# FFY2021 Title V Maternal and Child Health Needs Assessment

Adolescent Health Domain Summary

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

# Acknowledgements

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

## Iowa Maternal and Child Health Program Overview

### Iowa Block Grant Description and Structure

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

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

### Iowa Adolescent Health Population Profile

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.

## Methods

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

### Framework

The framework of conducting the Needs Assessment was developed based on literature review of methodologies from past Title V NA reviews, Iowa's previous NA process, comments from federal

reviewers on previous NAs, and the guidance and resources provided by the Maternal and Child Health Bureau (MCHB) at Health Resources and Services Administration (HRSA).

The 2021 Title V Needs Assessment developed a vision and mission statements to guide the work.

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

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

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

## Leadership Team

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

## Health Equity Advisory Committee

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

## Stakeholder Involvement

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

## Data

### ***Data Sources***

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

### ***Quantitative***

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

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

### ***Qualitative***

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

For the Adolescent Health Domain, IDPH conducted two focus groups with adolescents and ten Key Informant Conversations (KIC) for a total of 25 participants. Focus groups were held in both urban and rural areas and had a set of common questions across all population domains, with specific questions for the Adolescent Health Domain.  The focus group and KIC questions are included in Appendix B.

KICs were conducted with 1-3 participants from each of the identified underrepresented populations. Title V utilized trained community champions as facilitators who also acted as recruiters for KICs. KICs were conducted either in-person or through teleconferencing based upon participant needs. KICs were conducted using interpreters when needed for the following languages: Spanish, Karen, Tigrinya, Vietnamese, Marshallese and Captioning.

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

# Findings

## Stakeholder Survey

A survey was conducted to seek input about the greatest health needs and challenges for Iowa's families. A brief video was created to describe the intent and background for the survey (https://tinyurl.com/y5my4t3g). Each population group included a set of questions relating to different national and state priorities. General data about each of the priority areas was embedded into the survey. Consideration of respondents' professional, personal, and community experience was used

to answer survey questions. For additional information on each population domain, the data snapshots and themes from Focus Groups and KICs were available by link within the survey. The following NPMs, SPMs and emerging issues were included in the survey:

- **National Performance Measure 7**
    - **B)** Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
- **National Performance Measure 8**
    - **B)** Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
- **National Performance Measure 9**
    - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- **National Performance Measure 10**
    - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
- **National Performance Measure 13**
    - **B)** Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- **National Performance Measure 14**
    - **B)** Percent of children, ages 0 through 17, who live in households where someone smokes
- **National Performance Measure 15**
    - Percent of children, ages 0 through 17, who are continuously and adequately insured
- **State Performance Measure 5**
    - Percent of young adults aged 18 through 24 years who report being physically active
- **Emergent Issues**
    - Mental Health
    - Vaping

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

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

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

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

*Table 1 Adolescent Health Population Domain Survey Ranking*

| | Rank: % Ranked as Top 3 Priorities | Importance: % Extremely or Very Important |
|---|---|---|
| Mental Health Issue | 89% | 97% |
| Teenage Vaping | 64% | 96% |
| Children 0 - 17 years who are adequately insured. | 54% | 83% |
| Adolescents, ages 12 - 17, with a preventive medical visit in the last year | 38% | 72% |
| Preventive dental visit in the past year | 16% | 62% |
| Children who live in households where someone smokes | 12% | 58% |
| Adolescents ages 12 - 17 years who are physically active at least 60 minutes per day. | 11% | 62% |
| Injury-related hospital admissions for ages 0 - 19 years | 10% | 59% |
| Adults aged 18-24 who report being physically active | 9% | 61% |

Total Survey Participants: 487
Population Group Responses:

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

## Capacity Assessment

***Local Capacity***

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

There were separate discussion groups for both rural and urban agencies for each Population Domain. Participants worked through a Solvability and Control Matrix to see where they could make the most local impact. Data Snapshots, Thematic Summaries from Focus Groups/ KIC, compilations of research informed practices specific to the domain were used to guide discussion. Members of the HEAC were on site for consultation during small group work to discuss health equity strategies in each domain. Based on consensus, the groups indicated the local system's capacity to address the selected measures (Table 2).

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

| | **Capacity to Address Priority** | |
|---|---|---|
| | ***Urban*** | ***Rural*** |
| Mental Health | Medium | Low |
| Vaping | Medium | Medium |
| Preventive Medical Visit in the last year | High | Medium |

***State Level Capacity***

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

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

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

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

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

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

| | ***Need*** | ***Capacity*** |
|---|---|---|
| Mental Health | High | Medium |
| Vaping | High | Medium |
| Preventive Medical Visit in the last year | Medium | Medium |

## Priority Selection

### Background

The Title V MCH needs assessment findings are designed to be used to identify priority areas to work on for the next five years. The selection of priority areas is also tied to federal guidance and requirements

regarding performance and outcome measurement. The MCHB guidance lists relevant National Performance Measures, and states need to select at least one federal measure for each population group. States are also free to develop State Performance Measures. The National Performance Measures that are directly related to Adolescent Health are:

- **National Performance Measure 7**
    - **B)** Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
- **National Performance Measure 8**
    - **B)** Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day
- **National Performance Measure 9**
    - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- **National Performance Measure 10**
    - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
- **National Performance Measure 13**
    - **B)** Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
- **National Performance Measure 14**
    - **B)** Percent of children, ages 0 through 17, who live in households where someone smokes
- **National Performance Measure 15**
    - Percent of children, ages 0 through 17, who are continuously and adequately insured

## Methods for Prioritizing

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

## Final Selected Priorities

The final selected priorities were:

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

The approaches will focus on

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

Progress will be measured through the following performance measures:

- **National Performance Measure 10**
    - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
- **State Performance Measure 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

- **State Performance Measure 6:** Percent of Title V contractors with a plan to identify and address health equity in the populations they serve (cross-cutting)

## Plans to Address Selected Priorities

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

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

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

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

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

Iowa's Title V RFA has taken a health equity lens in working on eliminating health disparities among ethnic and racial populations of color and other population groups with low income or who have historically had less access, power and privilege in Iowa. Priority populations that are known to experience significant levels of health disparity in child and adolescent health include African Americans/Black/African, Alaska Native/Native Americans, Asian/Pacific Islanders, fathers, Hispanic/Latinx, immigrants/refugees, people identifying as Lesbian, Gay, Bisexual, Transsexual, Queer,

Intersex, Asexual plus (LGBTQIA+), and persons with disabilities. Other populations may be addressed based on needs in the service area (e.g. Amish, families involved with the correctional system, pregnant women and adolescents experiencing homelessness, etc.) IDPH has maintained that our agencies should partner with specific organizations, programs or groups that address priority populations to increase culturally appropriate access, outreach and education on adolescent well visits.

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

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

Title V MCAH Agencies may provide gap-filling direct care services for adolescents based upon an assessment of need within the service area. (e.g. nutritional counseling, preventive medicine counseling, nursing assessments).

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

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

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

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

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

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

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

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

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

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

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

adolescent mental health. SIYAC is a non-partisan policy advising organization comprised of young people from across Iowa between the ages of 14 and 20. The IDPH Director serves on the Children's Board and the Title V Director serves on several workgroups of the Children's Board.

In previous work related to NPM 9 and the prevention of bullying or those that bully among adolescents, Iowa was successful in establishing a pilot project and utilizing an evidence based bullying prevention curriculum with local LGBTQIA+ youth Gay Straight Alliances (GSAs). Iowa's Title V program has an established partnership with Iowa Safe Schools. Iowa Safe Schools provides comprehensive support, victim services, resources, and events for LGBTQIA+ 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 LGBTQIA+ youth and how youth can be supported with access to services.

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

Iowa will work towards addressing health equity issues that arise around this SPM. For each of the four 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, LGBTQIA+, immigrants/refugees and people with disabilities. Being able to locate providers that look like them, are culturally competent in addressing their unique issues and speak their language near where they live is an important aspect of an individual's overall health. In rural areas, health care, specifically mental health care access (for adults and adolescents) is disparate in comparison to urban settings. We will explore, with our Title V agencies, how they can play a role in the children's mental health regional system and, where appropriate, consider gap-filling services.

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

The Bureau of Family, including Title V staff, have been incrementally increasing internal understanding and capacity to address health equity in programs and services. The Bureau/Title V is ready to expand capacity internally and to engage contractors in assuring an application of a health equity lens in services and programs administered at the community level.

The 2021 MCAH RFA requires contractors to address strategies and activities to demonstrate application of health equity strategies and engage diverse participant voices in program planning, decision making and implementation, and demonstrate inclusion of evidence-based/informed community engagement and collective impact strategies. These are beginning steps to assist contractors in being prepared to comply with the inclusion of a health equity plan requirement in the next RFP.

An environmental scan of current contractors will be conducted to assess the presence of health equity plans, current engagement in health equity strategies and partnerships, and assess the support needed by Title V contractors.  Title V plans to utilize the Health Equity Advisory Committee (HEAC) developed as part of the Title V Needs Assessment to provide input, technical assistance and content expertise on the

health equity strategies being developed at the state and contractor level. The HEAC is comprised of members of or service providers with expertise in working with the state identified priority populations: African American/Black/African, Asian/Pacific Islander, fathers, Hispanic/Latinx, immigrants/refugees, LGBTQIA+, Native American, and persons with disabilities.

The 2021 MCAH RFA outlines roles for Title V Contractors to engage diverse participant voices in program planning, decision making and implementation. Contractors shall incorporate strategies for family, youth, and community member participation into programming. Contractors will have access to the HEAC for consultation. Title V will increase membership of the state identified priority populations affected by health inequities on the MCH Advisory Committee to assure adequate representation.

Continuing to build internal capacity within the Bureau of Family Health/Title V Program is an important strategy in providing programs and services through a health equity lens. Strategies to build capacity include the development of a Health Equity Team, identification and completion of ongoing assessments/analyses of health equity data related to the Iowa Title V program, development and implementation of a data analysis plan to assess distribution of Title V resources and services through a health equity lens, and facilitation of staff professional development and technical assistance.

## Appendix A – Adolescent Health Data Snapshot

IOWA HEALTH DATA HIGHLIGHTS

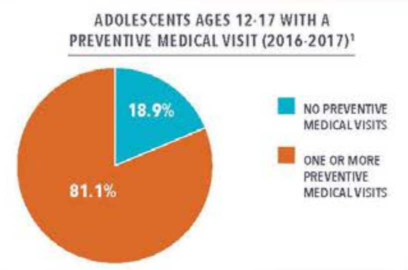
# Adolescent Health

## PREVENTIVE MEDICAL CARE

FOR ADOLESCENTS

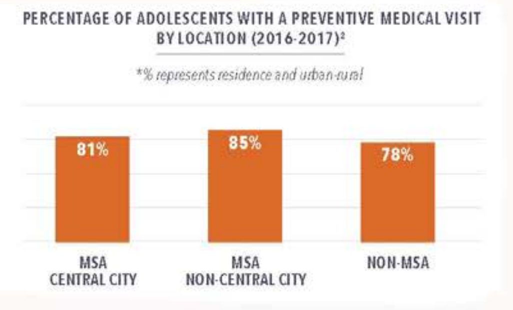
**Annual preventive medical visits improve adolescent health by providing opportunities to discuss healthy habits and behaviors, managing chronic conditions, and preventing illness.**

About 81% of adolescents received a preventive medical visit in 2016-2017.




HEALTH DISPARITY

**Adolescents in Non-Metropolitan Statistical Areas** (Non-MSA) **were least likely to receive a preventive medical visit**, when compared to adolescents in the MSA (central city, non-central city).

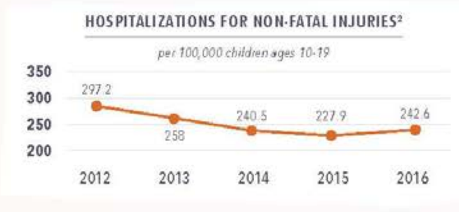



## HOSPITAL ADMISSIONS

DUE TO INJURY

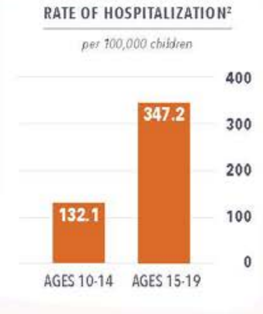
For children ages 0-19 in the United States, **injuries are the leading cause of death**. Most injuries are unintentional and can be prevented. According to the Centers for Disease Control and Prevention, **child injury is one of the most under-recognized public health problems in the US**.

**The rate of hospitalization for non-fatal injuries decreased** from 297.2 (per 100,000 children) in 2012 to 242.6 in 2016.




HEALTH DISPARITY

In 2016, the rate of hospitalization for children ages 15-19 was more than double that of children ages 10-14.



# PHYSICAL ACTIVITY

### AMONG ADOLESCENTS (AGES 12-18)

Regular physical activity among adolescents ages 12-18 can help improve cardiorespiratory fitness, build strong bones and muscles, control weight, reduce symptoms of anxiety and depression, and reduce the risk of developing health conditions.[3]

More students reported being active (60 active minutes/day) for five or more days a week than for all seven days per week. Additionally, the activity level of students remained relatively stable from 2011 to 2017.

**PHYSICAL ACTIVITY OF STUDENTS AGES 12-18[4]**

| | 2011 | 2013 | 2015 | 2017 |
|---|---|---|---|---|
| ACTIVE 60 MIN/DAY, 5+DAYS/WEEK | 51.5% | 55.6% | 54.7% | 49.2% |
| ACTIVE 60 MIN/DAY ALL 7 DAYS/WEEK | 29.1% | 32.6% | 30.7% | 29.4% |

### PHYSICAL ACTIVITY AMONG ADULTS

The percent of adults ages 18-24 who reported being physically active increased from 2013 to 2017 with some fluctuations each year in between.

**ADULTS AGES 18-24 PHYSICAL ACTIVITY**

| 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|
| 80.1% | 90.0% | 85.6% | 88.3% | 85.3% |

# SMOKING HOUSEHOLDS
## AND CHILDREN'S HEALTH

**Secondhand smoke (SHS) negatively affects children's health** by increasing lower respiratory tract infections and asthma, and by decreasing pulmonary function. **There is no safe level of exposure to SHS.**[5]

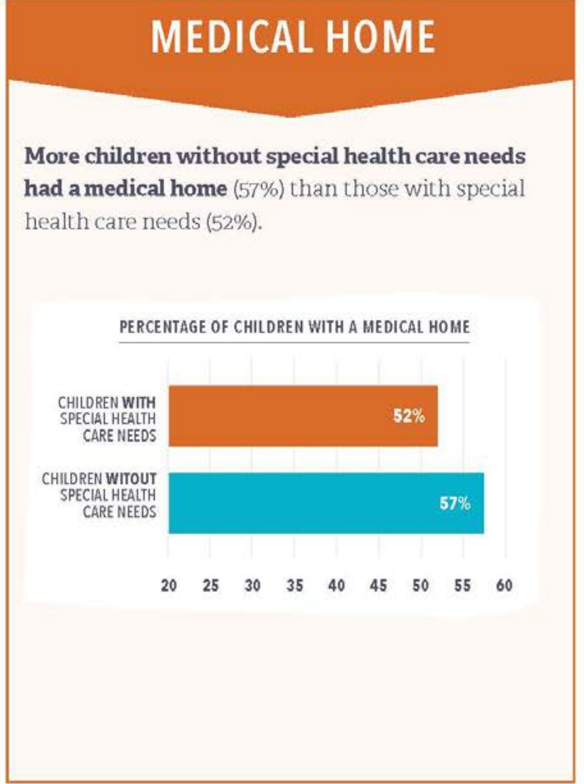
In Iowa, **the percentage of children living in household with someone who smokes has decreased** by approximately 12% (from 29% in 2011 to 17% in 2016).

**CHILDREN LIVING IN SMOKING HOUSEHOLDS[1]**

| 2011-2012 | 2016-2017 |
|---|---|
| 28.90% | 17.40% |

# MEDICAL HOME

**More children without special health care needs had a medical home** (57%) than those with special health care needs (52%).



# ADEQUATE HEALTH INSURANCE

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

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

CHILDREN WHO WERE ADEQUATELY INSURED (AGES 0-17), 2016

INSURED 71.3%

UNINSURED 28.7%

PERCENTAGE OF CHILDREN

### HEALTH DISPARITY

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

CHILDREN WHO WERE ADEQUATELY INSURED BY RACE, 2016

NON-HISPANIC WHITE 72%

HISPANIC 62%

PERCENTAGE OF CHILDREN

## SERVICES RELATED TO TRANSITIONS TO ADULT HEALTH CARE

**During childhood, parents usually help with medical needs** such as calling for appointments, filling out forms, and keeping track of medications. As youth reach adulthood, there are many changes in responsibility. Achieving life goals requires knowledge, preparation, and skills for youth and their parents. Often families of children and youth with special health care needs (CYSHCN) will require extra support when transitioning to the adult health care system.

CYSHCN WITH SERVICES NECESSARY TO TRANSITION TO ADULT CARE (AGES 0-17)[1]

RECEIVED CARE FROM A MEDICAL HOME 23.1%

OTHER 76.9%

According to National Survey of Children's Health data, 23.1% of Iowa's Youth with Special Health Care Needs (YSHCN) received services necessary to make transitions to adult health care.

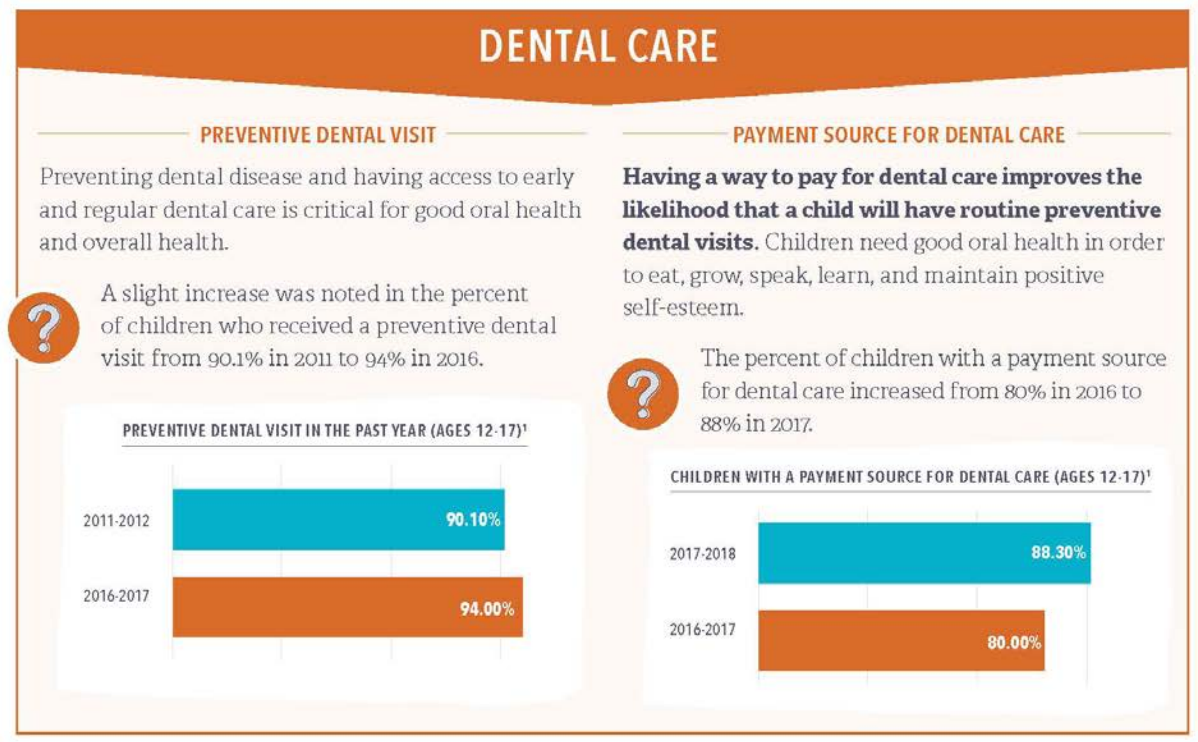
### HEALTH DISPARITY

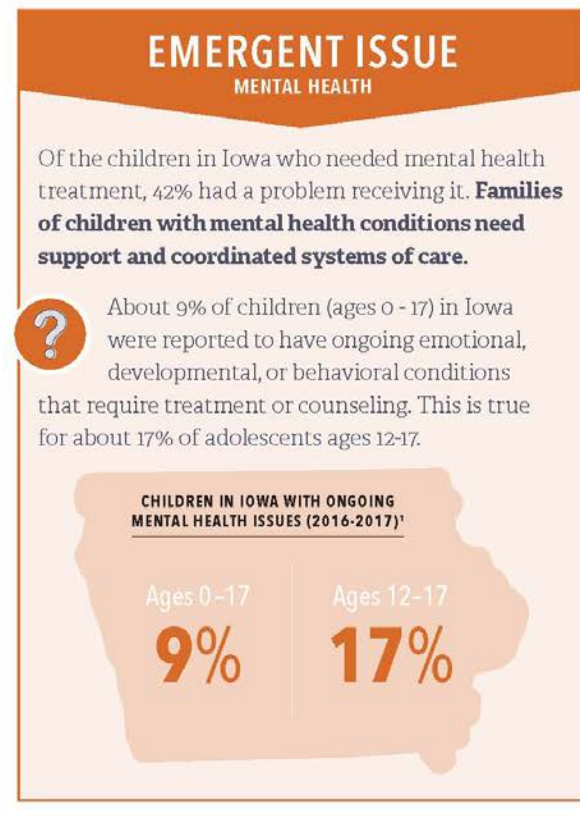
Males are more likely to have received transition services than females (27.9% vs 17.2%). Youth in suburban or mid-sized cities appear to be more likely to have received transition services than those in either more urban or rural areas.

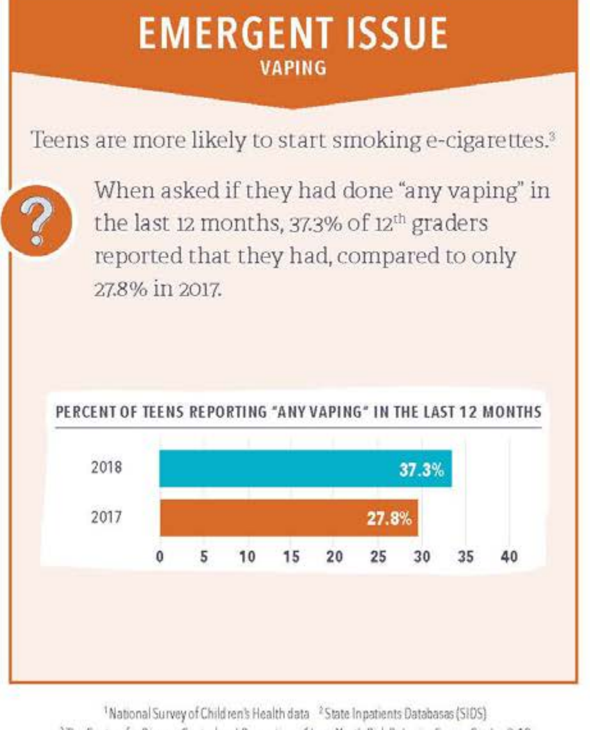
PERCENTAGE OF CYSHCN WITH TRANSITION SERVICES BY GENDER[1]

MALES 27.90%

FEMALES 17.20%




[1] National Survey of Children's Health data [2] State Inpatients Databasas (SIDS)
[3] The Centers for Disease Control and Prevention [4] Iowa Youth Risk Behavior Survey Grades 9-12
[5] U.S. Department of Health and Human Services, 2006 [6] I-Smile@School (TAV)
[7] 2018 Monitoring the Future (MTF) survey, National Institute on Drug Abuse

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

**Core Questions**

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

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

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

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

4. Where do you get health information you trust?

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

**Home Visiting Questions**

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

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

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

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

**Population Domain Questions**

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

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

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

3. What do you know about lead poisoning?

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

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

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

**Health Equity Questions**

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

1. How can your community help with these concerns?

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

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

4. How can your community support these cultural practices?

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

# Appendix C – Adolescent Health Focus Group Summary

***This is a preliminary summary of themes based on focus groups and interviews conducted with Iowa teens and caregivers of children 12 to 19 years old in July and August of 2019.***

## PROVIDER ISSUES

- Lack of knowledge of available resources
- Lack of knowledge about parent health concerns
- Inability to communicate in language English Language Learners can understand
- Discrimination/judgement
  - Racism
  - Ageism
- No time for one-on-one conversations between parent(s) and provider
- Long wait time from scheduling to appointment
- Poor follow-up regarding health concerns
- Appointments feel rushed

## HEALTH ISSUES

- Von Willebrand disease
- Body dysmorphic disorder
- ODD
- Depression
- Anxiety
- Bleeding issues
- Drug and alcohol use
- Violence
- Obesity
- Hole in heart
- Eyesight problems
- Speech problems
- Suicide
- Disabilities
- Asthma
- Stress
- Sexual abuse
- Pregnancy
- STDs
- Bullying (including from teachers)
- Fear (feeling unsafe)

# IOWA HEALTH DATA HIGHLIGHTS
# Adolescent Health

## ACCESS ISSUES

### TEENS HAVE LITTLE POWER OVER THEIR OWN HEALTHCARE

- Cannot make their own appointments
- Dismissed due to their age
- Not listened to until situations are very bad
- Unable to see a practitioner one-on-one without a caregiver present
    - Unable to talk about sensitive topics/concerns
- Disrespect/judgement
    - Age
    - Being a teen mom
- Forced to change birth control prescription

## INSURANCE ISSUES

- MCO/Medicaid issues
    - Services refused due to provider not accepting Medicaid
    - MCO changes
    - Few dental providers take Medicaid
- High deductibles
- Affordability
- No coverage for eye care

## SERVICES NEEDED OR DESIRED

- Improved accessibility to specialists
- Interpretation services
- Programs
    - Suicide prevention, bullying prevention, teen mental health education, teen engagement, parent education
- Improved dissemination/advertisement of resources and services
- Resources available in multiple languages
- Increased accessibility/coverage for mental/behavioral health services for teens
- Training
    - Teen engagement for providers, cultural competency for providers, suicide prevention for providers and school counselors
- Free/low cost sport/physical activities for teens
- Community collaborations to increase preventative care access (ex. libraries)