family members of CYSHCN as Family Navigators (FN) to work in regional centers and satellite locations. FNs work directly with families to provide family-to-family support and systems navigation. FNs vary in age, urban or rural geographic location, military family status, and special health care needs of their child. DCCH is building a focus on employing FNs from diverse racial and ethnic backgrounds. Additionally, DCCH has an active Family Advisory Council, which was started in 2014. Members of the FAC are compensated for meeting attendance and receive stipends for mileage. Both FNs and members of the FAC receive training on MCH core competencies. In addition DCCH works diligently to expand the workforce for family partnerships through the Family Peer Support program and the Iowa Family Leadership Training Institute.

Nature and substance: IDPH maintains family partnerships through 21 MH and 22 CH contract agencies that work directly with families within their service areas, providing care coordination, referral assistance, and gap-filling preventive health services. Families are represented on the Title V MCH Advisory Council (MCHAC) and on local health coalitions and similar types of councils.

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

Number engaged, the degree of engagement, compensation, and MCH core competencies: The MCHAC includes three family representatives. All members of the MCHAC are given resources for self-training in the MCH core competencies and orientation to the Title V program. Compensation is not provided for participation on MCHAC. The MCHAC assists with assessing needs, prioritizing services, establishing objectives, and encouraging public support for MCH and family planning programs. MCH contractors engage families often and respond to families' needs based upon interactions. Client surveys help evaluate satisfaction, determine if program services meet client needs, and identify changes to improve program quality. This feedback is not typically compensated.

Evidence and range of issues being addressed: IDPH works through local Title V MCH contractors to assure health services for families, which include helping clients become better consumers and navigators of the health care system. Contractors report that the majority of family issues they address are related to medical/dental appointments and health issues and services. Contractors also work with families to find assistance with transportation, translation, food, clothing, and housing as well as referrals to other programs.

Impact on programs and policies: MCH contractors seek input of families/consumers and respond through changes to programs and policies (e.g. using text messaging for care coordination, use of language lines, and transportation to mental health services).

Efforts to build and strengthen for all MCH populations: IDPH provides oversight and consultation for MCH contractors through phone and email communication, annual site visits, quarterly regional meetings, an annual seminar, and regular program-specific meetings such as I-Smile™ trainings. Staff provides technical assistance, monitors data, discusses promising practices, and verifies contractors' progress toward performance objectives to assure family-centered approaches and overall program quality.

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

Identifying Priority Needs and Linking to Performance Measures

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

Infusing Health Equity within the Title V System

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

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

Access to care for the MCH population

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

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

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

MCAH Systems Coordination

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

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

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

Dental Delivery Structure of the MCAH Population

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

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

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

Safe and Healthy Environments

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

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

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

Access to services, pediatric specialty providers, and care coordination

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

Support for making transitions to adulthood

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

Support for parenting CYSHCN

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

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,484,206	$6,768,355	$6,517,057	$6,039,679
State Funds	$6,868,860	$7,035,532	$7,157,773	$7,416,373
Local Funds	$0	$0	$0	$0
Other Funds	$6,801,353	$5,859,807	$7,155,548	$5,980,879
Program Funds	$480,000	$480,000	$480,000	$637,056
SubTotal	$20,634,419	$20,143,694	$21,310,378	$20,073,987
Other Federal Funds	$11,398,041	$10,462,442	$12,313,087	$12,261,235
Total	$32,032,460	$30,606,136	$33,623,465	$32,335,222

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,502,615	$5,122,040	$6,512,681	
State Funds	$7,038,987	$6,602,596	$6,334,543	
Local Funds	$0	$0	$0	
Other Funds	$8,533,916	$7,544,812	$8,847,074	
Program Funds	$480,000	$886,902	$480,000	
SubTotal	$22,555,518	$20,156,350	$22,174,298	
Other Federal Funds	$8,436,599	$9,271,550	$12,046,998	
Total	$30,992,117	$29,427,900	$34,221,296	

	2022	
	Budgeted	Expended
Federal Allocation	$6,549,016	
State Funds	$6,255,937	
Local Funds	$0	
Other Funds	$8,947,232	
Program Funds	$850,000	
SubTotal	$22,602,185	
Other Federal Funds	$11,648,481	
Total	$34,250,666	

III.D.1. Expenditures

Form 2, MCH Budget/Expenditure Details, shows $5,122,040 in federal Title V fund expenditures. See the Expenditure workbook attachment for a detailed breakdown of expenditures for the Federal/State Partnership.

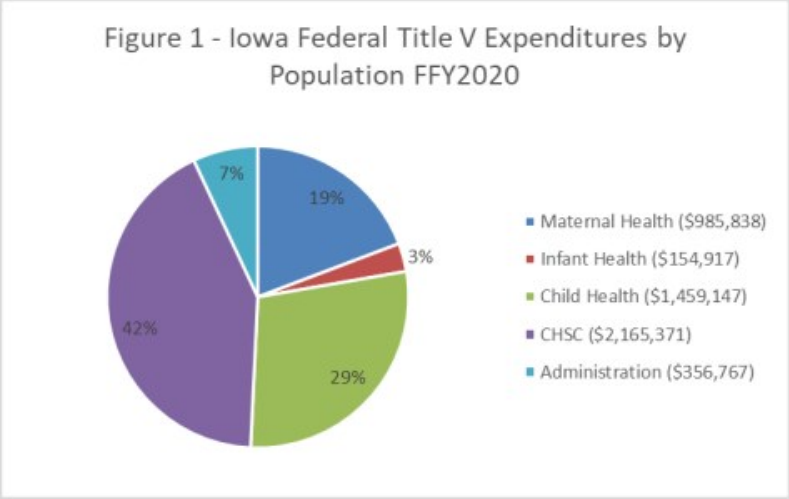
Form 3a, Budget and Expenditures Detail by Types of Individual Served, reports federal-state partnership expenditures for FFY20 in the amount of $19,799,583 excluding admin funds. Of this amount, $4,765,273 was funded by federal Title V. The state match expenditure is reported at $6,602,596. This exceeds both the state match requirement of $4,863,155 and the maintenance of effort requirement of $5,035,775.

Figure 1 displays the distribution of Title V expenditures by population served. Federal Title V funds expended for child health primary and preventive care was $1,459,147 or approximately 28 percent of the total Title V expenditures. At the time of submission, expenditures remain to be claimed in the Preventive and Primary Care for Children budget category; This category is fully obligated. IDPH anticipates this budget category to be fully expended by the end of the budget period and will meet the minimum 30% requirement as indicated in the budget.

The federal Title V expenditure for children and youth with special health care needs is reported at $2,165,371 or 35 percent of the federal block grant funds expended for the year.

Administration expenditures of $356,767 represent 7 percent of the federal Title V expenditures to date. At time of submission this amount reflects charges to administrative costs (MCH Director salary, travel, and other expenses) for the Title V Block Grant. The final indirect costs will be pulled prior to closeout based on actual expenses and will not exceed the 10% maximum.

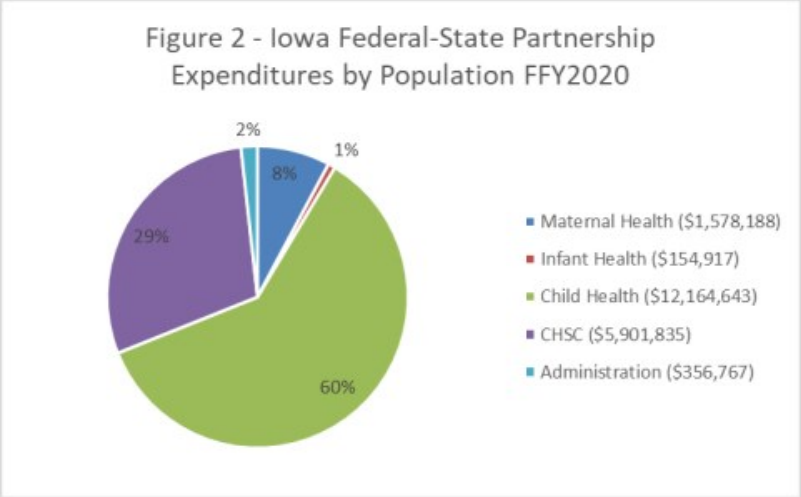
Current expenditures are based on the expenditures reported on 3/31/2021. All funds are obligated and are on target to be fully expended by the end of the budget period. Annually, approximately 75% of funding budgeted for Maternal, Infant and Child Health is contracted to local providers. In the current expenditures, 64% of the expenditures are local provider expenditures, the remaining obligations will be completed by 9/30/21.

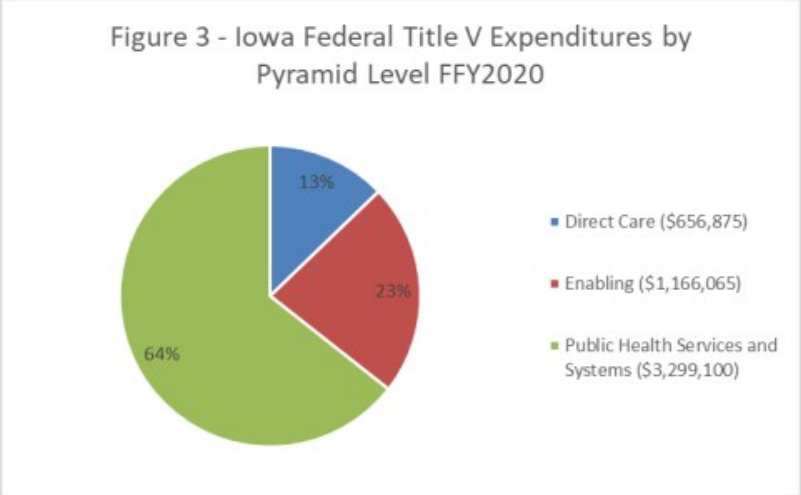


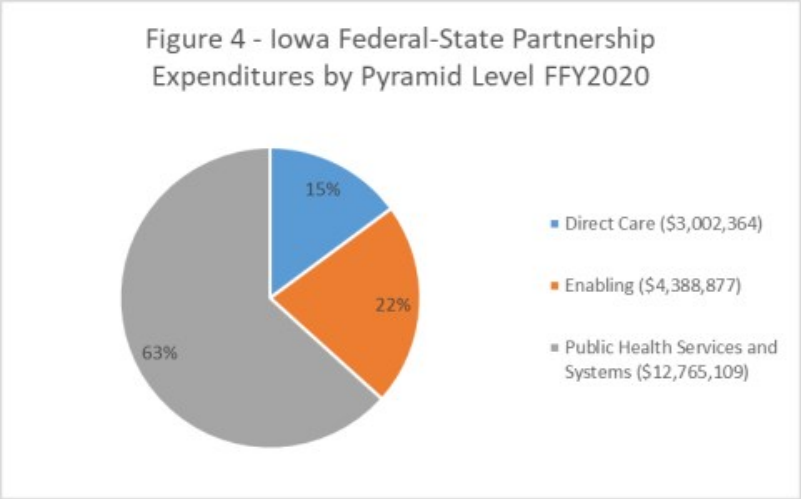
Form 3b, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to Public Health Services and Systems continue to increase for MCH compared to the proportional of funds directed to direct services.

Continued improvement has been achieved in reporting on expenditures by pyramid level.

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







As you will see from the Expenditure attachment, Iowa's Title V program is a blend of Title V funds, state match, program income and other federal/state funds. The Title V funds account for 25.4% of the Federal/State Partnership. 32.7% of the Partnership is made of matching funds. Other federal/state funds make up 41.8% of the annual expenditures.

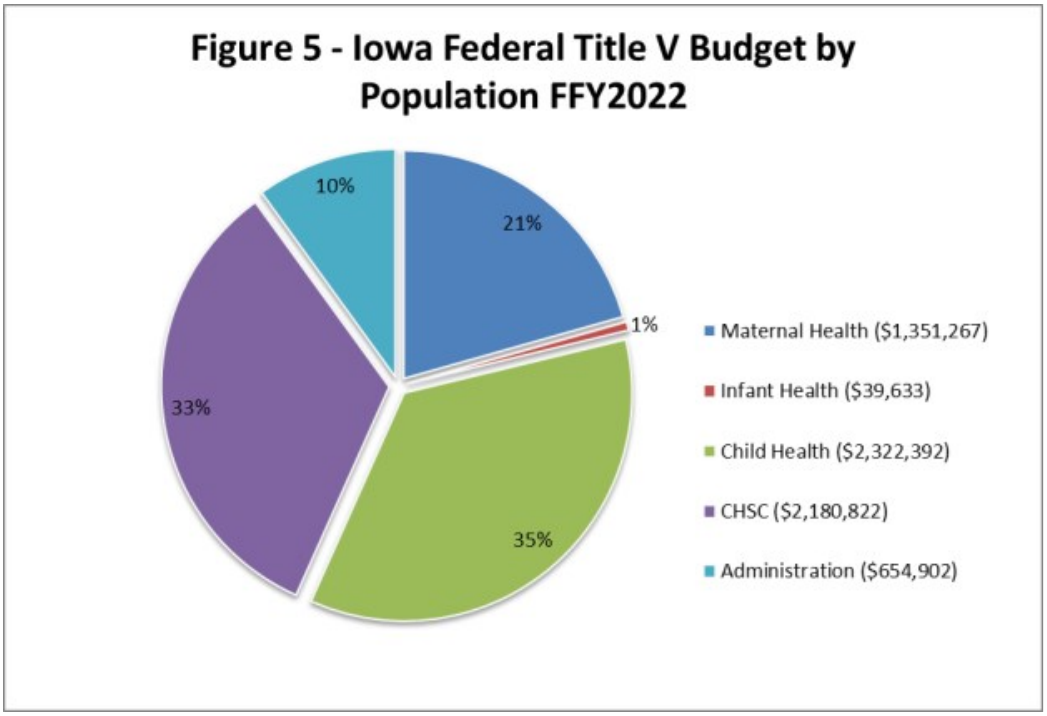
Through the Title XIX/Title V MOU, Iowa's local Title V contractors are designated a Medicaid provider status (Screening Center and/or Maternal Health Center) by virtue of their Title V application. These contractors are required to bill Medicaid for services for clients enrolled in Medicaid. Title V contractors are also able to provide Presumptive Eligibility to receive immediate coverage for those clients that may be eligible, but do not have Medicaid at the time of service. Title V direct care expenditures cover services for those that do not have another source of payment for services. Title V contractors are also encouraged to enroll with third party payers, as well; however, many have had little luck in enrolling with private insurance companies based upon their clinic status. Iowa Administrative Code for Iowa's MCAH program outlines that Title V is the payer of last resort.

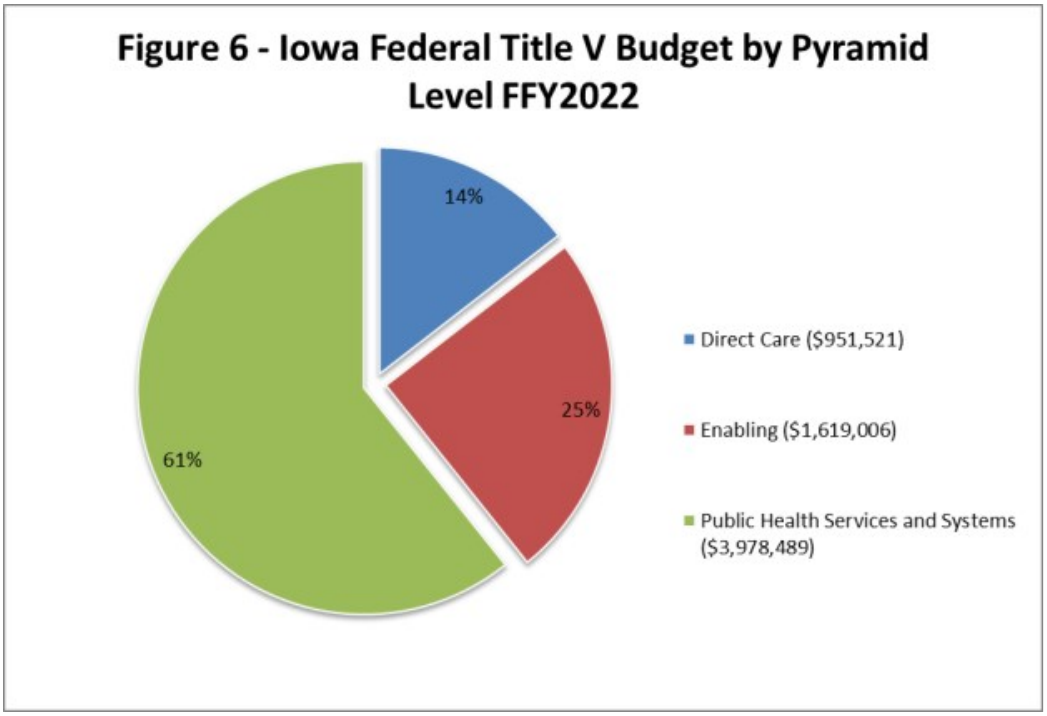
The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the "Iowa Comprehensive Annual Financial Report." The audit is conducted by the state Auditor's Office in compliance with Title 2, US Code of Federal Regulations, Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance). The most recent report is for the period July 1, 2018 to June 30, 2019. The Iowa Department of Public Health had no findings in the 2019 State of Iowa Single Audit Report for the Title V program, CFDA Number 93.994. The report is submitted to the federal clearinghouse by the state Auditor's Office.

III.D.2. Budget

The FFY22 Title V appropriation is projected to be $6,549,016, based on the current Notice of Grant Awards received. As itemized in the budget included in the attachments section, this expected allocation is budgeted as follows: $1,351,267 (21%) for maternal health services; $39,633 (1%) for infant health services; $2,322,392 (35%) for child health services; $2,180,822 (33%) for services to children with special health care needs; and $654,902 (10%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. Figure 5 below illustrates the budget plan for Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

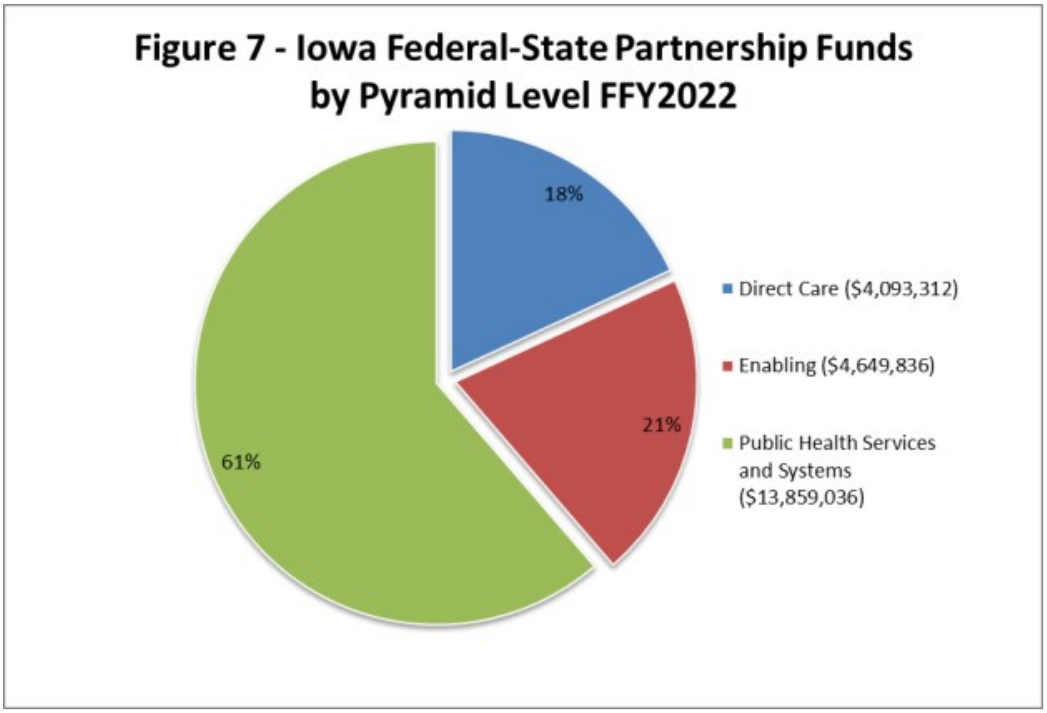
See forms 2, 3a, and 3b and the included budget attachment in supporting documents for detailed information.





The projected state match is $6,255,937. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989 and exceeds the required match of $4,883,780. This amount has decreased from previous years. The Title V program had used Immunization state funding as match, however, due to new match requirements in the Immunization Bureau, these funds were no longer eligible for Title V match.

The total budget for the federal-state partnership is projected to be $22,602,185. Figure 7 illustrates the allocation of funds by level of service for the total partnership budget. The attachment provides budget details by level of servi ce, as well as population group served. The Federal/State Partnership Budget supports the activities proposed within the State Action Plan for each population domain.



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

Public Health Services and Systems

Estimated budget for continuing development of core public health functions and system development are $13,859,036 or 61 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 36 percent of the funding for local child health agencies and 23 percent of local maternal health funds. In addition, it will include contract services with the University of Iowa, Departments of Pediatrics, Perinatal Review Team, Healthy Child Care Iowa, EPSDT dental and IDPH 1st Five Initiative. CHSC's budget for public health services and systems is estimated at $2,061,895 (35 percent of the CYSHCN budget).

Enabling Services

The federal-state partnership budget for continuation of enabling services are estimated at $4,649,836 representing 21 percent of the partnership budget. This category includes 50 percent of the funding for local child health agencies and 47 percent of local maternal health funds. Healthy Families toll free information and referral line, TEEN Line, Hawki Outreach, EPSDT, STD testing, immunization, lead poisoning prevention, and birth defects and audiological services are included in this category. CHSC's budget for enabling services is estimated at $1,836,096 (31 percent of the CYSHCN budget).CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Direct Health Care Services

The federal-state partnership budget for continuation of direct care services are estimated at $4,093,312. This represents approximately 18 percent of the partnership budget. The amount includes 14 percent of the funding for local child health agencies and 30 percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment, and dental sealant projects; and child vision screening. CHSC projects a direct care budget of $1,999,171 or approximately 34 percent of the CYSHCN budget.

Other State/Federal Funds

The funds in this column of the budget attachment are not eligible for match but enhance Iowa's MCH system. Examples of these programs include funding received through the Omnibus agreement with Iowa Department of Human Services these services include: EPSDT, I-Smile™, hawki outreach, and Healthy Child Care Iowa.

Other federal funds directed toward MCH include:

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

III.E. Five-Year State Action Plan

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

State: Iowa

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

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

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

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

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

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

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

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

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

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

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

Maternal and Child Health Advisory Council

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

Health Equity Advisory Committee

The Health Equity Advisory Committee (HEAC) was formed as an advisory group in 2019 to have community members represented in planning and advising for the Maternal, Child and Adolescent Health program. Members work in close collaboration with other members and the group's coordinators to identify and address disparities in health among communities of color and population groups with low income or who have historically had less access, power and privilege related to their health needs in Iowa. Specific populations identified in this work are called priority populations. The complete list of priority populations for Maternal, Child and Adolescent Health program for 2021-2026 are: Asian or Pacific Islander; Black, African American or African; Fathers; Latinx or Hispanic; Lesbian, gay, bisexual, transgender, queer, intersex plus (LGBTQI+); Native American or Alaska Native; persons with disabilities; and refugees or immigrants.

Iowa Statewide Perinatal Care Program

The Iowa Statewide Perinatal Care Program, established in 1973, provides education, development of standards/guidelines of care, consultation to regional and primary providers, and evaluation of the quality of perinatal care delivered in Iowa with the goal to reduce mortality and morbidity of mothers and infants. Through a contract between IDPH and the University of Iowa College of Medicine, these services are offered to all Iowa hospitals providing delivery services. As defined in Iowa Code this team’s work provides critical support and oversight for Iowa’s Regionalized System of Perinatal Care.

Iowa Maternal Quality Care Collaborative (IMQCC)

The IMQCC is a multidisciplinary group of key stakeholders for maternal health including public health professionals, healthcare and allied health providers, payers, statewide partners, patient and community representatives, and quality improvement experts who have come together with the goal to improve maternal health in Iowa.

The mission of the IMQCC is to improve the quality, safety, and culture of maternity care provision for all Iowans by partnering with healthcare and community stakeholders, supporting data-driven and evidence-informed quality improvement initiatives, and promoting patient-and family-centered care.

The IMQCC was formed by IDPH with funding from the HRSA Maternal Health Innovation (MHI) award received by the Iowa Department of Public Health in partnership with the University of Iowa. The IMQCC will address key drivers of maternal mortality in Iowa by utilizing data to identify opportunities for improvement in care quality and supporting local hospital teams in implementing best practices.

Alliance for Innovation on Maternal Health (AIM)

AIM is a national data-driven maternal safety and quality improvement initiative. AIM takes evidence-based approaches to improving maternity care and works with state teams to align practices and increase the quality and safety of care, all with the goal of improving maternal health outcomes in the United States.

AIM works through state teams and health systems to align national, state, and hospital level quality improvement efforts. Any Iowa hospital in a participating AIM State or hospital system can join the AIM community of healthcare providers, public health professionals and stakeholders who are committed to improving maternal outcomes.

Title V MCAH RFP/RFA Work Group

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

Family Advisory Council

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

RAP Expert Panel Advisory Committee

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

RAP Family Advisors

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

Partners and collaborators

DCCH staff work with many CYSHCN-focused groups such as the Developmental Disabilities Council, the Iowa Council for Early ACCESS, the Iowa Autism Council, and statewide collaborations focused on issues relevant to CYSHCN such as behavioral health and obesity. The CYSHCN program is co-located and works closely with Iowa's University Center for Excellence in Developmental Disabilities (UCEDD) and the Iowa Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program.

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

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

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

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

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

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

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

In 2021, Iowa is currently participating in the MCH Workforce Development Center Cohort. BFH will be issuing a new competitive Request for Proposals (RFP) for Title V services in FFY2023, and will use this opportunity to identify ways to restructure the work local agencies do at the beginning in the project period. The Cohort has assisted with identifying strategies to ensure family and consumer input is incorporated into the planning and implementation of Iowa's local Title V structure. Title V engaged families in needs assessments to identify needs, but not in implementing work to impact the selected NPMs and SPMs. Iowa Title V MCH programdoes not have the same infrastructure in place as the CYSHCN program to include families fully in program planning, implementation and evaluation. In the past family involvement included family satisfaction surveys received at the local level and the approval of the Title V state plan by the MCH Advisory Council, which includes multiple family/consumer membership.

BFH is currently using the MCH Navigator to assist with developing a professional development plan. All staff members within BFH will complete the self-assessment. The Title V Coordinator and Director will receive the results from Georgetown University and utilize these along with input from staff on what topics they need and would like to receive training on over the next year. Since Title V is the basis for nearly all of the work in the bureau, it is crucial that new and current staff have a baseline knowledge of MCH and how their work fits into the MCH system.

The Iowa Title V CYSHCN program operates through the University of Iowa, including 13 Child Health Specialty Clinics Regional Centers and 7 satellite locations. These community-based centers are located across the state. There are a total of 64 employees/19.45 FTEs directly funded by Title V and a total of 91 DCCH employees with a

total of 75.6 FTEs.

DCCH relies on the University of Iowa Healthcare system for Human Resources activities, including recruitment and retention. Because the nature of the Child Health Specialty Clinics Regional Center structure is to provide gap-filling services, many areas struggle to find qualified candidates. While recruitment of qualified candidates can be challenging at times, offers of employment with a generous benefit package available through the University of Iowa in a rural community is a helpful recruiting tool.

DCCH continually evaluates workforce development needs for staff. For example, following an assessment process with DCCH staff, trainings focused on transition to adulthood were implemented and Continuing Education credits awarded for eligible DCCH staff. As an organization that has operated from geographically diverse areas across the state, DCCH already had capability and experience to facilitate remote trainings, even before COVID-19.

DCCH prioritizes workforce development opportunities with a focus on health equity in the delivery of services. For example, this year DCCH's Human Resources representative arranged a training about working with transgender youth. This training included a personal family perspective, physician perspective, available resources, and a discussion of how to appropriately and compassionately discuss transgender issues with patients and families.

The Family Navigator Network provides monthly learning opportunities for Family Navigators. Furthermore, in order to develop the Title V Leadership Workforce, staff participated last year in the Next Generation Learning Lab and the Family Leadership Learning Lab. DCCH is a partner with the University of Iowa College of Public Health in providing experiential learning for undergraduate students and practicum experiences for MPH students. The UI College of Public Health recently received funding from MCHB to build their maternal and child health program and DCCH is a willing partner to collaborate with that effort.

DCCH also provides workforce development opportunities for students and the broader statewide CYSHCN workforce. DCCH played an integral role in the development of Iowa's Family Peer Support Specialist (FPSS) Certification curriculum. This program builds the peer support and family peer support workforce. The FPSS program worked closely with the Iowa Department of Human Services and the Iowa Board of Certification to implement a certification process for Family Peer Support Services professionals. This certification is available for all DCCH's family navigation staff. DCCH also offers frequent professional development opportunities to primary care providers statewide.

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

Iowa's Title V program sees the value and need for family and client involvement in the development and implementation of all state MCH activities. While the CYSHCN program has established protocols in place, the other population domains have struggled to successfully involve families and clients beyond involvement in the 5-year Needs Assessment. Staff have networked with Region VII and other state Title V Directors to discuss strategies for this involvement, however, this remains a challenge across the region and nation for all populations outside of CYSHCN. As discussed in the previous section, Iowa's MCH program is involved with the MCH Workforce Development Center Cohort, focusing on the development of strategies to improve family and consumer voice in the planning, implementation and evaluation processes.

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

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

CYSHCN
Iowa's Title V CYSHCN program has a long history of developing and supporting family partnerships. DCCH employs a full-time Family and Professional Partnership Program Manager who is the parent of a young adult with special health care needs. This program manager is responsible for assuring family partnership at all levels across DCCH. DCCH has a 10-member Strategic Operations Team, including the Family and Professional Partnership Program Manager and a Family Navigator Network Coordinator. The Family Partnership program works to build the family leadership workforce and ensure that the family perspective is represented at all levels of DCCH decision-making.

During recent updates to the DCCH strategic plan, Family Partnership program staff provided leadership to this team. This structure also allowed the family perspective to be included in recommendations to DCCH leadership regarding policy-level decisions. Family Support and Engagement was one of four main goals of the DCCH strategic plan created in 2017. A revision of this plan occurred in 2020, and this goal was renamed Family Partnership.

DCCH has a long history of employing family support professionals, now known as Family Navigators. Iowa's first

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

DCCH has developed a robust, statewide Family Navigator Network. Currently, there are 29 Family Navigators in the Network. All of DCCH's Child Health Specialty Clinics Regional Centers and satellite locations include at least one trained Family Navigator who is a paid staff member and the parent or primary caregiver of a CYSHCN. Four counties identified as medically underserved have satellite locations have family navigators employed where no Child Health Specialty Clinics Regional Centers are located. Family Navigators provide family-to-family support, systems navigation, and connections to community resources. Family Navigators assure that the family voice is heard. All families receiving direct services have access to family navigation services. In addition, family-centered Goal Setting occurs in all clinical visits. Goals are documented in the Electronic Medical Record, so all providers, including the child's medical home, understand family goals and preferences. Goals for their child are regularly reviewed with the parents to track progress and address any barriers to achieving those goals.

In October 2020, the Family Navigator Network was introduced as an Emerging Practice in the Association of Maternal and Child Health Programs (AMCHP) MCH Innovations Database. The handout associated with this practice is located here: https://www.amchpinnovation.org/wp-content/uploads/2021/02/Family-Navigator-Network_Practice-Handout-Emerging.pdf.

In 2014, DCCH created a Family Advisory Council (FAC) to assist with the planning, development, and evaluation of programs and policies that impact the System of Care for Iowa CYSHCN. Members come from both rural and urban regions across the state. A recent process review with the FAC identified new approaches to optimally utilize the valuable input of the FAC by providing a balance of content education and meaningful input from members of the FAC.

The Iowa CYSHCN program also has a focus on developing family leaders to ensure that family members are prepared to serve on advisory boards and councils and effectively advocate for their children with special needs. The Iowa Family Leadership Training Institute (IFLTI) provides regularly scheduled opportunities for family leaders. A longer description of the IFLTI can be found in the CYSHCN Annual Report section of this document.

Iowa's CYSHCN program has a relationship with Iowa's Family Voices affiliate, ASK Resource Center (ASK), which collaborates with Iowa Family Leadership Training Institute. Recognizing Everyone's Strengths by Peace building, Empathizing, Communicating and Trust building (RESPECT) trainers from ASK helped to shape the communication and conflict management curriculum for the Iowa Family Leadership Training Institute (IFLTI). Two trainers from ASK attended the 2021 IFLTI session, delivering a 90-minute presentation on conflict management – a short course of their longer RESPECT training. It was well received, and family participant feedback named it as one of the most helpful presentations. In addition, ASK was a collaborative partner in Iowa Family Peer Support Training program until that grant ended in February 2021.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Iowa has made progress in terms of recruiting and retaining a trained epidemiologists. Prior to 2021 there was no job classification for Epidemiologists. Title V staff at the federal level as well as past reviewers have highlighted this fact as a challenge. In early 2021, the state's personnel department approved two new epidemiologist job classifications: Epidemiologist and Senior Epidemiologist. With these new classifications, the Department has been able to recruit highly skilled epidemiology staff.

Bureau of Family Health has had a long lasting relationship with the CDC. Dr. Debra Kane has been the MCH Epi Assignee since 2005 and serves as the BFH Senior Epidemiologist. As the result of the new classification, two epidemiologists have been added to the team, Brooke Mehner and Amanda Hagerman. Brooke Mehner has been providing epidemiologic support as the PRAMS Data Analyst and Oral Health Epidemiologist since 2017. Amanda Hagerman joined the team in spring of 2021 with a focus on program level child health and newborn screening.

Dr. Debra Kane received a Bachelor of Science in Nursing from Marian College of Fond du Lac, WI and her Master's Degree in Community Health Nursing from the University of Wisconsin-Madison. Prior to seeking her PhD, she held a variety of community health and public health nursing positions at the City of Milwaukee Health Department and the State of Wisconsin Division of Health. Debra obtained a PhD from the University of Illinois-Chicago, School of Public Health. In 2005, she completed a CDC-ORISE sponsored post-doctoral fellowship in MCH Epidemiology at the Mississippi State Department of Health.

Dr. Kane has worked extensively with data linkages, vital records data, Iowa's Barriers to Prenatal Care Survey data, Medicaid paid claims data, the Iowa Hospital Discharge data file, and Title X data. She has provided data analysis to support and guide numerous programs and initiative, most recently, Iowa's AIM project and data dashboard. Dr. Kane's research interests include women's reproductive health, access and barriers to health care, and the use of data to promote public health action. Dr. Kane's recent publications include:

Zapata, L. B., Pazol K, Curtis, K. M., Kane, D. J., et al. Need for Contraceptive Services Among Women of Reproductive Age — 45 Jurisdictions, United States, 2017–2019. MMWR Morb Mortal Wkly Rep 2021;70:910–915. DOI: http://dx.doi.org/10.15585/mmwr.mm7025a2.

Okoroh, E.M., Kane, D.J., Gee, R.E., Kieltyka, L., Frederiksen, B.N., Baca, K.M., Rankin, K.M., Goodman, D.A., Kroelinger, C.D., & Barfield, W.D. (2018). Policy Change is Not Enough: Engaging Provider Champions on Immediate Postpartum Contraception. American Journal of Obstetrics & Gynecology. DOI.org/10.41016/j.ajog.2018.03.007

Frederiksen, B.N., Kane, D.J, Rivera, M., Wheeler, D. & Gavin, L. (2017). Use of Clinical Performance Measures for Contraceptive Care in Iowa, 2013. Contraception. 96 DOI: 10.1016/j.contraception.2017.05.008.

Frederiksen, B.N., Lillehoj, C.J., Kane, D.J, Goodman, D., Rankin, K. (2017). Iowa severe maternal morbidity trends and maternal risk factors: 2009-2014. Maternal and Child Health Journal, 21. DOI: 10.1007/s10995-017-2301-4.

Amanda Hagerman is the Newborn Screening and Childhood Epidemiologist at Iowa Department of Public Health (IDPH) and has been a part of the team since 2019. She is responsible for the analysis and dissemination of the following programs, EHDI (Early Hearing Detection & Intervention), 1st Five Healthy Mental Development, Childhood

Lead, Ages & Stages Questionnaire-3 (ASQ-3), Adolescent Well-Visits, and more, within the Bureau of Family Health. Apart from data evaluation, Amanda performs education, technical assistance, and data dissemination with a variety of stakeholders at state and national conferences, state committees, CDC workshops, and at the local level. Amanda has more than eight years of experience in qualitative and quantitative research, monitor and evaluation, and program planning and implementation in the realms of health policy, nutrition, and maternal and child health. Currently, Amanda is working on a publication to help inform audiologists and stakeholders in the realm of EHDI on the children who do not receive a diagnostic assessment after they fail a hearing screen.

Amanda received her Bachelor's in Nutritional Sciences & Dietetics at University of Arizona and worked as a university dietitian for three years. She also implemented nutrition programming for Hispanic/Latino children and individuals from the Tohono O'odham nation. She received her Master's in Public Health from Washington University in St. Louis and worked as a Data Analyst and Public Health Consultant for a USAID funded program, called Jordan Communication Advocacy and Policy (JCAP) Project. She performed quantitative and qualitative data analysis for the Demographic Health Survey (DHS) that was conducted in Jordan in 2015 and evaluated the socioeconomic factors and gender roles that influenced the usage of modern family planning. Amanda also performed research on Vitamin A Supplementation (VAS) Policies in Kenya and her work was presented at the VAS symposium in Nairobi in 2016.

Brooke Mehner received a Bachelor of Science in Applied Health Sciences and Biology from University of Wisconsin - Parkside in Kenosha, WI and her Master's Degree in Public Health Epidemiology from the University of Wisconsin-Milwaukee. Prior to becoming an Epidemiologist at the Iowa Department of Public Health, Brooke worked as a research assistant and data analyst in social welfare and epidemiology.

In her current role, Brooke has utilized her data collection, analysis, visualization, and program evaluation skills to aid in understanding oral health and pregnancy outcomes, behaviors, and access among Iowa populations and share them with others. She has worked extensively with Pregnancy Risk Factor Surveillance System (PRAMS), I-Smile and other oral health program data, the Behavioral Risk Factor Surveillance System, Iowa's Barriers to Prenatal Care Survey data, and the Iowa Hospital Discharge data, among others. Brooke is passionate about using of data to understand health concerns across the state and promote public health action. Brooke's recent publications include:

Segre LS, Mehner BT, Brock RL. *Perceived Racial Discrimination and Depressed Mood in Perinatal Women: An Extension of the Domain Specific Stress Index.* Women's Health Issues. 2021 May-Jun;31(3):254-262. doi: 10.1016/j.whi.2020.12.008. Epub 2021 Feb 23. PMID: 33637396.

Iowa Department of Public Health. Bureau of Family Health. *Oral Health Iowa Pregnancy Risk Assessment Monitoring System*. 2021. Web.

Iowa Department of Public Health. Bureau of Family Health. *2019 PRAMS Survey Frequencies*. Des Moines: Iowa Dept. of Public Health. 2021. Web.

Iowa Department of Public Health. Bureau of Oral and Health Delivery Systems. *The Hidden Cost of Tooth Decay*. April 2020. Web.

Iowa Department of Public Health. Bureau of Oral and Health Delivery Systems. *2020 Inside I-Smile: Update on Children's Oral Health in Iowa*. January 2021. Web.

Iowa Department of Public Health. Bureau of Oral and Health Delivery Systems. *WIC-Enrolled Children and Oral Health.* December 2019. Web.

The Iowa Title V CYSHCN program is able to access the resources available through the University of Iowa and does not employ dedicated epidemiologists for data management and analysis. CYSHCN staff includes members with expertise in data management and analysis. Approximately 0.6 FTE is dedicated to data management and analysis, through two Program Managers and one Electronic Medical Records Specialist. One Program Manager has an MPH in Community and Behavioral Health with primary responsibilities for evaluation activities. Over the past 10 years, the Evaluation Program Manager has managed evaluations for numerous projects funded through SAMHSA, HRSA, and state entities including the Iowa Department of Human Services. The Policy and Measurement Program Manager has an MPH in Public Health Policy and Administration. The Policy and Measurement Program Manager has over 20 years of experience, including 17 years doing health policy data analysis for statewide programs including Medicaid and CHIP, and the Iowa Child and Family Household Health Survey (2000, 2005, 2010). The Electronic Medical Records Specialist brings significant expertise required to extract data from Electronic Medical Records in a format that is useful for data analysis purposes.

The program also leverages expertise in qualitative analysis through a Program Coordinator with an MPH in Community and Behavioral Health and several other staff members. Additionally, the program is part of the University of Iowa, and has regular access to faculty biostatisticians from the University of Iowa Department of Biostatistics when additional support or advisement is necessary. The CYSHCN program has a relationship with the College of Public Health and over the past 3 years has sponsored two MPH Practicum students specializing in Quantitative Methods through the Department of Biostatistics. With the full support of faculty from the Department of Biostatistics, these students provided expertise and analysis for specific projects including multivariable analyses of data from the National Survey of Children’s Health regarding 1) family stress for families of children with medical complexity and 2) food insecurity for CYSHCN. This served to increase the capacity of the CYSHCN program, as well as helping add to the MCH quantitative analysis workforce.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

State System Development Initiative (SSDI)

SSDI supports IDPH through the identification of data sources to address and monitor MCH issues including maternal access to prenatal care, birth outcomes by hospital level and geographic location, and appropriate referrals for care in Iowa's regionalized system of perinatal care. BFH staff provide hospital level information to the Statewide Perinatal Team to support their efforts to monitor access to prenatal care, breastfeeding initiation, infant birth outcomes, as well as assurance that very low birth weight infants are born at appropriate level hospitals.

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

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

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

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

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

Iowa's Barriers to Prenatal Care Project

Ongoing since 1992, the purpose of this project is to obtain brief, accurate information about women delivering babies in Iowa hospitals. Specifically, the project seeks to learn about women's experiences getting prenatal or delivery care during their current pregnancy. Other information is included which may be pertinent to health planners or those concerned with the systematic development of health care services. This project is a cooperative venture of all Iowa's maternity hospitals, the University of Northern Iowa Center for Social and Behavioral Research, and the Iowa Department of Public Health. The Robert Wood Johnson Foundation funded the first three years of this project. The current funding is provided by the Iowa Department of Public Health. The Director is Dr. Mary Losch, University of Northern Iowa Center for Social and Behavioral Research. The Coordinator for the project is Rodney Muilenburg.

The questionnaire is distributed to all maternity hospitals across the state of Iowa (currently about 65). Nursing staff or those responsible for obtaining birth certificate information in the obstetrics unit are responsible for approaching all birth mothers prior to dismissal to request their participation in the study. The questionnaire takes approximately ten minutes to complete. Completed questionnaires are returned to the University of Northern Iowa Center for Social and Behavioral Research for data entry and analysis. Returns are made monthly, weekly, or biweekly depending on the number of births per week in a given hospital. Except in the case of a mother who is too ill to complete the questionnaire, all mothers are eligible to be recruited for participation.

PRAMS

PRAMS was initiated in 1987 to help state health departments establish and maintain an epidemiologic surveillance system of selected maternal behaviors and experiences. PRAMS was started at a time when the US infant mortality rate was no longer declining as rapidly as it had in past years and the prevalence of low birthweight was showing little change. Maternal behaviors such as alcohol and tobacco use and limited use of prenatal care and pediatric care were contributing to the slow rate of decline. PRAMS was designed to supplement data from vital records and to generate data for planning and assessing perinatal health programs in each participating state.

Iowa PRAMS has identified 10 research priorities based on the maternal and child health priorities as determined through the Title V and Title X needs assessment processes for Iowa, as well as Healthy People 2020 objectives.

- Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability
- Reduce infant morbidity and mortality
- Improve pregnancy planning and spacing and prevent unintended pregnancy
- Incorporate mental health into relevant preventive health efforts within MCH programs
- Improve rates of breastfeeding
- Decrease the use of tobacco in pregnant women and new mothers
- Explore the prevalence of maternal alcohol use and binge drinking
- Improve access to preventive and restorative dental care for low-income pregnant women
- Reduce racial disparities in maternal and child health outcomes
- Apply the Life Course Model to help women obtain optimum health

BRFSS

The Behavioral Risk Factor Surveillance System (BRFSS) is a yearly survey that measures changes in the health of people in Iowa. It is the largest continuously running telephone survey in the world. All 50 states, the District of Columbia and three U.S. territories, conduct the survey under the direction of the Centers for Disease Control and Prevention (CDC). The Iowa BRFSS is an important tool for data-driven decision making in the public health community.

Iowa BRFSS survey data is used to design, implement, and support public health activities with the goal of reducing chronic diseases and other leading causes of death for Iowans. Programs within BFH financially support the module for Mental Health and Adverse Childhood Experiences. Title V staff utilize this information for multiple NPMs and SPMs plan development.

signify*community*

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

This data system is a collaboration between multiple programs within HPCDP and within the state. The Omnibus Agreement with DHS is one of the funding mechanisms braided together along with multiple within BFH.

Iowa's Integrated Data System for Decision Making (i2d2)

Iowa has invested in developing and refining an integrated data system since 2015. The development team gained considerable momentum in 2019 with federal support from the Administration for Children and Families (Preschool Development Grant) and state support from the Iowa Department of Public Health.

What is I2D2?

- supports cycles of inquiry
- addresses state priority issues
- identifies gaps in current public service system networks
- enhances cross-system programming efforts
- promotes data-informed decisions

I2D2 Commits to Priorities for the Long-Term

- I2D2 works with stakeholders to assess effectiveness and identify shortcomings in reaching Iowa's goals through a process that uses data to inspire dialogue that informs decision-making.
- I2D2 integrates data already collected by agencies in a safe, secure, scientifically rigorous system designed for policy analysis.
- I2D2 integrates people as stakeholders stewards of data to gather collective insight and translate findings into actionable intelligence.
- I2D2 integrates data insights with executive leader and program manager decision-making to advance a statewide culture of evidence-based services to improve outcomes.

Enhancing Effectiveness and Efficiency for Decision-Makers

- I2D2 gives agencies the power to improve policies and programs with cross-system data.
- I2D2 standardizes legal processes to ensure all protections are in place and reduce the need to revisit comprehensive data sharing provisions with each use.
- I2D2 prioritizes data security by minimizing data sharing and enforcing strict user-based role access protocols.
- I2D2 fosters collaboration and maximizes efficiency by relieving the burden on agency staff to coordinate cross-agency responses to data requests.

I2D2 brings together the rigor and strength of Iowa State University with the policy experience and insight of Early Childhood Iowa – a statewide organization dedicated to providing early care, education, health, and human services

for children zero through five. Through this partnership, I2D2 puts the state's most informed, passionate, and data-driven resources to work ensuring all Iowa children are successful from birth.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Bureau of Emergency and Trauma Services Emergency Preparedness Program works with Iowa's local public health departments and hospitals to ensure they have the resources to be able to respond to a public health emergency. Some of our initiatives include grants management, maintenance, storage, and deployment of resources and assets, developing emergency plans and operational procedures, manage, maintain, and coordinate the IDPH Emergency Coordination Center, and plan, track, and document response activities.

The preparedness program in Iowa started in 2002 as a result of the terrorist attacks of September 11, 2001, and the anthrax threats the following year. A public health congress was held that summer and 98 of 99 local public health agencies were represented. The purpose of the congress was to establish goals, objectives and strategies for a new public health preparedness program in Iowa. The outcome was the beginning of a shared system infrastructure that continues to this day with Iowa's local Health Care Coalitions.

The preparedness advisory committee (PAC) shall provide technical assistance and make recommendations for the planning and implementation of the public health emergency preparedness program for the department. The committee shall advise the department on matters of policy, plan development, funding allocations, and coordination of state, regional and local entities that are responsible for promoting and protecting the health and safety of all Iowans prior to, during, or after a public health emergency or disaster.

HPCDP Division Director has been involved in many state level meetings on the topic of emergency planning and preparedness especially with the Covid-19 pandemic's ongoing needs. Title V staff and BFH staff were utilized in the call centers as well as multiple aspects of Covid-19 response.

Child Care Nurse Consultants follow the national Child Care Health Consultant (CCHC) Competencies. CCHC Competency 10A states that the CCHC/CCNC Helps programs prepare for, respond to, and recover from emergencies and disasters.
CCNCs work collaboratively with Early Care and Education (ECE) programs to develop written emergency preparedness, response, and recovery plans including plans for responding to emergency situations or natural disasters that may require evacuation, lock-down, or sheltering in place. The CCNC also helps ECE programs develop relationships with relevant community partners to support emergency preparedness, response, and recovery. CCNCs utilize Iowa specific resources available when providing consultation on emergency preparedness planning. In the event of a local emergency, CCNCs may take an active role as part of their local community emergency preparedness plan.

Iowa's Emergency Preparedness Plan for Child Care includes Healthy Child Care Iowa state staff and local CCNCs assisting in communicable disease response. During the COVID-19 pandemic, 76% of Iowa's child care remained open. Iowa's COVID-19 guidance for child care was a collaborative effort between Iowa Department of Public Health and Department of Human Services. ECE program requests for CCNC services increased during the pandemic with CCNCs providing consultation to programs on COVID-19 planning; reopening; health and safety policies; managing positive cases, exposures and outbreaks; and improving quality.

The Iowa Title V CYSHCN program is housed within the University of Iowa Health Care (UIHC) system, which is the largest tertiary care center in the state, and includes Iowa's largest and most comprehensive Children's Hospital. UIHC has adopted the National Incident Management System (NIMS) and the Hospital Incident Command System (HICS) as standardized organizational and operational structures for responding to disasters and major emergencies. The UIHC Emergency Management Subcommittee includes representatives from the Children's Hospital to ensure that the needs of children and youth, including those with special health care needs, are

recognized. Among other things, this subcommittee maintains relationships and participates in county, state, and federal programs related to emergency management.

Partnerships

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

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

Other Federal Investments: IDPH and DCCH manage and/or work closely with other federal agency programs that include the PREP, SRAE, Title X Family Planning, Maternal Mortality Review, and Head Start. Projects through the Centers for Disease Control and Prevention include an Oral Disease Prevention grant, a MCH Epidemiologist (CDC assignee), the Pregnancy Risk Assessment Monitoring System, and EHDI. Strong collaborations exist with the US Department of Agriculture's Special Supplemental Nutrition program for Women, Infants, and Children.

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

State and Local MCH Programs: IDPH contracts with local health departments and private, non-profit agencies to conduct MCH program activities. In addition to families, these local MCH contractors work with each county board of health within their service area, including participation in regular community health needs assessments and health planning. IDPH programs such as the 1st Five and I-Smile™ programs are administered through CH contractors, utilizing the Title V infrastructure in place locally. Both projects rely on local coordinators to facilitate partnerships and referrals with medical and dental offices and community organizations. Other state and local partnerships include programs addressing adolescent health, the Iowa Pediatric Mental Health Care Access program and the Regional Autism Assistance program.

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

Other Governmental Agencies: A Medicaid policy specialist at DHS provides technical assistance and support to state and local MCH staff. Interagency contracts between IDPH and DHS cover quality service provision for MCAH, 1st Five, and I-Smile™; Hawki outreach and PE; data sharing; and care coordination reimbursement. Collaborations also include the Healthy Child Care Iowa program, work with the Autism Support Program, and training and certification for adults with serious persistent mental illness and families of children with SED. Early Childhood Iowa and the Department of Education's Early ACCESS (IDEA, Part C), Regional Autism Assistance, Head Start State Collaboration Office, and School Nurse Consultant are also partners.

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

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

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

Family/Consumer Partnerships

DCCH employs a Family and Professional Partnership Program Manager. This position requires lived experience caregiving for a CYSHCN. The Program Manager assures family partnership at all levels. In addition, DCCH employs 29 family members with experience as caregivers of CYSHCN as Family Navigators (FN) to work in Regional Centers and satellite locations. FNs work directly with families to provide family-to-family support systems navigation, and connections to community resources. FNs vary in age, urban or rural geographic location, military family status, and special health care needs of their child. DCCH is building a focus on employing FNs from diverse racial and ethnic backgrounds. Additionally, DCCH has an active Family Advisory Council, which was started in 2014. Members of the FAC are compensated for meeting attendance and receive stipends for mileage for in-person meetings. Both FNs and members of the FAC receive training on MCH core competencies. In addition DCCH works diligently to expand the workforce for family partnerships through the Family Peer Support program and the Iowa Family Leadership Training Institute.

Nature and substance: IDPH maintains family partnerships through 21 MH and 22 CH contract agencies that work directly with families within their service areas, providing care coordination, referral assistance, and gap-filling preventive health services. Families are represented on the Title V MCH Advisory Council (MCHAC) and on local health coalitions and similar types of councils.

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

Number engaged, the degree of engagement, compensation, and MCH core competencies: The MCHAC includes three family representatives. All members of the MCHAC are given resources for self-training in the MCH core competencies and orientation to the Title V program. Compensation is not provided for participation on MCHAC. The MCHAC assists with assessing needs, prioritizing services, establishing objectives, and encouraging public support for MCH and family planning programs. MCH contractors engage families often and respond to families' needs based upon interactions. Client surveys help evaluate satisfaction, determine if program services meet client needs, and identify changes to improve program quality. This feedback is not typically compensated.

Evidence and range of issues being addressed: IDPH works through local Title V MCH contractors to assure health services for families, which include helping clients become better consumers and navigators of the health care system. Contractors report that the majority of family issues they address are related to medical/dental appointments and health issues and services. Contractors also work with families to find assistance with transportation, translation, food, clothing, and housing as well as referrals to other programs.

Impact on programs and policies: MCH contractors seek input of families/consumers and respond through changes to programs and policies (e.g. using text messaging for care coordination, use of language lines, and transportation to mental health services).

Efforts to build and strengthen for all MCH populations: IDPH provides oversight and consultation for MCH contractors through phone and email communication, annual site visits, quarterly regional meetings, an annual seminar, and regular program-specific meetings such as I-Smile™ trainings. Staff provides technical assistance, monitors data, discusses promising practices, and verifies contractors' progress toward performance objectives to assure family-centered approaches and overall program quality.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

Iowa's Title V program and the Iowa Medicaid program have a strong working relationship through a contract established yearly between IDPH and DHS, specifically Iowa Medicaid Enterprise (IME). This agreement is for six years and renewed annually through an amendment that addresses language and budget updates. This contract, the Omnibus Agreement, does not include services for children with special health care needs.

The Omnibus Agreement addresses cooperation between Title V, Title X, WIC, Title XIX, and Title XXI programs. Roles of DHS and IDPH are identified, and program descriptions are included. The purpose of each component is as follows:

- Attachment A - Informing and Care Engagement Administrative Services: This establishes parameters for Title V local contract agencies to provide and receive payment for the following:
    - Informing families of new Medicaid eligible children ages 0 to 21 years of the benefits and services within the EPSDT program.
    - Providing medical care coordination services for pregnant women and children on Medicaid who are not enrolled in a Medicaid MCO. The Medicaid MCOs hold the contractual responsibility for providing care coordination for MCO enrolled clients.
    - Providing dental care coordination for any Medicaid enrolled pregnant woman or child. This allows clients to be linked to oral health services provided by a dentist and coordinate oral health care services.
    - Providing presumptive eligibility for low income pregnant women. This service is open to the uninsured – both citizens and non-citizens. The pregnant woman is able to receive Medicaid covered maternal health services right away and establish an OB provider.
- Attachment B - EPSDT, Maternal Health, Oral Health, and 1st Five: This defines staffing for program support for the following:
    - EPSDT: Provides IDPH staff support for quality monitoring of EPSDT services provided by Title V contract agencies. Bureau of Family Health staff provide training, consultation, technical assistance, and quality review of local contract agencies (e.g. chart audits).
    - Maternal Health: Provides IDPH staff support for quality monitoring of maternal health services provided by Title V contract agencies. Bureau of Family Health staff provide training, consultation, technical assistance, and quality review of local contract agencies (e.g. chart audits).
    - Oral Health: Provides IDPH staff support for implementation of the I-Smile™ dental home initiative to improve access to Medicaid dental prevention and treatment services for children and pregnant women. IDPH staff provide training, consultation, technical assistance, and quality review of local contract agencies.
    - 1st Five Children's Healthy Mental Development: Provides IDPH staff support for quality monitoring of 1st Five sites located within Title V contract agencies in 88 of Iowa's 99 counties
- Attachment C – Maternal and Child Health and Hawki Outreach Services: This attachment provides support for the following:
    - Maternal and Child Health Outreach Services: Supports implementation of the toll-free 1-800 phone line so that women, youth, and families can receive information and referral for questions relating to prenatal care and well child services in addition to other services the family may need.
    - Hawki Outreach: Provides support for a state level Hawki Outreach Coordinator and funding for

local Title V CAH contract agencies to conduct Medicaid and Hawki outreach activities to promote enrollment. Local outreach activities are conducted with schools, faith-based organizations, medical and dental providers, special populations, and others.

- Attachment D – Medicaid and Vital Records Linked Data: Provides support for linking vital records data files and Medicaid paid claims data to evaluate health outcomes to related to Medicaid services provided for pregnant women and children. It provides important information on maternal characteristics and birth outcomes used for policy development and program planning. Through this attachment, IDPH funds the MCH Epidemiologist, through an agreement with the CDC. **Program outreach and enrollment**

Promoting outreach and enrollment occurs at a number of levels. Title V supports various websites and the 1-800 Healthy Families Line and Teen Line, and contracts with local community-based public or private non-profit organizations serving all counties in Iowa. Local contractors conduct outreach for Title V, Medicaid, and Hawki by linking with other programs (e.g. WIC), collaborating with local partners, participating in community events.

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

Health care financing

Funding to support Title V is a blend of IDPH, Iowa DHS, and Medicaid matching funds. IDPH provides payments to local Title V contract agencies that provide the services for clients in their service area. Non-direct care is considered Medicaid administrative services. Therefore, this funding is derived from a 50 -50 split of Iowa DHS and Medicaid matching funds.

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

Medical care coordination transportation is included in the MCO's contract with DHS. As a result, local Title V MCAH contract agencies are not able to bill for medical care coordination services or transportation services provided for MCO enrolled clients. This has had a significant impact on the continuity of care that Title V contract agencies are able to provide for their population.

Waiver Programs

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

Joint Policy Level Decision Making

Over the years, the Title V Director has experienced many opportunities to meet with Iowa's Medicaid Director on joint policy issues and problem resolution. Examples include working together to plan, pilot, and fully implement the informing and care coordination program; shifting Iowa's care management from 'targeted case management' to 'administrative care coordination' based upon federal clarification; including interpretation for PE, informing, and

care coordination as a service paid by IDPH to local MCAH agencies through DHS funding; increasing Medicaid's reimbursement rate for certain services based upon Cost Analyses completed by local Title V MCAH contract agencies; establishing third party billing policies; and resolving some instances of lack of payment to local contract agencies from the MCOs.

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

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

State Action Plan Introduction

State Action Plan Introduction

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

The State Action Plan and Annual Reports highlight the planned activities for FFY2022, ongoing activities, and accomplishments of FFY2020. The State Action Plan is broken into the Population Domains selected by HRSA.

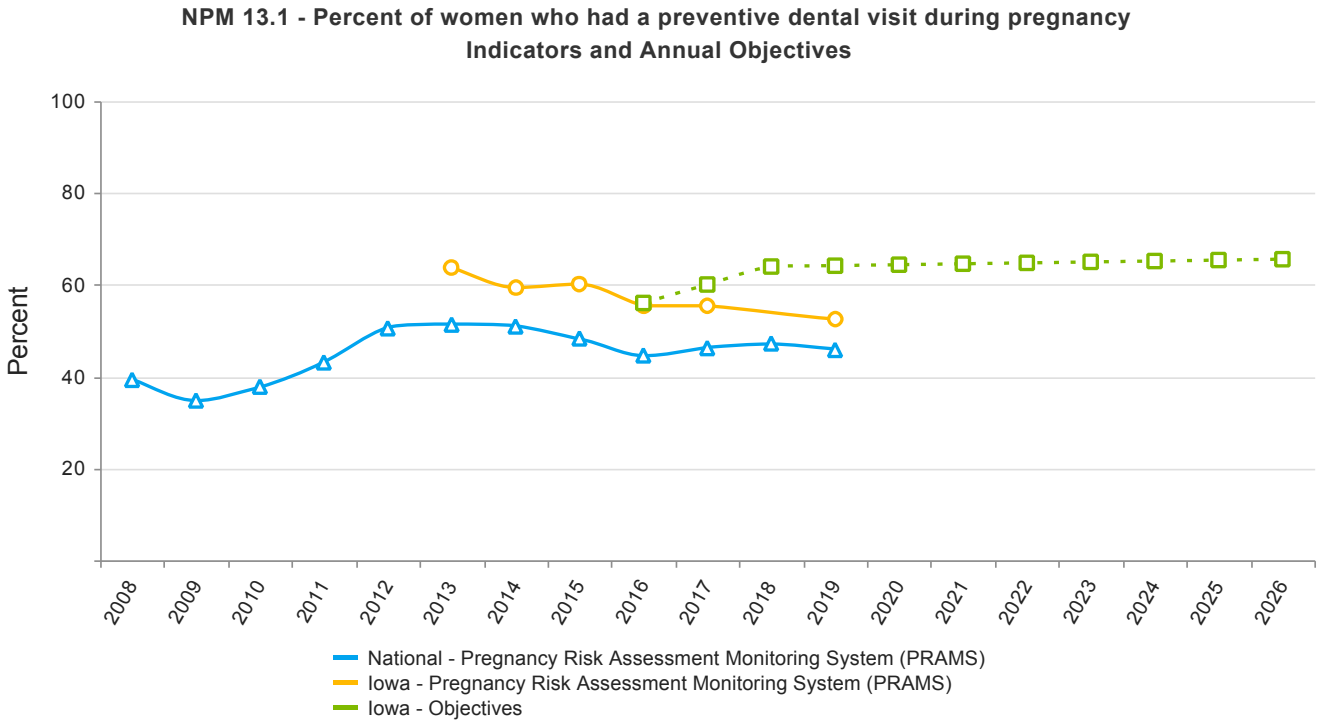
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	54.3	NPM 1 NPM 14.1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	10.4	NPM 1 NPM 14.1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	6.8 %	NPM 1 NPM 14.1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.5 %	NPM 1 NPM 14.1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	26.0 %	NPM 1 NPM 14.1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.4	NPM 1 NPM 14.1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.0	NPM 1 NPM 14.1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.1	NPM 1 NPM 14.1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.9	NPM 1 NPM 14.1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	150.9	NPM 1 NPM 14.1
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	90.0	NPM 14.1

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2015	5.7 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	2.9	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	9.9 %	NPM 13.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	27.3 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 13.1 NPM 14.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	14.1	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	10.2 %	NPM 1

National Performance Measures



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	56	60	63.9	64.1	64.3
Annual Indicator	59.2	60.2	55.3	55.3	52.4
Numerator	21,739	21,891	19,796	19,796	18,294
Denominator	36,708	36,352	35,811	35,811	34,942
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	64.5	64.7	64.9	65.1	65.3	65.5

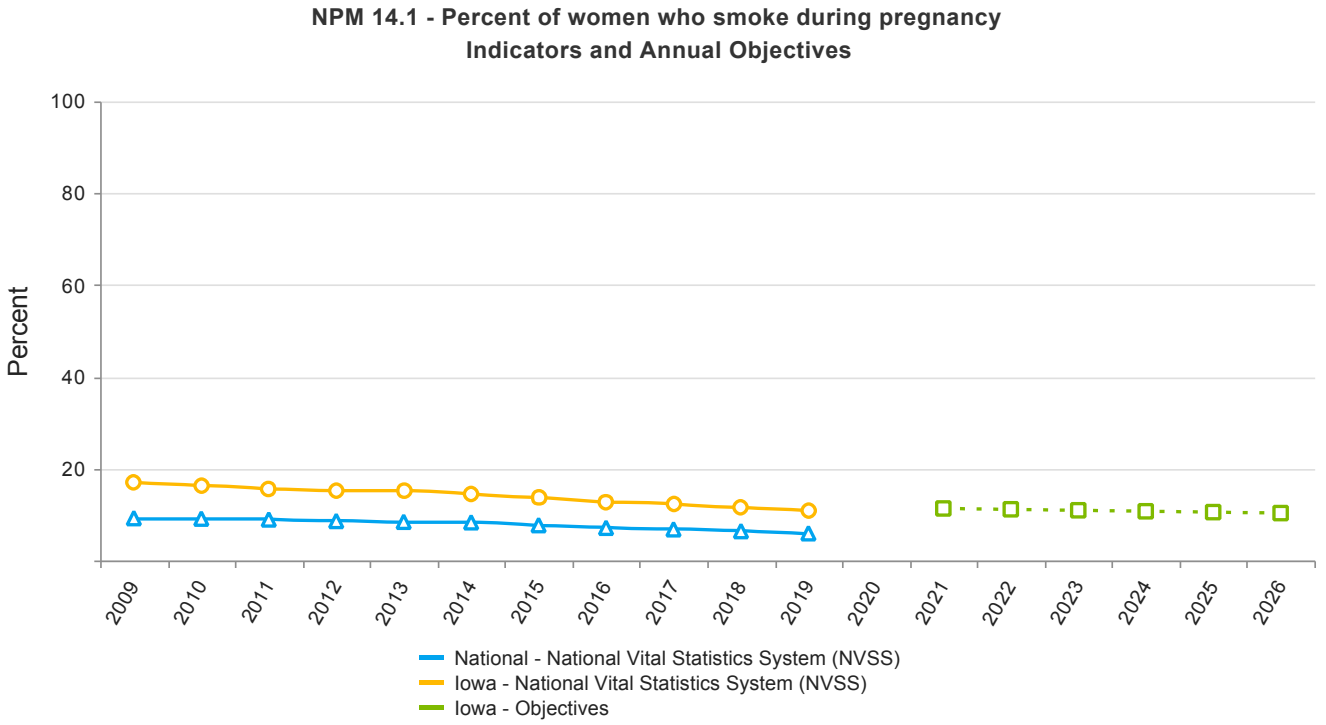
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			355	400
Annual Indicator			397	397
Numerator				
Denominator				
Data Source			Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year			2019	2019
Provisional or Final ?			Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0



Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	11.6	11.0
Numerator	4,388	4,120
Denominator	37,751	37,613
Data Source	NVSS	NVSS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	11.4	11.2	11.0	10.8	10.6	10.4

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		9.4
Numerator		
Denominator		
Data Source		Iowa's Maternal Mortality Review Committee (IMMRC)
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.0	8.9	8.8	8.7	8.6	8.5

State Action Plan Table

State Action Plan Table (Iowa) - Women/Maternal Health - Entry 1	
Priority Need	
Dental Delivery Structure of the MCAH Population	
NPM	
NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy	
Objectives	
By 2025, increase the percent of women who had a preventive dental visit during pregnancy to 65.3%	
Strategies	
Build partnerships with organizations and health care providers	
Outreach to dental and medical providers	
Oral health promotion	
Care coordination and referrals	
Gap-filling preventive services	
Collect race and ethnicity data to help identify gaps in services	
ESMs	**Status**
ESM 13.1.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

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

Priority Need

MCAH Systems Coordination

NPM

NPM 14.1 - Percent of women who smoke during pregnancy

Objectives

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

Strategies

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

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

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

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

Provide individualized health education to all maternal health clients on the importance of tobacco cessation, and provide referrals to resources

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

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

NOMs

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

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

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

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

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

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

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

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

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

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

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

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

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

Priority Need

MCAH Systems Coordination

SPM

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

Objectives

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

Strategies

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

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

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

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

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

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

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

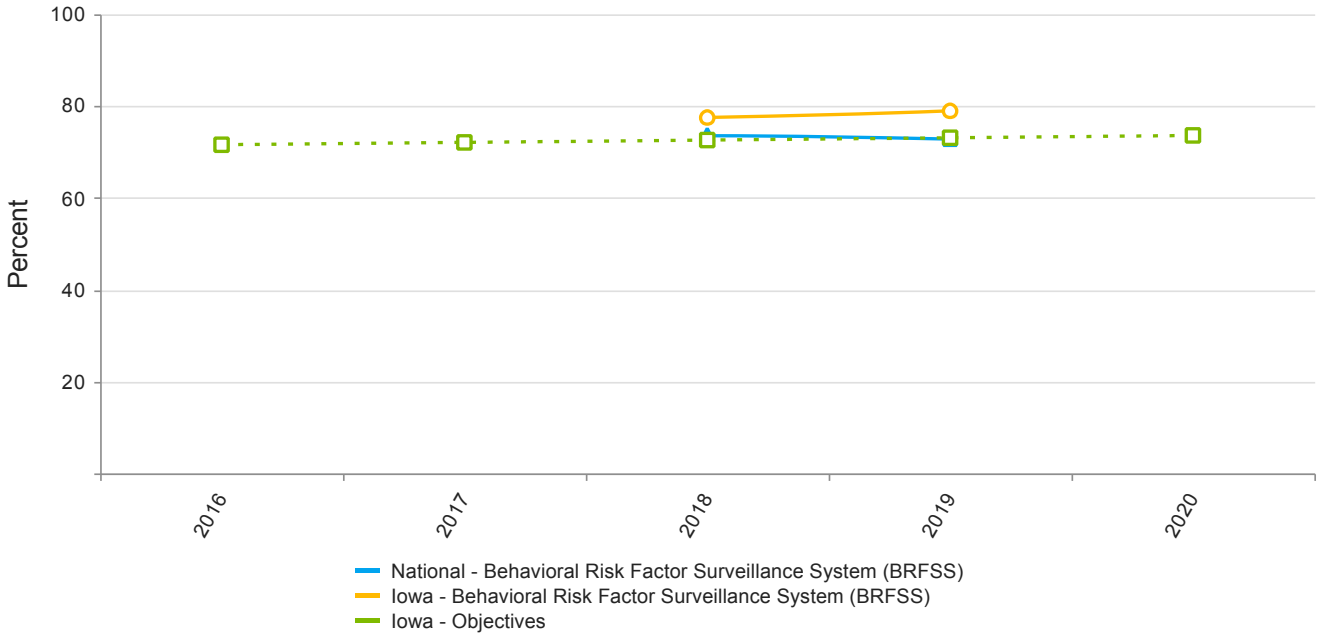
Maternal Mortality Committee will recruit multidisciplinary members to participate in the review process

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

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

2016-2020: National Performance Measures

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



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					73.5
Annual Indicator				77.3	78.7
Numerator				407,591	417,043
Denominator				527,210	529,605
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

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

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

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		65	35	54	59
Annual Indicator	64	27.2	48.6	51.8	53
Numerator	5,478	296	1,357	1,842	2,339
Denominator	8,560	1,090	2,794	3,559	4,416
Data Source	WHIS	TAV Connect	TAV Connect	Signifycommunity	Signifycommunity
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

2016-2020: State Performance Measures

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

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		91	84.5	88	89
Annual Indicator	90.5	84	87	86.2	82.4
Numerator					
Denominator					
Data Source	CAReS and WHIS	TAV Connect	TAV Connect	Signifycommunity	Signifycommunity
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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

All new Title V MH staff received education on Iowa's State Family Planning Program, either through in person training or by viewing a recorded webinar. In July of 2017 Iowa's State Family Program replaced the Family Planning Medicaid 1115 Waiver which provides coverage for birth control for low income women. The program was shifted from a Federal Waiver through Iowa Medicaid to a State funded program through direct state appropriation. In FFY20, ongoing education was provided to local Title V agencies to ensure agency staff understood the program and were able to help eligible women access free or reduced cost birth control.

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

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

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

Although the COVID-19 pandemic did not truly impact the I-Smile™ program until March, it was felt significantly from March through September. The burden of the pandemic on low-income pregnant women and children's access to dental services can be seen by looking at the large decrease in Iowa dentists billing Medicaid for services provided to children. Medicaid data indicates that in SFY20, just 950 dentists billed Medicaid compared to 1,066 in SFY17, 1,038 in SFY18, and 1,035 in SFY19.

In response to the Governor's pandemic declaration, dental offices were required to close for more than a month. Once reopened, the additional costs of personal protective equipment, changes in office procedures for patient appointments, and backlog of patients from the closures resulted in many dental offices limiting or declining to see Medicaid-enrolled patients. Prior to dental offices reopening, the Iowa Dental Board adopted specific COVID-related infection control recommendations; OHDS staff then developed infection control guidelines for I-Smile and I-Smile@School based on dental board requirements. OHDS staff provided a great deal of technical assistance to I-Smile™ contractors with the ever-changing COVID-19 protocols and research.

I-Smile@School offered no services from mid-March through August and resumed very limited direct services in September 2020. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics used virtual appointments, reducing the maternal and child health clients' access to preventive dental services (which are only available in-person). The inability to provide direct dental services resulted in some local I-Smile™ staff to be laid off. County health departments enlisted I-Smile™ staff to assist with pandemic response efforts.

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

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

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

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

Women/Maternal Health - Application Year

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

The I-Smile™ program's primary goal is to connect children and pregnant women with dental homes. In addition, the efforts of Maternal, Adolescent, and Child Health (MCAH) contractors' administration of I-Smile™ across the state have helped to get children and pregnant women needing preventive dental care, despite the limited ability for low-income children and adults to access dentists.

The lack of dentists' enthusiasm to see and treat Medicaid patients may be negatively affecting the rates of children and pregnant women getting regular preventive dental visits. Despite all the work Iowa is doing to connect children and pregnant women with dentists and preventive services, the rate may decrease if this does not improve and also prevent Iowa from hitting the objective. If rates of children accessing a preventive dental visit do not increase, it is likely the National Outcome Measure (reduce the percent of children and adolescents who have dental caries or decayed teeth) will increase, meaning more children will experience cavities and poor oral health outcomes. The work of the Bureau of Oral and Health Delivery Systems (OHDS) and I-Smile™ benefits children and pregnant women; there aren't always distinctions between how the activities we do benefit one population versus the other.

OHDS staff will continue to hold quarterly I-Smile™ Coordinator training to ensure program consistency, share best practices, develop leadership skills, discuss new opportunities, and promote current standards and procedures. Training will include continuing education on current oral health topics and provide an open forum for sharing between the Coordinators. OHDS staff will have a site visit with each MCAH contractor to discuss local work plans, review data, and troubleshoot concerns in addition to spring site visits to review current data. OHDS staff will also participate in yearly chart audits to ensure service documentation accuracy.

Assuring optimal 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, Count the Kicks, and the University Of Iowa College Of Dentistry. Partnership activities in FY22 will include training of local WIC staff; networking meetings with Head Start Health Coordinators; and collaborating on oral health promotion campaigns, such as "Rethink Your Drink". OHDS will continue working with new partner, Count the Kicks, which uses best practices and evidence-based strategies to save babies and prevent stillbirths – incorporating more oral health education within its messaging for pregnant women. In FFY2022, OHDS staff will assist Count the Kicks with oral health education and resources to keep moms and babies healthy, including reviewing materials for the Count the Kicks website. I-Smile™ Coordinators will continue to distribute Count the Kicks educational materials while doing outreach to medical and dental offices.

A partnership with Title X will continue, seeking to educate adolescent and maternal health clients on Human Papillomavirus (HPV) and oral health. I-Smile™ Coordinators will distribute education on HPV vaccines and oral cancer screenings - available on rack cards - at family planning clinics, WIC, and dental offices. OHDS staff will collaborate with Quitline Iowa staff to produce oral health education about the effects of tobacco products for maternal health clients, distributed by I-Smile™ Coordinators to dental clinics, FQHC's, WIC, and family planning clinics and will include: toolkits, educational materials, and training programs for providers on quitting tobacco use.

OHDS staff will maintain its 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. 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. Medical office training is provided by I-Smile™ Coordinators.

OHDS staff recently obtained results from a department Maternal Health Strategic Plan Survey that found community members get their health information from health care providers, internet, and friends/family members. OHDS will use this information to implement more maternal health and medical provider outreach. Also, OHDS staff will begin to implement the use of QR codes on promotional materials to ease access to resources.

In FFY2022, each I-Smile™ Coordinator will develop 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 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 training for medical office staff as requested, and conduct oral health promotion at community events. I-Smile™ Coordinators were previously provided educational materials and training for collaborating with Child Health Specialty Clinics (CHSC) providing education and implementing a referral process. This program will be evaluated over the next year to determine ways to increase contact with CHSC and create stronger relationships. OHDS staff will work to increase the relationship between CHSC administration and I-Smile™. Coordinators will also be expected to implement SDF in their activities. With many children not getting preventive dental care over the last year and unable to access a dentist for restorative care due to COVID-19, OHDS staff expect to see an increase of SDF use over the next year and will continue to address barriers.

I-Smile™ Coordinators will train MCAH staff 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, silver diamine fluoride) 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.

OHDS staff and the I-Smile™ program will advance its ability to reach clients in innovative ways. The National Outcome Measure (reduce the percent of children and adolescents who have dental caries or decayed teeth) will remain a goal of the program. OHDS staff are continuously monitoring state and county specific data to direct client care and see where the program focus should be. OHDS staff and I-Smile™ Coordinators look forward to next year seeing more Iowa families in person and increasing the education on oral health.

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

A variety of reasons could have caused this slight decline in tobacco use during pregnancy including the potential use of vaping or e-cigarette products instead of tobacco, therefore there is the potential for underreporting of nicotine use. Over the past year there has been an increase in local activities and referrals for tobacco cessation at the IDPH Title V agencies, this could be a potential aid to declining the rates in future years.

IDPH MH staff will actively continue collaborate with staff from the Division of Tobacco Use and Prevention. This

includes 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 collaborating 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 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 includes 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 provide training resources to all MH agencies, including online access to the Ask, Advise, Refer training. This is a standardized assessment and referral tool all agencies will be required to use with pregnant women who use tobacco. IDPH staff 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 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 2022, 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.

Conduct annual Maternal Mortality Reviews with a multi-disciplinary review committee and distribute findings and recommendations widely. 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 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. Staff are continuing the development of the IMQCC, 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 continue to support the IMQCC, in efforts to continue participation in the AIM and implement hospital safety bundles. The IDPH director or designee will appoint members and co-chair the IMQCC, and IDPH MH staff will participate in the collaborative to assist in the coordination of meetings, subcommittees, and other needs to ensure success of the IMQCC.

Perinatal/Infant Health

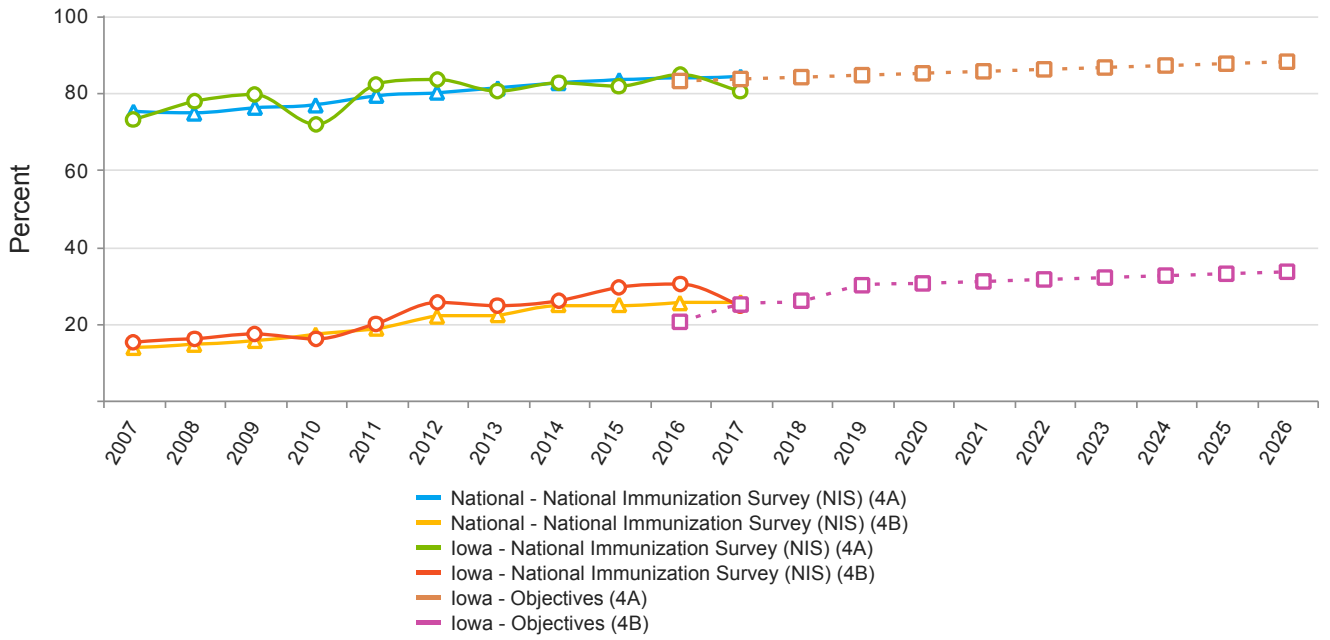
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	5.0	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.9	NPM 4 NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	90.0	NPM 4 NPM 5

National Performance Measures

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

Indicators and Annual Objectives



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	83	83.5	84	84.5	85
Annual Indicator	80.5	82.7	81.5	84.5	80.2
Numerator	26,118	31,692	29,306	27,589	28,001
Denominator	32,462	38,306	35,951	32,646	34,927
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	85.5	86.0	86.5	87.0	87.5	88.0

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20.5	25	26	30	30.5
Annual Indicator	24.9	26.1	29.5	30.5	24.8
Numerator	7,875	9,655	10,092	9,785	8,458
Denominator	31,681	36,965	34,193	32,069	34,057
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.0	31.5	32.0	32.5	33.0	33.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.0	46.0	69.0	92.0	112.0	122.0

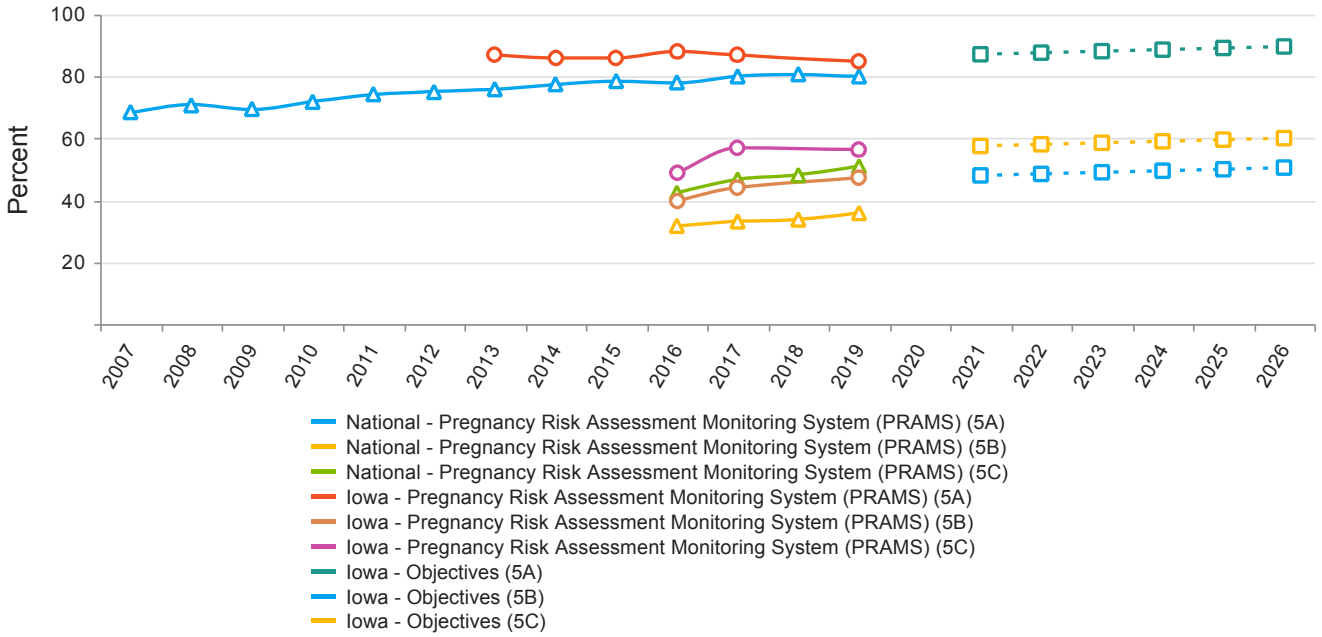
ESM 4.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

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



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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective		
Annual Indicator	86.7	84.8
Numerator	30,649	29,197
Denominator	35,356	34,418
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	87.5	88.0	88.5	89.0	89.5

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective		
Annual Indicator	44.2	47.5
Numerator	15,044	15,850
Denominator	34,022	33,343
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	48.0	48.5	49.0	49.5	50.0	50.5

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective		
Annual Indicator	57.0	56.1
Numerator	19,594	18,702
Denominator	34,396	33,309
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	57.5	58.0	58.5	59.0	59.5	60.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	14.0	16.0	18.0	20.0	22.0

State Action Plan Table

State Action Plan Table (Iowa) - Perinatal/Infant Health - Entry 1
Priority Need
Access to care for the MCAH Population
NPM
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Objectives
By 2025, increase the percent of infants breastfed exclusively for 6 months to 33%
Strategies
Title V agency will collaborate with the hospital lactation consultant in their service area to ensure mutual referrals
Title V agency staff will join their local breastfeeding coalition
Title V agencies will work with a minimum of 1 local employer with a minimum of 50 employees per year to educate on breast pumping policy, laws and best practice
Title V agencies will ensure their staff are appropriately trained on current breastfeeding best practice through continued education
Title V agencies will link their clients to a WIC peer counselor when one is available
Title V agencies will maintain a list or directory of local breastfeeding resources to share with clients and the community
Title V agencies will refer clients to a lactation counselor when appropriate
TItle V agencies will provide breastfeeding educational materials to all clients
Title V agencies will provide health education on breastfeeding when providing direct care services, including postpartum home visit. Education will be culturally and linguistically appropriate.
Title V agencies with develop individualized breastfeeding education that is tailored to each client's needs, and will take into account cultural beliefs and experiences that may impact breastfeeding
Local Title V agencies will provide breastfeeding classes for women in their service area if other classes are not available

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

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

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

Priority Need

Safe and Healthy Environments

NPM

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

Objectives

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

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

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

Strategies

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

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

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

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

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

A flyer on safe sleep will be distributed with each birth certificate on an annual basis

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

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

NOMs

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

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

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

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

Iowa's data for NPM 4 showed a decrease in the percent of infants who ever breastfed and the percent of infants breastfed exclusively through 6 months. The 2017 data does not reflect the work outlined in the Title V action plan for FFY2020. IDPH increased breastfeeding education and support, began working with workplaces to increase breastfeeding opportunities and Title V strengthened its relationship with the WIC program. Iowa hopes to see improvements in the data in future years.

IDPH has worked diligently over the past year to continue to support the need for improving rates of exclusive breastfeeding through at least 6 months of age despite the COVID-19 pandemic. The pandemic has caused a shift in many things for the families Title V serves in Iowa, but staff at the state and local levels shifted quickly as well.

Statewide initiatives went primarily virtual. IDPH staff attended the virtual Iowa Breastfeeding coalition meetings as well as their annual conference. The annual conference this year included topics such as Using Antidepressants in Breastfeeding Mothers, presented by Thomas Hale. The meetings have focused on various types of breastfeeding supports through the pandemic as well as informational sessions on postpartum mental health supports. These meetings have served as great ways for the IDPH team to network with local breastfeeding experts and stay up to date with current work in the clinical world.

The IDPH WIC program started the process to develop the Statewide Breastfeeding Strategic Plan for Iowa. They are working with an outside contractor to facilitate the process, and have included the Title V maternal health team on the internal team. Involvement in the process has allowed the Title V staff to include information about the work Title V is doing to support statewide breastfeeding efforts.

The Bureau of Family Health is also in the planning phase of a pilot program that will support doulas through Iowa's Title V local structure. Iowa's Title V Doula project has multifaceted goals including improving maternal and infant health outcomes, with an emphasis on breastfeeding support. Doulas in the program will have the opportunity to obtain further breastfeeding training in the form of a certified lactation specialist or certified lactation counselor certificate. This program is expected to launch September 1, 2021.

Work at the local level has been plentiful, despite the pandemic. All 23 maternal health agencies have virtually sent staff to breastfeeding continuing education, many attended the Iowa Breastfeeding Coalition annual meeting. The agencies also all have representation on either local or state breastfeeding coalitions leading to increased networking opportunities on different levels. Over the course of the year, the agencies have also been reaching out to and developing referral processes with their local hospitals and local lactation consultants. The agencies also created a local breastfeeding resource guide for distribution in their communities and with their clients. Title V clients at the local level also received culturally sensitive, and individualized breastfeeding support as needed. One Title V agency has provided lactation classes for local mothers as well.

Community education is also an important element of the local Title V Agencies' work. This year agencies worked with a local employer, with a minimum of 50 employees, on what the current breastfeeding laws and rules apply to the workplace. Local staff also referred to the WIC peer counselors when possible and educated themselves and their clients on the WIC breast pump policies to make sure accurate information is spread in the community.

COVID-19 has pushed all those involved with Title V work out of their comfort zones and into the new world of virtual

support. Local agencies began using telehealth to reach clients for health education and psychosocial support visits. This had the surprising silver lining of proving to be very successful as barriers such as travel and work for clients were removed. Clinic have returned to in person services generally, but are still utilizing telehealth on an as needed basis when a client has a barrier to getting to the clinic. This option will be suspended when the public health emergency ends.

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

Multiple resources have been supporting and educating about the importance of breastfeeding for both the infant and mother for the past 20 years. Rates have continued to improve with the continued education and support. With the current COVID-19 pandemic, there is a possibility that the rates of exclusive breastfeeding may remain the same or even decrease. Post-COVID, it is anticipated that with continued education and infrastructure work, the percentage of women breastfeeding their infants exclusively for 6 months will continue to increase.

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

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

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

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

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

The current rate of 86.7% of infants in Iowa placed to sleep on their back has been impacted by the significant work done by IDPH, hospitals, healthcare providers and non-profit organizations to educate about the importance of the “back to sleep” practice. This rate will continue to improve incrementally as IDPH contractors start to tailor education to the needs of individual clients, taking into account their cultural and personal beliefs.

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

The Title V agencies in Iowa will each reach out to at least community organization per year who works with anyone

who puts a baby down to sleep to provide education about safe sleep environments. This education will cover topics such as: back to sleep, safe sleep environment, no co-sleeping, no extra items in the crib and any other recommendations from the Child Death Review team. Additionally, this can potentially open a line of communication between the agency and retailer for future collaborative purposes.

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

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

Child Health

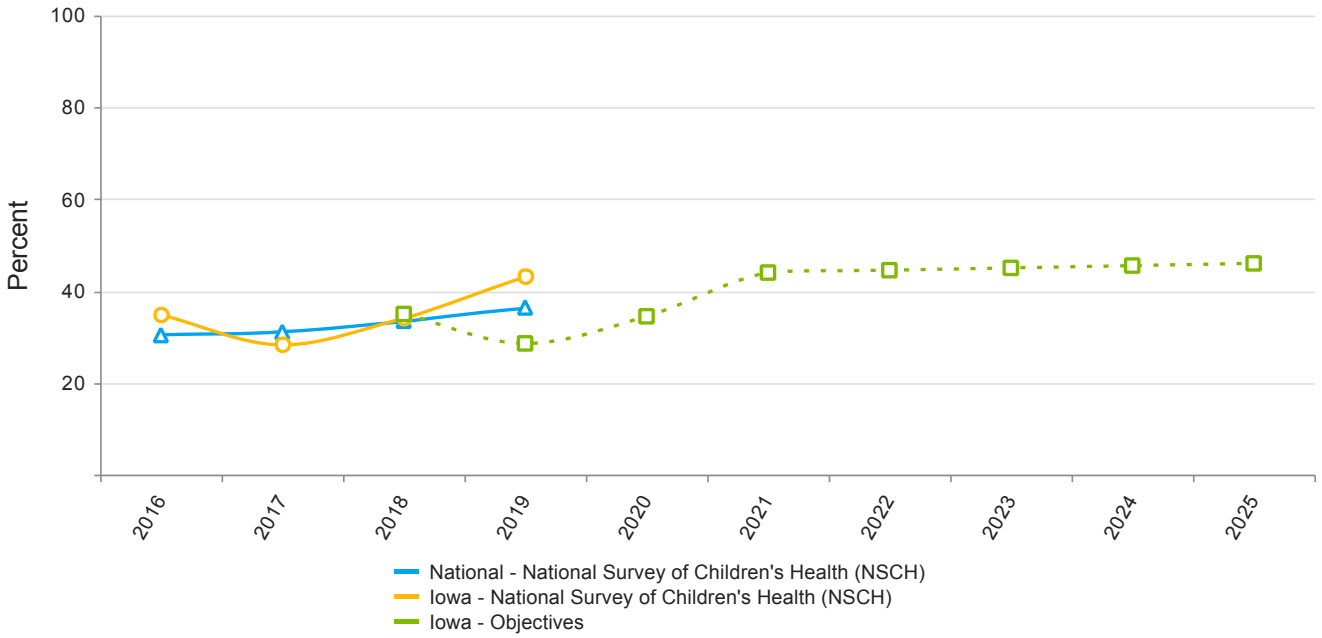
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available or Not Reportable	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	9.9 %	NPM 13.2
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	27.3 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 6 NPM 13.2

National Performance Measures

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

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			35	28.6	34.5
Annual Indicator		34.8	28.4	34.2	43.2
Numerator		31,438	27,467	32,539	43,907
Denominator		90,233	96,650	95,266	101,539
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	44.0	44.5	45.0	45.5	46.0	46.5

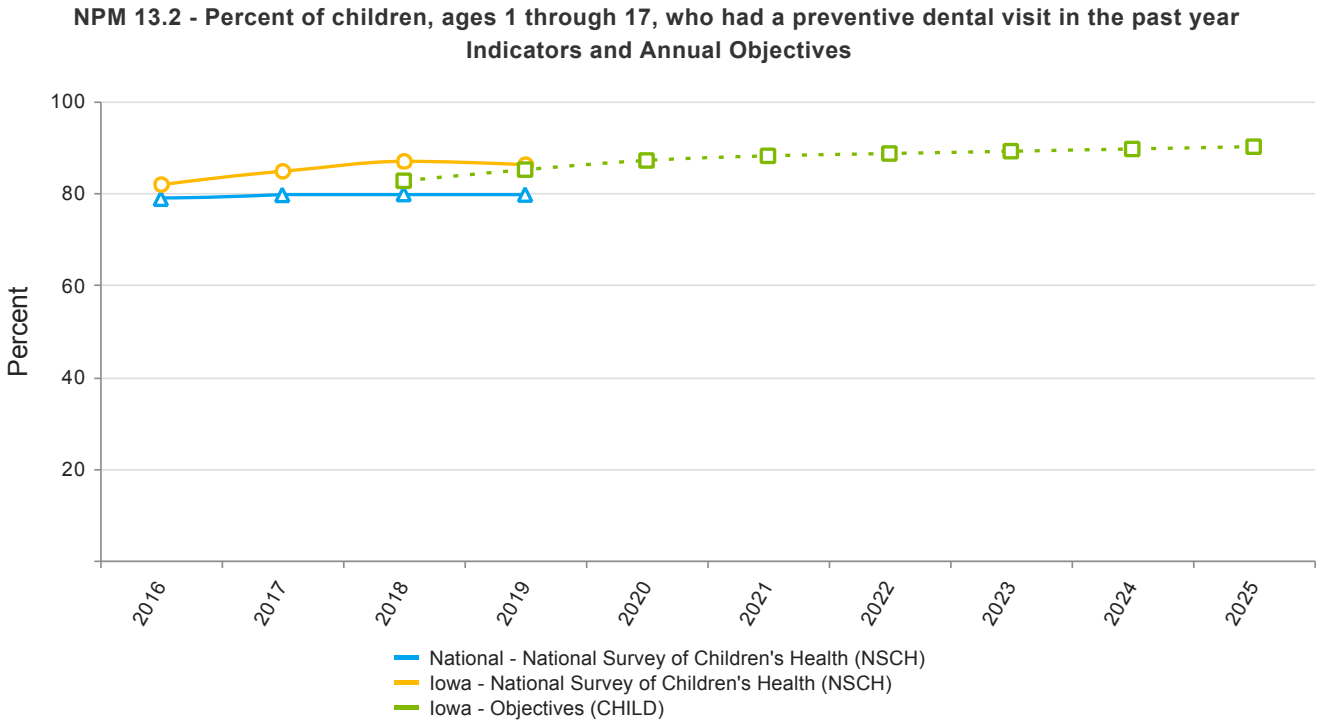
Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		1.5	2	2	2.5
Annual Indicator	0.9	1.6	1.9	1.9	2
Numerator	971	1,744	1,076	1,076	2,537
Denominator	110,608	110,577	56,307	56,307	125,164
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2016	2017	2018	2018	2020
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.2	2.3	2.4	2.5	2.6	2.7



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			82.6	85	87
Annual Indicator		81.7	84.7	86.7	86.1
Numerator		563,970	573,272	585,814	583,397
Denominator		690,337	676,624	675,638	677,662
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.0	88.5	89.0	89.5	90.0	90.2

Evidence-Based or –Informed Strategy Measures

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

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			350	385	400
Annual Indicator	93	341	380	397	397
Numerator					
Denominator					
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68
Numerator		
Denominator		
Data Source		IDPH Lead Report Card
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	72.0	74.0	76.0	78.0	80.0

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		30	32	36	38
Annual Indicator	28.5	25.6	34.6	37.2	42.1
Numerator	1,512	1,347	1,558	1,563	1,759
Denominator	5,299	5,265	4,507	4,201	4,183
Data Source	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.0	44.0	45.0	46.0	47.0	48.0

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	873	1,080
Numerator		
Denominator		
Data Source	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1,100.0	1,200.0	1,300.0	1,400.0	1,500.0	1,600.0

State Action Plan Table

State Action Plan Table (Iowa) - Child Health - Entry 1	
Priority Need	
Access to care for the MCAH Population	
NPM	
NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year	
Objectives	
By 2025, increase the percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year to 24.5%	
Strategies	
Provide System Coordination of development screens with local providers. This includes child care providers, home visiting programs, primary care providers, CCNC, Head Start to assess for gaps, assure access and avoid duplication	
Community Partnerships with Children's Mental Health System Regions throughout the state	
Promotion of screening to Early Childhood Education Programs (ECE)	
Priority Population Partnerships. Partner with specific organizations, programs or groups that address priority populations to increase culturally appropriate access, outreach and education on developmental screening and emotional behavioral assessments	
Educate parents on developmental milestones in their children's lives and promote the Iowa Family Support Network and Early Access	
Developmental Monitoring for required Early ACCESS Activity - infants and toddlers ages 0-3 found not be eligible for Early ACCESS services	
Monitor and assess the rates of ASQ or ASQ: SE Referrals for both Title V local agencies and 1st Five Healthy Mental Development contractors.	
Utilize the evaluation of 1st Five Healthy Mental Development program to identify gaps and avenues for continued collaboration.	
ESMs	**Status**
ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.	Active

NOMs

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

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

Priority Need

Dental Delivery Structure of the MCAH Population

NPM

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

Objectives

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

Strategies

Building partnerships with organizations and health care providers
Outreach to dental and medical providers
Oral health promotion
Care coordination and referrals
Collect race and ethnicity data to help identify gaps in services

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

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Priority Need

Safe and Healthy Environments

SPM

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

Objectives

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

Strategies

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

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

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

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

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

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

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

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

Pursue a peer to peer contractor to promote blood lead testing of one and two year old individuals with primary care providers

Collaborate with the IDPH Lead Poisoning Prevention Program to provide access to the HHLPSS system for Title V contractors to allow timely review of blood lead testing results

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

Priority Need

Safe and Healthy Environments

SPM

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

Objectives

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

Strategies

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

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

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

State HCCI staff will evaluate local CCNC agencies for program fidelity including annual inter-rater reliability visits with local CCNCs utilizing the Health and Safety Checklist assessment tool. Fidelity with the tool will be at 90% or higher

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

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

HCCI CCNC program will center around equity incorporating health equity language into the CCNC Role Guidance, contracts and promote (champion) equity into our state child care system. HCCI will incorporate the 10 Essential Public Health Services into program model and structure

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

Priority Need

Dental Delivery Structure of the MCAH Population

SPM

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

Objectives

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

Strategies

Maintain and develop state and local partnerships

Outreach and training for medical providers

Outreach to dentists

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

As part of Iowa's Federal/State Partnership, Iowa's state-funded 1st Five program engaged healthcare providers in supporting the use of developmental surveillance and standardized developmental screening tools. A partnership between providers and 1st Five staff is established for developmental support services (an enhanced form of referral and follow up services).

Local 1st Five site coordinators continued to work on outreach to primary care practices. Outreach included, but is not limited to, screening information displayed in newsletters, trainings, and guide books. Local 1st Five site coordinators worked with 1st Five Medical Consultants on providing developmental screening trainings to office staff and engaged healthcare partners.

Contracts with local 1st Five sites included a revised performance measure to increase the percentage of referrals that follow results of a standardized developmental screen. The revised measure tiered the increase expectations so that lower performing sites will need to make greater progress to achieve the measure. This strategy showed marked improvements in the numbers of primary care practices engaging with 1st Five.

1st Five's IDPH staffing has changed to bring in staff with more direct experience working with practices to transition them to full use of standardized developmental screening tools. Through this staffing, technical assistance for local sites included enhanced assistance with planning, preparation, and skill-building to better prepare local staff for approaching and working with primary care practices. The initiative also adjusted staffing requirements to include additional competencies with developmental support services, including efficient effective tracking of referral and follow-up services, and bring increased technical assistance to local sites for this skill set as well.

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

In the FFY 2020 MCAH RFA application process and resulting contract, the BFH continued the requirement for provision of developmental screening services, including maintaining a working relationship with the Area Education Agencies (AEAs) regarding developmental screening and providing developmental monitoring for children referred to Early ACCESS (IDEA, Part C) who were not deemed eligible for Early ACCESS services. Data was collected, and quarterly reports were created based upon aggregated ASQ and ASQ:SE scores identified by Title V CAH agencies.

BFH staff continued the strong working relationship between Title V MCAH and Iowa Medicaid Enterprise (IME). BFH staff worked with Medicaid's project manager to continue payable developmental screening services under the Screening Center provider status by both Iowa Medicaid and the Medicaid Managed Care Organizations (MCO). The Iowa Department of Human Services (DHS) began contracting with a new MCO - Centene's Iowa Total Care - who began processing claims for services provided July 1, 2019 and after. With the departure of UnitedHealthcare, local CAH agencies assisted clients in transitioning coverage to the remaining MCOs - Amerigroup and Iowa Total Care.

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

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

Although the COVID-19 pandemic did not truly impact the I-Smile™ program until March, it was felt significantly from March through September. The burden of the pandemic on low-income pregnant women and children's access to dental services can be seen by looking at the large decrease in Iowa dentists billing Medicaid for services provided to children. Medicaid data indicates that in SFY20, just 950 dentists billed Medicaid compared to 1,066 in SFY17, 1,038 in SFY18, and 1,035 in SFY19.

In response to the Governor's pandemic declaration, dental offices were required to close for more than a month. Once reopened, the additional costs of personal protective equipment, changes in office procedures for patient appointments, and backlog of patients from the closures resulted in many dental offices limiting or declining to see Medicaid-enrolled patients. Prior to dental offices reopening, the Iowa Dental Board adopted specific COVID-related infection control recommendations; OHDS staff then developed infection control guidelines for I-Smile and I-Smile@School based on dental board requirements. OHDS staff provided a great deal of technical assistance to I-Smile™ contractors with the ever-changing COVID-19 protocols and research.

I-Smile@School offered no services from mid-March through August and resumed very limited direct services in September 2020. Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinics used virtual appointments, reducing the maternal and child health clients' access to preventive dental services (which are only available in-person). The inability to provide direct dental services resulted in some local I-Smile™ staff to be laid off. County health departments enlisted I-Smile™ staff to assist with pandemic response efforts.

Local I-Smile™ program activities were modified from original plans to reflect what was possible during the pandemic. For example, Coordinators' outreach to dentists and physicians were completed by phone or virtually, rather than in person. I-Smile™ Coordinators found new ways to reach families including: oral screenings during drive-through meal pickups at schools, creating YouTube oral health education videos, and offering care coordination and preventive services at vaccination sites. Care coordination continued, with additional focus on contacting families due for regular check-ups.

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

In FFY2020, the medical home percentage was 82.47. This rate is down from previous years, however it exceeds the annual objective set for 2020 (81.5%).In FY20, Title V changed how medical home was documented in the MCAH database from a one-time report to an ongoing measure. Prior to FY20, medical home was asked at first contact with the family, and may not have been updated after that. Families face ongoing barriers to establishing a medical home. This question is now asked at each contact with the family. This way of assessing medical home will be a truer picture of families' access to care in a medical home. The drop this year, may also reflect the change in data collection. Contractors had to document medical home differently, and it took some time for contractors to adjust and document correctly. We anticipate the rate will go up slightly, after contractors have adjusted to the documentation. However, COVID-19 may also have an impact on medical home in the coming years.

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

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

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

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

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

BFH staff continued to work with Child Health Specialty Clinics regarding efforts to promote medical homes for children with special health care needs to support NPM #11 and assure appropriate resources for referral from CAH agencies. These included telehealth projects like Phones for Families.

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

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

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

for presumptive eligibility.

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

In Iowa, 75% of working families with children under the age of 6 years utilize child care. Iowa has over 4,100 regulated child care providers (centers, preschools and homes). 76% of child care remained open during the COVID-19 pandemic however many at reduced capacity. Programs that closed were mostly associated with local school districts. Currently there are not enough child care slots to meet the needs of working families and almost one-fourth of Iowans live in child care deserts. That number is even higher when looking for infant and toddler child care. Nationwide and in Iowa there has been an increase in childhood chronic health conditions and allergies. Child Care Nurse Consultants (CCNC) provide best practice guidance, assessment visits, training and care planning for children with special health needs to help ensure equitable access and improve child care quality. The CCNC program is non-regulatory and is available statewide with all 99 counties having local CCNC services. In FY20, we exceeded our goal for the percentage of child care programs participating with their local child care nurse consultant, with 42% of programs receiving CCNC services. Services included 3082 child care visits (on-site and virtual), 9,113 technical assistance (increased 47%) and 680 children with special health needs identified, 91% with a care plan in place at the child care program.

Healthy Child Care Iowa continued to provide support to Title V Child Health partners/local CCNC agencies in the following activities:

- Developed/revised data collection tools for streamlined tracking and reporting data
- State and regional CCNC meetings for review of the *Child Care Nurse Consultant Role Guidance* to achieve SPM 4 and standards of services; data collection tools; program fidelity
- Continued to facilitate the development of partnerships between Title V Child Health agencies/CCNC programs with local Early Childhood Iowa boards and other local stakeholders
- Statewide coverage for CCNC services in all 99 counties
- Collaborated with state partners on identified PM adding in chronic health conditions data to align with Iowa school data collection for special needs care planning
- Continued participation on the QRIS Oversight Team for development of required CCNC services for meeting Medication Administration Skills Competency and on-site health and safety assessment utilizing a nationally recognized research based assessment tool for child care programs applying for Iowa's new quality rating system (Iowa Quality For Kids - IQ4K)
- Provided oversight and guidance to the TA and Mentoring CCNC Team for supporting local CCNCs, precepting of nurses enrolled in the Iowa Training Project for Child Care Nurse Consultants, mentoring of local CCNCs and providing on-site child care provider visits to programs in the 3 county area without access to local CCNC services

Title V staff and HCCI staff will continue researching potential partnerships to increase funding for gap filling services throughout the state.

Child Health - Application Year

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

Each of Iowa's 23 Title V Child and Adolescent Health (CAH) contract agencies are approved Medicaid Screening Centers. They are enrolled with the IME and two MCOs (managed care organizations) operating in Iowa are (Amerigroup and Iowa Total Care -July 2019). Developmental screenings and emotional/behavioral assessments are provided by CAH agencies using the ASQ and ASQ:SE tools. Contract agencies are able to receive payment from the IME for services provided for Medicaid fee-for-service clients and from the Medicaid MCO for children enrolled in an MCO.

The FFY 2022 Request for Application (continuation of the RFP 2016 - due to COVID-19) will continue to require all CAH applicants to develop plans to address NPM 6 - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year. Agencies will continue coordinating developmental screening with local providers such as child care providers, home visiting programs, and primary care practitioners to assess need, assure access, and avoid duplication; collaborating with early care and education providers that encourage developmental screening; and educating families on the importance of developmental screening at recommended age intervals.

Currently, IDPH is reviewing results from a state-wide environmental scan conducted by the University of Iowa on where and how developmental screenings are occurring. The results of the data analysis will be used for planning for the FFY2023 RFP.

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

Continuation in 2022, Title V agencies will be asked to continue to engage with the Children's Behavioral Health Coordinator in their Children's Mental Health System Region in system building to advance universal, periodic behavioral health screening and assessments, education, prevention and access to mental health consultation services in collaboration with the Children's Mental Health Systems Region covering all counties their service area. Detecting early signs of mental health conditions in children, will circumvent issues later. If children can be referred to mental health professionals (counselors, therapists, psychologists, etc) earlier in life, long-term benefits will result.

Continuation in 2022, Title V agencies will continue to be asked to write to one of the priority populations in the FFY 2022 RFA. This includes- African Americans/Black American, Alaska Native/Native Americans, Asian/Pacific Islanders, Fathers, Hispanic/Latinx, Immigrants/Refugees, LGBTQ+ and Persons with Disabilities. Other populations may be addressed in addition to the priority populations, based on the service area (e.g. Amish, families involved with the correctional system, children in foster care). This includes building partnerships with alliances who support one or all of these priority populations. It can include joining the Refugee and Immigrant Alliance in a local community, educating and training local public health staff on annual cultural competency training that serves one of these populations.

Continuation in 2022, partnerships will continue with 1st Five, early care and education programs, home visiting (MIECHV), Family Support and CHSC to promote developmental screening. BFH monthly meetings with Iowa Medicaid staff provided an avenue to discuss contracting, coding, and billing issues pertaining to developmental services. In the FFY 2018 RFA, applications included a plan to work with Iowa's Area Education Agencies on referrals to Early ACCESS based upon screening results.

Continuation in 2022, BFH staff will continue to meet with MIECHV program staff to discuss opportunities for collaboration including coordination of developmental screening promoted by CAH, 1st Five, and home visiting programs and the need to avoid duplication. Since 2015, BFH staff have participated on a state-wide (stakeholder) Leadership Team coordinated by Iowa Children's Justice to address the impact of substance use/abuse on pregnant women, infants, and children. Promoting children's healthy growth and development is an inherent component of this work. Aggregated data reports of results of ASQ and ASQ:SE screening provided by Title V CAH contract agencies have been of particular interest to this workgroup.

At the state level, IDPH will continue in 2022, to provide technical assistance where needed particularly to agencies (providing direct services) who will be providing ongoing developing screening (ASQ) and emotional /behavioral

assessments (ASQ-SE) to infants and toddlers ages 0-3 years found not be eligible for Early ACCESS services. The state will continue to enhance our partnership with our other Title V partner Child Health Specialty Clinics from the University of Iowa Stead Family Children's Hospital; serving those children with special healthcare needs.

In 2022, IDPH will continue exploring more resources for Title V agencies specifically around culturally appropriate developmental screening tools for parents and children of different cultures and backgrounds. In addition, the state will explore the abundant parental apps to assist parents in their child's development.

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

Iowa's 1st Five program engages healthcare providers in supporting the use of developmental monitoring/surveillance and standardized developmental screening tools. A partnership between providers and 1st Five staff is established for developmental support services (an enhanced form of referral and follow up services).

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

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

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

The I-Smile™ program's primary goal is to connect children and pregnant women with dental homes. In addition, the efforts of Maternal, Adolescent, and Child Health (MCAH) contractors' administration of I-Smile™ across the state have helped to get children and pregnant women needing preventive dental care, despite the limited ability for low-income children and adults to access dentists.

The lack of dentists' enthusiasm to see and treat Medicaid patients may be negatively affecting the rates of children and pregnant women getting regular preventive dental visits. Despite all the work Iowa is doing to connect children and pregnant women with dentists and preventive services, the rate may decrease if this does not improve and also prevent Iowa from hitting the objective. If rates of children accessing a preventive dental visit do not increase, it is likely the National Outcome Measure (reduce the percent of children and adolescents who have dental caries or decayed teeth) will increase, meaning more children will experience cavities and poor oral health outcomes. The work of the Bureau of Oral and Health Delivery Systems (OHDS) and I-Smile™ benefits children and pregnant women; there aren't always distinctions between how the activities we do benefit one population versus the other.

OHDS staff will continue to hold quarterly I-Smile™ Coordinator training to ensure program consistency, share best practices, develop leadership skills, discuss new opportunities, and promote current standards and procedures. Training will include continuing education on current oral health topics and provide an open forum for sharing between the Coordinators. OHDS staff will have a site visit with each MCAH contractor to discuss local work plans, review data, and troubleshoot concerns in addition to spring site visits to review current data. OHDS staff will also participate in yearly chart audits to ensure service documentation accuracy.

Assuring optimal 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, Count the Kicks, and the University Of Iowa College Of Dentistry. Partnership activities in FY22 will include training of local WIC staff; networking meetings with Head Start Health Coordinators; and collaborating on oral health promotion campaigns, such as "Rethink Your Drink". OHDS will continue working with new partner, Count the Kicks, which uses best practices and evidence-based strategies to save babies and prevent stillbirths – incorporating more oral health education within its messaging for pregnant women. In FFY2022, OHDS

staff will assist Count the Kicks with oral health education and resources to keep moms and babies healthy, including reviewing materials for the Count the Kicks website. I-Smile™ Coordinators will continue to distribute Count the Kicks educational materials while doing outreach to medical and dental offices.

A partnership with Title X will continue, seeking to educate adolescent and maternal health clients on Human Papillomavirus (HPV) and oral health. I-Smile™ Coordinators will distribute education on HPV vaccines and oral cancer screenings - available on rack cards - at family planning clinics, WIC, and dental offices. OHDS staff will collaborate with Quitline Iowa staff to produce oral health education about the effects of tobacco products for maternal health clients, distributed by I-Smile™ Coordinators to dental clinics, FQHC's, WIC, and family planning clinics and will include: toolkits, educational materials, and training programs for providers on quitting tobacco use.

OHDS staff will maintain its 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. 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. Medical office training is provided by I-Smile™ Coordinators.

OHDS staff recently obtained results from a department Maternal Health Strategic Plan Survey that found community members get their health information from health care providers, internet, and friends/family members. OHDS will use this information to implement more maternal health and medical provider outreach. Also, OHDS staff will begin to implement the use of QR codes on promotional materials to ease access to resources.

In FFY2022, each I-Smile™ Coordinator will develop 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 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 training for medical office staff as requested, and conduct oral health promotion at community events. I-Smile™ Coordinators were previously provided educational materials and training for collaborating with Child Health Specialty Clinics (CHSC) providing education and implementing a referral process. This program will be evaluated over the next year to determine ways to increase contact with CHSC and create stronger relationships. OHDS staff will work to increase the relationship between CHSC administration and I-Smile™. Coordinators will also be expected to implement SDF in their activities. With many children not getting preventive dental care over the last year and unable to access a dentist for restorative care due to COVID-19, OHDS staff expect to see an increase of SDF use over the next year and will continue to address barriers.

I-Smile™ Coordinators will train MCAH staff 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, silver diamine fluoride) 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.

OHDS staff and the I-Smile™ program will advance its ability to reach clients in innovative ways. The National Outcome Measure (reduce the percent of children and adolescents who have dental caries or decayed teeth) will remain a goal of the program. OHDS staff are continuously monitoring state and county specific data to direct client care and see where the program focus should be. OHDS staff and I-Smile™ Coordinators look forward to next year seeing more Iowa families in person and increasing the education on oral health.

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

Iowa's Emergency Preparedness Plan for Child Care included Healthy Child Care Iowa (HCCI) state staff and local CCNCs assisting in communicable disease response. Iowa's COVID-19 guidance for child care was a collaborative effort between the Iowa Department of Public Health and Iowa Department of Human Services. Exceeding our goal was primarily due to the number of programs requesting CCNC services to assist them with COVID-19 planning;

reopening; health and safety policies; managing positive cases, exposures and outbreaks; and improving quality. This rate will continue to increase when Iowa's new quality rating system (Iowa Quality For Kids - IQ4K) is released in 2022. IQ4K will have a continuous quality improvement approach incorporating a focus on health and safety as well as medication administration. CCNC services will be a requirement for both homes and centers in IQ4K starting at a level 2.

HCCI State staff will continue to 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 agencies and other local stakeholders (including Early Childhood Iowa areas) for supports and funding of local CCNC services.

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

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

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

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

HCCI CCNC program will center on equity incorporating health equity language into the CCNC Role Guidance, contracts and promote (champion) equity into our state child care system. HCCI will incorporate the 10 Essential Public Health Services into our state structure.

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

During FFY2022, 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. OHDS staff will lead the Cavity Free Iowa (CFI) initiative – planning and facilitating meetings and discussing possible strategies and providing updates to I-Smile™ Coordinators. Based on Iowa's large rural population, OHDS staff are collaborating with the State Office of Rural Health to identify ways to increase fluoride varnish applications in Rural Health Medical Clinics located throughout Iowa. OHDS staff are working through billing considerations and procedures needed for the Rural Health Clinics to see how to reach more rural families. OHDS staff and I-Smile Coordinators will continue to explore ways to incorporate dental hygienists within medical clinics for preventive services.

The CFI workgroup plans to identify the barriers that are keeping medical offices from participating in the initiative and seek solutions to address them. The central Iowa pediatrician who has championed this initiative has begun contacting physicians around the state to start this process. In addition, through his One Hundred Million Mouths Project award, he plans to provide 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 works closely with the pediatrician and will assist with the trainings for medical students.

OHDS will continue to leverage its CFI partnerships in FFY2022. For example, Delta Dental of Iowa Foundation brings experience in public relations and marketing and provides commemorative plaques and training certificates for medical offices trained by I-Smile™ Coordinators. OHDS staff will work with Medicaid's Dental Program

Manager to assure reimbursement to medical offices and troubleshoot any billing issues. Another opportunity for leveraging partnerships lies in OHDS participation in a newly formed Oral Health Iowa coalition. The coalition formed to provide a unified advocacy voice regarding oral health of Iowans; the OHDS staff member who leads CFI is on the coalition steering committee.

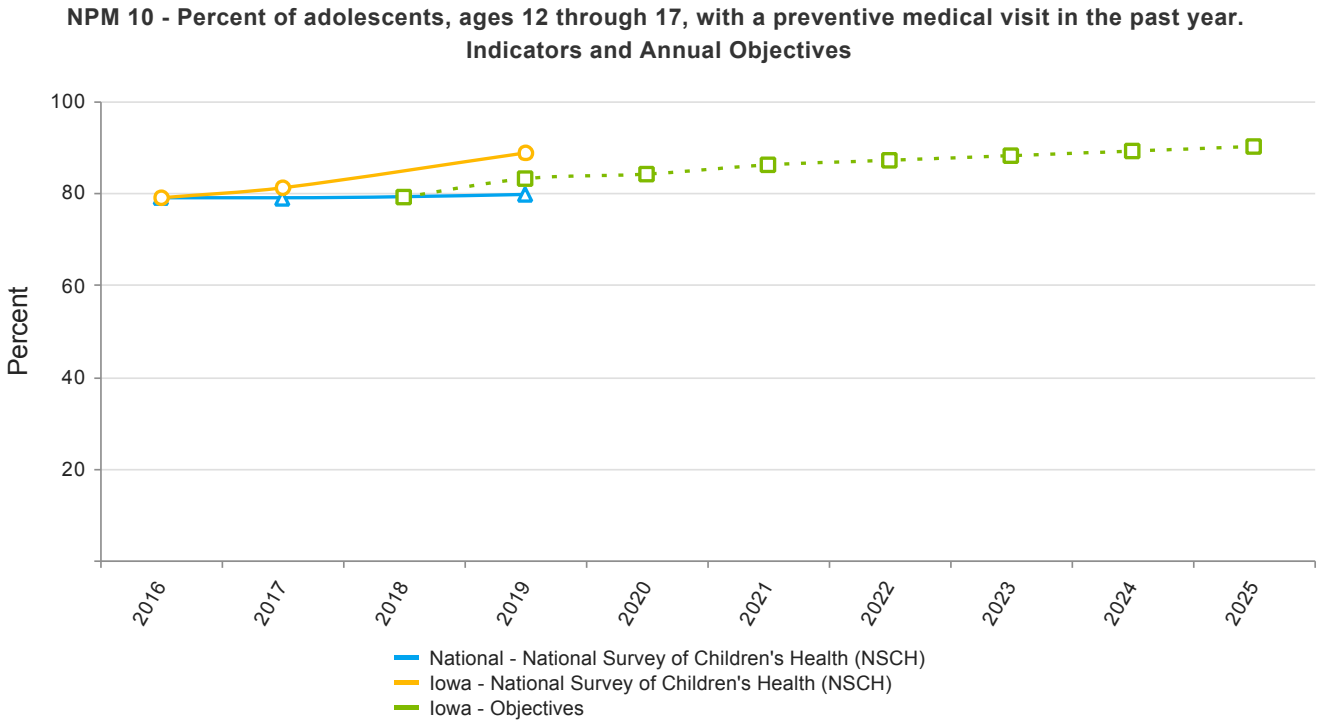
During summer 2021 I-Smile™ Coordinator meetings, OHDS staff facilitated brainstorming to identify new ways to reach very young children to prevent dental disease. The ideas are being compiled and will be discussed at meetings and site visits during FFY2022 to expand how I-Smile™ can assure optimal oral health beginning at birth. For example, Coordinators identified working with libraries for oral health story walks and increasing education for women considering becoming pregnant or who are already pregnant – addressing infant oral health care before baby arrives.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	33.1	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	13.7	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	13.9	NPM 9 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	27.3 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	65.4 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2018_2019	15.3 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2018	15.6 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2019	17.0 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	66.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	75.1 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	94.1 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	93.6 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	14.1	NPM 10

National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			79	83	84
Annual Indicator		78.8	81.1	81.1	88.5
Numerator		202,051	191,475	191,475	195,697
Denominator		256,527	236,185	236,185	221,185
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	86.0	87.0	88.0	89.0	90.0	91.0

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.0	92.0	138.0	161.0	184.0	200.0

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		25
Numerator		
Denominator		
Data Source		Iowa Youth Survey
Data Source Year		2018
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	25.0	24.5	24.0	23.5	23.0

State Action Plan Table

State Action Plan Table (Iowa) - Adolescent Health - Entry 1
Priority Need
Access to care for the MCAH Population
NPM
NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Objectives
By 2025, increase the percent of adolescents ages 12 through 17 with a preventive medical visit in the past year to 85%
Strategies
Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, universities, and/or community colleges to promote adolescent well visits to parents/guardians
Local Title V agencies will educate parents of adolescents on the importance of annual well visits during the Informing process
Provide culturally and linguistically appropriate annual well visit reminders for adolescents who are Title V clients and for adolescents enrolled in Medicaid Fee For Service
Bureau of Family Health will utilize Every Age Even Teenage promotions and social media platforms to promote the adolescent well visit
Conduct an environmental scan(s) to identify which providers are conducting adolescent well visits, what hours well visits are available and ages they are routinely offered
Bureau of Family Health staff will explore possible collaborations with Iowa Medicaid Enterprise, Department of Human Services, Department of Education, Managed Care Organizations, the University of Iowa EPSDT physician group, and provider associations, to assure adolescents receive annual well visits
Local Title V agencies will be encouraged to work with adolescents or organizations serving adolescents to increase health literacy, promote healthy behaviors, and promote well visits
Communicate with and share resources with the school nurse designee from each school district within the applicant's service area to promote adolescent well visits to parents/guardian
Provide gap-filling direct care services for adolescents based upon an assessment of need within the service area
Subcontract with an outside entity(ies) to conduct an environmental scan(s) in the first twelve months of FFY2021 to identify which providers are conducting adolescent well visits, what hours well visits are available and ages they are routinely offered
State Title V staff will assure the documentation of the results of the environmental scan will be shared with local providers and community stakeholders

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

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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

Priority Need

MCAH Systems Coordination

SPM

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

Objectives

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

Strategies

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

Provide adolescent mental health training for local Title V agencies

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

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

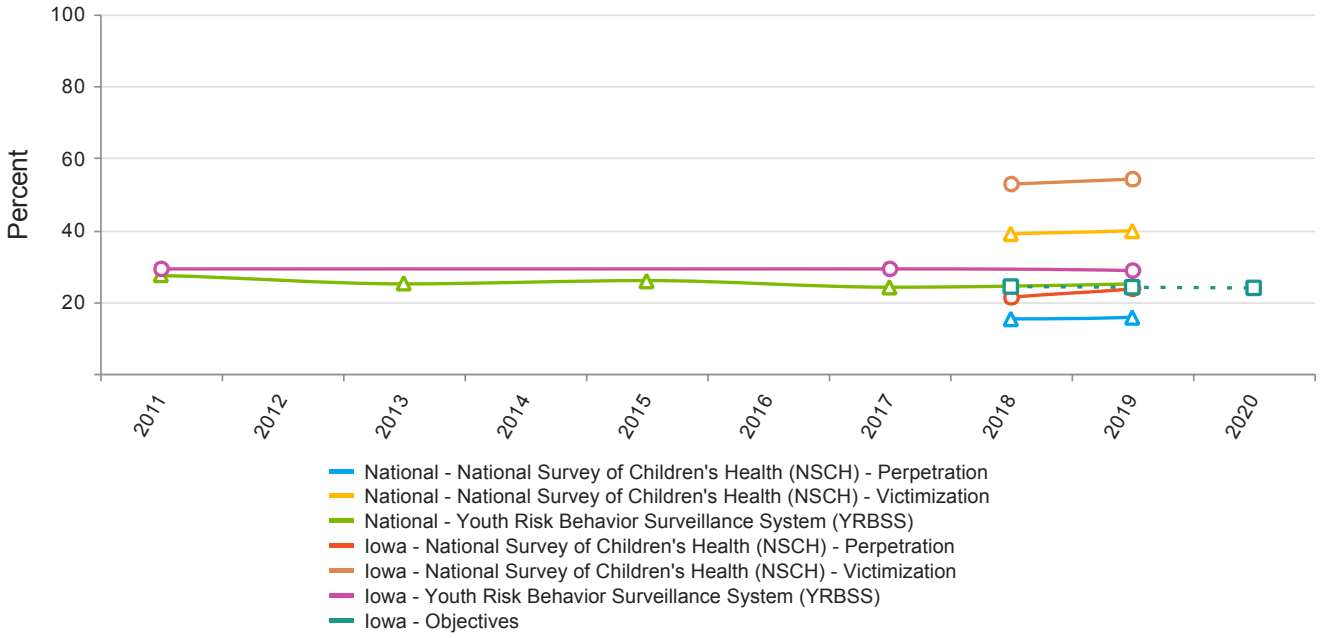
Continue to maintain partnerships with organizations that support LGBTQI youth and collaborate in the development of evidence based strategies improving the mental well being of adolescents

Participate in the AYAH CoIIN with a long term focus on system-level policies and practices to support integration of behavioral health in primary care

Re-engage the state Adolescent Health Collaborative

2016-2020: National Performance Measures

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



Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	14.8	14.6	24.3	24.1	23.9
Annual Indicator	29.1	29.1	29.3	29.3	28.8
Numerator	43,459	43,459	41,460	41,460	41,783
Denominator	149,221	149,221	141,691	141,691	144,931
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2011	2011	2017	2017	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2017	**2018**	**2019**	**2020**
Annual Objective			24.1	23.9
Annual Indicator			21.2	23.7
Numerator			52,515	55,502
Denominator			248,081	234,406
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

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

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2017	**2018**	**2019**	**2020**
Annual Objective			24.1	23.9
Annual Indicator			52.7	53.9
Numerator			130,850	126,294
Denominator			248,281	234,506
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

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

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

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

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			4
Annual Indicator			2
Numerator			
Denominator			
Data Source			Meeting Agendas
Data Source Year			2020
Provisional or Final ?			Final

2016-2020: State Performance Measures

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

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		91	84.5	88	89
Annual Indicator	90.5	84	87	86.2	82.4
Numerator					
Denominator					
Data Source	CAReS and WHIS	TAV Connect	TAV Connect	Signifycommunity	Signifycommunity
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

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

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		85.8	86	86.2	86.4
Annual Indicator	85.6	88.3	85.5	83.4	81.8
Numerator					
Denominator					
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

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

The Iowa Department of Public Health's Bureau of Family Health and Bureau of Substance Abuse were accepted as participants in a Child Safety Learning Collaborative (CSLC) administered by the Children's Safety Network. The bureaus collaborated to address two specific areas with the goal of reducing fatal and serious injuries among Iowa's infants, children and adolescents.

Iowa's objective in the Bullying Prevention topic team of the CSLC was to engage in work that promoted and improved bullying prevention strategies in Iowa as part of the Title V National Performance Measure 9: Percent of adolescents, ages 12-17, who are bullied or who bully others.

After assessing Iowa's bullying prevention capacity by utilizing the HRSA Maternal and Child Health Change Package, the topic team's aim for the project was to reduce bullying victimization among children and adolescents by building and improving partnerships and implementing evidence based bullying prevention strategies, especially among the most vulnerable populations.

Iowa submitted a technical assistance request to the CSLC. In response to the request, the CSLC staff assisted the Iowa in researching and identifying developmentally appropriate evidence-based bullying prevention programs and practices that would fit the needs of the target population. Through this process, Iowa began to advance a Plan-Do-Study-Act cycle. With the help of local level stakeholders, Iowa chose an evidence-based bullying prevention program and planned a small pilot project. Iowa entered into a service agreement with Iowa Safe Schools to pilot the prevention program, gather feedback from participants, implement the curriculum, and if successful, offer the programming to significantly more participants. The pilot project offered the evidence-based bullying prevention program to LGBTQ+ students attending a week long Gay Straight Alliance (GSA) camp. Participants and Iowa Safe School Staff assessed the implementation of the program in the pilot and identified several nuances and made small adjustments in the delivery of the programming. The programming was expanded and offered to a larger cohort of students in several Iowa GSA's in rural and urban areas. Pre-testing and post-testing data was compiled and Iowa Safe Schools' report indicated that the programming made a positive impact on participants. Iowa Safe Schools agreed that the evidence-based bullying prevention program could be integrated into future school-based GSA programming and also agreed the evidence-based bullying prevention program is decidedly sustainable with very little financial resources.

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

The 2019 NSCH shows the percent of adolescents with a preventive visit in the past year increased to 88.5% from the 81.1% as reported in 2017/2017 data.

The Department distributed Adolescent Health Profiles to state and local partners as requested. The profiles include county level data; Population, Poverty, Mental Health, Protective Factors, Tobacco Use, Substance Use and Sexual Health. Each county profile includes comparative statistics to see how individual counties compared to the state average.

International Adolescent Health Week (IAHW) 2020 is a grass-roots initiative for young people, their health care providers, their teachers, their parents, their advocates and their communities to come together and celebrate young people and with an ultimate goal of working collectively towards improving the health and well-being of adolescents.

During IAHW, March 15-21, 2020, the Adolescent Health team in collaboration with program staff within the Department created and posted positive health messages via Iowa Department of Public Health social media channels, Facebook, Twitter and Instagram. The health topics included; Parent Engagement, Adolescent Connectedness, Oral Health, Adolescent Well Visit, Healthy Relationships and Adolescent Mental Health.

October is “Let’s Talk Month,” an opportunity to encourage adults, parents and caregivers to have open and ongoing conversations with young people about their overall health. The Adolescent Health team created and posted messages via Iowa Department of Public Health social media channels, Facebook, Twitter and Instagram. The topics included; positive friendships, healthy dating relationships, the adolescent well visit, and adolescent development.

As part of IAHW, the Adolescent Health team submitted and received a grant award from the Delta Dental of Iowa Foundation to raise awareness about the importance of Oral Health to the teens served through the Department’s federal Sexual Risk Avoidance Education (SRAE) and Personal Responsibility Education Program (PREP) grants. Approximately 1,200 youth received toothbrushes and information about Oral Health care.

The Adolescent Health team collaborated with the Department of Education, School Nurse Consultant, to promote IAHW via the school nurse listserv.

The Adolescent Health team continued collaboration with the Department of Education to promote Iowa Adolescents: Let’s Talk Health google site and updated content as requested.
MCAH agencies were encouraged to develop a plan to promote adolescent well visits. These plans involve working with local Title X providers and primary care practitioners to increase the number of preventative visits, promote quality EPSDT exams, and facilitate establishment of a medical home. Local MCAH agencies work with school nurses from each Iowa school district and other adolescent serving organizations to promote adolescent well visits and medical homes for pregnant teens.

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

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

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

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

Adolescent Health - Application Year

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

According to the Data Resource Center for Child & Adolescent Health, due to changes to the NSCH survey, updated data for NPM 10 is not available. The most recent year available is 2017 with a percentage of 81.1.

In 2018, Iowa changed our EPSDT Periodicity Recommendation to match AAP's Bright Futures, including annual well visits for adolescents. This marked a significant decrease in our CMS 416 data, but provides a more accurate picture of the actual percent of annual well visits of adolescents enrolled in Medicaid.

Based on Iowa's CMS 416 report: 51% of 10-14 year olds, 45% of 15-18 year olds; and 23% of 19-20 year olds had a preventive medical visit in the past year (2018). These percentages increased to 52% for 10-14 year olds, stayed the same at 45% for 15-18 year olds and decreased to 19% for 19-20 year olds in 2019. Unfortunately, Iowa does not believe the rate will increase for 2020 or 2021 due to the COVID 19 pandemic. Contractors are required to reach out to primary care providers in 2022 utilizing the results of the 2021 Environmental Scan of provider practices. In addition, plans are underway for additional evidence-based strategies for increasing primary care provider utilization of annual well visits, as well as outreach to families in 2022 and for the next RFP.

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

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

Local CAH agencies will work on partnering with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well visits to parents/guardians. Agencies will document a description of the groups, organizations or programs that they will be partnered with, history of prior experience with the organization/program (if any), the goals of the partnership, roles and responsibilities of the applicant and organization/program in the partnership, and timeline for activities.
CAH agencies are encouraged to communicate with and share resources with the school nurse designee from each school district within the applicant's service area to promote adolescent well visits to parents/guardians. They will include a narrative describing the school districts they are partnering with, history or prior experience with the nurse (if any), goals of the partnership, roles and responsibilities of the applicant and the nurse activities.

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

outreach and education on adolescent well visits.

The Informing Process is the process by which staff at the Title V Child and Adolescent Health agency contact newly eligible clients to explain the EPSDT Care for Kids program and its benefits. The discussion with the family addresses the benefits available, importance of preventive health care services, location of services, support services, and local resources available to help the clients. For FFY22 an emphasis has been placed on the education of parents/guardians of adolescents on the importance of the annual well visit.

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

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

The Bureau of Family Health staff will develop social media posts during International Adolescent Health Week (IAHW) 2022. IAHW is a grass-roots initiative for young people, their health care providers, their teachers, their parents, their advocates and their communities to come together and celebrate young people and with an ultimate goal of working collectively towards improving health.
Continue collaboration with the Department of Education to promote and manage the Iowa Adolescents: Let's Talk Health google site and update content as requested.

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

IDPH and local contractors will review the Environmental Scan conducted by the University of Iowa in FFY21 to prioritize primary care providers for outreach and identify potential adolescent well visit champions.

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

Iowa Youth Survey is conducted every two years. The average score of the three (3) grades surveyed, 6th, 8th, and 11th for 2012 was 16%, 2014 was 17%, 2016 was 18% and 2018 was 25%. The large increase from 2012 to 2018 is concerning. Even more concerning is the delay in administering the 2020 Iowa Youth Survey, given the COVID-19 pandemic. As teens were knowingly more isolated during the pandemic, we are anticipating that the 2021 survey rates will remain stable, or worse, increase. Our goal with this SPM is to maintain this rate for 2022 and 2023 and reduce the overall score across the three grades by 1% each year starting in 2024.

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.

Iowa plans to explore and research the use of psychosocial assessments provided to adolescents in primary care settings across the state. If gaps in services are identified, Iowa will partner with the Iowa Medicaid Enterprise (IME) to identify billing codes (non-home visit codes) that local Title V agencies can pursue under their purview of their child screening center designation. Iowa will explore partnering with the Iowa Academy of Pediatrics to provide training to primary care physicians on the use of motivational interviewing with adolescents.

Additionally, Title V will explore collaboration with the State of Iowa Youth Advisory Council (SIYAC) to gain the youth perspective on adolescent mental health. SIYAC is a non-partisan policy advising organization made up of young people from across Iowa between the ages of 14 and 20.

Iowa's Title V program has a strong infrastructure that is conducive to hosting a solid training network available to local Title V agencies. Iowa plans to host a wide array of statewide adolescent mental health training such as: youth mental health first aid, youth peer to peer training, training for parents of adolescents, and training for local Title V agencies.

Iowa's Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need, including children and youth with special health care needs (CYSHCN). Iowa's Title V program is committed to partnering with this statewide effort and linking local Title V agencies with the mental health systems developed in their region of the state. The state Title V program plans to provide education to local Title V agencies about the state's advancements in building the Children's Behavioral Health System and how the local Title V agency might interface their MCAH programming with the new children's mental health regional system to provide gap filling services. Iowa's Title V program has an established partnership with Iowa Safe Schools. Iowa Safe Schools provides comprehensive support, victim services, resources, and events for LGBTQ and Allied youth. Iowa will continue to collaborate with Iowa Safe Schools in providing training for adolescents and training for parents/community members on mental health issues facing LGBTQI youth and how youth can be supported with access to services.

Iowa will work towards addressing health equity issues that arise around this SPM. For each of the 7 strategies listed above technical assistance provided to local Title V agencies will focus on social determinants of health and health equity strategies. Specifically, in Iowa, many disparities exist that encompass people of color, ESL, LGBTQI, immigrants/refugees and people with disabilities. In the 2018 Iowa Youth Survey, 11th grade female students of color experienced persistent feelings of sadness or hopelessness more than any other group of students. For Native American females, 62% experienced these persistent feelings. The same was true for nearly half of Latinx females (49%) as well as half of females who identified as multiple races (48%). For Black females, 41% experienced these feelings--a rate equal to white females. For Asian females, the rate was 38%.

In rural areas, health care, specifically mental health care access (for adults and adolescents) is disparate in comparison to urban settings. We will explore, with our Title V agencies, how they can play a role in the children's mental health regional system and, where appropriate, consider gap-filling services.

Children with Special Health Care Needs

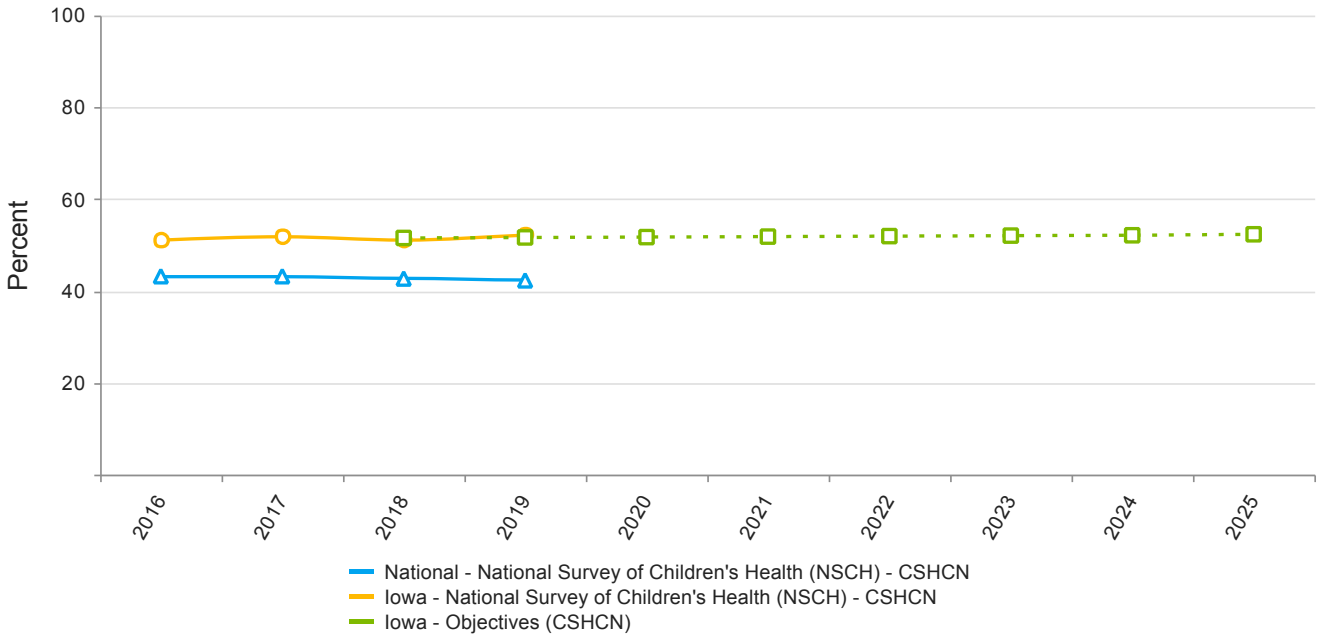
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	27.3 %	NPM 11 NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	65.4 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	89.7 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	1.1 %	NPM 11

National Performance Measures

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

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			51.5	51.6	51.7
Annual Indicator		50.9	51.9	51.0	52.3
Numerator		65,262	70,636	74,037	75,172
Denominator		128,218	136,125	145,140	143,725
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	51.8	51.9	52.0	52.1	52.3	52.5

Evidence-Based or –Informed Strategy Measures

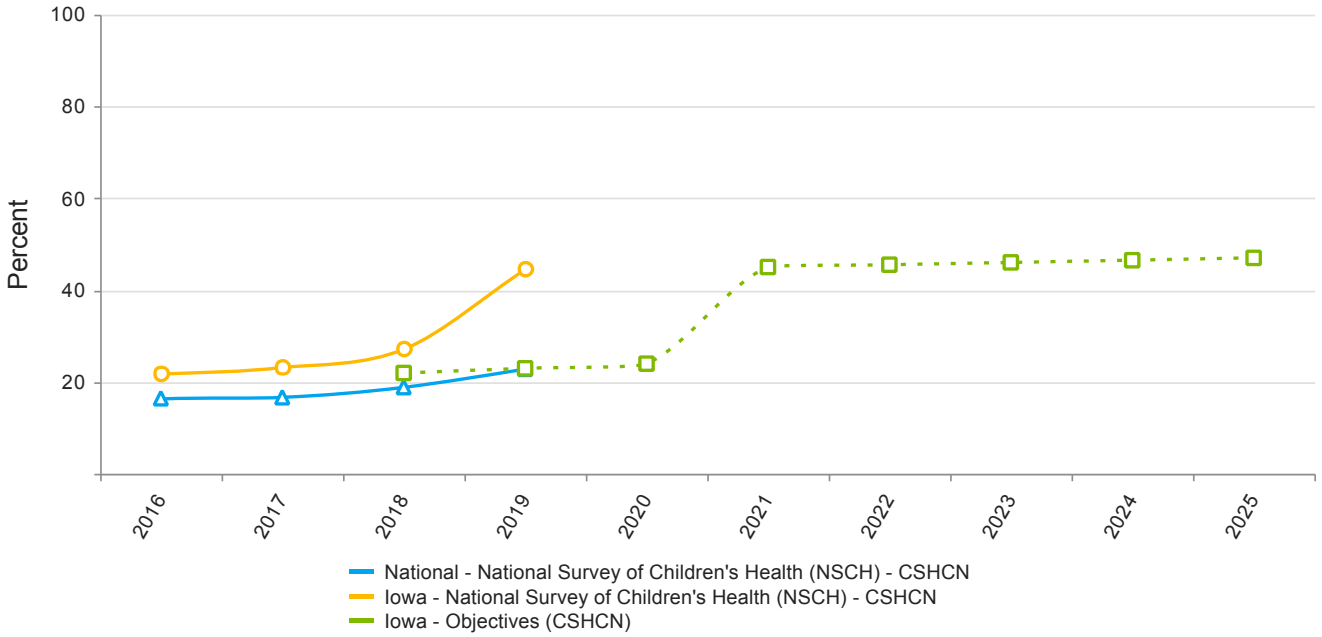
ESM 11.1 - Number of telehealth visits through Child Health Specialty Clinics

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	3,115	
Numerator		
Denominator		
Data Source	Program Data	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3,150.0	3,185.0	3,215.0	3,245.0	3,275.0	3,300.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			22	23	24
Annual Indicator		21.9	23.1	27.2	44.5
Numerator		13,904	16,833	20,601	30,962
Denominator		63,445	72,960	75,605	69,559
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	45.0	45.5	46.0	46.5	47.0	47.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	62.1	
Numerator	218	
Denominator	351	
Data Source	Electronic Medical Record	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	64.0	66.0	68.0	70.0	72.0	74.0

State Performance Measures

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	88.3	
Numerator	98	
Denominator	111	
Data Source	Youth Services Survey for Families	
Data Source Year	2016	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	88.0	88.5	89.0	89.5	90.0	90.5

State Action Plan Table

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Access to community-based services and supports, pediatric specialty providers, and coordination of care	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
By 2025, increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home to 53.4%	
Strategies	
Provide access to specialty care through Child Health Specialty Clinics (CHSC), including attention to culturally and linguistically appropriate care	
Strengthen infrastructure and increase opportunities for pediatric specialty care through Telehealth	
Increase Primary Care capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities	
ESMs	**Status**
ESM 11.1 - Number of telehealth visits through Child Health Specialty Clinics	Active
NOMs	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

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

Priority Need

Access to support for making necessary transitions to adulthood

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Objectives

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

Strategies

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

Ensure appropriate transition resources for families accessing CHSC Regional Center services

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

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

NOMs

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

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 3

Priority Need

Support for parenting Children and Youth with Special Health Care Needs

SPM

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

Objectives

By 2025, increase the percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V to 90%

Strategies

Provide family support services to Iowa families of CYSHCN, including recruiting and supporting ethnically diverse staff including cultural liaisons

Increase appreciation of strengths and understanding of barriers to family participation and care for direct services staff statewide

Ensure caregiver confidence and capacity to advocate for CYSHCN on all levels (personal/family, community, and policy), including family training to underserved/underrepresented populations

During FFY2020, DCCH focused on three priority areas: 1) Care Coordination, 2) Transition to Adulthood, and 3) Integration of Services. CYSHCN and their families faced exceptional challenges due to the COVID-19 pandemic during FFY2020. In Iowa, the first cases were identified, and the primary impacts were felt in early March 2020. Schools and most childcare facilities were closed, and non-essential health and dental care services were halted. Many families of CYSHCN, especially those with medical complexity requiring more intensive services struggled to access community-based services and supports. Access to childcare options was especially difficult for these families, many of whom were also newly unemployed either due to workplace closures and layoffs, or due to the special care needs of their children. This was the final year in the last 5-year cycle, and DCCH worked to migrate the Integration of Services priority to become part of the new Access to Services, Pediatric Specialty Providers, and Care Coordination priority area.

Priority Need

Care Coordination (Oct 1, 2019 through Sept 30, 2020)

NPM 11. Percent of children with and without special health care needs having access to a medical home

In FFY2020, the priority area of Care Coordination was measured through NPM 11. The Standards for Systems of Care for Children and Youth with Special Health Care Needs includes Care Coordination as part of the medical home.

DCCH provided gap-filling direct services to 6,530 Iowa children, youth, and their families from all 99 counties in Iowa. Title V provides foundational support for this work, allowing DCCH to operate 13 Child Health Specialty Clinic Regional Centers and 7 satellite locations across the state. Services are provided in-person, via telehealth, or via telephone. Care delivery is provided through a health team approach that includes family navigators, advanced registered nurse practitioners, registered nurses, social workers, dietitians, and telehealth-based pediatric specialty providers. Specific information about access to care through telehealth is provided in the section covering Integration of Services.

The Title V CYSHCN program provides foundational support for a number of DCCH programs that provide training to primary care providers (PCPs) and their staff with the aim of increasing PCP capacity to treat CYSHCN with mild to moderate special health care needs and improve access to community-based family support services. This support along with funding from other HRSA grants and state funded contracts enabled DCCH to facilitate 24 presentations in FFY2020. Attendees included 97 PCPs, and 341 PCP support staff (not unduplicated). Continuing Medical Education credits were available to providers. The topics included the following:

- ACE This: Adverse Childhood Experiences, Early Childhood Neurodevelopment and the Importance of Trauma-Informed Care
- Adverse Childhood Experiences (ACEs), Well Child Developmental Surveillance and Screening
- Anxiety Disorders and Depressive Disorders in Children and Adolescents
- Autism 101: A Primer for Primary Care Providers
- Collaborative and Proactive Solutions: Reaching Pair-adise (Overview of CPS and Case Examples with Twins)
- Eating Disorders: Being Thin is Not Always In!
- Eating Disorders: Recognition and Treatment

- Enhancing the Well Child Visit: Strategies to Improve Identification of Developmental Delays within your patient population
- Helping Parents Manage Common Behavior Problems
- Interventions to Support Children with Autism Spectrum Disorder
- Nutrition and Eating for Children with Autism Spectrum Disorders
- Psychosocial Considerations for Youth with Type 1 Diabetes
- Sensory Processing and Behavior in Autism
- Targeting Tics: A Review of Tourette's Phenomenology, Comorbidities & Treatment
- The Regional Autism Assistance Program
- The Relationship Between ADHD and Primitive Reflexes
- When to Worry About Worry: An Overview of Childhood Anxiety Disorders
- Youth and Substance Use
- 1st Five Basics (the 1st Five Healthy Mental Development Initiative)

In order to build the capacity of PCPs to treat children and youth with mild to moderate mental and behavioral conditions within their medical home, the University of Iowa Division of Child and Adolescent Psychiatry operates UI Consult, a toll-free referral consultation service available to any provider 24 hours a day, 7 days a week. DCCH program staff have worked closely with the director of Child and Adolescent Psychiatry to promote the use of this service. Promotion activities included several presentations about typical patient cases and topics fielded on the consultation line; the development and distribution of an infographic illustrating the types of questions and concerns addressed during these consults; and publicizing the availability of the consult line during conferences and webinars designed for primary care providers. During FFY2020, 48 primary care providers utilized the consult line.

DCCH promotes the use of the Standards of Systems of Care for CYSHCN through a number of programs that have foundational support from Title V funding. Through DCCH, the Regional Autism Assistance Program receives state funds to provide community-based clinical consultation, multidisciplinary care planning recommendations, and family-to-family support for children with Autism Spectrum Disorder and their families. During the first half of State Fiscal Year 2020, RAP provided information, care coordination, and family-to-family support for over 1500 children and their families, reaching nearly all 99 counties in Iowa. During this time period, RAP provided outreach and information to nearly 3000 people, provided training to 43 emergency personnel on autism and provided training to 500 families, educators, providers, case managers, and others.

Priority Need

Transition Planning for CYSHCN (Oct 1, 2019 through Sept 30, 2020)

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

In FFY2020, DCCH continued to provide services and supports for youth to make the necessary transitions to adult health care. Current transition plan documentation workflows were re-evaluated to reinforce the regular initiation and

review of transition planning during clinical visits. Transition resources were also reviewed to fit the diverse needs of families served by Child Health Specialty Clinic Regional Centers and satellite locations, while aligning with recommendations from Got Transition® and the Standards for Systems of Care for Children and Youth with Special Health Care Needs. Planning for the incorporation of youth engagement in the transition to adult health care was also integral to FFY2020 activities.

DCCH staff continued to support families of transition-aged youth and health care team staff in addressing transition at every visit for youth or young adults ages 12–21 years, documenting the initiation and review of transition plans for eligible youth. In October 2019, the documentation protocol was reviewed through a process that involved conversations with family support, direct services, and administrative staff, that included discussions surrounding the distinction between transition plans and transition-related family goals (see Integration of Care Priority Area). DCCH program staff and the electronic medical record expert built a system within the electronic medical record that allowed for staff to clearly document the initiation and review of transition plans for patients ages 12–21 years that was independent of family goal initiation and review. Tools were developed that allowed the care team, including family support staff, to efficiently document transition planning initiation and review for every eligible patient in the electronic medical record. The transition plans documented in the electronic medical record are available to providers, including the patient's medical home.

For youth ages 12–21 years, conversations about transition continued to be documented at every visit, with the introduction of the Transition Checklist (developed in FFY2019) defining the initiation of transition planning. The Transition Checklist was developed to assess family and adolescent preferences for topics on which families thought they needed to learn more. It was integrated in the transition planning protocol in March 2019 and was re-evaluated in June 2020 to reflect the evolving COVID-19 clinic priorities. With the increase in telehealth and in-home telehealth appointments due to the pandemic, protocols were revised to fit Regional Center workflow needs.

COVID-19 had an impact on DCCH clinical functions, including the documentation of the initiation and review of transition plans. As normal clinic activities resumed, the rates of transition plan documentation continued to increase. Data are regularly collated and reported to staff to ensure compliance with the developed transition protocol. In FFY2020, 61% of youth ages 12–21 served by DCCH had transition plans initiated. In FFY2020, 74% of youth ages 12–21 served by DCCH had transition plans reviewed.

In FFY2019, DCCH created a Transition to Adult Health Care Quick Guide to be distributed to DCCH families and organizations statewide. During FFY2020, this Quick Guide continued to be available to DCCH staff, families, and different entities that aid in the transition to adult health care. The Quick Guide can be found on the DCCH website for download (https://chsciowa.org/sites/chsciowa.org/files/resource/files/transiton_quick_guide_april_2019.pdf).

DCCH program staff used care teams, including family support staff input, to re-evaluate the contents of the Quick Guide. Conversations with family navigators with either personal experience transitioning YSHCN or experience working closely with this population revealed that the Quick Guide, although comprehensive, did not fit the specific needs of many of the youth served by DCCH. Plans for revising the Quick Guide to include additional resources and information for youth with complex medical needs and youth that cannot functionally participate in their transition were made, with this project continuing into FFY2021. Plans also included the in-depth review of all DCCH transition resources to include topic areas highlighted by family navigators as necessary to the successful transition to adult health care, including but not limited to: substitute-decision making, making healthy choices, and transitioning youth with neurodevelopmental disabilities.

Plans to evaluate parent engagement and satisfaction with DCCH transition programs were postponed due to the COVID-19 pandemic. However, COVID-19 allowed for the expansion of DCCH virtual learning opportunities, which included the development of additional transition to adult health care trainings for both Iowa families and DCCH care teams, including family support staff. The traditionally in-person DCCH Caregiver Retreat was developed into a

webinar series designed for Iowa parents, legal guardians, and caregivers of transition-aged youth with special health care needs. While webinars did not begin until FFY2021, planning for this series began in FFY2020 and included identification of community partners in the transition to adult health care to collaborate with planning and presenter recruitment. Partners in this planning effort included the University of Iowa Center for Disability and Development (CDD), Iowa Developmental Disabilities Council, the Iowa Regional Autism Assistance Program, Disability Rights Iowa, and Iowa Vocational Rehabilitation Services. In an effort to accommodate the increasing number of linguistically diverse families attending trainings, plans were developed to offer simultaneous Spanish interpretation through DCCH's relationship with University of Iowa Interpretation Services.

In April 2020, planning began for a webinar series designed to prepare DCCH staff to successfully assist families of youth transitioning to adulthood. During FFY2020, DCCH hosted two webinars. Continuing education credits were offered to nurses and family navigators attending the live event, and webinar recordings were distributed to staff unable to attend the live sessions. This webinar series continued to address topic areas highlighted by DCCH staff as being necessary for aiding families in the transition to adult health care as the webinar series continued into FFY2021.

Table: Staff webinars to assist with transition planning for YSHCN

Date	Topic	Partners	Number of Trainees	CEUs Awarded
June 18, 2020	Substitute Decision-Making and the Rights of Adults with Disabilities	Disability Rights Iowa	38	• 9 nursing CEUs • 13 IBC FPSS credits*
September 3, 2020	Vocational Rehabilitation and the Transition to Adulthood	Iowa Vocational Rehabilitation Services	18	• 9 nursing CEUS • 8 IBC FPSS credits*

*The Iowa Board of Certification (IBC) facilitates the administration continuing education credits for Family Peer Support Services (FPSS) certification.

In June 2020, planning began for the development of the DCCH Youth Advisory Council. DCCH program staff began this process by reaching out to experts in youth engagement, including program staff from AMCHP's Adolescent Health team and Kids As Self Advocates (KASA) on how to implement Positive Youth Involvement within youth advisory council activities, an evidence-based public health strategy for developing innate strengths in young people that support healthy behavioral development and successful transition to adulthood. Expertise of program staff from the University of Iowa's Center for Disabilities and Development (CDD) and Iowa's University Center for Excellence

in Developmental Disabilities (UCEDD) was also used in the early planning stages of the youth advisory council, with plans to continue these partnerships into FFY2021. COVID-19 brought uncertainty in how the Division's Youth Advisory Council would be implemented, including the planning of in-person versus virtual meetings. Implementation planning for the youth advisory council continued into FFY2021.

Priority Need

Integration of Services for CYSHCN (Oct 1, 2019 through Sept 30, 2020)

SPM 6: Percent of CYSHCN with parents who are very satisfied with the communication among doctors and other health care providers

Activities associated with the Integration of Services priority focused on three areas in FFY2020: 1) Facilitating and documenting family goal setting activities; 2) Providing opportunities for increasing family leadership and advocacy skills; and 3) Continuing to expand access to pediatric specialty services through telehealth. During the needs assessment process, the Integration of Services priority area was incorporated into the Access to Care priority area. With the evaluation of needs and capacity, a shift in priorities away from Shared Plans of Care occurred along with a renewed emphasis on family-centered goal setting. This transition also included replacing the ACT.md platform with an integrated system of collecting goals within Epic, the University of Iowa's existing electronic medical record program.

Family goal setting continued to be foundational to providing family centered care through shared decision-making. Health teams, including family support staff, continued to encourage families to set goals and tracked the initiation and review of goals at every clinical visit. Trainings on goal setting best practices and how to incorporate goal setting into existing clinic activities were offered to health teams, including family support staff through all-staff and discipline-specific meetings. Additionally, there were monthly consultations between DCCH program staff and clinical staff to address workflow concerns due to shifting clinic priorities during the COVID-19 pandemic.

Prior to FFY2020, DCCH used ACT.md, a HIPAA compliant, cloud-based platform to capture the goals and Shared Plans of Care for families seen through clinical visits. The goal of using a care coordination platform, such as ACT.md, was to provide seamless care coordination by inviting key players of a patient's medical home to the platform to aid in comprehensive goal collection and review. Upon further assessment of ACT.md user experience and usage, it was found that even when invited to the platform, very few providers outside of DCCH direct service staff utilized ACT.md. Further investigation also revealed that very few DCCH families were active users on the ACT.md platform. Additionally, DCCH staff faced barriers in entering information into the platform. For these reasons, DCCH's contract with ACT.md was ended on September 20, 2019.

In preparation for this transition, a similar workflow that included features of ACT.md was built within Epic. This update produced efficiencies by 1) reducing double documentation of goals by staff, 2) allowing families to more easily access their information within the Epic patient portal, MyChart, 3) increasing cost effectiveness, 4) allowing primary care providers to view goals through the Epic CareLink program, and 4) allowing for more efficient data collection for DCCH goal setting initiatives.

The revised goal tracking system launched in October 2019. This system included a list of common goals to select from, aiming to assist families through the process of choosing a goal. Goals continued to be initiated or reviewed at every visit. DCCH program staff review goal documentation data weekly and have monthly consultations with Regional Center clinic supervisors to address any concerns. In FFY2020, 86% of patients had goals initiated. In FFY2020, 83% of patients had goals reviewed.

DCCH is committed to providing resources to families to ensure they have the tools they need to be active, core partners in decision making. Strengthening family capacity to navigate systems at all levels can help develop

leadership and advocacy skills among families. The Iowa Family Leadership Training Institute (IFLTI) was developed for parents and primary caregivers of CYSHCN to develop their leadership and advocacy skills. This four session, in-person training is held each spring. The curriculum is based on the Progression of Leadership rings (self, community, system) and the Maternal and Child Health leadership competencies. The 2020 cohort of the IFLTI began in March 2020. The first session was held-in person March 6–7. The subsequent sessions were held virtually due to the COVID pandemic. Seven family members completed the training and went on to develop a Community Service Project.

IFLTI presented a Navigating Special Needs Family Training: Lunch and Learn webinar series, which had an average attendance of 25 family members for the series. Sessions were aimed at families who have children who were recently diagnosed with a disability or special need. Sessions were held from late June through early October 2020. Topics included:

- Finding your way in the world of special needs
- Communication skills for families
- Organizing information
- Exploring care coordination
- Navigating school
- Navigating insurance & waivers
- Finding reliable resources
- From cope to hope

DCCH is building programs to address family training and advocacy needs that reach communities that have traditionally been underserved. Moving in this direction started with providing more resources to DCCH providers. For example, in November, 2019, the Family Navigator Network learned more about working with some of the Pacific Islander populations in Iowa. FFY2021, efforts have moved more strongly in this direction, beginning with a structure, vision statement, goals, and work plan of the Health Equity Committee.

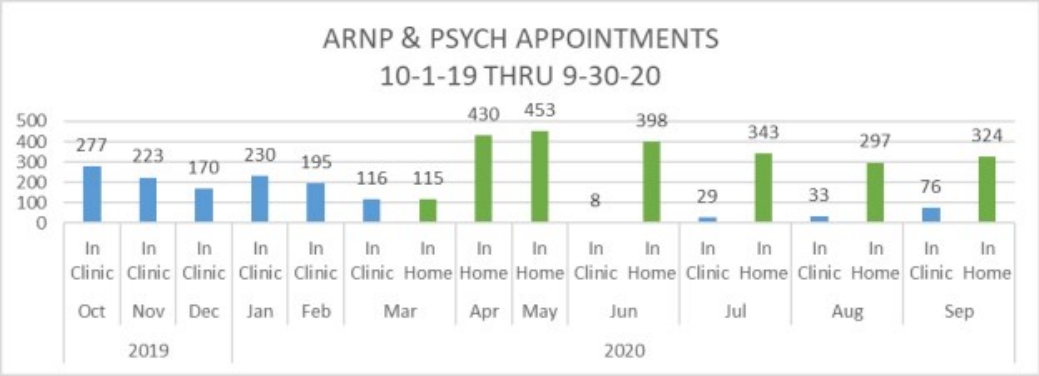
Telehealth: In FFY2020, DCCH completed a total of 4464 telehealth visits. Prior to the COVID-19 pandemic, families traveled to their closest Child Health Specialty Clinics Regional Center to connect with pediatric specialists via telehealth. Specialty areas included Psychiatry, Nutrition, Genetics, Developmental and Behavioral Pediatrics, Intellectual Disability and Mental Illness (IDMI), Nephrology, Neonatology, Neurology, and Endocrinology. The table below outlines the number of telehealth visits by pediatric specialty.

Table: Telehealth appointments by specialty

10/1/19- 9/30/20	
Psychiatry	1532
CHSC ARNP	2185
Dietitian	694
Developmental and Behavioral Pediatrics	6
Genetics	6
Neurology	6
Neonatology	2
Nephrology	5
Endocrinology	3
Hematology/Oncology	2
IDMI	23
Total	**4464**

As access to pediatric specialty care for families of CYSHCN became more difficult to conduct in a clinical setting due to COVID-19, continuity of care was provided through the transition of all clinic telehealth and in-person appointments to in-home telehealth appointments in March 2020. Federal and State Emergency Declarations resulted in lifting several telehealth restrictions and allowed for increased telehealth flexibilities. This made telehealth services more accessible for families, including seeing patients in their homes, use of additional telehealth platforms, and an audio only option. The figure below shows the transition to in-home telehealth visits for ARNP and Psychiatry visits.

Figure: Number of CHSC ARNP and Psychiatry Telehealth visits, in-office and in-home



DCCH staff had extensive experience facilitating telehealth prior to the pandemic. When the pandemic began,

significant staff resources were contributed to support other specialty groups within the University of Iowa Health Care system. Technical assistance and technology support were provided to groups such as faculty in the Division of Developmental and Behavioral Pediatrics and Pediatric Psychology. Additionally, DCCH staff supported families as they navigated a new way of receiving health care during a chaotic time.

Children with Special Health Care Needs - Application Year

III.E.2.c. CSHCN Application Year

Priority areas for CYSHCN identified through the Iowa Title V FFY21 Needs Assessment process included: 1) access to community-based services and supports; pediatric specialty providers, especially mental health providers; and coordination of care; 2) access to support for making necessary transitions to adulthood; and 3) support for parenting CYSHCN. DCCH is open to providing services, training, and advocacy to support all CYSHCN and their families in Iowa; populations of special focus include children with behavioral or mental health challenges, chronic and complex health needs, or developmental and intellectual disability.

Priority Need

Access to Services, Pediatric Specialty Providers, and Care Coordination (Oct 1, 2021 through Sept 30, 2022)

NPM 11. Percent of children with and without special health care needs having access to a medical home

During FFY2022, the University of Iowa Division of Child and Community Health (DCCH) will continue to focus on 1) providing access to specialty care through Child Health Specialty Clinics Regional Centers and satellite locations, 2) strengthening infrastructure and increasing opportunities for specialty care through telehealth, and 3) increasing Primary Care capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities. Continued emphasis will be placed on DCCH's health equity strategic priority.

In FFY2022, DCCH will continue to develop and evaluate workflows in Child Health Specialty Clinics Regional Centers and satellite locations to provide specialty care to families with enhanced supports, including interpretation and translation services. Data from interpretation services used by DCCH will continue to be regularly monitored to inform programming and tailored to the needs of linguistically diverse families seen in Regional Centers and satellite locations. DCCH will continue to develop clinic infrastructure that supports the use of telehealth, including the participation in programming that supports families with technological barriers to receiving care, such as the FFY2021 Phones for Families program that was done in collaboration with the Iowa Department of Public Health. Additionally, there will be an emphasis on increasing provider capacity statewide to treat children with complex and/or mental health needs by providing continuing education opportunities with a health equity lens for primary care providers and DCCH clinical staff.

Statewide, the need for care coordination, family support, systems navigation, and gap-filling clinical services will be addressed through the existing regional network of Child Health Specialty Clinics Regional Centers and satellite locations. DCCH will build on the current framework to continue to enhance care coordination best practices at the individual care delivery level. This framework includes multiple care delivery models including telehealth for children with medical complexity, mental health diagnoses, developmental and intellectual disabilities. An emphasis will be placed on providing trauma informed and culturally responsive care coordination. DCCH will continue frequent assessments of how Child Health Specialty Clinics Regional Centers and satellite locations can best align with community needs.

FFY2022 activities will include a renewed focus on family-centered goal setting during clinic visits. A structured goal-setting process with families of CYSHCN began as a result of the HRSA-funded Enhancing a System of Care for Children and Youth with Special Health Care Needs project that ended in 2017. Since that time, Regional Center staff have continued to initiate, review, and document family goals at each clinical visit. DCCH will conduct a review of staff training needs regarding the creation and documentation of family-centered goals, and staff development opportunities will be provided to staff. Regional Center staff will continue to coach families to develop goals that are

family-driven and tailored to family needs. Documentation will continue to be reviewed weekly by program staff, with monthly consultations and data sharing with Child Health Specialty Clinics Regional Center and satellite location staff.

Access to pediatric specialty care in Iowa is limited, especially in rural areas. DCCH has built a robust telehealth network in order to help address geographic barriers to access. In FFY2022, DCCH will adjust telehealth practices and procedures to align with new systems implemented by the broader University of Iowa Health Care (UIHC) system. As an early adopter of telehealth through UIHC, the workflows were built around older systems and processes. DCCH will transition to the updated UIHC platform, allowing for a streamlined system of scheduling and clinic workflows, integrated with the electronic medical record. The expected outcome of this transition is that more pediatric specialty providers in the UI Stead Department of Pediatrics will utilize the telehealth infrastructure through DCCH Regional Centers and satellite locations. In FFY2022, DCCH will begin planning for a review of telehealth processes.

Adapting to the COVID-19 pandemic has resulted in rapid changes in telehealth. As the dust hasn't settled yet, there is some uncertainty about which of the changes will continue into the future. Recent changes in state law and policy will allow for continued reimbursement for in-home telehealth mental health visits. In the past, these telehealth visits through DCCH always occurred in the Regional Center setting, with a Child and Adolescent Psychiatrist based in a different part of the state. DCCH Regional Centers will continue to be available as a resource for families who prefer to attend appointments this way. DCCH will continue to assess the best way to provide the extra supports such as family-to-family support for patients who are not physically in the Regional Center.

DCCH is committed to increasing access for Children and Youth with Special Health Care Needs to medical home approaches to care. To this end DCCH will continue to provide opportunities for primary care practices to increase their capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities within a medical home. Through the Epic CareLink system, primary care providers statewide have access to University of Iowa pediatric specialty provider clinic notes for their patients, including notes from Child Health Specialty Clinics. Workforce development initiatives for primary care providers (PCPs) in Iowa will continue with online and, if the COVID-19 situation allows, in-person opportunities. DCCH will build on working relationships with professional organizations; enhance resources for provider access to information about treating CYSHCN, including medical home approaches, family partnerships, culturally and linguistically appropriate care; and provide primary care focused regional and state-wide conferences and webinar trainings. As an example, in FY2020 24 webinars and virtual conferences were provided to primary care providers and support staff in Iowa. These webinars continued in FFY2021. DCCH will continue to educate on and market the 24/7 Psychiatry Consultation line to PCPs utilizing resources enabled through the Health Resources Services Administration (HRSA) funded Pediatric Mental Health Care Access Program.

Priority Need

Transition to Adulthood for CYSHCN (Oct 1, 2021 through Sept 30, 2022)

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

In the upcoming fiscal year, DCCH will continue the existing initiatives and implement new strategies to address needs for youth ages 12–21 years who are transitioning to adult health care. Approaches to improving access to transition to adulthood services and resources include: 1) involving families and youth in DCCH transition programming efforts, 2) providing direct services for youth with special health care needs and their families, and 3) providing resources aimed at supporting families and youth with special health care needs from underrepresented

backgrounds.

To continue incorporating family and youth input in DCCH transition to adult health care programming, workforce development opportunities will be provided for clinical and family support staff to assist in working with transition-aged youth. These trainings, in the form of webinars, began in FFY2020 and will continue into FFY2022. DCCH will also aim to gather feedback from clinical and family support staff to tailor webinars to topics needed to continue supporting transition-age youth.

DCCH will move into the next phase of implementation of a youth advisory council in attempts to involve the youth voice in DCCH transition programming. Substantial planning progress was made in FFY2021, and this will continue into the upcoming fiscal year with a goal of recruiting mentors and youth members and having the meetings start in FY2022. DCCH will solicit input for Title V CYSHCN program services through the Youth Advisory Council.

A formal assessment of family and youth satisfaction with DCCH transition programming is planned for FFY2022. This effort will help DCCH program staff develop actionable steps for addressing family and youth comments and concerns, including the development of additional trainings and the expansion of transition to adult health care resources offered by DCCH.

The DCCH Transition to adulthood program uses Got Transtion® as a guide to working with families. DCCH created a Transition to Adult Health Care Quick Guide based on the Six Core Elements of Transition. DCCH incorporates Got Transition® handouts in our resources for families and often uses the Health Care Transition Timeline and the Family Toolkit. To ensure access to appropriate transition resources for families served by Regional Centers and satellite locations, DCCH will continue to regularly review and update resources, including the Transition to Adult Health Care Quick Guide, based on best practices and patient and family needs. In order to expand the reach of these resources, they will be made available to families and organizations statewide.

Transition plan initiation and review for transition-aged patients will continue to be documented at every clinical visit. This process will continue to be evaluated by program staff and updated as needed to address Regional Center needs. This will include the regular review and data sharing of the percentage of visits where transition plans are initiated or reviewed by DCCH staff for patients aged 12-21 years.

In FFY2021, DCCH program staff began to review transition resources developed in FFY2018. This project will continue, with a focus on developing a comprehensive guide to the transition to adult health care that includes resources for caregivers, young adults, and caregivers of youth with extensive medical complexities.

In the upcoming fiscal year, DCCH will continue to prioritize efforts to ensure that youth and families from underrepresented backgrounds are provided with the appropriate resources for the transition to adult health care. These efforts will include the continual review of DCCH's transition resources to ensure that culturally responsive information is tailored towards families of youth with complex and/or mental health needs, one of DCCH's priority areas highlighted in the needs assessment and division strategic plan. DCCH will develop a plan to identify cultural brokers to aid in the review of DCCH transition resources to ensure that they fit within the cultural needs of the families participating in transition programming. DCCH will also continue to focus on ensuring consistency in workflows in Regional Centers and satellite locations for families with enhanced support needs. This includes providing staff with training opportunities on how to meet the support needs of all families, including, for example, those who need interpretation services.

Priority Need

Support for parenting Children and Youth with Special Health Care Needs (Oct 1, 2021 through Sept 30, 2022)

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

During the Iowa Statewide Needs Assessment process, support for families was identified as a significant need for CYSHCN. 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 of families across the state; and 3) building the infrastructure for strengthening family leadership capacity statewide.

Family-to-family support is provided through the existing DCCH Family Navigator Network (FNN), which was recently identified as an Emerging Practice this year by the Association of Maternal and Child Health Programs (AMCHP) Innovation Hub. A new manager for the Family and Professional Partnership program was hired last year following the retirement of the previous manager. A number of Family and Professional Partnership programs are currently undergoing strategic reviews. The FNN leadership team has added new members, including a co-chair from the Health Equity Committee and members of DCCH's upper management. During the upcoming fiscal year, efforts will focus on aligning the goals of DCCH and the FNN especially in the areas of family support and health equity. DCCH outreach to families will include an emphasis on building partnerships within diverse communities and increased family support services to traditionally underserved populations.

The DCCH Family Advisory Council (FAC) has new staff leadership as well as new Council leaders. A review of the FAC is underway and this review of Council operations will continue into FFY2022. Future plans include enhancing pathways for this group to advise DCCH with a family perspective in a more strategic manner. The Council will continue to operate through the next fiscal year to assure that DCCH provides support for families through the principles of Family Centered Care.

In FFY2022, DCCH will continue to support family advocacy efforts. These efforts enable communities and policy makers to appreciate the strengths and challenges faced by families of CYSHCN. DCCH recognizes that a well-crafted story makes all the difference in advocacy and awareness raising. DCCH will facilitate Storytelling for Family Leaders training with online modules and Zoom sessions for peer coaching. The goal is to develop a range of 10-minute stories for use in advocacy activities. Additionally, Digital Storytelling is an in-person training based on The StoryCenter model, which produces a 3-minute digital story to share in social media for advocacy and change. It involves the family member creating a voiceover of their story with visual images and effects. An example of a digital story created as part of this training in FFY2021 can be seen here: We Climb Together (https://www.youtube.com/watch?v=qKQ0VvCJgQQ). DCCH will continue to facilitate Digital Storytelling trainings in FFY2022.

Building family capacity to advocate for Children and Youth with Special Health Care Needs on all levels (Personal/Family, Community, and Policy) is a strategy that DCCH will continue to implement in the upcoming fiscal year. Through formal trainings for families through programs such as the Iowa Family Leadership Training Institute, trainings in Child Health Specialty Clinics Regional Center communities, and Family Peer Support Specialist trainings, the family advocacy capacity and workforce will be strengthened in Iowa. A specific focus on family leadership capacity will be on increasing relationships and family support trainings for underserved and underrepresented populations to reduce isolation and increase knowledge.

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	20.0	90.0	95.0	99.0	100.0

State Action Plan Table

State Action Plan Table (Iowa) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Infusing Health Equity with in the Title V System
SPM
SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve
Objectives
By 2025, 99% of all Title V contractors will have developed a plan to identify and address health equity in the populations they serve
Strategies
Inclusion of health equity plan requirement language in BFH grant agreements
Increase the percent of contractors that demonstrate application of health equity strategies
Utilize Health Equity Advisory Committee (HEAC) to provide input into the health equity strategies for each NPM and SPM and local contractors
Inclusion of health equity activities in all Title V funded BFH Staff positions
Increase the percentage of Title V Contractors that engage diverse participant voices in program planning, decision making and implementation
Build internal capacity within the Bureau of Family Health/Title V Program Health Equity Team; completion of an organizational assessment of equity practices, and facilitation of staff professional development and technical assistance
Develop and implement a data analysis plan to assess distribution of Title V resources and services through a health equity lens
Conduct an environmental scan of current contractors engagement in health equity and presence of health equity plans

Cross-Cutting/Systems Builiding - Annual Report

Performance Measures previously addressed in Cross-Cutting/Life Course Domain have been incorporated in to the appropriate Population Domains.

Cross-Cutting/Systems Building - Application Year

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

Starting in 2021 Local Contractors had to begin to create steps for a plan to address including:

- Assess effectiveness of health equity activities
- Policy change through Cultural and Linguistically Appropriate Goals
- Recruit membership from priority populations
- Collaborative Partnerships

With the FFY2023 RFP, IDPH will require local Title V Contractors to have and submit a plan to identify and address health equity in the populations they serve. Small, independent contractors (conference speakers, logistic [food, meeting space, etc.]), may need additional time. In addition, Title V is unsure about the ability to influence other large state agencies in the development of a plan while needing to contract with these entities to conduct state and Title V business. An additional factor that may influence Title V's ability to address this measure fully is a current project to align the Iowa Department of Public Health and Iowa Department of Human Services.

Over the last few years the Bureau of Family, including Title V staff, have been incrementally increasing internal understanding and capacity to address health equity in programs and services. The Bureau/Title V is ready to expand capacity internally and to engage contractors in assuring health equity in services and programs administered at the community level.

The 2021 MCAH RFA required 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. Due to COVID-19 Title V is extending the FY21 RFA into FY22 through contract amendments. New work and services were not implemented for FY22.

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 individuals with lived experience 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 which is continuing into 2022, outlines roles for Title V Contractors to engage diverse participant voices in program planning, decision making and implementation. Contractors shall incorporate strategies for family, youth, and community member participation into programming. Contractors will have access to the HEAC for consultation. Title V will increase membership of the state identified priority populations affected by health inequities on MCH Advisory Committee to assure adequate representation.

All Title V Contractors providing maternal health services will ensure clients receive individualized education for each performance measure (NPM 4, NPM 6, NPM 14.1, and SPM 1) in culturally appropriate ways that incorporate a health equity lens and meet the client where she is.

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 all staff in concepts and strategies of Health Equity Team; Identification and completion of ongoing assessments/analyses of health equity of Iowa Title V program, development and implementation of a data analysis plan to assess distribution of Title V resources and services through a health equity lens, and facilitation of staff professional development and technical assistance.

III.F. Public Input

During FFY21, the Iowa MCH Advisory Council provided input into the proposed goals and activities as well as during the public comment period. The Council approved and endorsed the proposed priority needs, goals, and activities via an electronic vote due to the next scheduled meeting occurring post submission deadline.

Iowa continued to utilize the IDPH website to post the proposed plans for the NPMs and SPMs. IDPH allowed a two-week period for interested MCH stakeholders and partners to provide feedback on Iowa's state priorities, proposed activities and performance measures through an online survey. The survey link and ask for responses was posted to the IDPH Facebook. The Title V Director sent the survey with an ask to many partners to forward it on to their distribution lists including Early Childhood Iowa and local Title V agencies.

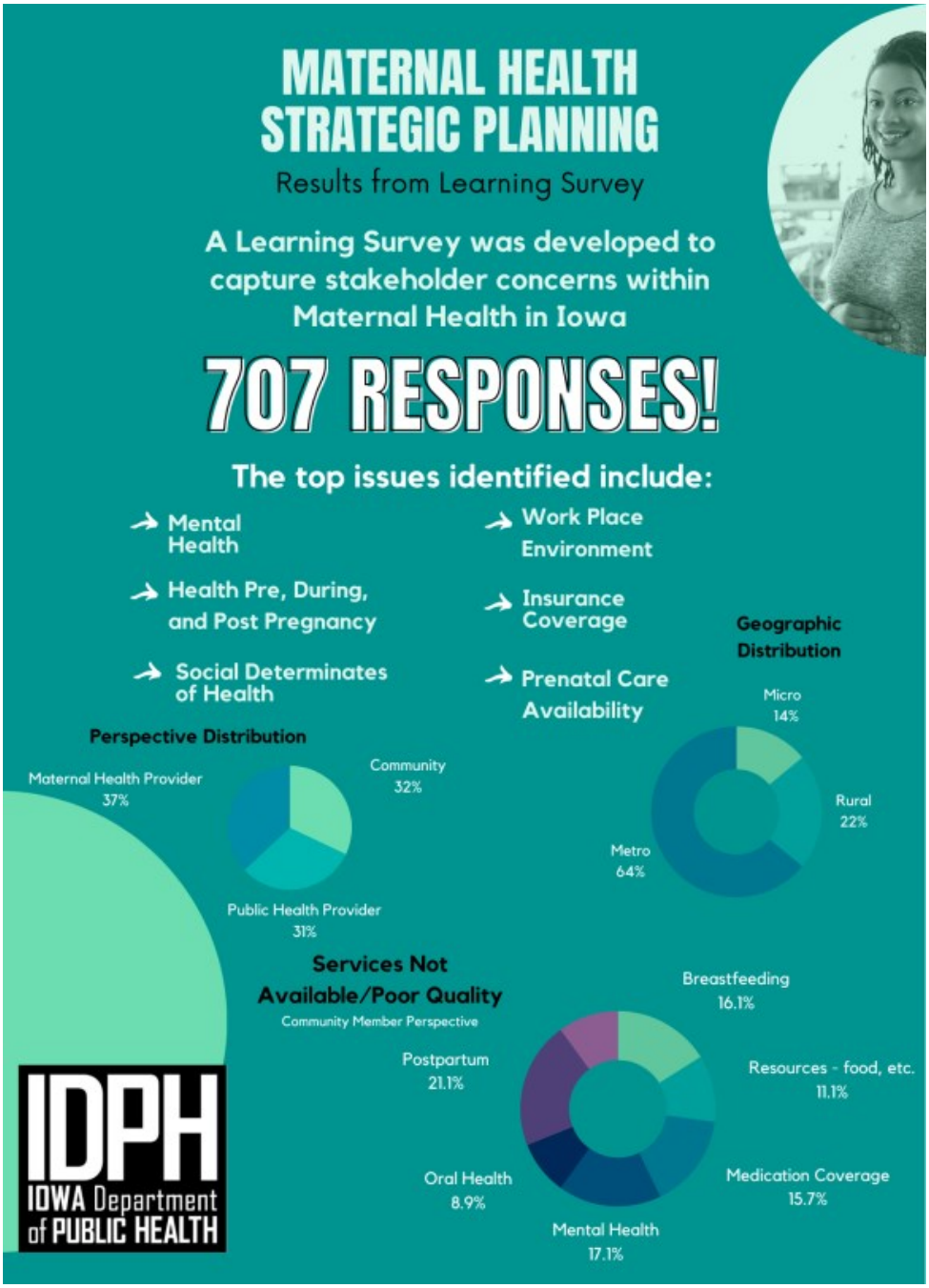
During the public input period, 84 individuals completed the online feedback survey. Nearly all of those that completed the survey supported the proposed performance measure activities. Comments received mostly encouraged the expansion of performance measures to include larger populations and ideas that could help move the needle on many performance measures. All feedback was shared with program staff to include updates, as necessary, into the FFY22 plan.

Public Input during ongoing Title V Needs Assessment Efforts

Learning Survey:

The purpose of the learning survey was to capture feedback from individual perspectives with regard to strengths, challenges and areas of focus you believe are critical regarding the state's maternal health needs. Utilized Survey Monkey, an electronic survey consisting of ten (10) questions and was shared broadly using multiple forms of communication.

The goal of the survey was to reach first and foremost individual perspectives, providers, staff of community based organizations, other community programs, engaged stakeholders, and associations across the state. The survey was open for eleven (11) days with a reminder sent on the seventh day it was available. Below is an infographic depicting the results of the survey.


MATERNAL HEALTH STRATEGIC PLANNING
Results from Learning Survey
A Learning Survey was developed to capture stakeholder concerns within Maternal Health in Iowa
707 RESPONSES!
The top issues identified include:
Mental Health
Health Pre, During, and Post Pregnancy
Social Determinates of Health
Work Place Environment
Insurance Coverage
Prenatal Care Availability
Geographic Distribution
Micro 14%
Rural 22%
Metro 64%
Perspective Distribution
Maternal Health Provider 37%
Community 32%
Public Health Provider 31%
Services Not Available/Poor Quality
Community Member Perspective
Breastfeeding 16.1%
Resources - food, etc. 11.1%
Medication Coverage 15.7%
Mental Health 17.1%
Oral Health 8.9%
Postpartum 21.1%
IDPH
IOWA Department of PUBLIC HEALTH

III.G. Technical Assistance

Health Equity continues to be a large focus for Iowa's Title V program over the next project period and beyond. Technical assistance opportunities for trainings at the state and local level will be explored to better equip the workforce to work with priority populations identified in the Needs Assessment process. Iowa would like to work with experts who have had success in program planning and administration when it comes to serving disparate populations. This could be an opportunity to work with other state's Title V programs across the nation or within Region VII to better pool our resources and share the best practices widely. Over the past year Iowa has been exploring new ways to research new evidence based strategies around health equity and utilizing best practices from other states or entities who have had success would enhance Iowa's activities and move the needle in the positive direction.

A primary and ongoing concern for CYSHCN is transition to adulthood and the adult health care system. DCCH will seek technical assistance opportunities to assist with the development of a robust training program for health care providers who are assisting families in the transition to the adult system. Trainings will focus on workforce including DCCH Family Navigators, Registered Nurses, Social Workers, and Nurse Practitioners. Additionally, DCCH will seek training for developing the workforce for pediatric primary and specialty care beyond DCCH providers.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - Title V Medicaid IAA MOU with Attachment 8.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - FY22 Maps.pdf

Supporting Document #02 - FFY20 Expenditures Workbook.pdf

Supporting Document #03 - FY22 Budget Workbook.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Iowa Title V Org Charts.pdf

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Iowa

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,549,016	
A. Preventive and Primary Care for Children	$ 2,322,393	(35.4%)
B. Children with Special Health Care Needs	$ 2,180,822	(33.2%)
C. Title V Administrative Costs	$ 654,901	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,158,116	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,255,937	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 8,947,232	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 850,000	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 16,053,169	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,035,775		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 22,602,185	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 11,648,481	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 34,250,666	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 520,729
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 455,608
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 447,100
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,200,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 5,792,253
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 455,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,010,055
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Doula through PHHS	$ 212,716

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,502,615		$ 5,122,040	
A. Preventive and Primary Care for Children	$ 2,111,682	(32.5%)	$ 1,459,147	(28.4%)
B. Children with Special Health Care Needs	$ 2,165,371	(33.3%)	$ 2,165,371	(42.2%)
C. Title V Administrative Costs	$ 650,261	(10%)	$ 356,767	(7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 4,927,314		$ 3,981,285	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,038,987		$ 6,602,596	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 8,533,916		$ 7,544,812	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 480,000		$ 886,902	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 16,052,903		$ 15,034,310	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,035,775				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 22,555,518		$ 20,156,350	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 8,436,599		$ 9,271,550	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 30,992,117		$ 29,427,900	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 89,356
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 401,978	$ 399,148
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 518,192	$ 472,269
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Screening State Evaluation Program	$ 250,000	$ 234,562
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 157,500	$ 144,884
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 5,737,858	$ 5,586,249
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) and Other Developmental Disabilities	$ 154,545	$ 154,970
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 405,820	$ 405,820
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 115,706	$ 115,706
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000	$ 445,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 150,000	$ 122,850
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning		$ 1,100,736

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: At the time of submission, expenditures remain to be claimed. This Title V Federal Allocation is fully obligated. IDPH expects to be fully expended by the end of the budget period.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: At the time of submission, expenditures remain to be claimed in the Preventive and Primary Care for Children budget category; this category is fully obligated. IDPH anticipates this budget category to be fully expended by the end of the budget period and will meet the minimum 30% requirement as indicated in the budget.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: At time of submission this amount reflects charges to administrative costs (MCH Director salary, travel, and other expenses) for the Title V Block Grant. The final indirect costs will be pulled prior to closeout based on actual expenses and will not exceed the 10% maximum.	
4.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The FY20 expenditures for the 1st Five Healthy Mental Development were lower than anticipated.	
5.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Overall telehealth visits increased for that lead to greater program income than what was budgeted.	

Data Alerts:

- The value in Line 1A, Preventive and Primary Care for Children, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Iowa

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 1,351,267	$ 985,838
2. Infants < 1 year	$ 39,633	$ 154,917
3. Children 1 through 21 Years	$ 2,322,393	$ 1,459,147
4. CSHCN	$ 2,180,822	$ 2,165,371
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 5,894,115	$ 4,765,273

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 469,381	$ 592,350
2. Infants < 1 year	$ 4,360	$ 0
3. Children 1 through 21 Years	$ 11,863,088	$ 10,705,496
4. CSHCN	$ 3,716,340	$ 3,736,464
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 16,053,169	$ 15,034,310
Federal State MCH Block Grant Partnership Total	$ 21,947,284	$ 19,799,583

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Iowa

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 951,521	$ 656,875
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 258,847	$ 155,351
B. Preventive and Primary Care Services for Children	$ 365,551	$ 176,718
C. Services for CSHCN	$ 327,123	$ 324,806
2. Enabling Services	$ 1,619,006	$ 1,166,065
3. Public Health Services and Systems	$ 3,978,489	$ 3,299,100
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 324,806
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 113,113
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 1,783
Other		
Gap Filling Services		$ 217,173
Direct Services Line 4 Expended Total		$ 656,875
Federal Total	$ 6,549,016	$ 5,122,040

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 3,141,791	$ 2,345,489
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 68,236	$ 121,613
B. Preventive and Primary Care Services for Children	$ 1,401,507	$ 1,273,213
C. Services for CSHCN	$ 1,672,048	$ 950,663
2. Enabling Services	$ 3,030,830	$ 3,222,813
3. Public Health Services and Systems	$ 9,880,548	$ 9,466,009
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 950,663
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 475,119
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 7,491
Other		
Gap Filling Services		$ 912,216
Direct Services Line 4 Expended Total		$ 2,345,489
Non-Federal Total	$ 16,053,169	$ 15,034,311

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Includes $91,686 of Admin funds.	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: $49,947 is included of Admin	
3.	**Field Name:**	**IIA. - Other - Gap Filling Services**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Gap Filling Services NOT provided in a physician office which include: Developmental testing Domestic violence screen Evaluation and Management (E&M) Health history Hearing Immunizations Mental health screenings Nursing assessments Nutrition assessments Preventive medicine counseling Social assessments Social Work assessments Substance abuse screenings Vision screenings	
4.	**Field Name:**	**IIB. - Other - Gap Filling Services**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**

Field Note:
Gap Filling Services NOT provided in a physician office which include:
Developmental testing
Domestic violence screen
Evaluation and Management (E&M)
Health history
Hearing
Immunizations
Mental health screenings
Nursing assessments
Nutrition assessments
Preventive medicine counseling
Social assessments
Social Work assessments
Substance abuse screenings
Vision screenings

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Iowa

Total Births by Occurrence: 35,996 **Data Source Year: 2020**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	35,774 (99.4%)	1,871	125	125 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Hearing Loss	Holocarboxylase Synthase Deficiency	Homocystinuria
Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)
Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease
S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency
Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency			

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Short-term follow up staff assist the primary care provider with referrals of newborns with a confirmed newborn screening diagnosis to specialty care/treatment as is appropriate. If the newborn is seen by one of the Cystic Fibrosis, Metabolic, Neuromuscular, Immunology, or Endocrinology clinics, we are able to obtain long-term follow-up information. If the newborn is managed by their primary care provider or a clinic outside of those listed, the Iowa Newborn Screening Program does not have access to the long-term-follow-up information.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Iowa

Annual Report Year 2020

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	4,493	74.2	0.2	10.4	12.9	2.3
2. Infants < 1 Year of Age	2,584	70.2	0.4	13.7	13.2	2.5
3. Children 1 through 21 Years of Age	94,276	81.0	0.4	3.9	14.7	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	6,838	53.8	0.4	28.4	10.2	7.2
4. Others	0					
Total	101,353					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	37,649	Yes	37,649	100.0	37,649	4,493
2. Infants < 1 Year of Age	37,558	Yes	37,558	100.0	37,558	2,584
3. Children 1 through 21 Years of Age	872,473	Yes	872,473	100.0	872,473	94,276
3a. Children with Special Health Care Needs 0 through 21 years of age^	180,183	Yes	180,183	100.0	180,183	6,838
4. Others	2,245,057	Yes	2,245,057	0.0	0	0

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Data was pulled from SignifyConnect, Iowa's Title V program data system. This count includes women served through the Maternal Health program. Services include: maternal health risk assessment, health education, psychosocial services, oral health services, care coordination, and presumptive eligibility.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Data was pulled from SignifyConnect, Iowa's Title V program data system. This count includes infants served through the Child Health program. Services include: informing, care coordination, and gap filling direct care services.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Data was pulled from SignifyConnect, Iowa's Title V program data system. This count includes children served through the Child Health program. Services include: informing, care coordination, and gap filling direct care services.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Data was derived through review of the electronic medical record. Some organizations that refer CYSHCN to DCCH do not provide primary source of coverage upon referral, which reflects the high "unknown" percentage. Some of the "unknowns" may have no insurance, though DCCH is unable to discriminate between these two categories	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: All individuals served by Title V are accounted for in the previous categories.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: The Statewide Perinatal Care Team, funded by Title V, visits all birthing hospitals to provide training and technical assistance.	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: The Statewide Perinatal Care Team, funded by Title V, visits all birthing hospitals to provide training and technical assistance.	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Iowa's Title V program has the potential reach of all children in Iowa because of activities that fall within the Public Health Services and Systems level of the MCH Pyramid. Activities included promotion of the AAP recommended screenings to primary care providers, statewide promotional campaigns, and statewide data collection and dissemination of ACEs.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Iowa's Title V program has the potential to reach all children in Iowa which includes all CYSHCN. Additionally, CYSHCN specific activities include policy and infrastructure activities designed to impact all CYSHCN in Iowa.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: All individuals served by Title V are accounted for in the previous categories.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Iowa

Annual Report Year 2020

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	35,418	26,170	2,538	3,684	137	1,031	228	686	944
Title V Served	5,303	3,482	523	879	4	106	80	149	80
Eligible for Title XIX	14,412	8,706	1,923	2,450	99	375	158	438	263
2. Total Infants in State	36,058	26,674	2,595	3,723	141	1,039	230	698	958
Title V Served	2,998	2,081	281	414	1	74	48	69	30
Eligible for Title XIX	14,530	8,782	1,946	2,463	100	377	158	441	263

Form Notes for Form 6:

None

Field Level Notes for Form 6:

None

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Iowa

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 369-2229	(800) 369-2229
2. State MCH Toll-Free "Hotline" Name	Iowa Healthy Families Line	Iowa Healthy Families Line
3. Name of Contact Person for State MCH "Hotline"	Tammy Jacobs	Tammy Jacobs
4. Contact Person's Telephone Number	(515) 727-0656	(515) 727-0656
5. Number of Calls Received on the State MCH "Hotline"		433

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Teen Line	Teen Line
2. Number of Calls on Other Toll-Free "Hotlines"		259
3. State Title V Program Website Address	http://idph.iowa.gov/familyhealth and http://chsciowa.org	http://idph.iowa.gov/familyhealth and http://chsciowa.org
4. Number of Hits to the State Title V Program Website		37,456
5. State Title V Social Media Websites	Iowa Department of Public Health on Facebook	
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Iowa

1. Title V Maternal and Child Health (MCH) Director	
Name	Marcus Johnson-Miller
Title	Chief, Bureau of Family Health and Title V Director
Address 1	321 E 12th St
Address 2	
City/State/Zip	Des Moines / IA / 50319
Telephone	5152814911
Extension	
Email	marcus.johnson-miller@idph.iowa.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Dr. Thomas Scholz
Title	CYSHCN Title V Director
Address 1	100 Hawkins Dr
Address 2	247 CDD
City/State/Zip	Iowa City / IA / 52242
Telephone	3194675009
Extension	
Email	thomas-scholz@uiowa.edu

3. State Family or Youth Leader (Optional)	
Name	Rachel Charlot
Title	Program Coordinator
Address 1	100 Hawkins Dr
Address 2	247 CDD
City/State/Zip	Iowa City / IA / 52242
Telephone	7127925530
Extension	
Email	rachel-charlot@uiowa.edu

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Iowa

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Infusing Health Equity with in the Title V System	New
2.	Access to care for the MCAH Population	Continued
3.	MCAH Systems Coordination	Continued
4.	Dental Delivery Structure of the MCAH Population	Continued
5.	Safe and Healthy Environments	New
6.	Access to community-based services and supports, pediatric specialty providers, and coordination of care	Continued
7.	Access to support for making necessary transitions to adulthood	Continued
8.	Support for parenting Children and Youth with Special Health Care Needs	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Infusing Health Equity with in the Title V System	New
2.	Access to care for the MCAH Population	Continued
3.	MCAH Systems Coordination	Continued
4.	Dental Delivery Structure of the MCAH Population	Continued
5.	Safe and Healthy Environments	New
6.	Access to community-based services and supports, pediatric specialty providers, and coordination of care	Continued
7.	Access to support for making necessary transitions to adulthood	Continued
8.	Support for parenting Children and Youth with Special Health Care Needs	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Iowa

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	81.5 %	0.2 %	30,543	37,461
2018	81.5 %	0.2 %	30,619	37,568
2017	80.9 %	0.2 %	30,922	38,217
2016	81.1 %	0.2 %	31,801	39,213
2015	80.2 %	0.2 %	31,516	39,275
2014	80.2 %	0.2 %	31,680	39,516
2013	76.7 %	0.2 %	29,902	38,967
2012	76.6 %	0.2 %	29,528	38,556
2011	77.1 %	0.2 %	29,310	38,017
2010	76.4 %	0.2 %	29,210	38,212
2009	75.3 %	0.2 %	29,296	38,917

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	54.3	3.9	198	36,451
2017	56.3	3.9	210	37,275
2016	53.4	3.8	202	37,807
2015	54.4	4.4	156	28,702
2014	45.9	3.5	175	38,096
2013	56.4	3.9	212	37,606
2012	48.9	3.6	182	37,228
2011	49.9	3.7	185	37,045
2010	47.4	3.6	178	37,531
2009	44.5	3.4	171	38,437
2008	44.0	3.4	169	38,397

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2019	10.4	2.3	20	192,749
2014_2018	13.9	2.7	27	194,787

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	6.8 %	0.1 %	2,543	37,633
2018	6.9 %	0.1 %	2,608	37,768
2017	6.6 %	0.1 %	2,526	38,418
2016	6.8 %	0.1 %	2,661	39,385
2015	6.7 %	0.1 %	2,663	39,471
2014	6.7 %	0.1 %	2,675	39,667
2013	6.6 %	0.1 %	2,561	39,080
2012	6.7 %	0.1 %	2,579	38,689
2011	6.5 %	0.1 %	2,495	38,196
2010	7.0 %	0.1 %	2,700	38,695
2009	6.7 %	0.1 %	2,671	39,683

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	9.5 %	0.2 %	3,569	37,633
2018	9.9 %	0.2 %	3,745	37,774
2017	9.2 %	0.2 %	3,524	38,421
2016	9.3 %	0.2 %	3,652	39,393
2015	9.0 %	0.1 %	3,565	39,470
2014	9.3 %	0.2 %	3,677	39,676
2013	9.0 %	0.1 %	3,512	39,070
2012	9.5 %	0.2 %	3,690	38,668
2011	9.2 %	0.2 %	3,505	38,166
2010	9.6 %	0.2 %	3,728	38,674
2009	9.4 %	0.2 %	3,720	39,662

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	26.0 %	0.2 %	9,770	37,633
2018	25.3 %	0.2 %	9,575	37,774
2017	24.3 %	0.2 %	9,344	38,421
2016	23.1 %	0.2 %	9,104	39,393
2015	22.5 %	0.2 %	8,878	39,470
2014	22.7 %	0.2 %	9,003	39,676
2013	22.3 %	0.2 %	8,708	39,070
2012	23.2 %	0.2 %	8,976	38,668
2011	23.1 %	0.2 %	8,835	38,166
2010	23.7 %	0.2 %	9,151	38,674
2009	23.7 %	0.2 %	9,403	39,662

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	4.4	0.3	166	37,861
2017	4.9	0.4	188	38,527
2016	5.4	0.4	215	39,504
2015	3.9	0.3	154	39,564
2014	5.1	0.4	204	39,788
2013	4.7	0.4	185	39,190
2012	5.1	0.4	197	38,801
2011	4.9	0.4	189	38,312
2010	4.6	0.3	177	38,818
2009	4.8	0.4	191	39,805

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	5.0	0.4	188	37,785
2017	5.3	0.4	204	38,430
2016	6.0	0.4	235	39,403
2015	4.2	0.3	167	39,482
2014	4.8	0.4	189	39,687
2013	4.2	0.3	166	39,094
2012	5.3	0.4	206	38,702
2011	4.7	0.4	181	38,214
2010	4.9	0.4	188	38,719
2009	4.6	0.3	183	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	3.1	0.3	117	37,785
2017	3.3	0.3	126	38,430
2016	3.7	0.3	146	39,403
2015	2.5	0.3	99	39,482
2014	3.1	0.3	125	39,687
2013	2.7	0.3	105	39,094
2012	3.3	0.3	128	38,702
2011	2.9	0.3	110	38,214
2010	2.6	0.3	101	38,719
2009	2.6	0.3	105	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	1.9	0.2	71	37,785
2017	2.0	0.2	78	38,430
2016	2.3	0.2	89	39,403
2015	1.7	0.2	68	39,482
2014	1.6	0.2	64	39,687
2013	1.6	0.2	61	39,094
2012	2.0	0.2	78	38,702
2011	1.9	0.2	71	38,214
2010	2.2	0.2	87	38,719
2009	2.0	0.2	78	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2018	150.9	20.0	57	37,785
2017	130.1	18.4	50	38,430
2016	172.6	21.0	68	39,403
2015	103.8	16.2	41	39,482
2014	148.7	19.4	59	39,687
2013	120.2	17.6	47	39,094
2012	121.4	17.7	47	38,702
2011	149.2	19.8	57	38,214
2010	134.3	18.6	52	38,719
2009	115.9	17.1	46	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	90.0	15.4	34	37,785
2017	98.9	16.1	38	38,430
2016	101.5	16.1	40	39,403
2015	88.6	15.0	35	39,482
2014	58.0	12.1	23	39,687
2013	89.5	15.1	35	39,094
2012	80.1	14.4	31	38,702
2011	83.7	14.8	32	38,214
2010	108.5	16.8	42	38,719
2009	80.6	14.3	32	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.7 %	1.1 %	2,061	36,451
2014	4.6 %	1.0 %	1,686	36,813
2013	5.5 %	1.0 %	1,979	36,123

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	2.9	0.3	105	36,722
2017	2.7	0.3	101	37,481
2016	2.6	0.3	101	38,132
2015	2.9	0.3	84	28,917
2014	2.8	0.3	109	38,603
2013	2.2	0.2	84	38,016
2012	2.0	0.2	74	37,690
2011	1.4	0.2	52	37,533
2010	1.1	0.2	42	37,987
2009	0.8	0.1	30	38,906
2008	0.7	0.1	27	38,936

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	9.9 %	1.3 %	67,232	678,918
2017_2018	9.3 %	1.2 %	63,400	678,171
2016_2017	8.6 %	1.0 %	57,913	677,227
2016	7.7 %	1.1 %	52,833	685,398

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	13.1	1.9	47	358,252
2018	16.9	2.2	61	361,042
2017	16.8	2.2	61	362,719
2016	17.6	2.2	64	363,753
2015	18.5	2.3	67	362,852
2014	18.2	2.3	66	361,818
2013	16.6	2.1	60	361,652
2012	17.4	2.2	63	361,686
2011	19.6	2.3	71	361,834
2010	13.5	1.9	49	363,614
2009	18.9	2.3	68	360,733

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	33.1	2.8	139	420,543
2018	31.9	2.8	135	422,686
2017	35.8	2.9	151	421,448
2016	30.6	2.7	128	418,789
2015	31.6	2.8	132	417,513
2014	26.5	2.5	110	415,812
2013	26.8	2.5	111	414,779
2012	29.6	2.7	123	415,083
2011	35.5	2.9	148	417,468
2010	32.3	2.8	135	417,741
2009	28.8	2.6	121	419,835

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	13.7	1.5	88	641,170
2016_2018	13.7	1.5	88	644,088
2015_2017	13.0	1.4	84	644,325
2014_2016	11.7	1.4	75	642,181
2013_2015	10.9	1.3	70	639,567
2012_2014	11.1	1.3	71	638,549
2011_2013	14.0	1.5	90	641,683
2010_2012	16.3	1.6	105	646,012
2009_2011	16.3	1.6	106	651,930
2008_2010	14.6	1.5	96	657,062
2007_2009	18.0	1.7	119	661,090

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2019	13.9	1.5	89	641,170
2016_2018	12.6	1.4	81	644,088
2015_2017	13.7	1.5	88	644,325
2014_2016	11.4	1.3	73	642,181
2013_2015	11.7	1.4	75	639,567
2012_2014	10.5	1.3	67	638,549
2011_2013	11.7	1.4	75	641,683
2010_2012	11.8	1.4	76	646,012
2009_2011	11.2	1.3	73	651,930
2008_2010	11.4	1.3	75	657,062
2007_2009	10.9	1.3	72	661,090

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	19.8 %	1.5 %	143,725	727,412
2017_2018	20.0 %	1.6 %	145,140	725,207
2016_2017	18.8 %	1.4 %	136,250	725,205
2016	17.7 %	1.5 %	128,468	725,960

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	27.3 %	3.9 %	39,249	143,725
2017_2018	24.1 %	3.7 %	34,928	145,140
2016_2017	24.1 %	3.4 %	32,873	136,250
2016	23.5 %	3.7 %	30,239	128,468

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	2.4 %	0.6 %	13,983	591,223
2017_2018	2.6 %	0.6 %	15,747	600,776
2016_2017	2.7 %	0.6 %	16,257	599,933
2016	3.1 %	0.8 %	18,652	611,443

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	10.6 %	1.2 %	62,204	586,374
2017_2018	10.9 %	1.4 %	65,074	597,558
2016_2017	9.0 %	1.2 %	53,855	596,935
2016	7.7 %	1.2 %	47,120	608,745

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	65.4 %	4.6 %	60,399	92,380
2017_2018	61.8 %	5.6 %	60,985	98,742
2016_2017	60.7 %	5.9 %	55,010	90,571
2016	62.8 %	6.2 %	47,665	75,958

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	89.7 %	1.4 %	652,407	727,262
2017_2018	89.0 %	1.5 %	645,018	725,056
2016_2017	91.1 %	1.2 %	659,928	724,068
2016	92.4 %	1.1 %	668,504	723,687

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

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

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	15.6 %	0.2 %	3,643	23,331
2016	15.2 %	0.2 %	3,724	24,427
2014	14.7 %	0.2 %	3,656	24,835
2012	15.1 %	0.2 %	4,033	26,722
2010	15.6 %	0.2 %	4,590	29,481
2008	15.7 %	0.2 %	4,089	26,103

Legends:

Indicator has a denominator <50 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	17.0 %	1.4 %	23,541	138,177
2017	15.3 %	1.7 %	21,043	137,135
2011	13.2 %	1.5 %	18,393	138,892
2007	11.1 %	1.4 %	15,756	141,858
2005	12.2 %	1.4 %	17,896	146,685

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	15.3 %	2.2 %	47,519	311,402
2017_2018	16.4 %	2.3 %	50,171	306,093
2016_2017	17.7 %	2.1 %	53,104	299,529
2016	17.5 %	2.3 %	55,364	315,462

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.4 %	0.3 %	17,506	721,021
2018	3.1 %	0.5 %	22,513	731,105
2017	2.6 %	0.4 %	19,135	730,569
2016	2.2 %	0.3 %	15,817	723,558
2015	3.3 %	0.4 %	23,663	724,960
2014	3.2 %	0.4 %	22,951	724,668
2013	4.8 %	0.5 %	34,835	724,105
2012	4.3 %	0.5 %	31,251	721,858
2011	4.6 %	0.5 %	33,041	722,389
2010	4.3 %	0.4 %	31,080	722,835
2009	4.4 %	0.4 %	31,347	708,602

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	73.5 %	4.1 %	29,000	39,000
2015	75.0 %	3.5 %	30,000	40,000
2014	70.7 %	3.4 %	28,000	39,000
2013	70.2 %	3.6 %	27,000	39,000
2012	77.2 %	3.5 %	30,000	39,000
2011	71.4 %	4.2 %	27,000	38,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	66.3 %	1.7 %	488,181	736,322
2018_2019	65.8 %	1.9 %	452,825	688,184
2017_2018	58.9 %	2.1 %	404,858	687,676
2016_2017	58.7 %	2.1 %	401,512	683,774
2015_2016	59.1 %	1.7 %	401,179	679,043
2014_2015	57.5 %	2.0 %	391,098	680,763
2013_2014	54.4 %	2.2 %	373,587	687,152
2012_2013	52.6 %	2.2 %	361,225	686,646
2011_2012	50.1 %	2.2 %	336,614	672,137
2010_2011	50.6 %	2.6 %	342,515	676,908
2009_2010	46.6 %	2.2 %	306,473	657,668

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	75.1 %	2.9 %	154,299	205,386
2018	73.4 %	3.1 %	149,228	203,329
2017	71.4 %	2.8 %	144,996	203,089
2016	60.7 %	3.0 %	123,186	202,834
2015	57.2 %	3.1 %	116,137	203,164

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	94.1 %	1.4 %	193,216	205,386
2018	94.0 %	1.5 %	191,105	203,329
2017	93.4 %	1.5 %	189,740	203,089
2016	89.2 %	1.8 %	180,848	202,834
2015	85.5 %	2.4 %	173,608	203,164
2014	76.7 %	3.3 %	156,645	204,263
2013	79.6 %	2.6 %	161,155	202,457
2012	77.8 %	3.0 %	157,505	202,458
2011	74.8 %	3.0 %	152,366	203,835
2010	64.2 %	3.3 %	131,182	204,220
2009	61.2 %	3.1 %	124,745	203,850

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

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

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	93.6 %	1.6 %	192,241	205,386
2018	89.2 %	2.3 %	181,356	203,329
2017	83.6 %	2.4 %	169,737	203,089
2016	74.9 %	2.6 %	151,976	202,834
2015	75.0 %	2.7 %	152,339	203,164
2014	64.4 %	3.5 %	131,631	204,263
2013	63.7 %	3.0 %	128,863	202,457
2012	64.4 %	3.4 %	130,376	202,458
2011	60.5 %	3.4 %	123,342	203,835
2010	53.7 %	3.4 %	109,756	204,220
2009	46.4 %	3.1 %	94,649	203,850

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	14.1	0.4	1,460	103,383
2018	15.3	0.4	1,603	104,650
2017	16.0	0.4	1,678	104,979
2016	17.2	0.4	1,804	105,029
2015	18.6	0.4	1,943	104,477
2014	19.7	0.4	2,048	104,065
2013	22.1	0.5	2,289	103,809
2012	24.1	0.5	2,498	103,716
2011	25.3	0.5	2,665	105,140
2010	28.6	0.5	3,017	105,526
2009	32.1	0.6	3,421	106,721

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	10.2 %	1.6 %	3,491	34,337
2017	7.4 %	1.2 %	2,615	35,459
2016	12.1 %	1.5 %	4,376	36,319
2015	8.8 %	1.4 %	3,205	36,438
2014	10.1 %	1.4 %	3,709	36,666
2013	9.3 %	1.3 %	3,287	35,512

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2019	1.1 %	0.3 %	7,625	725,743
2017_2018	1.2 %	0.4 %	8,961	724,471
2016_2017	2.0 %	0.5 %	14,326	724,356
2016	2.5 %	0.8 %	18,460	724,262

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Iowa

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	83	83.5	84	84.5	85
Annual Indicator	80.5	82.7	81.5	84.5	80.2
Numerator	26,118	31,692	29,306	27,589	28,001
Denominator	32,462	38,306	35,951	32,646	34,927
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	85.5	86.0	86.5	87.0	87.5	88.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	20.5	25	26	30	30.5
Annual Indicator	24.9	26.1	29.5	30.5	24.8
Numerator	7,875	9,655	10,092	9,785	8,458
Denominator	31,681	36,965	34,193	32,069	34,057
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2013	2014	2015	2016	2017

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	31.0	31.5	32.0	32.5	33.0	33.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective		
Annual Indicator	86.7	84.8
Numerator	30,649	29,197
Denominator	35,356	34,418
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	87.0	87.5	88.0	88.5	89.0	89.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective		
Annual Indicator	44.2	47.5
Numerator	15,044	15,850
Denominator	34,022	33,343
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	48.0	48.5	49.0	49.5	50.0	50.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2019	**2020**
Annual Objective		
Annual Indicator	57.0	56.1
Numerator	19,594	18,702
Denominator	34,396	33,309
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	57.5	58.0	58.5	59.0	59.5	60.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			35	28.6	34.5
Annual Indicator		34.8	28.4	34.2	43.2
Numerator		31,438	27,467	32,539	43,907
Denominator		90,233	96,650	95,266	101,539
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	44.0	44.5	45.0	45.5	46.0	46.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			79	83	84
Annual Indicator		78.8	81.1	81.1	88.5
Numerator		202,051	191,475	191,475	195,697
Denominator		256,527	236,185	236,185	221,185
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	86.0	87.0	88.0	89.0	90.0	91.0

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			51.5	51.6	51.7
Annual Indicator		50.9	51.9	51.0	52.3
Numerator		65,262	70,636	74,037	75,172
Denominator		128,218	136,125	145,140	143,725
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	51.8	51.9	52.0	52.1	52.3	52.5

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			22	23	24
Annual Indicator		21.9	23.1	27.2	44.5
Numerator		13,904	16,833	20,601	30,962
Denominator		63,445	72,960	75,605	69,559
Data Source		NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	45.0	45.5	46.0	46.5	47.0	47.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	56	60	63.9	64.1	64.3
Annual Indicator	59.2	60.2	55.3	55.3	52.4
Numerator	21,739	21,891	19,796	19,796	18,294
Denominator	36,708	36,352	35,811	35,811	34,942
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2014	2015	2017	2017	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	64.5	64.7	64.9	65.1	65.3	65.5

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			82.6	85	87
Annual Indicator		81.7	84.7	86.7	86.1
Numerator		563,970	573,272	585,814	583,397
Denominator		690,337	676,624	675,638	677,662
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2017_2018	2018_2019

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

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	88.0	88.5	89.0	89.5	90.0	90.2

Field Level Notes for Form 10 NPMs:

None

NPM 14.1 - Percent of women who smoke during pregnancy

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	11.6	11.0
Numerator	4,388	4,120
Denominator	37,751	37,613
Data Source	NVSS	NVSS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	11.4	11.2	11.0	10.8	10.6	10.4

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Iowa

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

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective					73.5
Annual Indicator				77.3	78.7
Numerator				407,591	417,043
Denominator				527,210	529,605
Data Source				BRFSS	BRFSS
Data Source Year				2018	2019

Previous NPM-1 BRFSS data for survey years 2015, 2016 and 2017 that was pre-populated under the 2016, 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	14.8	14.6	24.3	24.1	23.9
Annual Indicator	29.1	29.1	29.3	29.3	28.8
Numerator	43,459	43,459	41,460	41,460	41,783
Denominator	149,221	149,221	141,691	141,691	144,931
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2011	2011	2017	2017	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2017	**2018**	**2019**	**2020**
Annual Objective			24.1	23.9
Annual Indicator			21.2	23.7
Numerator			52,515	55,502
Denominator			248,081	234,406
Data Source			NSCHP	NSCHP
Data Source Year			2018	2018_2019

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

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2017	**2018**	**2019**	**2020**
Annual Objective			24.1	23.9
Annual Indicator			52.7	53.9
Numerator			130,850	126,294
Denominator			248,281	234,506
Data Source			NSCHV	NSCHV
Data Source Year			2018	2018_2019

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

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Iowa

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		9.4
Numerator		
Denominator		
Data Source		Iowa's Maternal Mortality Review Committee (IMMRC)
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	9.0	8.9	8.8	8.7	8.6	8.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The rate for non-Hispanic White women was 6.0, for non-Hispanic Black women 36.9, for Asian/Pacific Islander 23.5 and for Hispanic women 9.7. The Black/White ratio is 6.1, Asian/Pacific Islander/White ratio is 3.9 and the Hispanic/White ratio is 1.6.

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		68
Numerator		
Denominator		
Data Source		IDPH Lead Report Card
Data Source Year		2019
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	70.0	72.0	74.0	76.0	78.0	80.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
68% 1 year olds; 38% 2 year olds (2019)

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		30	32	36	38
Annual Indicator	28.5	25.6	34.6	37.2	42.1
Numerator	1,512	1,347	1,558	1,563	1,759
Denominator	5,299	5,265	4,507	4,201	4,183
Data Source	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	43.0	44.0	45.0	46.0	47.0	48.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator		25
Numerator		
Denominator		
Data Source		Iowa Youth Survey
Data Source Year		2018
Provisional or Final ?		Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	25.0	25.0	24.5	24.0	23.5	23.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
The Iowa Youth Survey is conducted every two years. The most recent data is from 2018. Due to Covid-19 the 2020 survey was not completed. The Iowa Youth Survey (IYS) and Youth Risk Behavior Survey (YRBS) will be jointly administered in Iowa from September 27 to November 12, 2021. These surveys collect valuable youth health behavior data that drives funding, program and policy decisions in communities across the state

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	873	1,080
Numerator		
Denominator		
Data Source	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2019	2020
Provisional or Final ?	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	1,100.0	1,200.0	1,300.0	1,400.0	1,500.0	1,600.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	20.0	90.0	95.0	99.0	100.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	88.3	
Numerator	98	
Denominator	111	
Data Source	Youth Services Survey for Families	
Data Source Year	2016	
Provisional or Final ?	Provisional	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	88.0	88.5	89.0	89.5	90.0	90.5

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2016-2020 Needs Assessment Cycle)

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

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		91	84.5	88	89
Annual Indicator	90.5	84	87	86.2	82.4
Numerator					
Denominator					
Data Source	CAReS and WHIS	TAV Connect	TAV Connect	Signifycommunity	Signifycommunity
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: a) 90.5% b) 91.5%	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: A) 84% B) 80%	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: A) 87% B) 74%	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: A) 86.2% B) 74%	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: A) 86.2% B) 74%	

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

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		88	89	82.5	83
Annual Indicator	87.1	82	82	90.2	89.5
Numerator	14,141	15,385	15,385	14,462	12,131
Denominator	16,244	18,773	18,773	16,039	13,553
Data Source	I-Smile@School	I-Smile@School TAVConnect	I-Smile@School TAVConnect	I-Smile@School signifycommunity data	I-Smile@School signifycommunity data
Data Source Year	2016	2017	2017-2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
With the transition to TAVConnect there are some inconsistencies throughout the 2017 school-based sealant program data in TAV. Staff will continue to provide TA to ensure this is being documented correctly.

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

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		85.8	86	86.2	86.4
Annual Indicator	85.6	88.3	85.5	83.4	81.8
Numerator					
Denominator					
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2015	2016	2017	2018	2019
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2016-2020: SPM 6 - Percent of CYSHCN with parents who are very satisfied with the communication among doctors and other health care providers

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			69	70
Annual Indicator			70.2	61.7
Numerator			82,857	65,444
Denominator			117,950	106,020
Data Source			NSCH	NSCH
Data Source Year			2017-2018	2018-2019
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Please interpret with caution: estimate has a 95% confidence interval width exceeding 20 percentage points or 1.2 times the estimate and may not be reliable.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Iowa

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	23.0	46.0	69.0	92.0	112.0	122.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	32.0	34.0	36.0	38.0	40.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	12.0	14.0	16.0	18.0	20.0	22.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		1.5	2	2	2.5
Annual Indicator	0.9	1.6	1.9	1.9	2
Numerator	971	1,744	1,076	1,076	2,537
Denominator	110,608	110,577	56,307	56,307	125,164
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2016	2017	2018	2018	2020
Provisional or Final ?	Final	Final	Final	Provisional	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	2.2	2.3	2.4	2.5	2.6	2.7

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Data for ESM has been adjusted to match the NPM age ranges.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Will work with data system staff to get the updated numbers form 2019.	

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	46.0	92.0	138.0	161.0	184.0	200.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	3,115	
Numerator		
Denominator		
Data Source	Program Data	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	3,150.0	3,185.0	3,215.0	3,245.0	3,275.0	3,300.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data		
	2019	2020
Annual Objective		
Annual Indicator	62.1	
Numerator	218	
Denominator	351	
Data Source	Electronic Medical Record	
Data Source Year	2019	
Provisional or Final ?	Final	

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	64.0	66.0	68.0	70.0	72.0	74.0

Field Level Notes for Form 10 ESMs:

None

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

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			355	400
Annual Indicator			397	397
Numerator				
Denominator				
Data Source			Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year			2019	2019
Provisional or Final ?			Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
2020 will be updated when available.

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

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective			350	385	400
Annual Indicator	93	341	380	397	397
Numerator					
Denominator					
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2016	2017	2018	2019	2019
Provisional or Final ?	Final	Final	Final	Final	Provisional

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	400.0	400.0	400.0	400.0	400.0	400.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: I-Smile Coordinators are required to provide visit all pediatric medical offices in each county of the service area. Data includes the number of pediatric medical offices in the state. In Iowa there are 93 pediatric medical practices and 511 family medicine practices. When this ESM was developed a tracking form was developed for the I-Smile Coordinators to collect this data.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: In Iowa there are 93 pediatric medical practices and 511 family medicine practices.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: In Iowa there are 93 pediatric medical practices and 511 family medicine practices.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 2020 data will be provided when avaiable.	

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

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	50.0	55.0	60.0	65.0	70.0	75.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

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

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		65	35	54	59
Annual Indicator	64	27.2	48.6	51.8	53
Numerator	5,478	296	1,357	1,842	2,339
Denominator	8,560	1,090	2,794	3,559	4,416
Data Source	WHIS	TAV Connect	TAV Connect	Signifycommunity	Signifycommunity
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: With the transition to the new integrated data system this question has been added as a data point.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Iowa's Title V programs have transitioned to a new database for documenting discharge of clients. There is not a set protocol for discharge, each agency is able to establish their own process. Technical assistance will be provided on the importance of educating women on continuing health care coverage after discharge from Maternal Health Program.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: There is not a set protocol for discharge, each agency is able to establish their own process. Technical assistance will be provided on the importance of educating women on continuing health care coverage after discharge from Maternal Health Program	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: There is not a set protocol for discharge, each agency is able to establish their own process. Technical assistance will be provided on the importance of educating women on continuing health care coverage after discharge from Maternal Health Program	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: There is not a set protocol for discharge, each agency is able to establish their own process. Technical assistance will be provided on the importance of educating women on continuing health care coverage after discharge from Maternal Health Program	

2016-2020: ESM 4.1 - Percent of women educated on the importance of breastfeeding to ensure that the feeding decision is fully-informed.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		87	80	54	59
Annual Indicator	86.7	6.6	48.7	45	53
Numerator	938	167	1,362	1,600	2,339
Denominator	1,082	2,548	2,794	3,559	4,416
Data Source	WHIS	TAV Connect	TAV Connect	Signifycommunity	Signifycommunity
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: While the ESM data shows a low number of MH clients receiving breastfeeding education this could be due to a data entry error. Iowa's Title V programs have transitioned to a new database for documenting health education there is a drop down option to list to select critical topics covered. The staff may have not been selecting all topics covered. This will be included in TA provided over the next year. All Title V agencies are required to provide education on the benefits of breastfeeding to clients and provided resources and referrals during postpartum visits when appropriate. IDPH provide copies of "My 9 months" a guide to a healthy pregnancy published by the March of Dimes which is given to each pregnant mom this educational magazine is offered in English and Spanish and has four pages of education on breastfeeding.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This count is for clients who received health education. MH agencies are required to address breastfeeding at one of the health education visits for all clients. Agencies are currently in the process of collecting specific health education topics addressed, however there have been data entry issues with this data collection field. Title V staff have provided training and reminders to agencies and conduct regular QA checks on this measure..	

2016-2020: ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a developmental screen using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		13.5	14	30	31
Annual Indicator	12.9	13.9	29.4	29.4	17.3
Numerator	14,315	15,381	16,529	16,529	21,642
Denominator	110,608	110,577	56,307	56,307	125,164
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Signifycommunity
Data Source Year	2016	2017	2018	2018	2020
Provisional or Final ?	Final	Final	Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Medicaid data pulled has been adjust to match the age ranges specified in NPM.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Waiting on 2019 data.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 21642 - Medicaid Paid Claims with CPT code G0451 or 96110 for children ages 0-6 in time frame FFY 2020 125,164 - Children 0-6 Medicaid Eligible at the present time	

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

Measure Status:			**Active**
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			4
Annual Indicator			2
Numerator			
Denominator			
Data Source			Meeting Agendas
Data Source Year			2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Bullying taskforce is currently being re-evaluated due to change in National Performance Measure changes.	

2016-2020: ESM 10.1 - Number of school districts and other adolescent serving organizations with whom Title V CAH agencies partner with and/or educate on the promotion of preventive medical visits among adolescents ages 12-17.

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		84	105	90	92
Annual Indicator	88	88	88	88	88
Numerator					
Denominator					
Data Source	Local Title V MCAH Application	Local Title V MCAH Application	Local Title V MCAH Application	Local Title V MCAH Application	Local Title V MCAH Application
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2017 RFP 22 agencies selected NPM 10.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2018 RFA 22 agencies selected NPM 10.	
3.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2018 RFA 22 agencies selected NPM 10.	
4.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2019 RFA 22 agencies selected NPM 10.	
5.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Local agencies selecting NPM 10 are required to partner with at least four adolescent serving organizations. For the 2020 continuation RFA 22 agencies selected NPM 10.	

2016-2020: ESM 11.1 - The percent of CYSHCN served by DCCH Regional Centers who have a Shared Plan of Care

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		0	5	10	15
Annual Indicator	0	1.5	1.3	84.5	81.1
Numerator	0	105	96	4,857	5,546
Denominator	100	7,061	7,500	5,746	6,838
Data Source	Chart review and program data	Chart review and program data	Chart review and program data	Chart review and program data	Chart review and program data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 11.2 - The number of care coordinators serving CYSHCN who received trainings about the Shared Plan of Care.

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			20	23	25
Annual Indicator	0	29	23	34	45
Numerator					
Denominator					
Data Source	Program Data	Program Data	Program Data	Program Data	Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.1 - Percent of YSHCN served by DCCH Regional Centers with an initiated transition plan

Measure Status:				Active	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		0	15	30	45
Annual Indicator	6	6.2	42.5	62.1	61.3
Numerator	5	15	144	218	103
Denominator	83	242	339	351	168
Data Source	Program data	Program data	Program Data	Program Data	Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

2016-2020: ESM 12.2 - Percent of YSHCN served by DCCH Regional Centers with at least annual transition reviews

Measure Status:				**Active**	
State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective		0	15	30	45
Annual Indicator	0	0	0	88	73.5
Numerator	0	0	0	477	361
Denominator	83	242	339	542	491
Data Source	Program data	Program data	Program Data	Program Data	Program Data
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: No data regarding annual reviews of transition plans because the new transition planning protocol had not been implemented for a full year at the end of FFY17.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: No data regarding annual reviews of transition plans because the new transition planning protocol had not been implemented for a full year at the end of FFY18.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Iowa

SPM 1 - Number of pregnancy-related deaths for every 100,000 live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce preventable maternal mortality through modifiable actions based on recommendations from the Maternal Mortality Review Committee
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of maternal deaths **Denominator:** 100,000 live births
Data Sources and Data Issues:	Iowa Maternal Mortality Review Committee report and Viral Records. In the current Maternal Mortality Review Committee report there is 3 years worth of data. Vital Records data is based on 1 calendar year. Occasionally, this causes an incongruity between reported data.
Significance:	Maternal mortality rates are continuing to rise in the United States and Iowa, while all other Countries reporting data are seeing a decline in maternal mortality rates. The Maternal Mortality Review Committee has seen an increase in the rate of women dying due to pregnancy-related complications.

SPM 2 - Percent of children ages 1 and 2, with a blood lead test in the past year
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percent of Iowa children ages 1 and 2 with a blood lead test.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 1 and 2 (12-35 months) with a blood lead test **Denominator:** Number of children ages 1 and 2 (12-35 months)
Data Sources and Data Issues:	Healthy Homes & Lead Poisoning Surveillance System (HHLPSS) database and Annual Estimated Census Data by County
Significance:	Statewide in 2017, 88% of one year olds were tested for blood lead, compared to 43% of two year olds and 14% of three year olds. The typical development of toddlers increases their risk to environmental lead exposure during their second and third year of life through hand to mouth behavior and increased mobility. There is a significant need to test increase testing of 2 year olds, while maintaining the high rate of one year olds being tested.

SPM 3 - Percent of early care and education programs that receive Child Care Nurse Consultant services.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of early care and education programs receiving Child Care Nurse Consultant services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of early care and education programs receiving Child Care Nurse Consultant services. **Denominator:** Total number of early care and education programs.
Data Sources and Data Issues:	Healthy Child Care Iowa and Early Childhood Iowa
Significance:	Improving the quality of child care allows Iowa to address cross-cutting MCH needs such as nutrition and physical activity, breastfeeding support, developmental screenings, and safe sleep environments. Families of CYSHCN also reported difficulties finding childcare providers that are qualified and comfortable caring for their children. Iowa has a history in working with registered day care providers, both centers and in-home, through the Healthy Child Care Iowa program. The role of child care nurse consultants (CCNCs) is based on the Blueprint for Action from the Healthy Child Care America campaign. The CCNC program has the ability to reach a wide range of settings and provide support to day care providers in establishing practices that are medically sound and meet the objectives of Title V programs.

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

Measure Status:	Active
Goal:	Decrease the percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number reporting during the past 12 months that they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities **Denominator:** Total number of 6th, 8th and 11th graders completing Question B62 of the Iowa Youth Survey.
Data Sources and Data Issues:	Iowa Youth Survey
Significance:	This measure is significant as it is a direct result of the qualitative and quantitative data gathered during the needs assessment, in addition to emerging legislation creating a children's regional mental health system structure statewide in response to what has been a child/adolescent mental health crisis in the state. Title V in Iowa has not played a significant role in adolescent mental health previously, therefore an exploratory phase is required to better understand the gap filling role for Title V.

SPM 5 - Number of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the number of children 0-35 months who have had fluoride varnish during a well visit with physician/health care provider
Definition:	**Unit Type:** Count **Unit Number:** 20,000 **Numerator:** Children 0-35 months enrolled in Iowa Medicaid who received a fluoride varnish application from a medical provider **Denominator:**
Data Sources and Data Issues:	Medicaid paid claims – requested by the Bureau of Oral and Health Delivery Systems annually
Significance:	Medicaid-enrolled children are more likely to receive routine care from a primary care or pediatric physician than a dentist, particularly for those younger than 3 years of age. Since low income children are more likely to suffer from dental decease, receiving fluoride varnish from physicians addresses this disparity.

SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Ensure the local Title V contractors have a plan to identify and address health equity in the populations they serve
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local Title V contractors with a plan to identify and address health equity **Denominator:** Total local Title V contractors
Data Sources and Data Issues:	Local Title V RFA/RFP action plans
Significance:	To make progress in health equity, our local contractors delivering Title V services need to be planful and intentional about addressing health equity. Contractors need partnerships and knowledge of their community and to be engaged with priority populations in their community, to develop and implement a plan.

SPM 7 - Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the satisfaction with support services received through Title V
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families who report overall satisfaction with services received **Denominator:** Total Families receiving CYSHCN services through DCCH
Data Sources and Data Issues:	Youth Services Survey for Families. DCCH will administer this survey annually
Significance:	CYSHCN whose parents receive needed support have better health outcomes

Form 10
State Performance Measure (SPM) Detail Sheets (2016-2020 Needs Assessment Cycle)

2016-2020: SPM 2 - A)Percent of children 0-21 served by Title V who meet Iowa's Title V criteria as having a medical home B)Percent of women served by Title V who meet Iowa's Title V criteria as having a medical home
Population Domain(s) – Women/Maternal Health, Child Health, Adolescent Health

Measure Status:	Active
Goal:	Increase the percent of children 0-21 and percent of women served by Title V who meet Iowa's criteria as having a medical home.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children 0-21 who report a medical home Number of women who report a medical home **Denominator:** Total number of children 0-21 served by Title V Total number of women served by Title V
Data Sources and Data Issues:	TAV Connect
Significance:	A medical home provides a family-centered approach to comprehensive primary care that values the whole person, communication with patients and families, and coordination of care. Women and children with a medical home are significantly less likely to have an unmet medical need and are more likely to have received preventive medical care in the last year. Women and children with a medical home are more likely to have improved functional health outcomes and increased family engagement than those without a medical home. Establishing a medical home has also resulted in reduced morbidity and mortality, hospitalizations, readmissions, and emergency room visits. "Served by Title V" is defined as individuals that receive direct or enabling services from local CAH and MH agencies.

2016-2020: SPM 3 - Percent of children with a payment source for dental care
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of children with a payment source for dental care
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Title V Child Health clients reporting a payment source for dental care **Denominator:** Total number of Title V Child Health clients.
Data Sources and Data Issues:	TAV Connect
Significance:	In the Iowa health insurance marketplace dental insurance is an additional policy and cost. Individuals are able to opt-out of purchasing dental insurance.

2016-2020: SPM 5 - Percent of adults aged 18-24 who report being physically active
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	Increase the percent of adults aged 18-24 who report being physically active.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of adults aged 18-24 who report being physically active. **Denominator:** Total number of adults aged 18-24.
Data Sources and Data Issues:	Behavioral Risk Factor Surveillance System
Significance:	The implications for engaging in physical activity cut across the lifespan for all MCH populations. Iowa's women of reproductive age suffer from a range of chronic conditions, including obesity. Additionally, minority women are less likely to engage in the recommended amount of physical activity than non-Hispanic white women. Increasing physical activity would help to address issues of obesity and other chronic conditions that can lead to more complications during pregnancy. Additionally, CYSHCN may not perform the recommended amount of physical activity per day. CYSHCN often experience unique barriers to physical activity, such as functional limitations, medication side effects that cause weight gain and make physical activity difficult, the high cost of specialized programs and equipment, and a lack of nearby facilities or programs. When CYSHCN exercise safely and regularly, socialization increases, weight status and overall health are improved, and the progression of chronic disease and functional decline decreases.

2016-2020: SPM 6 - Percent of CYSHCN with parents who are very satisfied with the communication among doctors and other health care providers
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase communication between health care providers
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CYSHCN with parents who are satisfied with the communication among doctors and other health care providers **Denominator:** Total number of CYSCHN in Iowa
Data Sources and Data Issues:	The National Survey of Children's Health (2016 NSCH). This is an updated State Performance Measure for FFY19. Our original Quality of Care indicator is no longer available through the Data Resource Center.
Significance:	Communication among health care providers is an important component of service integration. Communication between providers is a standard within The Standards for Systems of Care for CYSHCN 2.0: The medical home integrates care with other providers and ensures that information is shared effectively with families and among and between providers.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Iowa

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Iowa

ESM 4.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the education of businesses and organizations on the importance of strong policies to support employees to continue to breastfeed through or beyond 6 months of age.
Definition:	**Unit Type:** Count **Unit Number:** 150 **Numerator:** Number of businesses or organizations who were provided education by Title V agencies **Denominator:**
Data Sources and Data Issues:	RFA/RFP documentation from Local Title V Agencies
Significance:	Educating businesses and/or organizations on best practices and policies to implement within their practices will help ensure employees are able to continue to breastfeed when returning to work.

ESM 4.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	Increase the number of Maternal Health clients who receive education about breastfeeding through 6 months and information on pumping at work
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Maternal Health clients who receive education **Denominator:** Total number of Maternal Health clients served
Data Sources and Data Issues:	Title V data system report. Ensuring agencies are aware of how to document the this activity in the data system
Significance:	Educating women on the benefits of breastfeeding through 6 months and their rights and best methods on pumping at work will help increase the rate on initiation and breastfeeding through 6 months.

ESM 5.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Provide evidence based training opportunities for state and local partners/contractors on the importance and best practices on the topic of safe sleep.
Definition:	**Unit Type:** Count **Unit Number:** 50 **Numerator:** Number of training opportunities provided on the topic of safe sleep **Denominator:**
Data Sources and Data Issues:	Title V state and local reporting
Significance:	Increasing the knowledge of staff on the importance and best practices of safe sleep will ensure the education being provided to maternal health clients is up to date and evidence based.

ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the percentage of children with Medicaid coverage receiving a brief emotional behavioral assessment using a standardized tool.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Medicaid claims data for children ages 9 through 71 months for whom CPT code 96127 was billed. **Denominator:** All children ages 9 through 71 months with Medicaid coverage.
Data Sources and Data Issues:	Medicaid claims data.
Significance:	Emotional/behavioral assessments are important to detect delays early and link the families to services needed.

ESM 10.1 - Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the number of partnerships with adolescent serving organizations who are able to provide promotion of the importance of adolescent well visits.
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Number of organizations or agencies partnering with local agencies **Denominator:**
Data Sources and Data Issues:	Local RFA/RFP reporting. Ensure agencies track and document new and existing partnerships.
Significance:	Partnering with adolescent serving organizations will increase the instances education on well visits can be provided to clients.

ESM 11.1 - Number of telehealth visits through Child Health Specialty Clinics
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase the number of telehealth visits conducted for CYSCHN in the state
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** Number of telehealth visits conducted **Denominator:**
Data Sources and Data Issues:	University of Iowa Health Care Electronic Medical Record
Significance:	Telehealth visits are an important component of access to pediatric specialty care in rural areas where there are few providers.

ESM 12.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

Measure Status:	Active
Goal:	Increase the percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of clients served who have a transition checklist documented **Denominator:** Total number of clients served
Data Sources and Data Issues:	University of Iowa Health Care Electronic Medical Record
Significance:	The transition checklist is the tool that initiates transition services for youth served by Child Health Specialty Clinics

ESM 13.1.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase the number of medical practices receiving an outreach visit from an I-Smile Coordinator
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of medical practices received an outreach visit from an I-Smile Coordinator **Denominator:**
Data Sources and Data Issues:	Year end reports from local Title V agencies
Significance:	Partnering with local medical providers to do continued education for pregnant women on the importance of a dental visit will ensure the information is coming from a trusted source and will increase the number of patients with a dental visit in the past year.

ESM 13.2.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of medical practices receiving an outreach visit from an I-Smile Coordinator.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of medical practices who received an outreach visit from an I-Smile Coordinator **Denominator:**
Data Sources and Data Issues:	Year End Reports from local Title V agencies.
Significance:	Partnering with local medical providers to do continued education for pregnant women and children (1-17) on the importance of a dental visit will ensure information is coming from a trusted source and will increase the number of patients with a dental visit in the past year.

ESM 14.1.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer
NPM 14.1 – Percent of women who smoke during pregnancy

Measure Status:	Active
Goal:	Increase the percent of Maternal Health clients who are screened for tobacco use with Ask, Advise, Refer
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of maternal health clients who have been screened for tobacco use using the Ask, Advise, Refer **Denominator:** Total number of maternal health clients served
Data Sources and Data Issues:	Title V data system. Ensure agencies are documenting the screening and education appropriately.
Significance:	Ask, Advise, Refer is an evidence based product to screen for tobacco use with women. This will ensure Title V staff are appropriately screening and referring clients who need tobacco cessation services.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 1.1 - Percent of Title V maternal health participants that received education on continuing their health care coverage.
2016-2020: NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase Title V maternal health participants' knowledge on the topic of continuing their health insurance coverage.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>New field in WHIS collecting number of women educated about how to get help for how to receive health insurance coverage.</td></tr>
<tr><td>Denominator:</td><td>Total number of women who receive direct or enabling services from a MH agency</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Will need to add a field in WHIS (Maternal Health data system) to capture if a maternal health client received education on the topic of continuing health insurance coverage.</td></tr>
<tr><td>Significance:</td><td>Health insurance plays an important role because women with insurance are more likely to obtain preventive health care. Women are more vulnerable to loose their coverage as they may depend coverage through their partners job, so if he looses his job or they are divorced or widowed they may have no insurance. Also income eligibility decreases after pregnancy so many women lose Medicaid eligibility 60 days post partum.</td></tr>
</table>

2016-2020: ESM 4.1 - Percent of women educated on the importance of breastfeeding to ensure that the feeding decision is fully-informed.
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase knowledge of importance of breastfeeding to ensure that the feeding decision is fully-informed.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of maternal health clients who receive education on breastfeeding.</td></tr>
<tr><td>Denominator:</td><td>Total number of women who receive direct or enabling services from a MH agency</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data field will need to be added to WHIS to capture if maternal health clients received breastfeeding education.</td></tr>
<tr><td>Significance:</td><td>Education of the importance of breastfeeding has been shown to increase the initiation and continuation of breastfeeding in mothers.</td></tr>
</table>

2016-2020: ESM 6.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a developmental screen using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active
Goal:	Increase the number of Title V Child Health clients and Medicaid enrolled receiving a developmental screening using a standardized tool.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Medicaid claims data for children ages 9 through 71 months for whom CPT code 96110 or HCPCS code G0451 was billed. **Denominator:** All children ages 9 through 71 months with Medicaid coverage.
Data Sources and Data Issues:	Medicaid claims data.
Significance:	Earlier detection of social-emotional and developmental delays and family risk-related factors in children will increase the needed referrals, interventions and follow-up.

2016-2020: ESM 9.2 - Convene a Bullying Prevention Task Force
2016-2020: NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Convene a task force comprised of state level leaders to coordinate anti-bullying efforts at least 4 meetings a year.
Definition:	**Unit Type:** Count **Unit Number:** 4 **Numerator:** Number of meetings conducted **Denominator:**
Data Sources and Data Issues:	Program data
Significance:	Better coordination of bullying prevention efforts across systems within the state will enable collaboration and sharing of best practices.

2016-2020: ESM 10.1 - Number of school districts and other adolescent serving organizations with whom Title V CAH agencies partner with and/or educate on the promotion of preventive medical visits among adolescents ages 12-17.
NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Increase the knowledge of school districts and other adolescent serving organizations on the topic of strategies to increase preventive medical visits among adolescents ages 12 through 17.
Definition:	**Unit Type:** Count **Unit Number:** 200 **Numerator:** Number of school districts and other adolescent serving organizations educated and/or partnered with to increase preventive medical visits among adolescents ages 12-17. **Denominator:**
Data Sources and Data Issues:	Year End Reports from local Title V Child Health agencies. A foreseeable issue for the first year is that this is a new measure and activity for the agencies to be collecting on and coordinating.
Significance:	Increasing the knowledge of school officials, adolescent serving community agencies, and adolescents on the importance of preventive medical visits will likely increase the participation rate.

2016-2020: ESM 11.1 - The percent of CYSHCN served by DCCH Regional Centers who have a Shared Plan of Care
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	By 2020, 20% of CYSHCN served by DCCH Regional Centers have a Shared Plan of Care
Definition:	<table><tr><td>**Unit Type:**</td><td>Percentage</td></tr><tr><td>**Unit Number:**</td><td>100</td></tr><tr><td>**Numerator:**</td><td>Number of CYSHCN served by DCCH who have a Shared Plan of Care</td></tr><tr><td>**Denominator:**</td><td>Total number of CYSHCN served by DCCH Regional Centers</td></tr></table>
Data Sources and Data Issues:	Epic/Record Review
Significance:	The SPoC template and protocol recommendations will allow medical homes to easily collaborate and communicate with multiple stakeholders and the family in Iowa's System of Care. The Lucile Packard Standards for Systems of Care for Children and Youth with Special Health Care Needs describes a SPoC as including information necessary to assure issues affecting a child's health and health care are identified and accessible across systems and that activities. The SPoC also documents the person accountable for addressing those activities. The SPoC results from a process of family-centered, team-based care coordination and is developed jointly among families, clinicians and coordinators. Research has shown that care plans centralize care, enhance information exchange and strengthen relationships between providers and families, and improve perceived quality of care outcomes including; enhanced patient safety, caregiver health and well-being, patient- and family-centered care, efficient and timely care, care coordination, and continuity of care. This ESM focuses on scaling up the SPoC to eventually reach all Iowa CYSHCN with moderate or greater health care needs, beginning with families served within DCCH.

2016-2020: ESM 11.2 - The number of care coordinators serving CYSHCN who received trainings about the Shared Plan of Care.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	By 2020, at least 25 people employed as care coordinators for CYSHCN will have received trainings about the use and implementation of Shared Plans of Care.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** The number of care coordinators serving CYSHCN who received trainings about the Shared Plan of Care. **Denominator:**
Data Sources and Data Issues:	Title V DCCH program data
Significance:	This ESM will disseminate Shared Plans of Care (SPoCs) to CYSHCN and their families across Iowa. SPoCs are a mechanism that allows CYSHCN to receive services through a coordinated medical/health home approach to care.

2016-2020: ESM 12.1 - Percent of YSHCN served by DCCH Regional Centers with an initiated transition plan
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, 60% of Youth with Special Health Care Needs (YSHCN) served by DCCH Regional Centers will have an initiated transition readiness assessment and Shared Plan of Care, including a medical summary and emergency care plan by age 14 years</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of YSHCN ages 14-21 years served by DCCH Regional Centers with an initiated transition plan</td></tr>
<tr><td>Denominator:</td><td>Number of YSHCN ages 14-21 years served by DCCH Regional Centers</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Internal chart review</td></tr>
<tr><td>Significance:</td><td>The transition plan will help ensure that YSHCN receive services necessary to make transitions to adult health care. This ESM will allow DCCH to monitor the engagement of YSHCN and their families in the development of transition plans.</td></tr>
</table>

2016-2020: ESM 12.2 - Percent of YSHCN served by DCCH Regional Centers with at least annual transition reviews NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2020, 60% of Youth with Special Health Care Needs (YSHCN) served by DCCH Regional Centers will have an annual review of their transition readiness assessment until age 21 years.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number YSHCN served by DCCH Regional Centers with at least an annual review of transition readiness plan</td></tr>
<tr><td>Denominator:</td><td>Number YSHCN served by DCCH Regional Centers ages 14-21 with a transition readiness plan</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Internal chart review</td></tr>
<tr><td>Significance:</td><td>The transition plan will help ensure that YSHCN receive services necessary to make transitions to adult health care. This ESM will allow DCCH to monitor the engagement of YSHCN and their families in the development and continual review of the transition plan.</td></tr>
</table>

Form 11
Other State Data

State: Iowa

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Iowa

Annual Report Year 2020

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Annually	2		
2) Vital Records Death	Yes	Yes	Annually	3	Yes	
3) Medicaid	Yes	Yes	Daily	0	Yes	
4) WIC	Yes	Yes	More often than monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	1	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Annually	4	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Daily	12	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Barriers to Prenatal Care	Yes	Yes	Annually	6	Yes	
10) Behavior Risk Factor Surveillance System	Yes	Yes	Annually	12	No	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

Data Source Name:	3) Medicaid
	Field Note: Daily eligibility imported into SignifyCommunity

Other Data Source(s) (Optional) Field Notes: