Iowa Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

2020

Statewide Needs Assessment

IDPH Iowa Department of Public Health

Iowa MIECHV Maternal | Infant | Early Childhood | Home Visiting

KU The University of Kansas

This report was prepared for the Iowa Department of Public Health.

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Iowa celebrates people of all races, ethnicities, gender identities, ages, sexual orientations,and abilities. Deliberate efforts have been made to showcase the broad diversity of our state (represented both within the narrative and through visual depictions) with dignity, honor, and cultural competency.

The report created In collaboration with:

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About KU-CPPR

Our mission at the University of Kansas Center for Public Partnership and Research (KU-CPPR) is to optimize the well-being of children, youth, and families by generating responsive solutions that improve practice, inform policy, and advance knowledge. KU-CPPR works closely with national, state, and local agencies, nonprofit organizations, and private foundations to assist partners in solving complex social problems and evaluating the impact and effectiveness of those efforts. KU-CPPR staff have experience and expertise in education, psychology, child welfare, substance use, behavioral health, maternal and child health, and early childhood systems.

We are committed to representing the data herein responsibly and equitably and we therefore make every effort to be transparent in that process. The content of this report was carried out for the Iowa Department of Public Health under the direction of Janet Horras. The primary author was Neil Rowe, Ph.D and Eliza Bullock created the design.

Contents

Welcome Message

Greetings!

In the pages that follow you will hear the voices of families who would be eligible for family support—some are participating in home visiting programs and others have chosen not to participate. You will see an in-depth analysis of factors that contribute to the well-being of families in Iowa. You can identify communities where families are thriving and communities where families struggle for survival across our state. Our hope is that you will be able to use the needs assessment findings to improve programming for families and focus additional resources on struggling communities.

A critical element of the needs assessment was to conduct focus groups with families with young children—some were participating in home visiting services and others had never had the experience. Their thoughts and ideas are incredibly valuable. We want to thank each of them for giving us their time and sharing their thoughts. Their honest and heart-felt feedback will improve home visiting services.

We would be remiss if we did not also recognize the significant contributions made daily by early childhood home visitors across the state of Iowa. Their dedication to the families they serve is truly inspiring.

The 2020 Maternal, Infant and Early Childhood Home Visiting (MIECHV) needs assessment was a multi-year project made possible with funding from the Health Resources and Services Administration. MIECHV partnered with Title V, Maternal-Child Health, Office of Early Childhood Iowa, Iowa State University and the University of Kansas to provide a comprehensive assessment.

Happy Reading!

Janet Nickell Horras
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Language Used in this Report

In preparing this report, the MIECHV Needs Assessment Team and the Iowa Department of Public Health wanted the language used to positively reflect the communities, people, and services the words were representing. For this reason, throughout this document "family support" is used in lieu of "home visiting", "family support professional" is used in place of "home visitor", "high-need" is used instead of "at-risk".

Family Support The state of Iowa[1] uses the term "family support" to describe voluntary programs for expectant parents and parents of children in the period of life from birth through age five providing educational family support experiences designed to assist parents in learning about the physical, mental, and emotional development of their children. Using "family support" directs the focus on the service provided rather than the service delivery mechanism—which is the case when we use the term "home visiting." Additionally, when we conducted focus groups and used the terms "home visiting programs" and "home visitor", many participants who had never enrolled in such programs had perceptions of surveillance and DHS involvement when discussing their interest and barriers to enrollment. For all these reasons, we use the term "family support" instead of "home visiting" and the term "family support professional" instead of "home visitor".

High-Need The term "at-risk" follows a deficit-oriented framework and the use of it perpetuates the normalization of judgment on communities, children, and families[2]. We have chosen to reclassify what is referred to as "risk" or "at-risk" in MIECHV Needs Assessment guidelines, so the language used in this report better conveys what the classification means. So, instead of "risk" or "at-risk", the term "high-need" is used. In this report, high-need indicates a high need for family support programs.

Introduction

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program is authorized by Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c))[3]. Section 50601 of the Bipartisan Budget Act of 2018[4] (BBA) extended appropriated funding for the MIECHV Program through fiscal year 2022. Section 50603 of the BBA required states to conduct a statewide needs assessment by October 1, 2020.

Iowa's 2020 MIECHV Needs Assessment Update Goals

- Identify Iowa communities with concentrations of risk
- Identify the quality and capacity of existing Iowa family support programs in communities with concentrations of risk and describe the extent to which existing programs are meeting the needs of families
- Describe Iowa's capacity for providing substance use disorder treatment related to the needs of pregnant women and families with young children who may be eligible for MIECHV services

The 2020 Iowa MIECHV Needs Assessment Update fulfilled these purposes through active coordination with the Iowa Title V Maternal and Child Health (MCH) Block Grant Program Needs Assessment and Preschool Development Grant Workgroups, as well as the Iowa MIECHV Needs Assessment Committee. Additionally, the Iowa Child Maltreatment Prevention Needs Assessment funded by the Child Abuse Prevention and Treatment Act (CAPTA) and community-wide Head Start needs assessments were consulted and integrated into the 2020 Iowa MIECHV Needs Assessment.

Coordination with Other State Needs Assessments

The MIECHV authorizing statute[5] requires coordination with and taking into account other needs assessments conducted by the state, including those facilitated through the Title V Maternal and Child Health (MCH) Block Grant Program, Child Abuse Prevention and Treatment Act (CAPTA), and Head Start.

Convening Stakeholders

Early childhood stakeholders representing Title V, Early Childhood Iowa (ECI), Department of Human Services (DHS), Community Partnerships for Protecting Children (CPPC), Iowa ACEs 360, Early Access, and the Iowa Association for the Education of Young Children (IAEYC) participated in the MIECHV Needs Assessment Committee to guide the MIECHV needs assessment process through interagency collaboration and incorporating and building on the work of other needs assessments. The committee included stakeholders involved in the Title V, Preschool Development Grant (PDG), and CAPTA, needs assessments. Additionally, the processes, methodology, and results of the needs assessment were shared with the Iowa Family Support Leadership Group (FSLG) on an on-going basis for comments and feedback. The FSLG included state and local managers of family support programs as well as direct service providers. The coordinator of the Iowa Head Start State Collaboration Office was a member of the FSLG.

Title V MCH Block Grant Needs Assessment

The Iowa Title V MCH Block Grant Needs Assessment[6] was completed in 2020. The Iowa Title V Block Grant Coordinator served on the MIECHV Needs Assessment Committee to assist with the coordination of needs assessments. Additionally, the Title V Coordination Workgroup was formed to collaborate with the MIECHV Needs Assessment Team on data collection. Iowa coordinated qualitative data collection efforts during the summer of 2019, so a diverse collection of voices of service recipients, eligible families, and underrepresented populations were included in the needs assessments for Title V and MIECHV. Coordination workgroup meetings were used to develop data collection plans and methodology and to analyze, interpret, and contextualize the results of each needs assessment.

Preschool Development Grant (PDG) Needs Assessment

The statewide needs assessment funded by PDG was completed in 2019[7]. The administrator for Early Childhood Iowa (ECI)—the recipient of PDG funding—and contracting researchers working with ECI on the PDG needs assessment served on the MIECHV Needs Assessment Committee to coordinate needs assessments. The PDG research team at Iowa State University held monthly coordination work group meetings with MIECHV needs assessment team members to incorporate and contextualize data used for the PDG needs assessment for use in the MIECHV needs assessment. The risk assessment completed for the 2020 MIECHV Needs Assessment Update included cumulative birth risk data used in the PDG Needs Assessment.

Child Abuse Prevention and Treatment Act (CAPTA) Needs Assessment

A statewide child maltreatment prevention needs assessment was completed in 2017[8]. This needs assessment was updated in 2019[9] to include current data. The program manager for Community-Based Child Abuse Prevention (CBCAP), funded through CAPTA, and the Iowa Child Abuse Prevention Program (ICAPP) served on the MIECHV Needs Assessment Committee to integrate and build on the CAPTA needs assessment. The CAPTA needs assessments were used to compare county risk levels with counties identified as high need in the MIECHV Needs Assessment Update and to identify any potential high need counties that should be monitored.

Head Start Needs Assessment

The MIECHV needs assessment team worked with the Iowa Head Start State Collaboration Office (IHSSCO) to identify Head Start needs assessments which could be incorporated into the 2020 MIECHV needs assessment update. The last statewide Head Start needs assessment was completed in 2009, so it was omitted due to outdated data. In Iowa, Head Start community needs assessments are completed by 18 different agencies with service areas which can include multiple counties. This did not fit the county-level approach necessary for risk assessment, so these were excluded as well. The needs assessment team worked with the Iowa Head Start State Collaboration Office and the Iowa Head Start Association (IHSA) to obtain the Early Head Start Home-Based Option quality and capacity information necessary to complete the needs assessment. Additionally, feedback on the needs assessment from the IHSSCO was obtained through the FSLG.

Community High Need Assessment

As part of the 2020 MIECHV Statewide Needs Assessment Update[10], the Health Resources and Service Administration (HRSA) required states to identify communities with concentrations of risk indicators.

Risk indicators (this list is representative but not complete)[11]

- Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of high need prenatal, maternal, newborn, or child health
- Poverty
- Crime
- Domestic violence
- High rates of high-school drop-outs
- Substance abuse
- Unemployment
- Child maltreatment

A MIECHV needs assessment committee of early childhood stakeholders guided the needs assessment process to determine the indicators of risk and methodology for assessing high need. A guiding principle for the high need assessment was comparability to the 2010 Iowa MIECHV risk assessment[12]. This necessitated an independent method for determining concentrations of risk indicators, so Iowa could include indicators and methodology used in 2010.

GUIDING PRINCIPLE

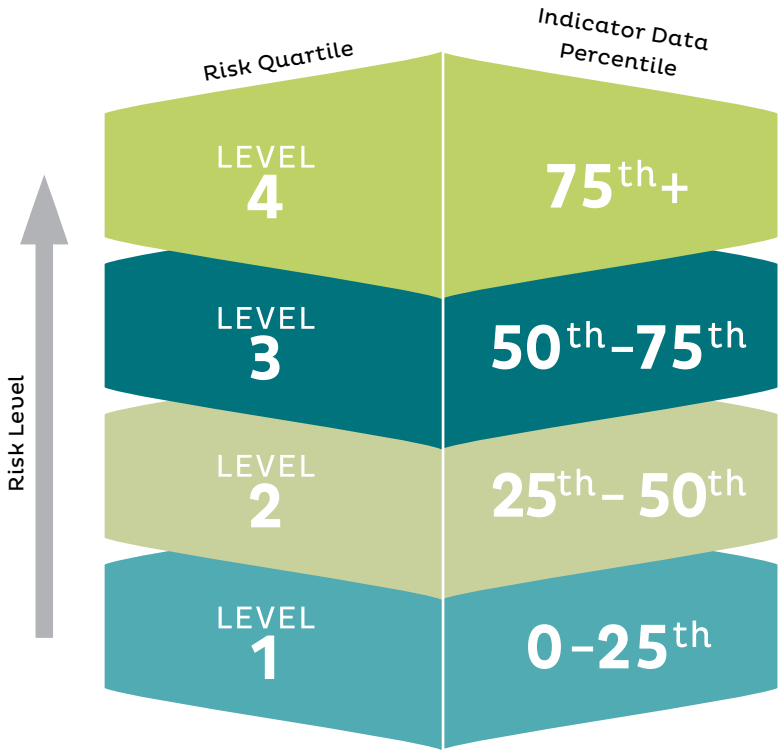
How does this assessment compare to the 2010 Iowa MIECHV risk assessment[28]?

High Need Assessment Methods

The 2020 MIECHV high need assessment aggregated the results of two different methods to identify high need counties. The first method measured county need based on prevalence of risk across 23 indicators from state and federal data sources. The second method measured county need based on the proportion of births with three or more maternal and child risk factors present. County rankings based on these two methods were averaged to determine high need status.

RISK ASSESSMENT METHOD 1

For the first high need assessment method, analysts compiled county-level data from federal and state sources. Each risk indicator was converted to a risk quartile.



Indicator data above the 75th percentile received a 4; higher than the 50th percentile, but equal to or below the 75th percentile received a 3; higher than the 25th percentile, but equal to or below the 50th percentile received a 2; and equal to or below the 25th percentile received a 1. A higher score indicated higher risk. Missing data did not receive a quartile. The quartiles for indicators with data were averaged for each county to calculate the county risk score.

Risk indicators

- 4th Grade reading proficiency
- Premature birth
- Low birth weight
- Infant mortality
- Poverty
- Child poverty
- Unemployment
- Child abuse and neglect
- High school dropout
- Crime
- Juvenile crime
- Domestic violence
- 3rd Trimester smoking
- Maternal education
- Income inequality
- Opioid-related hospitalizations
- Alcohol and drug-related crime
- 3rd Trimester alcohol use
- Medicaid-reimbursed births
- Teen births
- School lunch program
- No prenatal care in 1st trimester
- Maternal depression

Years, measures, and sources for indicators used in method 1 are located in Appendix A. County-level data for risk indicators are located in Appendix B.1 and Appendix B.2.

HIGH NEED ASSESSMENT METHOD 2

The second high need assessment method utilized Iowa's recently developed early childhood Integrated Data System (IDS) to analyze state administrative datasets that included Iowa Department of Public Health (IDPH) Vital Statistics birth records. Analysts used IDPH Vital Statistics birth records from 2013 and 2017 to examine individual and cumulative birth risk experiences. This approach identified the percentage of children born in each county with three or more of the identified risk indicators.

Identified Risk Indicators Related to Birth

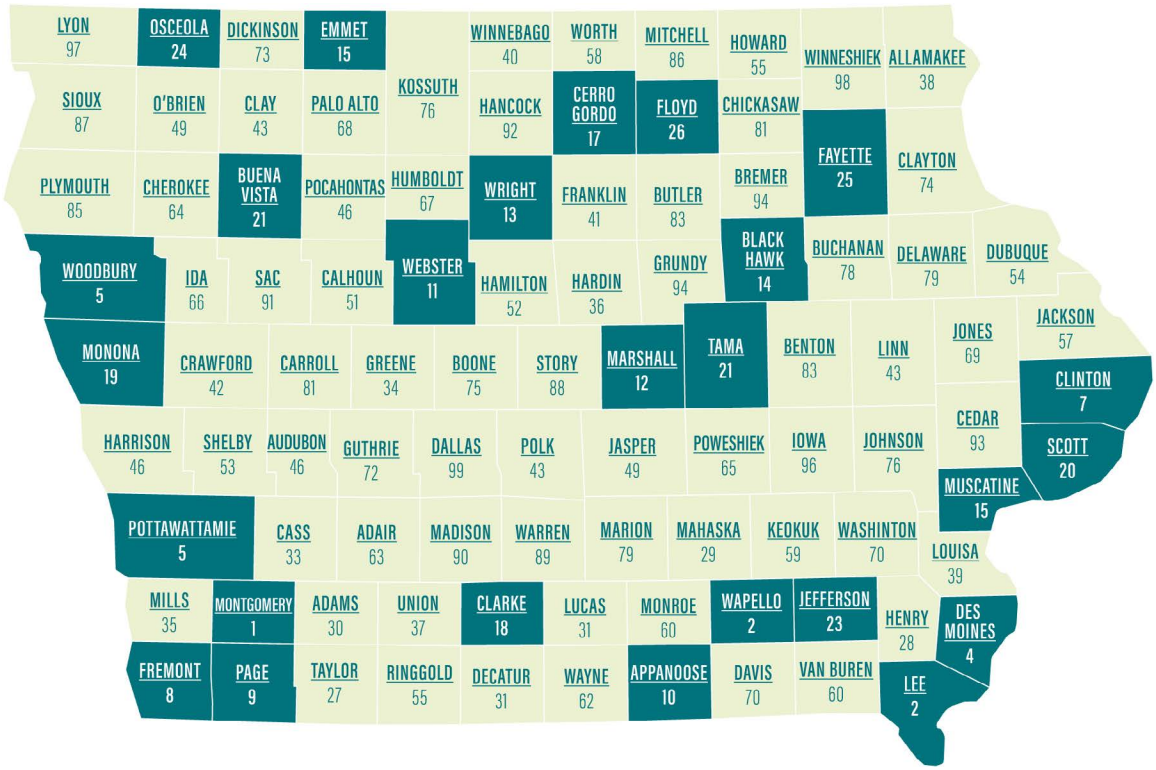
- Enrollment in Medicaid or WIC at the time of birth
- Mother unmarried
- Mother with less than high school education
- Mother under the age of 20
- Mother smoked during pregnancy or in the three months prior to pregnancy
- Baby born with low birth weight (<2,500 grams) or preterm birth (<36 weeks)
- Mother did not receive first trimester prenatal care and had less than four prenatal visits overall

Communities with Concentrations of Risk Indicators

A county was identified as high need if it was ranked in the top 25 counties based on an average ranking across both high need assessment methods. In total, 26 counties were identified as high need. Figure 1 (below) highlights the 26 high need counties and the overall risk ranking for each. See Appendix J for a comparison between 2020 and 2010 rankings. See Appendix C for the results and rankings for each high need assessment method and overall risk rankings. High need counties are indicated.

Figure 1

Map of Iowa High Need Counties and Overall Risk Rankings



Comparison with CAPTA Needs Assessment

Since the MIECHV needs assessment required coordinating with and taking into account the CAPTA needs assessment, the 26 high need counties were compared with the high need counties from the most recent Iowa child maltreatment prevention needs assessments[13]. Each of the counties identified as a high-risk county in both the 2017 and 2019 child maltreatment prevention needs assessments—six total—were also identified as high need counties in the 2020 MIECHV needs assessment. Additionally, 18 of the MIECHV high need counties were also in the top 26 counties ranked for risk of child maltreatment in the 2019 CAPTA needs assessment update. Of the 8 counties that ranked in the top 26 for risk of child maltreatment in 2019, but were not MIECHV high need counties, only Union county (15th for risk of child maltreatment) appeared in the top 26 counties for a risk assessment method (16th in risk assessment method 1) used in the MIECHV needs assessment. Therefore, Union county should be monitored as a potential high need county in the future.

Quality and Capacity of Existing Programs

The MIECHV authorizing statute[14] requires the submission of a statewide needs assessment that identifies the quality and capacity of existing programs and initiatives for early childhood family support services in the State.

Needs assessment content requirements

- The number and types of individuals and families who are receiving services under such programs or initiatives
- The gaps in early childhood home visitation in the State
- The extent to which such programs or initiatives are meeting the needs of eligible families

The MIECHV Program Supplemental Information Request (SIR)[15] for the submission of the statewide needs assessment update also required a data summary of the quality and capacity of family support programs in high need counties. The needs assessment team facilitated focus groups and interviews with Iowa families to highlight the gaps in early childhood family support services and help describe the extent to which family support programs are meeting the needs of eligible families.

Number and Types of Individuals and Families Receiving Family Support Services

The MIECHV needs assessment team examined data from the statewide Data Application and Integration Solutions for the Early Years (DAISEY) database from fiscal year 2019 to identify the number and types of families receiving family support services. The statewide DAISEY database stores data for IDPH-funded MIECHV programs and also houses the Family Support Statewide Database (FSSD). The FSSD includes data from Early Childhood Iowa funded support programs, Iowa Department of Education Shared Vision Parent Support programs, Iowa Department of Human Services Child Abuse Prevention family support services and parent education programming, and ICAPP/CBCAP IDPH HOPES Healthy Families Iowa programs. Information on the number and types of families served by the Early Head Start Home-Based Option (EHS-HBO) was obtained through coordination with the Head Start State Collaboration Office (HSSCO) and Iowa Head Start Association (IHSA).

Statewide information on the numbers and types of individuals and families who received family support services in the last fiscal year is available in Tables 1 through 3 below. More information on the reach and impact of Iowa family support programs is available at: http://www.iowafamilysupportimpact.org.

Table 1. Statewide Family support services Demographics by Race

Race*	Frequency	Percentage
White	7,729	73.7%
Black or African American	1,355	12.9%
Asian	838	8.0%
Multiracial	197	1.9%
Other	368	3.5%

**Note: Data missing for 1,149 families; percentages reflect families who provided race information*

Table 2. Statewide Family support services Demographics by Ethnicity

Ethnicity*	Frequency	Percentage
Not Hispanic or Latinx	9,035	83.8%
Hispanic or Latinx	1,747	16.2%

**Note: Data missing for 754 families; percentages reflect families who provided ethnicity information*

Table 3. Statewide Family support services Demographics by Service

Service	Frequency	Percentage
Home Visits	123,144	n/a
Families Served	11,536	n/a
Children Served	12,977	n/a
Families Enrolled Prenatally*	3,082	31.2%

**Note: Data missing for 1,665 families; percentage reflects the prenatal enrollment rate when this information was collected*

Quality and Capacity of Family Support Programs in High Need Counties

The quality and capacity data summary of high need counties includes the following information for each county:

- Served by at least one family support program (yes/no)
- Served by at least one evidence-based MIECHV-eligible model (yes/no)
- Served by family support program(s) funded by MIECHV (yes/no)
- Estimated families served by family support programs
- Estimated number of eligible families in need of family support services

The full data summary is available in **Appendix D.**

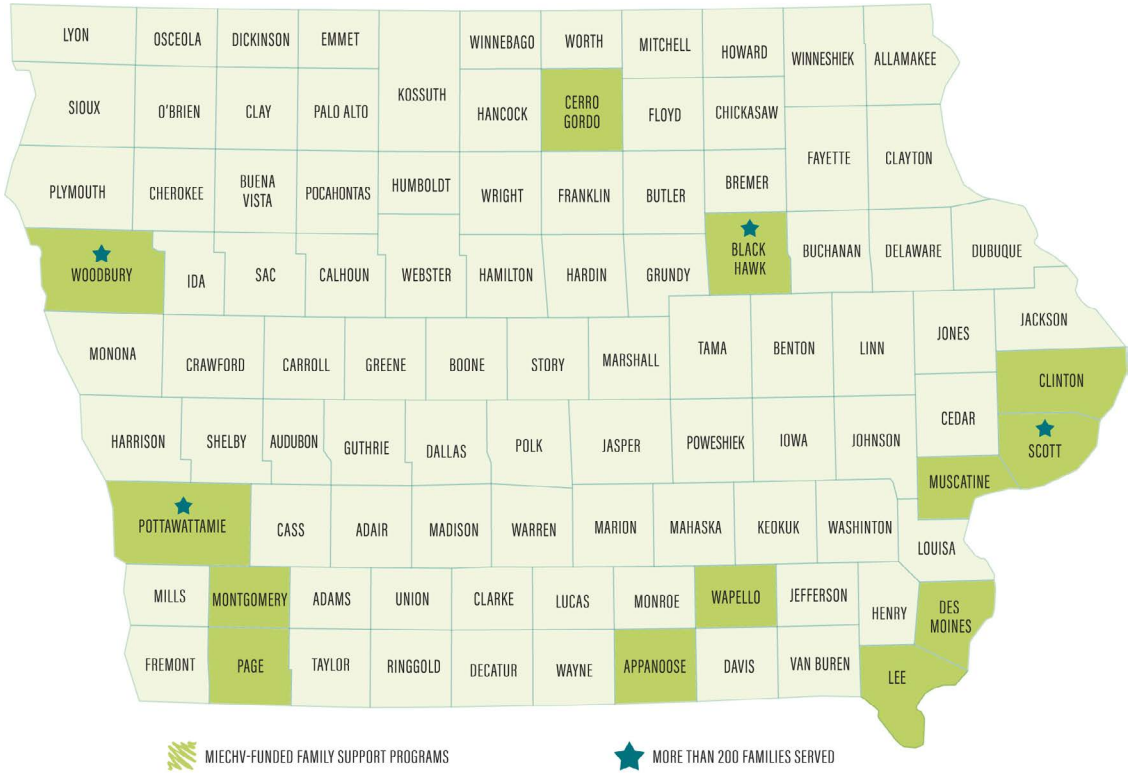
The following section summarizes the methodology (if applicable) and results included in the data summary.

All 26 high need counties operate at least one family support program and at least one evidence-based MIECHV-eligible model. MIECHV-eligible models include:

- Attachment and Biobehavioral Catch-Up (ABC) Intervention
- Child FIRST
- Durham Connects/Family Connects
- Early Head Start – Home-Based Option
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand)
- Family Check-Up for Children
- Family Spirit
- Health Access Nurturing Development Services (HANDS) Program
- Healthy Beginnings
- Healthy Families America
- Home Instruction for Parents of Preschool Youngsters
- Maternal Early Childhood Sustained Home Visiting Program
- Minding the Baby
- Nurse-Family Partnership
- Parents as Teachers
- Play and Learning Strategies – Infant
- SafeCare Augmented

Figure 1

Counties currently utilizing MIECHV-funded family support programs



FAMILIES SERVED BY FAMILY SUPPORT PROGRAMS IN HIGH NEED COUNTIES

The MIECHV SIR restricted the number of families served by family support programs included in the quality and capacity data summary to families served by programs that:

- Use family support services as a primary intervention strategy
- Serve pregnant women and/or children from birth to kindergarten entry

Also, the SIR directed the exclusion of programs with few or infrequent visits or where family support services is supplemental to other services. Programs that did not meet these requirements were removed from the FSSD data. The total families served by family support services in the data summary included families served by MIECHV programs, those served by programs meeting the above criteria in the FSSD, and those served by the Early Head Start Home-Based Option for each high need county.

The most families were served in the four urban high need counties: Black Hawk (462), Woodbury (407), Scott (347), and Pottawattamie (221). Osceola served the fewest families (8).

FAMILIES IN NEED OF FAMILY SUPPORT SERVICES IN HIGH NEED COUNTIES

An estimated number of families in need of family support services for each county was provided by HRSA. These numbers were based on 2017 American Consumer Survey (ACS) 1-year Public Use Microdata Sample (PUMS) data. These estimates were based on the following:

- The number of families with children under the age of 6 living below 100% of Federal poverty level added to the number of families in poverty with a child under the age of 1 and no other children under the age of 6 (used as a proxy for families with a pregnant woman that would also be eligible for MIECHV services)

And belonging to one or more of the following high need sub-populations:

- Mothers with low education (high school diploma or less)
- Young mothers under the age of 21
- Families with an infant (child under the age of 1)

Two alternative estimates of the number of families in need of family support services were calculated. The first method combined the ACS 2013-2017 five-year estimates for the number of pregnant women below poverty level and the number of households with children under five below poverty level. The second method used the Iowa Early Childhood IDS Vital Statistics data to identify the number of children born in each high need county from 2013-2017 with three or more birth risks present.

List of risk indicators included to evaluate level of need in children born in each high need county (a minimum of 3 required)

- Enrollment in Medicaid or WIC at the time of birth
- Mother unmarried
- Mother with less than high school education
- Mother under the age of 20
- Mother smoked during pregnancy or in the three months prior to pregnancy
- Baby born with low birth weight (<2,500 grams) or preterm birth (<36 weeks)
- Mother did not receive first trimester prenatal care and had less than four prenatal visits overall

County estimates varied across these three measures of families in need of family support servies. Despite this variation, three of the top four high need counties—Des Moines, Lee, and Wapello—were among the counties serving the least percentage of families in need of family support services across measures. In contrast, Emmet County served high percentages of families in need of family support services across measures, but it also had the highest rate of founded or confirmed child abuse and neglect in 2018 and ranked second in the 2019 Child Maltreatment Needs Assessment Update for risk of child maltreatment. In 2019, 43% of abuse victims in Emmet County were age five or younger[16]. Further investigation is warranted to examine the links between the proportion of families in need served, the types of families served, the types of programs serving families, dosage, and reduced risk in a community.

Voices of Families Receiving or Eligible for Family Support Services

Iowa MIECHV and Title V coordinated the most extensive collection of diverse voices of Title V and MIECHV-eligible families in our state's history. Data collection spanned across each of the six Title V regions, including 10 high need counties. Focus groups and interviews were conducted with three samples: Title V recipients, family support service recipients, and underrepresented populations. Participants were recruited to participate in focus groups based on Title V population domain. These included Maternal Health, Infant/Perinatal Health, Child Health, Adolescent Health, and Children and Youth with Special Health Care Needs (CYSHCN). Title V and MIECHV recipients were recruited through their local agencies. Participants for CYSHCN groups were recruited through Child Health Specialty Clinics, Iowa's Title V CYSHCN program.

Underrepresented populations

- African Americans
- Asian/Pacific Islanders
- Hispanic/Latinx
- Immigrants and refugees
- LGBTQI+
- Native Americans
- Fathers
- People with disabilities

RECRUITMENT

Underrepresented populations were recruited by community champions identified by the Health Equity Committee of community members established by IDPH. The Health Equity Committee provided guidance and recommendations throughout the planning, data collection, and data analysis processes. Community champions had connections to or belonged to the underrepresented population. The community champions received training on facilitating focus groups and were responsible for recruiting for and facilitating each group. All participants received either a $25 gift card or a package of diapers worth approximately the same amount. Community champions were compensated $150 for each group they recruited and facilitated. Health Equity Committee members were offered $600 each for their contributions and consultation time. Title V and MIECHV focus groups were offered childcare and transportation assistance to each participant. Family support agencies arranged where to host the focus groups, provided childcare (if needed), and provided food or refreshments. Most participating family support agencies hosted the groups at their facilities. Family support agencies were reimbursed (if requested) $25 for the food or refreshments provided for each group. Title V arranged for transportation assistance when requested.

In total, 46 focus groups and 10 interviews were conducted. The 46 focus groups included 26 key informant conversations. The key informant conversations were in-person or online focus groups with one to five participants from an underrepresented population. These groups had an additional focus on health equity and so are referred to as health equity groups. Overall, 158 Iowans participated—106 of which were in high need counties and asked the MIECHV needs assessment questions. A breakdown of the data collection for each sample in high need counties is available in Table 4 on the following page.

Table 4. Qualitative Data Collection from Families for MIECHV Needs Assessment by County

County	Family support services	Title V	Health Equity Group
Black Hawk	Focus Group	Interviews	People with Disabilities, Asian/Pacific Islander, African Americans
Des Moines	Focus Group	n/a	n/a
Lee	n/a	Focus Group	n/a
Marshall	Focus Group	Focus Group	Hispanic/Latinx Immigrants/Refugees
Montgomery	n/a	Focus Group	People with Disabilities
Page	Focus Group	n/a	n/a
Scott	Focus Group	Interviews	Hispanic/Latinx, Fathers
Tama - Meskwaki Settlement	n/a	n/a	Native American
Wapello	Focus Group	Focus Group	Immigrants/Refugees
Woodbury	Focus Group	Focus Group	Native American

Recruitment was difficult for Title V groups in Des Moines and Page counties, so participants were recruited out of Lee and Montgomery counties, respectively. Interviews were conducted with WIC recipients in Scott and Black Hawk counties due to no turn-out for the scheduled Title V focus groups. Data collection was limited to a 6-week period, and this made it difficult for community champions to build the relationships and trust necessary to successfully recruit underrepresented populations for health equity groups, especially in rural Iowa counties. Despite this challenge, seven of the eight populations were reached in at least one high need county. Specifically, LGBTQI+ participants were not successfully recruited.

Future data collection should plan significant time for the identification and training of community champions and for the recruitment of underrepresented populations, especially LGBTQI+. There are a host of historical dynamics between the research community and many populations. Thus, ample time is necessary to develop trusting and authentic partnerships and relationships with community organizations in order to support a broad spectrum of participation in our assessment efforts.

METHODOLOGY

Prior to their participation, each participant filled out a consent form and demographic questionnaire. Each group or interview was audio recorded and most had someone dedicated to live theme identification and notetaking. When this was done, participants were asked to verify the notes and themes and given the opportunity to add or change anything. When live theme identification and notetaking was not possible, these were documented later by listening to the audio recording.

The question format generally followed this pattern:

- Five Title V questions were asked to all participants
- Five Title V population domain-specific questions were asked depending on the population domain of the group
- Five MIECHV questions were asked; the question set was different for family support services recipients and those recruited outside family support programs
- Five health equity-focused questions were asked to underrepresented populations based on population domain

The facilitator guides for MIECHV questions used during focus groups and interviews are available in Appendix E. MIECHV questions were only asked to participants in Maternal, Infant/Perinatal, or Child Health groups.

After each group, the facilitator filled out a thematic summary with seven open-ended questions asking the facilitator to identify themes from the group related to MCH services including: service quality, barriers, resources, health issues, health disparities, and suggestions. Audio recordings were transcribed using a machine-learning transcription service.

Content analysis of participant responses and notes from MIECHV questions was used to identify service gaps and barriers to the receipt of family support services as well as the extent to which family support services were meeting the needs of families. Additionally, pathways participants described which could improve access or service delivery were identified. The analysis sample only included participants from high need counties who participated in Maternal, Infant, or Child Health groups or interviews. This sample included 54 family support services recipients, 22 Title V recipients, and 30 participants of health equity key informant conversations.

MIECHV Needs Assessment Sample

Full participant demographic characteristics are available in Appendix D.

59% were 30 years old or younger

48% had annual household incomes less than $20,000

47% had 3 or more children

18% were pregnant or expecting another child

85% had Medicaid coverage for their pregnancy, if applicable

86% of participants were mothers

94% had Medicaid or Hawk-I (CHIP) insurance coverage for their child(ren), if applicable

11% of participants were fathers

50% had a high school education or less

21% identified a primary language other than English spoken in the home

14% identified as Black or African American

10% identified as Native American or Alaska Native

8% identified as Asian

16% had a Hispanic or Latinx background

BARRIERS AND GAPS IN EARLY CHILDHOOD FAMILY SUPPORT SERVICES

The barriers and gaps in early childhood family support services are described for the workforce, utilizing the results from the Iowa Family Support Workforce Study[17], and for families, using thematic results from the 2020 Title V and MIECHV Needs Assessment qualitative data collection described earlier in this report.

Workforce Gaps and Barriers

IDPH funded a study of the family support workforce (Workforce Study) between 2013 and 2017. Family support professionals across the state were asked to complete a survey in 2013, 2015, and 2017. The Workforce Study identified gaps in staffing and educational preparation as well as barriers to providing services to families. The reported results are from the 2017 survey and include both MIECHV and non-MIECHV family support professionals, representing 81 of Iowa's 99 counties.

Staffing Gaps

The Iowa family support direct service workforce is overwhelmingly Caucasian (96.1%) and non-Hispanic (95.5%). This highlights a significant gap in workforce diversity compared to the racial and ethnic composition of families served. More than 25% of families served by family support programs in Iowa are non-white and 16% of families served are Hispanic.

In response to this persistent gap across the years of the workforce study, IDPH launched the MIECHV Workforce Development Diversity Pilot (Diversity Pilot). The Diversity Pilot was designed to address the racial and ethnic differences between families served and family support professionals in Iowa family support programs by recruiting family support professionals from underrepresented populations in two Iowa communities. An evaluation was conducted to examine the impact of increased workforce representation on underrepresented family engagement and outcomes.

Early results indicate this type of targeted recruitment and hiring can increase trust with both community partners serving underrepresented populations and underrepresented families themselves, resulting in increased referrals and family engagement from the underrepresented population.

> They were hesitant to send us referrals because our staff didn't match the African American community. So, they were really excited that we had someone here that would be available to support the people they might refer. I think now that the word is getting out and people are seeing her more out in the community, it's been a lot easier. We're getting a lot more referrals for her.
>
> - Diversity Pilot Supervisor

> We have a large Spanish speaking population we couldn't serve before. Some of our families that we already had enrolled were dual language and they might have friends that were Spanish speaking. We were able to tell them we were bringing on a Spanish speaking home visitor and ask them if they have friends or families that might be interested. They were able to make some referrals and spread information in the community.
>
> - Diversity Pilot Supervisor

> Since [the new Family Support Professional] has taken over, [a disengaged family] met at least once a month, probably twice a month. When she's not meeting, she'll give a reason why. That was something that [never happened with] any previous workers.
>
> - Diversity Pilot Supervisor

Staffing Qualifications

The Workforce Study also revealed a gap in educational preparation for family support professionals. Approximately 13% of the direct service workforce has a high school diploma or GED as their highest level of education. About 73% of direct service family support professionals have a bachelor's degree or higher education. Even though nearly three-fourths of family support professionals have a bachelor's degree or higher education, only 39% report that their academic work prepared them very well for their job. Family support professionals with degrees come from programs in human services (21%), education (19%), social work (16%), health care (14%), other fields related those fields (22%), and other unrelated fields (8%). The diversity in educational backgrounds and the lack of tailored academic programs for prospective family support professionals requires a lot of learning to be done on the job even for those with a college education.

To address the gap in educational preparation and training, IDPH—in partnership with the Virginia Department of Health, Early Impact Virginia, the University of Kansas Center for Public Partnerships and Research, and James Madison University's Health Education Design Group—launched the **Institute for the Advancement of Family Support Professionals** (The Institute) with funds obtained through the HRSA MIECHV Program FY'17 Innovation Grant (#UH4MC30710). The Institute is an online professional development platform that provides family support professionals with individualized training opportunities based on competency needs revealed in a pre-assessment that assesses competencies in the **National Family Support Competency Framework for Family Support Professionals**. In the summer of 2020, IDPH validated the National Family Support Certification Exam. The purpose of this exam is to provide a credential to family support professionals who meet the minimum competency standards necessary of a family support professional. The exam can be taken online through an online

proctoring service. In Iowa, all family support professionals will be required to obtain this certification to receive state funding. The Institute not only provides a way for family support professionals to obtain a national credential recognizing their competency, but it also provides family support professionals and those interested in or coming into the field with free access to online training modules to build their competencies. It is the hope of IDPH that the offerings available through The Institute will foster a more prepared and effective workforce regardless of education level or field of study.

Opinions from Staff

In the final year of the Workforce Study, each family support professional was asked, "what do you feel are the challenges that make it difficult to do your job in family support?" Approximately 75% of those surveyed answered the question. Dominant themes included: funding instability, paperwork, inadequate pay, client motivation, and workload. These themes were present in more than 10% of responses. Quotes are provided below for each theme, so that themes are represented in the words of family support professionals.

Funding instability

> Funding and the uncertainty of what will be available on a long-term basis. This makes it very difficult to maintain staff morale when 'budget cuts' are impacting the ability to provide services.

> It's a challenge to not constantly worry about the status of future funding, especially if cuts are large enough to have to let staff go or decrease their hours.

Paperwork

> TOO MUCH TYPING AND PAPERWORK - can't stress this one enough.

> The amount of paperwork that continues to compound such as, entering the same data over and over into different data systems. It seems at times the paperwork part of the job seems to be more important than the face to face work that we provide.

Inadequate pay

> As a supervisor, I feel it's hard to keep quality staff at times when the hourly rate is lower and raises are disappointing to staff. The past family support worker left due to money.

> Very low pay. I make less money than many of my clients. I have 34 years of human service experience and I started at the bottom of the pay scale.

Client motivation

> Families that could benefit the most, are unresponsive or unavailable.

> Keeping up with each family and the extreme needs they have. I have learned things don't change overnight and there are many baby steps we have to take to help them be aware of the strengths they have to support their children and themselves.

Workload

> The biggest challenge is the heavy caseload. Many of our families are in crisis situations, so it is difficult to plan effective home visits and help the family with that situation when we are required to support so many families. Added on the amount of assessments and screenings that are required and having a reasonable amount of time to enter those into data bases.

> High expectations for caseload and unrealistic expectations for the amount of time that it takes to complete all of the responsibilities associated with the job.

Family Gaps and Barriers

Thematic results from the 2020 MIECHV and Title V Needs Assessment qualitative data collection effort are provided for the gaps and barriers in early childhood family support services as well as the extent to which early childhood family support services are meeting the needs of eligible children and families. For the barriers and gaps section, themes are organized separately for family support services recipients and for Title V recipients/health equity participants because they were asked different questions. Title V recipients and health equity participants are grouped together because they were asked the same questions. When quotes are presented, the county and sample are provided and—if it is a health equity group—the underrepresented population is provided. For localized thematic results organized by high need county see **Appendix G**.

MIECHV Recipients

Schedule

Schedules were the most oft-cited reason for having difficulty continuing family support services or remaining in contact with their home visitor. Many families do not have a consistent or predictable schedule. Other families had a difficult time seeing how they could continue services while working or going to school.

> **My schedule…during the fall I'll go from school from 8:00 AM until 4:00 [PM] and then, I'll work from 4:00 to 9:00 at night.[I have] a very full schedule and it's difficult to schedule times with family support.**
>
> - Wapello MIECHV Recipient

> **Timing and schedules are hard to fit in time for visit.**
>
> - Des Moines MIECHV Recipient

> **If I worked a full-time job, it would be more difficult to schedule appointments.**
>
> - Page MIECHV Recipient

There were few barriers outside of scheduling that family support services recipients mentioned. A participant discussed finding out about the program too late for her oldest child. Another participant recounted being overwhelmed with information about programs in the hospital. Others mentioned fears of having someone come to their home. A couple participants mentioned problems enrolling a second child in the program.

Finding Out Too Late

> **When my son went to preschool two years ago and that's where his teacher asked me if I wanted the family support program for my daughter.**
>
> - Woodbury MIECHV Recipient

Overwhelmed with Information at the Hospital

> After you have a baby, you have like 15 people come into your room and say, I'm a part of this program. I'm part of this program. You want to sign up for this? Do you want this? Do you want that?
>
> - Woodbury MIECHV Recipient

Fear

> People see the name of the agency and think badly about it or that it's a part of DHS—at first I did. First thing somebody asks when I talk about the program is are they working with DHS? A lot of people are scared to bring people in the house, fear their kids being taken because of this or that's going on. They don't want that. But I think if somebody explained their job just a little better, what they're there for and how they're willing to help more people would be in the program.
>
> - Scott MIECHV Recipient

> When it's the first time and you've never met them, it's a little scary.
>
> - Page MIECHV Recipient

Problems Enrolling More Children

> I wish my current home visitor can provide services for my baby at the same time as my older child. I asked but they said no. So, when my three-year-old goes to preschool they can start services for the baby, but I have to wait and see if my current home visitor will be available for my baby. If not, I have to get another person.
>
> - Woodbury MIECHV Recipient

> I wish that my home visitor could take on my other child, when the child I originally signed up to receive services graduates from the program, I wish my current home visitor could come, but I have to have two separate home visitors because my son will be past three months old. There's like a minimum age that you have to sign up for.
>
> - Woodbury MIECHV Recipient

Lack of Knowledge

To be able to sign up for family support services, eligible families need to know that the service is available to them. Many Title V and health equity participants were interested in early childhood family support services but had never heard of it before and had no idea how or where to sign up.

> **When my son was in the PICU at first, and then moved into the NICU, nobody offered me anything.** - Woodbury Title V Recipient

> **I don't know where or how to sign up.**
> - Black Hawk Asian/Pacific Islander Health Equity Participant (interpreted)

> **No. I've never heard of [family support services].**
> - Marshall Title V Recipient

> **I would like to get to know what their mission is. It makes it difficult for me to enroll, because I don't know about it. I've never really heard about it until now.**
> - Scott Father Health Equity Participant

> **I don't know anything about [family support services].**
> - Wapello Immigrants/Refugees Health Equity Participant

Misperceptions

It was very common for Title V recipients to have misunderstandings about early childhood family support services. Participants discussed the service only being available older adults or children with diagnosed needs. Participants also mentioned transportation concerns, insurance issues, and DHS involvement as barriers to their participation. Many thoughts, past experiences, and concerns come to mind when someone hears about a program such as early childhood family support services. Without discussion or follow-up, an eligible family in need may disregard an opportunity for support because they either have a misunderstanding of the program itself or the eligibility requirements.

> **Waiting for HMO to approve it or when you have a waiver from DHS and that then they're taking their time and you're sitting here waiting.**
>
> - Black Hawk African American Health Equity Participant when asked about barriers to receiving family support services

> **I don't know the requirements or eligibility. Like, I know, public health you have to have a certain income. There are just certain things... if you didn't have certain insurance, they wouldn't come or you need to have a certain diagnosis. It's not like you can just call and they'll come.**
>
> - Tama Meskwaki Native American Health Equity Participant

> **From my point of view, my child doesn't have any issues that a lot of other kids do. So, I would feel like we were taking services away from somebody else that needed it. I would fall into that category that I don't need services.**
>
> - Woodbury Title V Recipient

Scheduling

Personal schedules were cited as one of the main reasons it would be difficult for eligible families to receive family support services. Many participants discussed the need for family support services available outside of traditional 8:00 AM to 5:00 PM weekday hours.

> Sometimes the people who need the most amount of help are the ones with the least amount of time. And so the time that it takes for me to set up an appointment, have someone come to my house for an hour, and I mean, it's not like they're coming in the evening, they're coming in the middle of the day. And so once I'm done with my six weeks of postpartum, I'm going back to work. And so when do I have time to meet with these people to get the information that I may desperately need? They don't work on weekends and they're not working in the evening. So, then I'm kind of just out of luck.
>
> - Black Hawk African American Health Equity Participant

> [The] hours should be more flexible and include more in the afternoon after 5:00.
>
> - Marshall Latinx Health Equity Participant (interpreted)

> I would be willing to do it and—you know—I didn't have a later in the afternoon job and until I figure that out, I don't want to schedule or get something going and then have to stop it.
>
> - Montgomery Title V Recipient

> It sounds like a nice program, but I just have a super busy household and I just don't have time. It would not really work for me because I work full time and my schedule is all over the place. It would just be hard to schedule a visit.
>
> - Scott Title V Recipient

Fear

Participants also discussed many fears which prevented them or would prevent them from receiving family support services. Common fears included judgment, having a stranger in their home, and DHS involvement resulting in their children being taken away.

> You don't want someone to come to your house and seeing something sitting out and potentially getting in any trouble from that.
>
> - Black Hawk WIC Recipient

> Sometimes I don't know how to trust anybody. I don't really like to let anybody in when I'm having this mental stuff because I don't want people to think just because I'm an African American woman that I'm using my, culture, my race, or my mental illness just to get the stuff that I need when I need it... I don't like to be judged. And sometimes I don't like to reach out for help for that because I'm scared. If I say the right, do the right thing or get the right thing, then you get that stigma—not just from your culture—you get it from everywhere...And those are the blocks and the barriers. And then you cry, because it's like your voice is not being heard.
>
> - Black Hawk People with Disabilities Health Equity Participant

> I mean—I know even me—I kind of feel almost like you feel like you're going to be judged before you meet the person, they come in and judge your housekeeping skills. I have five kids—my house is a disaster.
>
> - Montgomery Title V Recipient

> The lady called me to set up a visit, but she was very persistent on meeting in the house. And my husband was like, "no." If I can't meet her outside of my house, then we're not doing that.
>
> - Woodbury Title V Recipient

> When I think about DHS coming into my home, it's nothing ever good.
>
> - Woodbury Title V Recipient

Cultural Beliefs

Specific to health equity groups was a theme of cultural beliefs as a barrier. Participants talked about how cultural beliefs can create or enhance stigma and prevent help-seeking. Additionally, participants shared experiences of people disagreeing with their cultural beliefs and parenting practices.

> **Sometimes, you know, people not agreeing on what you said. They said, oh no, that's not true. Oh, that's not true, because they don't experience it.**
>
> - Marshall Immigrant/Refugee Health Equity Participant (interpreted)

> **I'm biracial. You know, and I know in the African culture—medically—they believe everything can be healed—even if you have a disability. They don't believe in [disabilities]. Okay. So, it's kinda hard. If you have a mental diagnosis, some of them hide it. They don't want people to actually know. And that, that also extends to the fact that the reason why so many of them don't reach out to get the help.**
>
> - People with Disabilities Health Equity Participant

MEETING THE NEEDS OF ELIGIBLE CHILDREN AND FAMILIES

MIECHV Recipients

Resources and Referrals

Participants mentioned how important the resources and referrals provided by family support professionals were. Participants also talked about how family support professionals made it easier to access community resources and services.

> They have resources everywhere and they always have like referrals and they're able to get the foot in the door. For me, all I have to do is call or whatever.
>
> - Des Moines MIECHV Recipient

> When I was pregnant with my first child and I first moved to the city, I didn't really know where to go and what to do. [My home visitor] helped me with everything: how to make appointments, prenatal care, how to take care of myself and my baby.
>
> - Marshall Family support Services Recipient

Non-Judgmental Caring Relationship

Participants noted the importance of their relationship with their family support professional. They praised their family support worker's ability to authentically care about them, not judge them, and listen to their thoughts and feelings.

> [She is] Very non-judgmental. She doesn't mind the crazy that happens in my house… when she would first come, I cleaned my house and now she's just like… family."
>
> - Wapello MIECHV Recipient

> I'm taking advantage of every single thing because I didn't feel like I knew what I was doing. As first-time parents, how would I have known when to put them on cereal? My home visitor pays attention to what I complained about during our visit or said I needed. And then next time she comes, 'Oh I remember you said…' My home visitor is really nice, and she really does care.
>
> - Woodbury MIECHV Recipient

Flexibility and Continued Support

Participants appreciated their family support professionals' flexibility. Many participants had to cancel or reschedule visits. Other participants required meeting outside the home or could not meet for an extended period of time due to mental health difficulties or domestic abuse. Providers were flexible and creative in maintaining contact with their families.

> She is totally fine with meeting at a Starbucks. She was willing to, to not be in the home right away. I told her we'll meet with you but we're going to meet at Starbucks first and then build that relationship.
>
> - MIECHV Recipient

> Helping both me and my child transition out of a very toxic, very abusive relationship and be able to heal from that and not let it affect their development. Keeps them on track. If I didn't have the support from her, that wouldn't be possible.
>
> - Marshall Family support services Recipient

Support that Comes to You!

Most families appreciated that they did not have go anywhere or have to reach out to get support.

> Support comes to you—you don't need to pack up everyone and everything to get services.
>
> - Wapello MIECHV Recipient

> Having someone come into your home takes away that need to reach out. And when they come to your home, then you are not totally isolated. You get emotional support; you get access to lots of great resources and things that help you provide care for your child.
>
> - Woodbury MIECHV Recipient

Overall, family support services recipients who participated in focus groups were very satisfied with their experiences, loved their home visitor, and appreciated the resources, referrals, and services offered. As described in the barriers and gaps section, some families need the option of weekend or evening visits and some families need the option to meet outside of their home.

Systemic Mistrust

Many families reported some degree of distrust in service providers—even if they reported receiving family support services. For some of these families, there was systemic mistrust, though. This mistrust was embedded in multiple past experiences where participants were neglected or mistreated by other service providers.

> When you know you need their help doing the things you're asking and you voluntarily ask for, you get treated like—I feel like I'm treated like I'm a burden to you. I can't be a burden when you're getting paid to help me. And yet it seems like, you don't, really truly want to help. You just want to get a paycheck.
>
> - Black Hawk People with Disabilities Health Equity Participant

> I don't bring a lot of things up when we have yearly checkups, because I just figure it goes in one ear and out the other, so I don't even say anything.
>
> - Montgomery People with Disabilities Health Equity Participant

Overall, a majority of the Title V participants receiving MCH services had never heard of family support services and—even when it was described to them—came away with misperceptions of what the service was and misunderstood their own eligibility. Further, many Title V and health equity participants acknowledged they could use extra support. The networks for reaching eligible families and disseminating information about family support programs within Title V MCH services and beyond could be strengthened. Family support professionals and the larger network that connects families to family support services have the added challenge of acknowledging and addressing systemic mistrust that families—especially families of color—have developed from repeated failures and mistreatment from other providers. With pathways to build trust such as starting services outside the home, there is an opportunity—family support professionals can be a critical ally and advocate who helps families get the services and help they need.

> Before [my family support program], trying to get help was nearly impossible. After, it makes it a whole lot easier. For the same thing [another participant] said, kind of getting not just the information or a phone number, but the foot in the door.
>
> - Des Moines MIECHV Recipient

/ / /

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

To describe our state's capacity for providing Substance Use Disorder (SUD) treatment and counseling services, the needs assessment team worked with the Division of Behavioral Health within the Iowa Department of Public Health (IDPH). IDPH serves as the State Agency Grantee for the federal Substance Abuse Prevention and Treatment Block Grant (SABG), which is funded by the United States Substance Abuse and Mental Health Services Administration (SAMHSA). Funds from the block grant are administered by the Bureau of Substance Abuse through a competitive proposal process, and programs are selected to provide and coordinate state-wide substance use prevention, treatment, and recovery support services. Unless otherwise noted, data referenced in this section came from the Iowa FY2020-2021 SABG Application and Plan.

Range of Treatment and Counseling Services

With one of the nation's highest levels of alcohol use and binge drinking, coupled with increasing methamphetamine use, Iowa has a full range of SUD treatment, prevention, and recovery support services available. Twenty treatment agencies form the Integrated Provider Network (IPN)—a statewide community-based, resiliency and recovery-oriented system of care with services available throughout the state. Programs use evidence-based prevention and early intervention services, particularly for high-need populations, to meet their goals of providing effective treatment, supporting early remission, and sustaining long-term recovery. Additionally, the IPN contractors assess local needs while understanding state and national policy as they collaborate to educate the public and reduce stigma. See Appendix H for map of all IPN contractors and services areas.

Women and Children Treatment facilities offer assistance with transportation and help clients secure other supports.

Four contractors within the IPN—in the counties of Linn, Polk, Pottawattamie, and Woodbury—offer SUD treatment specifically designed for women and children. To be a Women and Children Treatment

(WCT) provider in Iowa, programs must take a comprehensive, appropriate, and flexible approach to treating this special population with priority admissions and minimal wait time. Depending upon a client's assessed needs, care type may be outpatient, residential, or include hospitalization, and may vary in intensity. However, child care and medical care, both prenatal and pediatric, is provided in all situations. Family-centered case management is extensive, including developmental screenings and therapeutic interventions for children. WCT facilities also offer assistance with transportation and help clients secure other supports such as future housing, child care, and medical care.

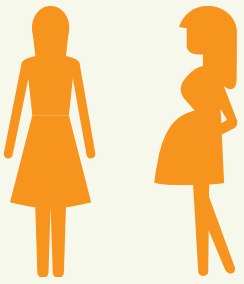
IDPH also offers a statewide 24-hour crisis and resource line. **Yourlifeiowa.org** provides information and referral, counseling, crisis screening and service coordination, and linkages for problem gambling, SUD, mental health, suicide, and children's mental health via text, talk, or live chat 24 hours per day, 365 days per year. This platform also features a search tool for finding providers by agency type, location, and services offered such as Medication Assisted Treatment (MAT), residential care, and fee assistance. A list of all 2020 IDPH-licensed providers for SUD and problem gambling treatment—organized by county—is available in **Appendix H**.

IDPH has addressed the critical need for meth treatment and prevention through a variety of educational strategies in 2019.

Trends

Iowa recorded a 38% increase in methamphetamine SUD admissions over the period of 2014-2017 and saw a particularly large increase in recent usage by women. Methamphetamines are by far the most frequently reported substance used by women admitted to treatment in the state at 48.2%, with pregnant women reporting an even greater rate of 58.9%. With this upward trend, the likelihood of family support professionals encountering families affected by meth are presumably increasing as well. IDPH has addressed the critical need for meth treatment and prevention through a variety of educational strategies in 2019 that included conference presentations, media campaigns specifically targeting women and pregnant women, and trainings for SUD contractors on data gathering and community assessment.

Women admitted for SUD treatment report that **Methamphetamines** are the most used substance.



48% **59%**

When describing gaps in treatment and counseling services and barriers to accessing treatment and counseling services, key issues are highlighted by including the voices of Iowans with a history of substance use. These Iowans participated in an IDPH and CDC supported study of substance use among Iowa families[7].

Gaps in Treatment and Counseling Services

SCREENING

In Iowa, Screening Brief Intervention and Referral to Treatment (SBIRT) was funded through a SAMHSA grant from 2012-2017 at five regional pilot sites, with an expansion to nine new locations currently underway. The SBIRT approach aims to identify those who might be at risk of SUD and intervene early to help set goals, change behavior, and/or access treatment. It is of particular benefit in assessing opioid use risk, as opioid addictions are considered easier to prevent than treat. It has been shown effective in both prevention of SUD and in the subsequent public health cost savings[18]. However, despite positive outcomes as a prevention technique, SBIRT it is not a statewide initiative. The lack of a screening requirement or universal system for SUD referral and follow-up is a significant gap in intervention and recovery for Iowans, particularly pregnant women. While Title V Maternal and Child Health (MCH) staff were trained in the administration of SBIRT, this effort's reach is limited to 23 health clinics.

MEDICATION ASSISTED TREATMENT

Medication Assisted Treatment (MAT) is viewed as the most effective form of opioid treatment, so increasing the number of providers and access to MAT is a priority area for IDPH in confronting rising opioid misuse. Since 2015, the number of authorized prescribers in Iowa has tripled to 107, in part due to a three-year federal grant to expand MAT services for providing Prescription Drug and Opioid Addiction (PDOA) treatment in four high-need counties[19]. However, in many rural portions of Iowa, the closest option remains 60-70 miles away. Gaps still exist in reaching less populous areas and providing the necessary transportation and support for those living in more rural parts of the state.

INCARCERATION

Drug convictions result in 17% of Iowa's incarceration population[20]. Many non-violent offenders with SUD are tied up in the criminal justice system when potential exists for diversion to treatment instead. The opportunity to receive help and avoid a criminal record can eliminate possible future barriers such as denial of employment or housing, which often lead to more substance use.

> I don't know if I can get certain things expunged off my record if they do a background check. Because that's usually how it goes whenever I get hired for a good job. My background is what stops me when they do a background check.
>
> Emily, who would like to go back to college, but worries good employment would still be unavailable to her.

In the hopes of interrupting addiction and decreasing the use of resources on a cycle of prosecution, incarceration, and relapse, three counties have piloted Pre/Post-Arrest Diversion to Treatment programs. Story, Black Hawk, and Jones counties received a U.S. Department of Justice grant for law enforcement officers and/or prosecutors to determine if low-risk individuals with SUD are suited for referral to a care coordinator and treatment options, rather than incarceration.

Barriers to Receiving Treatment and Counseling Services

GEOGRAPHICAL ISOLATION

As identified above with MAT and Arrest Diversion programs, one of the most significant barriers to services is frequently a result of one's location. Understandably, innovative programs are often piloted in more populous regions, so rural and isolated portions of the state must either wait for services to expand or configure complex transportation plans and/or relocation to receive help. As a part of Medicaid expansion, Iowa received and extended a waiver for assurance of Non-Emergency Medical Transportation (NEMT). NEMT is currently only available for those who meet traditional Medicaid requirements, meaning many families may be unable to access treatment if they have transportation needs and do not qualify. This is especially important if a client requires the special services provided by a WCT facility, of which there are only 4 in the state.

FEAR OF DEPARTMENT OF HUMAN SERVICES INVOLVEMENT

One of the key concerns of individuals with SUD is that seeking treatment could lead to their children being placed in state protective custody or even a complete loss of parenting rights[21] [22] [23]. Because of the generational nature of SUD, this fear is often quite founded in traumatic childhood experiences of their own where someone's addiction upended the family.

> I was like nine and my mom's house got raided or whatever, so we went to a foster care for a few months and then after that we went...my grandparents got custody of us.
>
> Amy, mother of five struggling in SUD treatment, while her mother is still using.

Mothers may struggle between weighing the desire to overcome addiction and become a better parent against the fear of divulging their SUD and risking the future of their family to DHS intervention. Many women do not seek prenatal care at all for this reason. There is a critical shortage of facilities that offer services to the entire family unit and allow mothers to be supported in parenting while undergoing treatment. From a family support service perspective, a similar issue continually emerges—providers try to earn and maintain trust to help parents get needed care, while simultaneously protecting children from harmful environments.

SOCIAL ISOLATION

Many individuals with SUD report beginning their experimentation with alcohol and drugs in a search for social connections and as a form of belonging, especially if they did not feel that support at home. The decision to seek treatment usually means cutting ties with friends or family who also use substances, leaving social circles, and sometimes moving entirely to a new town.

> I also learned that if you want to be sober, it's [more than] just the dropping of drugs, it's the matter of a new mindset, a new lifestyle and letting every person go that you use drugs with no matter how much they mean to you and it's–it's hard. It's definitely hard, but it gets easier and I know people say it doesn't.
>
> Elaine, describing her recovery.

This is a monumental barrier to accessing treatment, particularly if the duration of addiction has been several years and many relationships feel damaged beyond repair. Fearing the isolation that may follow treatment, plus the challenge of working through a long recovery without social support, frequently stops people from even beginning the process.

> Some people, you know when they go through treatment, they have family behind 'em to help 'em out, you know what I mean? Maybe give them rides and stuff. I didn't, I didn't have that.
>
> Vincent, describing how public treatment programs helped him when he had no support.

For those who do attempt treatment, the depression, anxiety, and loneliness experienced afterwards often increases the risk of future relapse[24].

CHOICE VS. DISEASE APPROACHES

SUD treatment professionals, including IDPH, prefer to approach addiction from the perspective that it is a disease one will learn to manage, rather than a choice that can simply be reversed. Overwhelmingly, Iowans experiencing SUD themselves tend to view their substance use much more in the context of "choice" and report that a person must tragically hit "rock bottom" to realize the effects of their addiction before they can change it[7]. With this pervasive belief, it is not surprising that many people do not seek treatment, as they are either waiting for a switch to flip or think it never will. This is especially true if the view is shared by family and friends who do not see a disease whose treatment they can support, but instead judge the inability to become sober as a choice.

> Um, my daughter sending me a [text] message that says, "Mom why can't, why's meth so important to you? Why can't you choose," you know it, that really, that stuck with me all this time.
>
> Michelle, illustrating a difficult moment.

NAVIGATION OF SYSTEMS

In addition to barriers that may prevent a pregnant or parenting woman from deciding to seek SUD treatment, there are many complexities to navigate once the decision is made. Lack of awareness of available options or the qualifying criteria for participation. For example, many women lose Medicaid coverage 2 months postpartum and must determine with a newborn how to adjust to this change[25]. Frustrations abound in navigating insurance coverage or lack thereof, and the process often requires communication across many provider networks causing clients to give up before completion. The digital divide can also impact how mothers access (or fail to access) available treatment when reliable internet and phone service is necessary to find and enroll in programs. If a family further encounters that transportation and/or childcare is unavailable, they are starting their search over. Trying to incorporate these services means more navigation across multiple systems which may or may not interact successfully.

Opportunities for Collaboration with Partners and Recommendations for Future

Many agencies across Iowa are already hard at work implementing evidence-based strategies to combat SUD while also developing creative approaches to improving existing services. In this section, we have identified seeds of change among various systems, including criminal courts, maternal and child health professionals, family support service, insurance, Medicaid, and legislative policy. The next step for Iowa is seeing an expansion of effective pilot programs, successful outreach to rural and underserved counties, and a more robust referral and communication network among the various partners. In summary, collaboration recommendations include:

- Medical facilities and social services (e.g. home visitors) connect to increase SBIRT for pregnant and parenting women and provide seamless transitions from screening to referral to treatment.

- Law enforcement and the court systems connect with case managers and SUD treatment providers to increase arrest diversion programs and help break the cycle of incarceration and drug use.

- Policy makers connect with those serving clients in all aspects of the field to improve Medicaid options and extend the duration of postpartum coverage. Further, legislators connect with physicians and pharmacists to increase MAT availability across regions and populations where needs are unmet.

- Insurance systems and treatment facilities connect to improve policies and poor reimbursement rates, which is a frequently cited barrier to increasing the number of SUD facilities overall.

- Providers serving pregnant and parenting women connect to SUD options that treat families as a unit and if needed, work with local agencies to find assistance for transportation, childcare, and other parental support through treatment.

Conclusions

The 2020 Iowa MIECHV Needs Assessment Update identified Iowa communities with concentrations of risk indicators, described the quality and capacity of existing family support programs in communities with concentrations of risk indicators, and identified Iowa's capacity for providing substance use disorder treatment for MIECHV-eligible pregnant women and families with young children. An executive summary of the results of the Needs Assessment is provided below.

High Need Assessment

The 2020 Iowa MIECHV Needs Assessment Update identified 26 counties with concentrations of risk indicators.

Iowa Counties with Concentrations of Risk Indicators

- Appanoose
- Black Hawk
- Buena Vista
- Cerro Gordo
- Clarke
- Clinton
- Des Moines
- Emmet
- Fayette
- Floyd
- Fremont
- Jefferson
- Lee
- Marshall
- Monona
- Montgomery
- Muscatine
- Osceola
- Page
- Pottawattamie
- Scott
- Tama
- Wapello
- Webster
- Woodbury
- Wright

Union county was the only county that was not identified as an high need county, but was featured among the top 26 counties at risk of child maltreatment (15th) from the CAPTA needs assessment and also among the top 26 counties for one of the high need assessment methods used in the needs assessment update. Thus, Union county should be monitored as a potential high need county in the future.

Quality and Capacity

Three of the top four high need counties—Wapello, Des Moines, and Lee—were among the counties serving the least percentage of families in need of family support services. Emmet county was among the counties serving the highest percentage of families in need of family support services, but it also had the highest rate of founded or confirmed child abuse and neglect in 2018 and ranked second in the 2019 Child Maltreatment Needs Assessment Update in risk for child maltreatment. In 2019, 43% of the victims of founded or confirmed abuse in Emmet were age five or younger[26]. Further investigation is warranted to examine the links between the proportion of families in need served, the types of families served, dosage, and reduced risk in a community.

Barriers to Receiving Family Support Services

Most Title V service recipients who participated in focus groups and interviews either did not know about early childhood family support services or had misconceptions about what it was. Even after providing an explanation of early childhood family support services, Title V service recipients shared misperceptions such as the services only being available to older adults, for medical purposes, or for children with developmental delays. In addition, there were concerns about costs, transportation, and approvals necessary which are not associated with family support programs. Previous negative experiences with other agencies and programs adversely affected how families perceived family support services and their level of trust. Families receiving family support services lauded their home visitors who were flexible and creative with maintaining contact and continuing services while families dealt with barriers such as mental health, domestic issues, work/school schedule, losing phone service, illness, and weather conditions.

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

The Iowa Department of Public Health has established the Integrated Provider Network (IPN) for the delivery of Department-funded substance use disorder and problem gambling prevention and treatment services. The IPN consists of 20 contractors throughout the state, and services are provided to patients who meet eligibility guidelines, are uninsured, or lack access to third party payment options. IPN contractors must coordinate and assure provision of all required services in their service area. Four IPN contractors provide specialized treatment services for pregnant women and women with dependent children. These contractors must ensure the family is treated as a unit and admit both women and their children, as appropriate. Women and Children services are located in Linn, Polk, Pottawattamie, and Woodbury counties, yet they serve individuals from across all of Iowa and ensure priority populations are admitted.

Dissemination

The 2020 MIECHV statewide needs assessment update will be disseminated publicly through the Iowa Department of Public Health Bureau of Family Health Family Support website[27]. The needs assessment results will also be presented to Iowa's Family Support Leadership Group (FSLG) that coordinates Iowa's state and federally funded family support programs, the Early Childhood Iowa Stakeholders Alliance, the Early Childhood Iowa Area Directors, and the Early Childhood Iowa state board.

Endnotes

1 Iowa Code Section 256A.4 (2020).

2 After the "At-Risk" Label: Reorienting Educational Policy and Practice (2016).

3 Social Security Act, Title V, Section 511.

4 Bipartisan Budget Act of 2018.

5 Social Security Act, Title V, Section 511(b)(2).

6 Title V Maternal and Child Health Block Grant Needs Assessment (2021).

7 Early Childhood Iowa Needs Assessment (2019).

8 Iowa Child Maltreatment Prevention Needs Assessment (2017).

9 Iowa Child Maltreatment Prevention Needs Assessment Data Update (2019).

10 Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request (SIR) for the Submission of the Statewide Needs Assessment Update.

11 Social Security Act, Title V, § 511(b).

12 Iowa's 2010 Maternal, Infant, and Early Childhood Home Visiting Program Needs Assessment.

13 Iowa Child Maltreatment Prevention Needs Assessment Data Update (2019).

14 Social Security Act, Title V, § 511.

15 Maternal, Infant, and Early Childhood Home Visiting Program Supplemental Information Request (SIR) for the Submission of the Statewide Needs Assessment Update.

16 Iowa Department of Human Services Child Abuse Statistics.

17 Iowa Family Support Workforce Study Final Report (2017).

18 Prevention of Opioid Misuse in Women (2019).

19 Iowa Drug Control Strategy & Drug Use Profile Annual Report (2020).

20 Iowa Department of Corrections Quarterly Quick Facts (2020).

21 'I took care of my kids': Mothering while incarcerated (2020).

22 Drug dependence, parenting responsibilities, and treatment history: Why doesn't mom go for help? (2002).

23 Drug-using mothers: Social, psychological and substance use problems of women opiate users with children (2000).

24 Substance Use among Iowa Families: An Intergenerational Mixed Method Approach for Informing Policy and Practice (2020).

25 Iowa Maternal Mortality Review Committee Report (2020).

26 Iowa Department of Human Services Child Abuse Statistics.

27 Iowa Department of Public Health Bureau of Family Health Family Support Website

28 Iowa's 2010 Maternal, Infant, and Early Childhood Home Visiting Program Needs Assessment.

Appendix

Appendix A. Indicators, Years, Measures, and Sources

Indicators, Years, Measures, and Sources

2010 Risk Indicators Used in Method 1	Year(s)	Measure	Source
4th Grade reading proficiency	2018*	Percentage of students who are proficient in fourth grade reading on the Iowa Tests of Basic Skills and Iowa Alternate Assessment	Iowa Department of Education
Premature birth	2018	Premature singleton births as a percent of all live singleton births	Iowa Department of Public Health Vital Statistics
Low birth weight	2018	Percentage of live births weighing at less than 5.5 pounds at the time of birth	Iowa Department of Public Health Vital Statistics
Infant mortality	2013-2017	Infant mortality rate per 1000 live births	Iowa Department of Public Health Vital Statistics
Poverty	2017	Percentage of population for all ages who live in poverty	United States Census Bureau
Child poverty	2017	Percentage of population under 18 who live in poverty	United States Census Bureau
Unemployment	June 2019	Percentage of labor force population who are unemployed	Iowa Workforce Development
Child abuse and neglect	2018	Rate of children age 0-17 who are confirmed to have been abused or neglected during the year per 1,000 children	Iowa Department of Human Services
High school dropout	2017-2018	Percentage of students enrolled in grades 9-12 who dropped out	Iowa Department of Education
Crime	2016	Crime rate per 1,000 people	Iowa Department of Public Safety Uniform Crime Reporting
Juvenile crime	2016	Juvenile arrest rate per 1,000 juveniles	Iowa Department of Public Safety Uniform Crime Reporting
Domestic violence	2016	Domestic abuse rate per 100,000 people	Iowa Department of Public Safety Uniform Crime Reporting
3rd Trimester smoking	2018	Percentage of mothers who gave birth who report smoking during 3rd trimester	Iowa Department of Public Health Vital Statistics
Maternal education	2018	Percentage of mothers who gave birth who have a high school education	Iowa Department of Public Health Vital Statistics

**2017 for Jefferson County*

Additional Risk Indicators Used in Method 1

Additional Risk Indicators Used in Method 1	Year(s)	Measure	Source
Income inequality	2013-2017	Ratio of household income at the 80th percentile to income at the 20th percentile	American Consumer Survey via countyhealthrankings.org
Opioid-related hospitalizations	2018	Opioid-related hospitalization rate per 1,000 hospitalizations	Iowa hospital discharge file
Alcohol and drug-related crime	2016	Alcohol or drug related crime rate per 1,000 people	Iowa Department of Public Safety Uniform Crime Reporting
3rd Trimester alcohol use	2015-2018	Percentage of mothers who gave birth who report having one or more alcoholic drinks per week during the last 3 months of their pregnancy	Iowa Department of Public Health Barriers to Prenatal Care Survey
Medicaid-reimbursed births	2018	Percentage of Iowa resident births that were Medicaid reimbursed	Iowa Department of Public Health Vital Statistics
Teen births	2011-2017	Number of births per 1,000 female population ages 15-19	Centers for Disease Control Natality File
School lunch program	2018-2019	Percentage of K-12 students eligible for free and reduced-price lunch	Iowa Department of Education
No prenatal care in 1st trimester	2018	Percentage of live births to mothers who did not begin prenatal care during the first trimester of pregnancy	Iowa Department of Public Health Vital Statistics
Maternal depression	2015-2017	Percentage of women who gave birth who report a depression diagnosis before or during pregnancy	Iowa Department of Public Health Barriers to Prenatal Care Survey

Appendix B.1: High Need Assessment Method 1

County Data for Indicators Used in 2010

Counties	Urban/ Rural	4th Grade reading proficiency	Premature birth	Low birth weight	Infant mortality	Poverty	Child poverty	Unemployment	Child abuse and neglect	High school dropout	Crime	Juvenile crime	Domestic violence	3rd Trimester smoking	Maternal education
State Total		74.7%	9.9%	6.8%	4.5	10.8%	12.6%	2.6%	15.8	1.8%	24.2	14.6	212.8	9.0%	88.6%
Adair	Rural	71.7%	n/a	7.4%	5.5	10.2%	13.3%	2.1%	19.6	2.4%	8.1	0.6	14.0	16.0%	96.8%
Adams	Rural	76.7%	17.6%	n/a	n/a	12.3%	18.7%	1.6%	28.6	3.2%	8.0	4.5	160.2	n/a	88.2%
Allamakee	Rural	74.5%	6.6%	7.1%	n/a	11.0%	15.8%	2.7%	13.8	2.0%	12.9	8.1	334.0	4.6%	78.1%
Appanoose	Rural	79.0%	11.7%	10.2%	9.8	16.9%	23.4%	3.2%	26.7	2.0%	30.5	13.6	184.8	21.2%	80.7%
Audubon	Rural	83.8%	n/a	n/a	5.8	10.7%	15.4%	2.3%	21.3	2.1%	10.4	3.4	105.3	13.3%	95.0%
Benton	Rural	81.4%	10.1%	5.6%	4.0	7.8%	9.0%	2.6%	12.5	2.7%	3.3	1.4	66.6	8.7%	94.4%
Black Hawk	Urban	66.4%	10.2%	7.3%	5.7	15.3%	16.5%	2.9%	14.0	3.1%	27.6	18.6	259.1	10.4%	87.1%
Boone	Rural	81.9%	6.7%	5.3%	2.1	7.3%	10.3%	2.5%	13.6	1.3%	10.6	12.1	82.5	11.6%	96.1%
Bremer	Rural	77.3%	10.3%	6.2%	2.3	7.1%	6.2%	2.1%	7.2	1.4%	11.5	16.1	0.0	6.3%	98.2%
Buchanan	Rural	70.9%	8.7%	6.6%	5.7	9.0%	12.6%	2.4%	13.2	1.1%	7.3	1.5	0.0	8.9%	75.3%
Buena Vista	Rural	67.2%	7.2%	7.2%	3.2	12.8%	16.3%	2.4%	14.8	2.1%	20.0	28.4	273.2	2.8%	70.3%
Butler	Rural	77.3%	n/a	6.5%	1.4	9.0%	10.6%	2.7%	12.2	0.4%	0.4	0.0	6.7	13.8%	93.5%
Calhoun	Rural	76.6%	15.5%	14.5%	12.9	12.4%	15.5%	2.5%	13.4	1.5%	8.5	0.0	174.6	20.0%	98.2%
Carroll	Rural	81.9%	7.9%	5.7%	2.3	9.1%	10.5%	2.0%	17.2	1.6%	12.3	4.9	78.4	8.3%	95.2%
Cass	Rural	78.8%	8.3%	6.4%	1.4	12.1%	16.5%	2.5%	28.1	6.0%	11.9	12.7	7.5	13.4%	90.4%
Cedar	Rural	70.7%	8.8%	3.6%	1.1	6.9%	7.5%	2.3%	16.5	2.3%	5.8	0.4	21.8	6.2%	97.4%
Cerro Gordo	Rural	73.5%	8.3%	6.4%	5.2	10.8%	13.1%	2.7%	26.0	2.8%	33.9	33.0	313.6	17.2%	90.7%
Cherokee	Rural	84.0%	n/a	n/a	n/a	9.6%	11.5%	2.6%	15.4	0.7%	10.1	11.7	0.0	9.6%	94.2%
Chickasaw	Rural	78.4%	8.2%	6.8%	4.4	9.5%	13.3%	2.3%	8.2	3.3%	6.1	4.1	25.0	10.2%	87.8%
Clarke	Rural	77.5%	12.6%	9.4%	1.6	11.0%	15.4%	2.6%	18.9	2.8%	19.2	3.3	216.6	11.7%	82.7%
Clay	Rural	79.3%	11.1%	7.6%	2.0	9.3%	11.6%	2.6%	16.7	1.9%	17.7	17.8	170.2	11.2%	92.4%
Clayton	Rural	72.8%	8.5%	4.8%	2.1	9.6%	13.4%	2.5%	12.4	3.9%	2.7	0.2	45.6	12.1%	87.3%
Clinton	Rural	77.5%	13.0%	9.1%	5.0	13.4%	16.4%	3.6%	28.5	2.8%	35.9	12.9	375.3	15.0%	89.1%
Crawford	Rural	67.0%	15.2%	7.8%	1.7	11.8%	14.3%	3.0%	15.0	3.1%	3.4	3.5	117.3	3.9%	76.5%
Dallas	Urban	83.7%	9.5%	5.3%	2.6	4.4%	4.8%	2.0%	5.0	0.8%	11.1	8.3	85.7	2.2%	94.6%
Davis	Rural	69.4%	7.4%	6.7%	4.0	12.1%	16.7%	2.3%	7.2	2.4%	1.0	5.9	114.2	6.1%	46.0%
Decatur	Rural	62.3%	9.3%	5.6%	4.1	17.1%	22.3%	2.5%	26.6	2.5%	2.9	0.5	24.5	12.0%	76.9%

Counties	Urban/ Rural	4th Grade reading proficiency	Premature birth	Low birth weight	Infant mortality	Poverty	Child poverty	Unemployment	Child abuse and neglect	High school dropout	Crime	Juvenile crime	Domestic violence	3rd Trimester smoking	Maternal education
Delaware	Rural	80.2%	17.5%	8.5%	3.8	9.3%	12.2%	2.1%	9.9	1.3%	11.8	8.1	52.8	9.0%	89.0%
Des Moines	Rural	67.3%	11.3%	6.6%	4.4	13.5%	20.0%	4.0%	24.5	5.5%	41.9	36.5	257.8	13.9%	83.9%
Dickinson	Rural	73.6%	8.2%	5.4%	3.7	7.5%	9.6%	2.2%	15.8	1.9%	12.2	12.1	87.3	8.2%	94.5%
Dubuque	Urban	74.5%	7.2%	5.9%	4.5	9.8%	10.7%	2.2%	17.0	2.3%	23.6	20.8	393.4	8.5%	92.3%
Emmet	Rural	77.0%	8.1%	5.4%	5.4	10.3%	13.9%	3.0%	43.4	1.2%	18.5	13.7	248.6	15.3%	86.5%
Fayette	Rural	71.5%	11.9%	9.1%	3.8	13.4%	17.5%	3.2%	11.7	2.3%	8.8	14.0	29.8	11.9%	91.3%
Floyd	Rural	72.4%	9.8%	9.2%	2.0	11.8%	16.5%	2.8%	24.5	2.7%	12.8	12.3	12.6	13.8%	86.2%
Franklin	Rural	71.1%	10.0%	4.0%	3.1	11.1%	15.5%	2.1%	9.4	0.7%	2.0	4.1	49.0	9.0%	79.0%
Fremont	Rural	59.4%	n/a	n/a	7.5	12.2%	15.9%	3.5%	19.1	1.5%	13.8	11.7	14.7	16.4%	91.0%
Greene	Rural	79.3%	8.2%	n/a	7.3	10.4%	14.9%	3.2%	26.9	3.1%	16.4	3.1	89.4	8.2%	93.8%
Grundy	Rural	82.4%	9.0%	5.3%	6.3	5.9%	6.8%	2.5%	9.9	0.5%	6.7	4.8	80.6	4.5%	95.5%
Guthrie	Rural	76.2%	10.0%	6.0%	1.8	9.5%	11.2%	2.6%	24.2	1.0%	3.3	0.0	0.0	15.0%	91.9%
Hamilton	Rural	72.0%	7.1%	6.0%	2.1	8.7%	11.6%	2.5%	8.3	1.3%	11.5	4.4	132.6	8.2%	89.0%
Hancock	Rural	82.2%	8.0%	4.8%	5.2	8.4%	10.9%	2.5%	7.7	1.0%	7.4	0.7	56.8	10.4%	92.8%
Hardin	Rural	79.3%	8.5%	5.1%	4.3	11.4%	16.1%	2.9%	23.2	3.0%	12.6	11.8	34.7	14.1%	92.0%
Harrison	Rural	74.4%	13.0%	8.0%	2.4	10.0%	11.9%	2.3%	15.9	1.3%	8.6	2.4	92.1	11.7%	94.4%
Henry	Rural	68.1%	8.7%	6.8%	5.2	11.6%	14.8%	2.5%	27.9	2.5%	16.3	23.2	145.8	9.6%	89.5%
Howard	Rural	72.8%	8.1%	5.4%	5.1	10.1%	13.5%	2.3%	13.6	1.1%	10.8	17.4	245.6	13.5%	79.3%
Humboldt	Rural	82.5%	5.3%	n/a	1.8	9.4%	11.8%	2.0%	6.7	2.4%	9.3	13.4	158.0	12.3%	91.2%
Ida	Rural	85.2%	20.0%	n/a	n/a	9.1%	10.6%	1.8%	16.9	1.2%	6.6	0.0	14.3	12.3%	96.9%
Iowa	Rural	77.8%	8.5%	3.4%	3.2	7.2%	7.7%	2.0%	13.6	1.1%	6.3	3.0	91.5	10.2%	97.7%
Jackson	Rural	76.6%	9.0%	9.5%	4.6	11.7%	16.2%	2.7%	13.9	1.6%	10.1	9.6	77.6	13.0%	94.0%
Jasper	Rural	81.4%	10.1%	7.4%	3.9	9.0%	10.8%	2.6%	17.1	1.6%	19.9	9.0	65.3	12.1%	91.6%
Jefferson	Rural	67.0%	6.7%	5.4%	3.8	14.0%	18.0%	2.5%	23.1	4.7%	22.9	11.3	220.6	10.1%	84.6%
Johnson	Urban	76.9%	8.9%	6.6%	4.7	15.3%	9.8%	2.2%	8.0	2.4%	20.8	11.0	259.8	3.1%	91.6%
Jones	Rural	71.7%	10.0%	5.5%	5.7	9.5%	11.5%	2.6%	10.6	1.4%	9.5	1.8	88.3	10.4%	93.5%
Keokuk	Rural	78.2%	10.9%	5.5%	6.5	11.5%	15.8%	2.9%	11.9	0.5%	6.5	0.0	79.4	9.1%	91.8%
Kossuth	Rural	79.2%	6.3%	2.9%	2.4	9.2%	11.5%	1.9%	13.2	3.4%	6.2	9.0	39.8	9.8%	93.1%
Lee	Rural	73.2%	11.7%	9.4%	7.2	14.1%	19.8%	3.7%	23.6	4.0%	34.9	23.3	103.2	17.8%	90.4%
Linn	Urban	74.8%	9.3%	6.9%	5.0	9.0%	11.1%	2.8%	14.4	3.3%	30.2	21.6	256.3	8.9%	90.6%
Louisa	Rural	76.1%	9.1%	6.1%	7.1	9.9%	12.8%	2.8%	21.4	2.4%	9.2	0.0	26.9	8.3%	84.8%

Counties	Urban/ Rural	4th Grade reading proficiency	Premature birth	Low birth weight	Infant mortality	Poverty	Child poverty	Unemployment	Child abuse and neglect	High school dropout	Crime	Juvenile crime	Domestic violence	3rd Trimester smoking	Maternal education
Lucas	Rural	70.9%	n/a	n/a	1.9	13.6%	23.7%	2.1%	10.0	0.5%	24.2	15.5	58.0	11.6%	89.5%
Lyon	Rural	84.8%	10.5%	6.4%	n/a	7.6%	9.0%	1.3%	14.0	0.9%	6.8	9.9	110.5	4.1%	94.1%
Madison	Rural	82.0%	5.2%	n/a	2.5	7.4%	8.4%	3.3%	12.6	0.7%	10.2	11.5	63.6	8.1%	91.3%
Mahaska	Rural	68.4%	9.5%	7.3%	2.9	13.0%	15.2%	2.5%	18.2	2.0%	20.1	12.5	98.8	16.8%	93.8%
Marion	Rural	82.0%	9.0%	5.9%	4.3	7.9%	8.6%	2.0%	10.5	1.2%	8.0	5.0	30.1	9.3%	95.0%
Marshall	Rural	61.9%	9.8%	6.2%	5.0	12.7%	15.5%	3.8%	21.6	3.6%	27.5	21.3	272.8	7.7%	75.8%
Mills	Rural	81.2%	9.0%	n/a	1.3	9.2%	10.6%	2.2%	14.6	1.2%	16.4	13.7	209.8	14.0%	96.7%
Mitchell	Rural	84.1%	7.9%	n/a	4.9	9.1%	13.9%	1.8%	11.6	0.6%	6.9	2.7	83.2	6.4%	83.6%
Monona	Rural	69.7%	17.2%	10.3%	9.0	11.6%	15.4%	2.9%	11.5	2.1%	9.4	2.4	56.1	17.4%	90.8%
Monroe	Rural	75.8%	9.3%	3.9%	2.3	10.9%	16.1%	2.6%	8.7	0.6%	9.9	1.5	62.8	11.8%	84.2%
Montgomery	Rural	74.7%	12.6%	7.2%	8.3	12.5%	17.7%	2.6%	28.1	2.6%	20.7	11.9	325.9	17.0%	91.1%
Muscatine	Rural	73.4%	11.1%	7.2%	1.8	10.7%	13.9%	2.7%	20.2	4.5%	20.2	24.4	123.4	11.9%	84.3%
O'Brien	Rural	82.1%	9.2%	5.5%	4.6	7.7%	10.0%	2.2%	19.4	2.5%	9.5	7.8	99.6	9.2%	87.1%
Osceola	Rural	76.7%	13.5%	3.9%	2.7	10.1%	14.8%	1.9%	22.2	2.5%	10.7	3.8	32.9	n/a	86.5%
Page	Rural	80.6%	7.8%	7.0%	6.1	14.5%	20.8%	2.5%	23.4	0.9%	20.0	6.4	110.2	24.8%	93.0%
Palo Alto	Rural	74.8%	10.6%	12.5%	1.8	10.4%	13.5%	2.0%	21.6	1.7%	10.1	18.5	88.2	10.6%	94.2%
Plymouth	Rural	78.1%	11.3%	7.2%	2.8	7.2%	8.6%	2.1%	12.1	0.9%	11.1	7.7	36.4	7.1%	93.2%
Pocahontas	Rural	77.3%	14.1%	n/a	2.5	12.9%	18.1%	1.9%	14.9	5.0%	8.4	3.4	100.8	n/a	89.1%
Polk	Urban	72.1%	10.2%	7.4%	5.8	9.5%	11.9%	2.7%	12.9	3.3%	32.1	12.0	220.7	6.8%	86.8%
Pottawattamie	Urban	70.2%	13.3%	8.0%	4.2	10.6%	13.9%	2.3%	25.5	2.0%	47.8	27.6	232.9	13.5%	89.3%
Poweshiek	Rural	89.9%	13.5%	6.5%	3.5	11.5%	11.9%	2.3%	12.9	1.3%	19.0	7.7	157.2	10.6%	92.9%
Ringgold	Rural	88.1%	n/a	0.0%	10.3	14.7%	22.2%	2.7%	13.7	1.7%	6.7	0.0	19.8	10.0%	86.4%
Sac	Rural	82.9%	5.6%	n/a	5.2	10.1%	14.0%	2.1%	14.2	0.8%	3.2	3.4	10.1	6.5%	94.4%
Scott	Urban	74.5%	10.7%	7.6%	3.6	11.3%	14.2%	3.3%	19.3	3.5%	38.2	14.0	464.8	8.7%	91.0%
Shelby	Rural	76.2%	11.6%	9.9%	5.2	8.4%	10.6%	2.1%	18.8	0.9%	0.8	0.6	33.7	11.6%	95.0%
Sioux	Rural	80.9%	9.4%	6.7%	4.0	7.1%	7.2%	1.8%	7.3	3.0%	4.8	0.3	57.2	2.6%	83.4%
Story	Urban	84.4%	9.4%	6.5%	4.8	16.9%	7.6%	2.3%	14.3	0.8%	15.1	10.9	87.7	4.2%	97.2%

Counties	Urban/ Rural	4th Grade reading proficiency	Premature birth	Low birth weight	Infant mortality	Poverty	Child poverty	Unemployment	Child abuse and neglect	High school dropout	Crime	Juvenile crime	Domestic violence	3rd Trimester smoking	Maternal education
Tama	Rural	60.6%	11.2%	8.1%	6.2	9.5%	13.4%	2.3%	22.6	2.2%	13.6	6.3	145.1	6.1%	88.4%
Taylor	Rural	85.5%	11.6%	n/a	n/a	11.6%	15.5%	2.0%	17.9	0.8%	4.5	0.0	48.6	15.9%	95.7%
Union	Rural	75.0%	10.1%	6.2%	3.0	14.6%	17.9%	3.1%	35.7	3.7%	19.2	10.0	128.6	18.0%	84.5%
Van Buren	Rural	75.9%	10.9%	5.0%	9.3	14.0%	20.7%	2.6%	8.1	1.1%	5.1	4.4	123.4	9.8%	69.3%
Wapello	Rural	63.3%	11.1%	5.1%	9.0	14.5%	17.7%	3.2%	23.5	4.1%	37.9	40.6	399.7	16.6%	80.7%
Warren	Rural	82.1%	11.5%	9.3%	2.9	6.1%	6.2%	2.4%	11.2	1.0%	18.0	9.3	260.1	6.7%	96.2%
Washington	Rural	65.9%	8.7%	5.9%	6.0	9.5%	11.8%	2.2%	9.1	2.4%	10.8	0.0	120.9	7.3%	87.9%
Wayne	Rural	78.1%	9.3%	6.9%	6.8	16.6%	24.7%	2.5%	21.5	2.5%	9.7	0.0	47.1	11.5%	57.5%
Webster	Rural	67.9%	8.1%	5.3%	3.2	15.0%	16.5%	3.3%	25.9	5.5%	34.0	31.3	38.0	17.9%	90.2%
Winnebago	Rural	81.0%	11.7%	10.7%	3.4	9.4%	13.0%	3.5%	24.1	1.9%	3.0	2.3	0.0	6.8%	93.2%
Winneshiek	Rural	79.2%	6.5%	3.2%	3.4	9.0%	8.7%	2.5%	10.5	0.5%	6.1	13.1	0.0	3.8%	95.2%
Woodbury	Urban	70.9%	10.8%	7.4%	3.6	13.4%	16.1%	2.5%	22.2	2.6%	37.9	26.2	551.1	10.4%	78.0%
Worth	Rural	73.9%	12.3%	11.1%	2.6	8.5%	13.4%	2.6%	14.9	0.0%	3.4	2.7	26.5	15.0%	93.8%
Wright	Rural	68.0%	13.0%	6.5%	7.7	10.0%	14.5%	2.6%	18.8	3.1%	8.6	5.2	102.6	8.4%	76.6%

Appendix B.2: Additional County-Level Data for High Need Assessment Method 1

Counties	Urban/ Rural	Income inequality	Opioid-related hospitalizations	Alcohol and drug-related crime	3rd Trimester alcohol use	Medicaid-reimbursed births	Teen births	School lunch program	No prenatal care in 1st trimester	Maternal depression
State Total		4.3	1.3	11.6	2.0%	43.4%	20.0	43.0%	16.7%	11.3%
Adair	Rural	4.0	1.1	4.3	2.3%	41.5%	17.1	52.3%	17.6%	15.7%
Adams	Rural	3.7	1.0	12.0	0.0%	52.9%	19.3	51.3%	n/a	10.1%
Allamakee	Rural	4.6	0.3	9.9	2.7%	39.8%	28.3	61.3%	28.2%	13.2%
Appanoose	Rural	4.6	2.3	14.4	2.6%	57.7%	33.5	61.9%	28.2%	16.2%
Audubon	Rural	4.1	1.1	8.8	1.1%	45.0%	19.2	45.0%	20.4%	16.7%
Benton	Rural	4.1	1.0	1.8	0.7%	31.5%	14.4	32.1%	11.0%	9.8%
Black Hawk	Urban	4.4	1.4	9.8	2.6%	50.7%	18.3	48.2%	20.2%	10.9%
Boone	Rural	3.9	2.1	11.9	1.9%	31.6%	18.7	37.2%	13.5%	11.2%
Bremer	Rural	4.0	1.1	7.3	3.1%	29.7%	6.1	24.9%	14.7%	10.4%
Buchanan	Rural	4.2	1.0	6.0	1.1%	29.9%	16.4	32.2%	31.9%	12.0%
Buena Vista	Rural	3.8	0.5	14.4	3.7%	67.6%	34.8	61.2%	24.7%	6.1%
Butler	Rural	3.6	1.3	3.6	1.9%	36.2%	12.5	33.5%	14.0%	9.9%
Calhoun	Rural	4.4	0.7	2.5	1.8%	40.0%	22.5	41.7%	9.1%	11.8%
Carroll	Rural	4.4	1.2	7.4	0.8%	33.8%	19.8	42.1%	12.3%	8.7%
Cass	Rural	4.2	1.2	9.9	0.0%	47.8%	22.5	48.7%	11.3%	13.2%
Cedar	Rural	3.4	1.1	3.4	1.4%	27.8%	13.2	28.9%	7.8%	9.7%
Cerro Gordo	Rural	4.1	3.0	19.3	1.1%	47.1%	20.6	44.3%	13.7%	16.6%
Cherokee	Rural	4.0	0.8	9.2	0.0%	51.0%	30.2	38.9%	15.0%	13.2%
Chickasaw	Rural	4.2	0.4	6.2	1.5%	34.0%	12.6	35.3%	16.0%	11.3%
Clarke	Rural	4.1	0.8	16.6	1.3%	51.6%	38.7	55.7%	18.0%	12.9%
Clay	Rural	4.7	0.7	16.4	2.3%	46.5%	20.9	44.7%	8.3%	13.0%
Clayton	Rural	3.9	1.1	3.3	1.2%	41.2%	14.7	38.6%	23.6%	13.1%
Clinton	Rural	4.6	1.6	12.9	1.8%	50.2%	32.5	48.6%	20.3%	14.5%
Crawford	Rural	4.2	0.7	3.8	3.2%	57.4%	32.8	66.4%	20.5%	10.6%
Dallas	Urban	3.9	0.6	4.9	1.4%	19.4%	12.3	21.3%	12.2%	7.5%
Davis	Rural	4.0	1.1	3.8	2.2%	22.1%	16.3	51.4%	40.1%	13.3%

Counties	Urban/ Rural	Income inequality	Opioid-related hospitalizations	Alcohol and drug-related crime	3rd Trimester alcohol use	Medicaid-reimbursed births	Teen births	School lunch program	No prenatal care in 1st trimester	Maternal depression
Decatur	Rural	4.7	1.0	2.0	1.8%	51.9%	22.7	59.0%	23.7%	11.0%
Delaware	Rural	3.7	0.4	7.2	0.5%	31.0%	12.7	36.2%	13.8%	8.3%
Des Moines	Rural	4.2	2.5	9.5	2.6%	59.1%	34.8	54.3%	26.2%	14.7%
Dickinson	Rural	4.3	0.4	11.2	3.1%	34.7%	18.0	34.2%	15.0%	10.0%
Dubuque	Urban	4.0	1.9	15.2	1.8%	38.4%	18.1	40.9%	16.6%	10.1%
Emmet	Rural	4.5	1.0	10.8	2.3%	51.4%	27.2	51.4%	17.3%	11.1%
Fayette	Rural	3.8	0.8	5.5	1.7%	41.1%	20.8	51.4%	18.2%	10.6%
Floyd	Rural	4.9	1.6	4.5	3.2%	54.0%	20.5	52.0%	27.4%	14.5%
Franklin	Rural	4.0	1.4	4.4	3.5%	54.0%	29.2	61.1%	16.0%	15.4%
Fremont	Rural	4.2	1.2	21.8	4.1%	40.3%	35.0	45.2%	n/a	15.4%
Greene	Rural	4.1	1.5	3.6	1.8%	42.9%	27.4	45.3%	13.4%	9.5%
Grundy	Rural	3.5	1.0	3.6	2.5%	27.6%	9.9	29.7%	17.3%	14.3%
Guthrie	Rural	3.9	1.4	0.6	0.8%	41.0%	18.5	39.8%	19.6%	8.6%
Hamilton	Rural	3.8	2.7	6.2	1.3%	37.4%	24.1	46.4%	12.2%	15.9%
Hancock	Rural	3.8	1.4	2.0	1.7%	44.0%	13.8	38.2%	9.8%	8.7%
Hardin	Rural	4.1	1.7	10.2	2.6%	44.6%	19.2	43.5%	12.0%	10.2%
Harrison	Rural	4.3	1.0	4.3	0.0%	41.4%	19.1	39.6%	20.4%	6.7%
Henry	Rural	3.7	1.5	12.0	0.7%	43.8%	24.7	49.0%	19.7%	9.8%
Howard	Rural	3.5	0.0	16.2	0.7%	41.4%	14.3	45.7%	20.4%	13.3%
Humboldt	Rural	4.5	0.9	5.4	3.0%	36.8%	14.3	40.2%	8.8%	12.0%
Ida	Rural	4.5	1.4	5.1	0.0%	44.6%	18.7	44.4%	n/a	9.6%
Iowa	Rural	3.8	1.1	3.5	3.2%	24.9%	13.4	35.1%	15.9%	8.7%
Jackson	Rural	4.0	1.4	7.5	1.2%	38.0%	18.4	47.7%	18.5%	9.9%
Jasper	Rural	3.8	1.3	9.2	1.7%	39.5%	24.0	44.7%	8.7%	15.1%
Jefferson	Rural	4.4	1.1	7.0	3.5%	53.7%	21.0	51.5%	24.3%	10.9%
Johnson	Urban	5.5	1.0	15.1	2.4%	31.3%	7.0	33.9%	18.8%	10.5%
Jones	Rural	3.6	0.9	3.4	2.3%	39.8%	13.7	41.8%	16.1%	13.9%
Keokuk	Rural	4.2	1.3	2.6	0.0%	42.7%	25.5	30.3%	6.4%	8.5%
Kossuth	Rural	4.0	0.9	5.6	3.4%	40.2%	11.7	44.7%	13.6%	9.4%
Lee	Rural	4.0	1.4	10.2	2.1%	58.5%	40.1	54.0%	19.0%	16.2%
Linn	Urban	4.0	1.4	15.8	2.1%	44.6%	17.5	37.7%	14.0%	11.8%
Louisa	Rural	3.8	1.0	1.0	3.1%	48.5%	27.2	47.7%	27.5%	13.1%

Counties	Urban/ Rural	Income inequality	Opioid-related hospitalizations	Alcohol and drug-related crime	3rd Trimester alcohol use	Medicaid-reimbursed births	Teen births	School lunch program	No prenatal care in 1st trimester	Maternal depression
Lucas	Rural	3.9	1.3	12.2	1.8%	50.5%	29.2	55.6%	23.7%	12.9%
Lyon	Rural	3.3	0.3	8.3	0.0%	25.7%	16.0	30.9%	n/a	16.1%
Madison	Rural	4.0	0.9	6.9	0.4%	30.8%	13.8	29.8%	13.2%	7.8%
Mahaska	Rural	4.8	1.5	15.5	1.3%	45.4%	21.7	47.4%	17.9%	12.8%
Marion	Rural	3.7	1.4	5.1	1.6%	29.5%	14.0	31.5%	10.3%	14.3%
Marshall	Rural	3.8	1.7	16.8	1.7%	62.1%	39.6	63.8%	19.6%	13.0%
Mills	Rural	4.0	1.5	13.5	0.0%	40.2%	20.5	38.5%	n/a	2.7%
Mitchell	Rural	3.9	1.2	5.6	2.1%	37.9%	9.5	32.6%	20.5%	14.1%
Monona	Rural	4.6	1.5	2.5	0.0%	59.8%	15.8	54.1%	9.7%	14.9%
Monroe	Rural	3.4	1.0	4.6	1.7%	35.5%	23.4	37.4%	18.4%	13.9%
Montgomery	Rural	4.4	1.1	12.3	4.8%	52.7%	31.1	58.4%	21.7%	16.9%
Muscatine	Rural	3.9	0.8	11.8	2.9%	51.9%	31.0	50.3%	13.1%	17.5%
O'Brien	Rural	4.1	0.7	6.8	1.7%	38.7%	22.0	44.7%	16.1%	16.8%
Osceola	Rural	4.2	0.0	9.4	2.8%	32.7%	27.2	46.0%	21.4%	22.5%
Page	Rural	4.5	1.1	6.8	3.0%	56.6%	34.7	48.9%	16.3%	21.0%
Palo Alto	Rural	3.7	0.8	12.1	1.0%	47.1%	16.0	43.1%	10.4%	12.6%
Plymouth	Rural	3.6	0.9	7.8	1.3%	35.7%	14.7	32.3%	10.9%	8.1%
Pocahontas	Rural	4.4	0.7	6.9	0.8%	34.4%	17.5	57.2%	n/a	15.1%
Polk	Urban	4.2	1.6	11.7	2.2%	44.6%	24.3	48.3%	16.6%	9.5%
Pottawattamie	Urban	4.0	1.8	16.2	3.3%	54.8%	29.6	40.7%	15.6%	12.7%
Poweshiek	Rural	4.3	1.0	7.5	2.0%	35.9%	11.0	35.8%	14.2%	13.7%
Ringgold	Rural	4.0	1.3	1.6	2.1%	36.7%	19.9	41.0%	11.5%	11.4%
Sac	Rural	3.7	0.9	3.1	1.9%	33.6%	19.0	46.6%	12.6%	6.0%
Scott	Urban	4.5	1.6	9.7	1.4%	44.7%	28.0	45.0%	15.6%	13.6%
Shelby	Rural	4.2	0.6	3.0	3.4%	52.9%	16.2	39.8%	12.0%	11.2%
Sioux	Rural	3.3	0.5	3.6	2.1%	40.9%	14.8	40.5%	19.9%	7.8%
Story	Urban	5.8	1.1	13.7	1.7%	28.4%	4.2	26.5%	13.5%	9.4%
Tama	Rural	3.9	1.1	7.4	2.2%	50.5%	26.7	52.8%	20.5%	10.2%
Taylor	Rural	4.3	2.3	0.8	0.0%	49.3%	25.0	50.1%	25.6%	16.1%
Union	Rural	3.9	0.9	10.5	0.0%	53.5%	26.9	60.9%	18.5%	10.7%
Van Buren	Rural	3.7	1.7	1.9	0.0%	34.3%	16.8	48.7%	23.1%	8.2%
Wapello	Rural	4.7	1.6	15.0	2.3%	70.4%	35.5	50.0%	18.6%	13.9%

Counties	Urban/ Rural	Income inequality	Opioid-related hospitalizations	Alcohol and drug-related crime	3rd Trimester alcohol use	Medicaid-reimbursed births	Teen births	School lunch program	No prenatal care in 1st trimester	Maternal depression
Warren	Rural	3.6	1.1	10.7	1.0%	28.1%	14.8	28.3%	11.7%	10.4%
Washington	Rural	3.6	1.0	5.4	1.7%	36.0%	21.0	35.2%	17.5%	15.4%
Wayne	Rural	3.8	2.0	1.3	2.8%	27.6%	20.0	51.1%	41.0%	10.0%
Webster	Rural	4.7	0.9	9.2	1.7%	54.3%	26.3	56.5%	16.6%	15.0%
Winnebago	Rural	3.8	1.7	5.9	3.8%	41.7%	15.5	37.8%	9.8%	16.3%
Winneshiek	Rural	3.9	0.8	9.6	1.1%	27.4%	6.1	27.3%	11.9%	7.4%
Woodbury	Urban	4.2	1.6	23.9	2.2%	65.0%	31.9	54.9%	19.0%	12.4%
Worth	Rural	3.8	1.5	5.6	0.0%	40.7%	15.0	40.3%	20.0%	12.9%
Wright	Rural	4.3	1.2	8.1	3.7%	49.4%	26.6	59.8%	26.0%	15.7%

APPENDIX C: HIGH NEED ASSESSMENT RESULTS AND RANKINGS

◆ Counties labelled with this marker are considered to be **high need**.

County	Overall Rank	Average Rank	Method 1 Rank	Method 2 Rank	Method 1 Risk Assessment - Risk Score	Method 2 Risk Assessment - % of children born in 2013–2017 with 3+ risks
Adair	61	59.5	50	69	2.45	15.08%
Adams	30	33.5	39	28	2.68	21.39%
Allamakee	39	39.5	25	54	3	16.95%
Appanoose ◆	10	11.5	1	22	3.87	22.42%
Audubon	46	45.5	42	49	2.62	18.12%
Benton	84	83	93	73	1.61	14.95%
Black Hawk ◆	14	14.5	10	19	3.26	23.40%
Boone	75	74	78	70	1.96	15.05%
Bremer	94	90.5	84	97	1.87	8.15%
Buchanan	78	76.5	66	87	2.22	12.19%
Buena Vista ◆	21	25.5	22	29	3.04	21.26%
Butler	84	83	86	80	1.82	13.85%
Calhoun	51	48	48	48	2.57	18.16%
Carroll	81	80.5	84	77	1.87	13.99%
Cass	33	34	43	25	2.61	21.75%
Cedar	93	90	97	83	1.52	13.61%
Cerro Gordo ◆	17	20	19	21	3.13	22.44%
Cherokee	64	60.5	68	53	2.15	16.98%
Chickasaw	82	81	83	79	1.91	13.98%
Clarke ◆	18	21	22	20	3.04	23.18%
Clay	43	43.5	36	51	2.74	17.93%
Clayton	74	72	70	74	2.13	14.69%
Clinton ◆	7	8.5	4	13	3.61	25.59%
Crawford	42	42.5	26	59	2.96	16.65%
Dallas	99	98.5	98	99	1.43	5.97%
Davis	70	68	48	88	2.57	11.92%
Decatur	30	33.5	31	36	2.83	20.58%
Delaware	79	80	78	82	1.96	13.73%
Des Moines ◆	4	5.5	2	9	3.78	27.18%
Dickinson	73	71	70	72	2.09	14.95%
Dubuque	54	51	40	62	2.65	15.75%
Emmet ◆	15	16.5	22	11	3	26.12%
Fayette ◆	25	29.5	36	23	2.74	22.10%
Floyd ◆	26	30	10	50	3.35	18.00%
Franklin	41	41	43	39	2.61	20.28%
Fremont ◆	8	10.5	18	3	3.15	33.15%
Greene	34	35	38	32	2.68	20.96%
Grundy	95	91	92	90	1.65	11.09%

County	Overall Rank	Average Rank	Method 1 Rank	Method 2 Rank	Method 1 Risk Assessment - Risk Score	Method 2 Risk Assessment - % of children born in 2013-2017 with 3+ risks
Guthrie	72	70	76	64	2.04	15.65%
Hamilton	52	48.5	64	33	2.26	20.82%
Hancock	92	89	87	91	1.74	11.05%
Hardin	36	37	34	40	2.78	20.20%
Harrison	46	45.5	57	34	2.3	20.73%
Henry	27	31	31	31	2.83	20.97%
Howard	56	54	51	57	2.5	16.70%
Humboldt	67	65	72	58	2.05	16.67%
Ida	66	64.5	82	47	1.95	18.33%
Iowa	95	91	93	89	1.61	11.65%
Jackson	56	54	43	65	2.61	15.46%
Jasper	49	47	53	41	2.43	20.00%
Jefferson ◆	23	27	12	42	3.22	19.77%
Johnson	76	74.5	53	96	2.43	8.63%
Jones	69	67.5	69	66	2.17	15.36%
Keokuk	61	59.5	73	46	2.09	18.39%
Kossuth	76	74.5	78	71	1.96	15.03%
Lee ◆	2	5	3	7	3.65	27.58%
Linn	43	43.5	31	56	2.83	16.85%
Louisa	38	39	40	38	2.65	20.29%
Lucas	30	33.5	30	37	2.9	20.34%
Lyon	97	93	91	95	1.71	10.05%
Madison	90	88	90	86	1.68	13.24%
Mahaska	29	31.5	20	43	3.09	19.51%
Marion	79	80	93	67	1.61	15.26%
Marshall ◆	12	12.5	9	16	3.35	24.23%
Mills	35	36.5	58	15	2.33	25.00%
Mitchell	86	84.5	75	94	2.05	10.14%
Monona ◆	19	22	27	17	2.91	23.99%
Monroe	59	59	66	52	2.22	17.13%
Montgomery ◆	1	2.5	4	1	3.61	35.54%
Muscatine ◆	15	16.5	15	18	3.17	23.71%
O'Brien	49	47	64	30	2.26	21.20%
Osceola ◆	24	27.5	47	8	2.67	27.50%
Page ◆	9	11	20	2	3.09	33.53%
Palo Alto	68	67	59	75	2.3	14.42%
Plymouth	83	82.5	89	76	1.65	14.41%
Pocahontas	46	45.5	46	45	2.6	18.72%
Polk	43	43.5	27	60	2.91	16.60%
Pottawattamie ◆	5	6	8	4	3.39	32.16%
Poweshiek	65	63.5	59	68	2.3	15.19%
Ringgold	55	53.5	63	44	2.27	19.03%

County	Overall Rank	Average Rank	Method 1 Rank	Method 2 Rank	Method 1 Risk Assessment - Risk Score	Method 2 Risk Assessment - % of children born in 2013–2017 with 3+ risks
Sac	91	88.5	96	81	1.55	13.75%
Scott ◆	20	25	15	35	3.22	20.72%
Shelby	53	50	73	27	2.09	21.41%
Sioux	87	85.5	87	84	1.74	13.51%
Story	89	87	76	98	2.04	7.54%
Tama ◆	21	25.5	27	24	2.91	21.92%
Taylor	27	31	52	10	2.48	26.61%
Union	37	38	15	61	3.17	16.10%
Van Buren	59	59	55	63	2.39	15.68%
Wapello ◆	2	5	4	6	3.61	27.65%
Warren	87	85.5	78	93	1.91	10.43%
Washington	71	68.5	59	78	2.3	13.98%
Wayne	61	59.5	34	85	2.78	13.47%
Webster ◆	11	12	12	12	3.22	25.85%
Winnebago	40	40.5	55	26	2.39	21.53%
Winneshiek	98	95	98	92	1.43	10.55%
Woodbury ◆	5	6	7	5	3.52	27.92%
Worth	58	57	59	55	2.3	16.93%
Wright ◆	13	13	12	14	3.22	25.10%

Appendix D. Quality & Capacity Data Summary

High need Counties	At least one family support program	At least one family support program funded by MIECHV	Estimated number of families served by all family support programs in the last fiscal year	HRSA estimate of eligible families in need of family support in the county
Appanoose	yes	yes	56	32
Black Hawk	yes	yes	462	456
Buena Vista	yes	no	107	242
Cerro Gordo	yes	yes	89	79
Clarke	yes	no	47	24
Clinton	yes	yes	160	266
Des Moines	yes	yes	42	483
Emmet	yes	no	89	57
Fayette	yes	no	78	82
Floyd	yes	no	44	29
Fremont	yes	no	41	29
Jefferson	yes	no	29	135
Lee	yes	yes	100	421
Marshall	yes	no	184	83
Monona	yes	no	41	107
Montgomery	yes	yes	71	43
Muscatine	yes	yes	121	242
Osceola	yes	no	8	36
Page	yes	yes	81	63
Pottawattamie	yes	yes	221	388
Scott	yes	yes	347	488
Tama	yes	no	44	36
Wapello	yes	yes	68	261
Webster	yes	no	187	319
Woodbury	yes	yes	407	1046
Wright	yes	no	60	110

Alternative estimates of eligible families in need of family support available upon request.

Tables D.1-D.11: Descriptives for MIECHV Needs Assessment Sample (n=106)

Table D.1: Currently Expecting or Pregnant

Currently Expecting or Pregnant	Frequency	Percentage
No	87	82.1%
Yes	19	17.9%
Did not answer	0	0.0%

Table D.2: Health Insurance during Pregnancy

Health Insurance during Pregnancy**	Frequency	Percentage
No insurance	2	2.2%
No insurance and Medicaid	1	1.1%
Medicaid**	75	82.4%
Private Health Insurance	4	4.4%
Military	1	1.1%
Indian Health Service	1	1.1%
Medicaid and Private Health Insurance	4	4.4%
Did not answer	3	3.3%
Not Applicable	15	*

**Not applicable removed from percentages*

***Note: Three participants incorrectly listed Hawk-I as their insurance during pregnancy. Hawk-I is Iowa's Children's Health Insurance Program (CHIP). Since the income requirements for Hawk-I are below the requirements for Medicaid during pregnancy, and because the Managed Care Organizations are the same, these participants were included with participants with Medicaid.*

Table D.3: Relationship to Child

Relationship to Child	Frequency	Percentage
Mother/Step-Mother	91	85.8%
Father/Step-Father	12	11.3%
Aunt/legal guardian	1	0.9%
Grandmother	1	0.9%
Did not answer	1	0.9%

Table D.4: Age

Age	Frequency	Percentage
Under 18	1	0.9%
18-21	6	5.7%
22-25	16	15.1%
26-30	40	37.7%
31-35	18	17.0%
36-40	15	14.2%
41-45	4	3.8%
46-50	4	3.8%
51-55	1	0.9%
Did not answer	1	0.9%

Table D.5: Highest Education

Highest Education	Frequency	Percentage
Less than High School	22	20.8%
High School Graduate or GED	31	29.2%
Some college but no degree	30	28.3%
Associate degree	10	9.4%
Bachelor's degree	10	9.4%
Master's degree	1	0.9%
Did not answer	2	1.9%

Table D.6: Hispanic/Latinx

Hispanic/Latinx	Frequency	Percentage
Yes	17	16.0%
No	89	84.0%
Did not answer	0	0.0%

Table D.7: Annual Household Income

Annual Household Income	Frequency	Percentage
Less than $20,000	51	48.1%
$20,000 - $29,999	10	9.4%
$30,000 - $39,999	20	18.9%
$40,000 - $49,999	14	13.2%
$50,000 - $59,999	1	0.9%
$70,000 - $79,999	1	0.9%
$80,000 - $89,999	1	0.9%
$90,000 - $99,999	1	0.9%
Over $100,000	1	0.9%
Did not answer	6	5.7%

Table D.8: Number of Children

Number of Children	Frequency	Percentage
0	7	6.6%
1	25	23.6%
2	23	21.7%
3	28	26.4%
4	13	12.3%
5	7	6.6%
6 or more	2	1.9%
Did not answer	1	0.9%

Table D.9: Child Health Insurance

Child Health Insurance*	Frequency	Percentage
No insurance	2	2.0%
Medicaid	84	82.4%
Hawk-I (CHIP)	4	3.9%
Private Health Insurance	4	3.9%
Medicaid and Hawk-I (CHIP)	3	2.9%
Medicaid and Private Health Insurance	4	3.9%
Medicaid, Military, and Private Health Insurance	1	1.0%
Not Applicable	4	*
Total	**102**	**100%**

**Not applicable removed from percentages*

Table D.10: Race

Race	Frequency	Percentage
Non-Hispanic White	52	49.06%
Hispanic White	11	10.38%
Black or African American	13	12.26%
Native American or Alaska Native	9	8.49%
Asian	8	7.55%
Native Hawaiian or Pacific Islander	1	0.94%
Puerto Rican	2	1.89%
Black or African American and White	2	1.89%
Native American or Alaska Native and White	2	1.89%
White and Cajun	1	0.94%
Did not answer	5	4.72%
Total	**106**	**100.01%**

Table D.11: Primary Language at Home

Primary Language at Home	Frequency	Percentage
English	82	77.4%
Spanish	9	8.5%
Karen	5	4.7%
Burmese	1	0.9%
Marshallese	1	0.9%
Tigrinya	1	0.9%
Vietnamese	1	0.9%
English and Spanish	1	0.9%
Kirundi and English	2	1.9%
Burmese and Karen	1	0.9%
Did not answer	2	1.9%
Total	**106**	**99.8%**

Appendix E. Focus Group and Interview Facilitator Guides for MIECHV Questions

Home Visiting Service Recipients

Now, I am going to ask you a few questions about your experiences with your home visiting program.

- How did you hear about your home visiting program?
- Probe: What influenced your decision to sign up?
- What about your home visiting program is most helpful or most important to you?
- What, if anything, has made it difficult for you to receive home visiting services or remain in contact with your home visitor?
- What (if anything) would you change about your home visiting program?
- What else would you like us to know about your program or your home visitor?

Title V Recipients and Underrepresented Populations

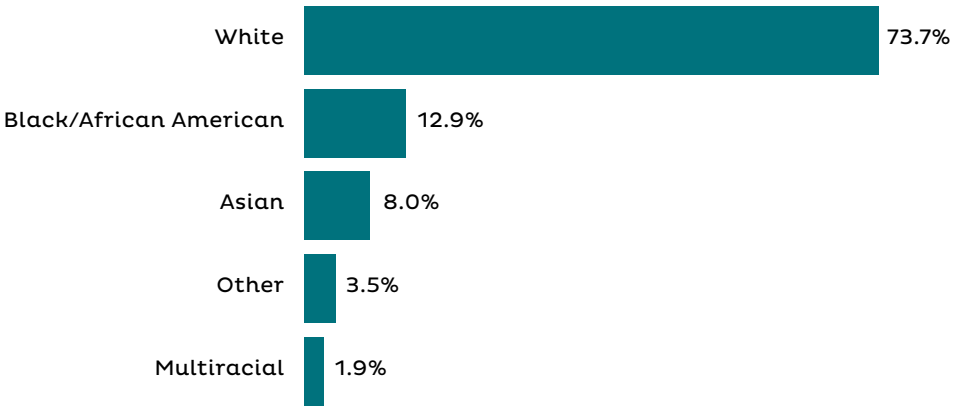
Now, I am going to ask you a few questions about family support home visiting programs. These are programs where a home visitor comes to your home anywhere from once a week to once a month free of charge to provide resources and parenting support for pregnant women and parents with young children.

- What do you know about home visiting programs in your community?
- How interested are you in home visiting services?
- Probe: How would you want to hear about home visiting programs?
- What, if anything, would make it difficult for you to sign up for or receive home visiting services?
- Who or where do you go for parenting/child development information?
- What should we know about why families may decide not to enroll in home visiting programs?

Appendix F. Statewide Family Support Services Demographics

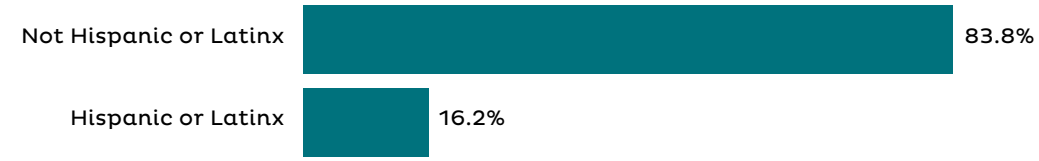
Statewide Family Support Services Demographics by Race

Data missing for 1,149 families; percentages reflect families who provided race information



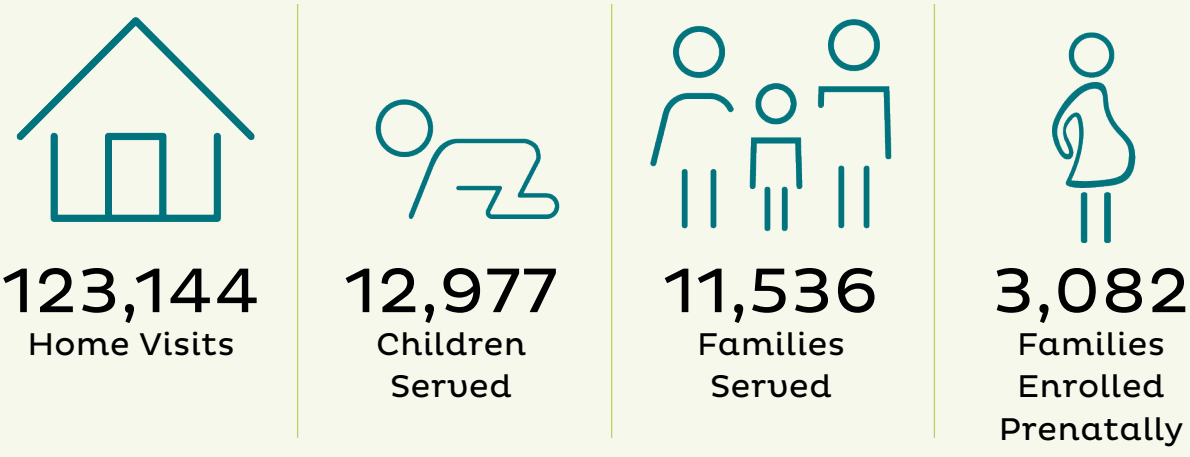
Statewide Family Support Services Demographics by Ethnicity

Data missing for 754 families; percentages reflect families who provided ethnicity information



Statewide Family Support Services Demographics by Service

Data missing for 1,665 families; percentage reflects the prenatal enrollment rate when this information was collected.



Appendix G. County-Level Themes for Focus Groups and Interviews with Families

Clink on the county name below to jump to that county.

Black Hawk County // MIECHV Recipients

Consistency

Developing relationships with service providers was noted as a significant benefit of program participation. Having consistency over time with their worker was also indicated as a factor that influenced positive experiences with the program.

Having the same home visitor is very helpful. Once you know someone, it's nice to have them stay consistent.

- MIECHV Recipient

Practical Support & Education

When asked about their experiences with family support services, many participants noted the practical supports and resources their service provider offered them. Many also pointed to their home visitor being able to help them find additional resources and supports when needed and stay on top of development expectations for their child as a significant benefit.

I was searching for some help with my son's situation, and then, with my daughter's situation. I talked to my doctor and my doctor is how I wound up with a registered nurse to come to my house once a week with the same weight scale and it was phenomenal.

- MIECHV Recipient

Anytime I call or text [my service provider] it is very helpful. [My home visitor] teaches me how to do things, I like to learn from [my home visitor].

- MIECHV Recipient

Familiarity and Trust with Referral Source

Knowing someone in the program or being referred by a trusted source (e.g., "doctor") impacted the decision to utilize family support services for some participants.

> I'm with [a family support program] and my friend actually runs [the program] and she was like, hey, you're pregnant, let's do this.
>
> - MIECHV Recipient

Black Hawk County // Title V Recipients and Underrepresented Populations

Misperceptions

In response to questions about barriers to signing up or receiving family support services, participants often pointed back to insurance-related issues. This was a frequent misunderstanding or misperception about the MIECHV program. Additionally, participants discussed being unsure of the qualifications.

> Waiting for HMO to approve it or when you have a waiver from DHS and that then they're taking their time and you're sitting here waiting.
>
> - African American Health Equity Participant

> I have to know about it first and if there are qualifications to participate. I'd love to be in these programs and have more support, but I make too much money.
>
> - WIC Recipient

> Sometimes that barrier is there with them agencies and the insurance. [Agencies] don't understand [my disability and needs] and it is the lack of communication and the system is broke.
>
> - People with Disabilities Health Equity Participant

Lack of Knowledge

> When asked what they knew about early childhood family support services, some participants had never heard of it before. Other participants described lack of knowledge as a barrier to receiving this service. [I] don't really know anything. [It's] my first baby.
>
> - WIC Recipient

> I don't know where or how to sign up.
>
> - Asian/Pacific Islander Health Equity Participant (interpreted)

Cultural/Personal Beliefs

Specific to the Health Equity groups cultural beliefs about help-seeking behavior was indicated as a barrier to accessing services. Others noted that feeling that they didn't need help was a potential hindrance to either reach out or accept services. One participant did not think they needed family support services but was glad they signed up anyway.

> I'm biracial. You know, and I know in the African culture, medically they believe everything can be healed, even if you have a disability. They don't believe in [disabilities]. Okay. So, it's kinda hard. If you have a mental diagnosis, some of them hide it. They don't want people to actually know. And that, that also extends to the fact that the reason why so many of them don't reach out to get the help.
>
> - People with Disabilities Health Equity Participant

> Not really [interested]. I don't think we need [family support services]. It's not something that we need to do.
>
> - WIC Recipient

> [People at the hospital] said... would you like access to, you know, having like weekly meetings? And I thought, eh, I don't think I need—like, this is my third kid—but I know that being a stay at home mom, that it can lead to depression really easily when you're just by yourself a lot. And so I thought, you know what? Let's try it. If I don't like it, I can cancel it or, you know, stop doing it, but let's go ahead and give it a try. And I'm glad that I did.
>
> - African American Health Equity Participant

Trust

Concerns about allowing someone unknown into the home was mentioned by many focus group participants as a potential barrier. Mentions of a "stranger in the home" and a desire to "build trust" prior to having the home visitor in their personal space (home) were frequent. One participant indicated they were "a control freak" and this personal trait led to their desire to avoid an outsider in their home. Others mentioned feeling that a home visitor would be "judgmental" or they reported a "prior bad experience" influencing their ability to build trust with a service worker. The discussion from one health equity group seems noteworthy because there is historical mistrust with Black American populations. Finally, many of these discussions about trust related to the idea of reports being made to DHS and threats of children being removed from the home.

> If you have anxiety, you're automatically going to be uncomfortable with having someone in your home or their intentions or if you're single mother because you don't know who's walking in your home.
>
> - WIC Recipient

> You don't want someone to come to your house and seeing something sitting out and potentially getting in any trouble from that.
>
> - WIC Recipient

> Sometimes I don't know how to trust anybody. I don't really like to let anybody in when I'm having this mental stuff because I don't want people to think just because I'm an African American woman that I'm using my, culture, my race, or my mental illness just to get the stuff that I need when I need it... I don't like to be judged. And sometimes I don't like to reach out for help for that because I'm scared. If I say the right, do the right thing or get the right thing, then you get that stigma—not just from your culture—you get it from everywhere...And those are the blocks and the barriers. And then you cry, because it's like your voice is not being heard.
>
> - People with Disabilities Health Equity Participant

> When you know you need their help doing the things you're asking and you voluntarily ask for, you get treated like, I feel like I'm treated like I'm a burden to you. I can't be a burden when you're getting paid to help me. And yet it seems like, you don't, really truly want to help. You just want to get a paycheck.
>
> - People with Disabilities Health Equity Participant

Scheduling

Having the time and availability when services can be provided is a key barrier noted by several participants. Simply put, families struggle to find time to schedule services. Between parent work schedules, school, and other obligations of home life, this feels burdensome for many. Some participants indicated expanded or more flexible hours would allow them to better utilize these services.

> Sometimes the people who need the most amount of help are the ones with the least amount of time. And so the time that it takes for me to set up an appointment, have someone come to my house for an hour, and I mean, it's not like they're coming in the evening, they're coming in the middle of the day. And so once I'm done with my six weeks of postpartum, I'm going back to work. And so when do I have time to meet with these people to get the information that I may desperately need? They don't work on weekends and they're not working in the evening. So, then I'm kind of just out of luck.
>
> - African American Health Equity Participant

Relationships

Participants who had received family support services noted the importance of the relationship with their worker. One participant said the relationship from the very beginning, helped them overcome their anxieties about having someone they have never met come into their home.

> They are awesome people. You get to know them real well.
>
> - People with Disabilities Health Equity Participant

> I guess you have a hesitation of thinking, man, I'm going to have like this stranger that I don't know in my home. [I was thinking] 'is this okay or are they going to give me good information?' … I definitely was hesitant about that, but once I met—when the lady came the first time—I was like, 'oh, okay.' Like we just meshed. It just made sense.
>
> - African American Health Equity Participant

> They came here weekly and just kind of—you know—checked on me, made sure that I was—you know—doing okay; that I didn't have any questions and things like that. I am a seasoned parent, so I didn't ever really have a whole lot of questions, but knowing that I was going to have someone come and check on me every week was extremely helpful.
>
> - African American Health Equity Participant

Des Moines County // MIECHV Recipients

Schedules

Participants shared about the barriers with scheduling home visits. Simply having busy schedules to coordinate between children, work, and other obligations often left little room for one more appointment. Additionally, participants mentioned their own mental health

> Timing and schedules are hard to fit in time for visit.
>
> - MIECHV Recipient

Personal Anxiety and Privacy Concerns

One participant specifically indicated that their family support program being "not DHS involved" as the reason they decided to participate. This seems to indicate that if the program was through DHS, it may have prevented them from signing up. Another mother struggled with postpartum anxiety, and mentioned it was a barrier to receipt of services and staying in contact with her home visitor.

> My own anxiety levels. I just can't deal with people somedays. After I had my son, I got really bad anxiety.
>
> - MIECHV Recipient

Information & Resources

Participants overwhelmingly noted how helpful program participation was. Most frequently they noted that having access to a knowledgeable support worker who provided development information as well as support and resource referrals when needed was a significant benefit of the program.

> The informational packets and papers that are brought in that explain your development while you're pregnant...like you should be counting your kicks at this month or you should be expecting to feel this this month or [other] development. You learn about development. So, I think that's what's important.
>
> - MIECHV Recipient

> It's taught me a lot on how to take care of my child better. What to expect from behaviors with him and just how to overall take care of him better.
>
> - MIECHV Recipient

Another set of eyes has been so helpful. Somebody that knows like a little bit more than I do. Also connecting to other resources and programs in the community out there to help.

- MIECHV Recipient

They have resources everywhere and they always have like referrals and they're able to get the foot in the door. For me, all I have to do is call or whatever.

- MIECHV Recipient

Before [my family support program], trying to get help was nearly impossible. After, it makes it a whole lot easier.

- MIECHV Recipient

Positive Relationships

In addition to appreciating the information and resources family support professionals provided, caring relationships were also noted and echoed around the room as a meaningful benefit of the program.

I like my worker a lot, that's really helpful…her actually caring about me and what I needed."

- MIECHV Recipient

I was able to call even though it wasn't like my scheduled day and ask, 'Hey is this normal?' Hey, 'is this, should I go to the hospital?' And that's really helpful to have someone there for you.

- MIECHV Recipient

Lee County // Title V Recipients

Privacy

When discussing why someone may not chose to participate in family support services the only idea that came to mind and was noted was a desire for privacy. However, it was also noted that despite a desire for a private life, services were still accepted and reported to be beneficial.

> I do kind of live, like, a private life.
>
> - Title V Recipient

Trusted Referral Source

One participant discussed why they signed up for visiting nurse services and associated the referral source with influencing whether or not they would have been interested in participating in other family support services.

> The Lee County Health Department contacted me about the visiting nurse, so maybe that would be a good way to let people know about home visiting services.
>
> - Title V Recipient

No Transportation Worries

Not having to leave home and pack up a baby and all the baby belongings was indicated as an appreciated benefit of having a family support professional. Transportation access and seasonal concerns such as winter conditions were also mentioned.

> They just come to my house. I don't have to worry about finding a ride.
>
> - Title V Recipient

Information & Support

Having an informed provider offer individualized and personal care in home was appreciated by this group.

> We talk. [The visiting nurse] asked if I need help with anything, whether it be, you know, emotional support or mental health, or services. Anything like that. She offers certain [suggestions] for things and asks me if I need anything, like help transportation or baby items and stuff like that.
>
> - Title V Recipient

Marshall County // Family Support Services Recipients

Marshall County does not currently have any MIECHV-funded family support programs. Recipients of a state-funded family support program were recruited for the family support services recipient focus group.

Comprehensive System of Support

Families enrolled in family support services emphasized how important and helpful the care they received was. Home visitors offered a wealth of valuable information and provided the families with reminders to make appointments as needed. Participants reported receiving assistance in figuring out what bills were coming due, potty training their children, parenting, referrals for financial support, and problem solving. One participant reported that their home visitor provided support for transitioning out of an abusive relationship.

> When I was pregnant with my first child and I first moved to the city, I didn't really know where to go and what to do. [My home visitor] helped me with everything: how to make appointments, prenatal care, how to take care of myself and my baby.
>
> - Family support services recipient

> Helping both me and my child transition out of a very toxic, very abusive relationship and be able to heal from that and not let it affect their development. Keeps them on track. If I didn't have the support from her, that wouldn't be possible.
>
> - Family support services recipient

> Especially when the baby is new and you're tired, you haven't been anywhere in a week, and your house is a mess, just someone to stop by with a big smile. You can talk about things that you try to talk to your husband or family member about that they don't understand, your home visitor will look it up and help you understand.
>
> - Family support services recipient

Marshall County // Title V Recipients and Underrepresented Populations

Lack of Knowledge About Services or Do Not Feel Like They Need Services

A few families had never heard of family support services. Other families utilized family support services when they were new parents, but felt that they no longer needed it with later children. After the first child is born, many parents build confidence in their abilities to successfully parent and manage or facilitate their child's development. This may affect how they view their need for the service.

> No. I've never heard of [family support services].
>
> - Title V Recipient

> The home visitors show you how you should do it, and this is what you should do. For the third child, I'm just trying to do it on my own. There isn't so much to worry about with the third child.
>
> - Immigrants/Refugees Health Equity Participant

Scheduling

Many families shared barriers to receiving family support services surrounding scheduling. Specifically, working around changing work schedules or having difficulty committing to a specific time because they don't know what their plans are very far in advance when they're managing a household with young children. Families may want to receive home visits after the typical nine-to-five workday.

> I work during the day and my husband works at [night]. Then, he sleeps during the day.
>
> - Title V Recipient

> [The] hours should be more flexible and include more in the afternoon after 5:00.
>
> - Latinx Health Equity Participant (interpreted)

Worry About Support for Cultural Beliefs

In the Health Equity immigrant/refugee group, families mentioned experiencing disagreement with the beliefs or parenting or challenging the participants' culture. Parents may not want to engage with family support services if they feel like it will be another system that will not honor the way they parent.

> Sometimes, you know, people not agreeing on what you said. They said, oh no, that's not true. Oh, that's not true, because they don't experience it.
>
> - Immigrant/Refugee Health Equity Participant (interpreted)

Support for Fathers

A health equity group participant mentioned that having community support for fathers as caregivers would be helpful in case something would happen to the mother.

> If something happened when I gave birth, I would hope the community would step in and help [the father] learn and take care of the baby and kind of be a secondary support for him.
>
> - Immigrant/Refugee Health Equity Participant (interpreted)

Need for Interpretation Services

Families mentioned the importance of communicating with family support professionals and their struggle accessing quality interpreters. Families are not confident that quality interpreters will be available whenever they are needed for service provision.

> [I] feel impotent because of the language barrier.
>
> - Latinx Health Equity Participant (interpreted)

> [They should] have people who work there who are bilingual.
>
> - Latinx Health Equity Participant (interpreted)

Montgomery County // Title V Recipients and Underrepresented Populations

Scheduling

Participants mentioned scheduling as a major barrier to signing up and receiving family support services. Some said navigating a schedule with two working parents on different shifts was a challenge. One parent was ready to go back to work and there were too many unknowns with a work schedule and childcare to be able to agree to family support services. Major transitions such as reentering the workforce after have baby make commitment to family support services even more difficult, as parents do not know what their schedule is going to look like in the future.

> I would be willing to do it and—you know—I didn't have a later in the afternoon job and until I figure that out, I don't want to schedule or get something going and then have to stop it.
>
> - Title V Recipient

Embarrassment

Parents shared that schools are not able to support the family and that they often feel isolated. For these reasons, support structures such as peer groups and family support services are greatly needed. However, while being interested in family support programs, participants thought some families may feel embarrassment or be unable to trust family support professionals.

> Embarrassment of situations… I would think maybe the condition of the home. The financial part. Maybe being worried about confidentiality… use [information] against the family.
>
> - People with Disabilities Health Equity Participant

Fear of Judgement

While most families mentioned that they would be interested in receiving family support services if they had known about them, they thought families might be hesitant to sign up for fear of being judged by the family support professional.

> I mean—I know even me—I kind of feel almost like you feel like you're going to be judged before you meet the person, they come in and judge your housekeeping skills. I have five kids, my house is a disaster.
>
> - Title V Recipient

Isolation

Many parents with disabilities also had children with disabilities. These parents often experienced isolation. They shared how they do not go anywhere and have few people to depend on for child development knowledge, medical needs, and parenting skills.

> **Basically, I don't go anywhere, I live and learn on my own.**
>
> - People with Disabilities Heath Equity Participant

> **I don't bring a lot of things up when we have yearly checkups because I just figure it goes in one ear and out the other so I don't even say anything.**
>
> - People with Disabilities Health Equity Participant

Page County // MIECHV Recipients

Time Commitment and Scheduling

While families in Page county were receiving family support services, they had some difficulty maintaining consistent services and they thought the issues they were facing might also be a barrier to families connecting with family support services. Families discussed not initially knowing the requirements of the program and the time commitment needed. Without knowing this information in advance, some families may not want to sign up for services. Additionally, they anticipated not knowing what their schedules would look like for future dates.

> If I worked a full-time job, it would be more difficult to schedule appointments.
>
> - MIECHV Recipient

Initial Meetings Outside of the Home

Families had suggestions for how to mitigate some of the barriers to signing up for family support services. They suggested offering opportunities to meet somewhere outside of the home, at least for the first visit. Reasoning provided included the burden of having to clean their home for someone coming to visit as well as the fear of inviting someone into your home before you have met or interacted with them in any capacity.

> I would much rather go somewhere than have someone at my house, 'cuz then you have to clean all week.
>
> - MIECHV Recipient

> When it's the first time and you've never met them, it's a little scary.
>
> - MIECHV Recipient

Scott County // MIECHV Recipients

Connections to services

The majority of participants discussed one of the reasons they enrolled in family support programs—in addition to the benefits embedded within each program—was the connection to other services in the community. Participants reported valuing detailed explanation of program services and the ways the program can connect them to other beneficial community support, when determining whether to enroll in the family support program.

> Before I decided to join the program, my home visitor was telling me a lot of stuff that they can help us with or might need help with. When I first got pregnant, I wanted to learn everything I could for my son, as a single parent, you never know what could happen down the line. I felt like I needed that for security for myself because I still have a lot of questions.
>
> - MIECHV Recipient

Comfort with Home Visitor

Several participants reported the importance of establishing a trusting relationship with their family support professional. Similarly, this relationship can be the determining factor in engagement and retention. Participants described potential discomfort if a family did not trust or have a trusting relationship with the family support professional. Participants recommended explicitly telling families that they can change providers if they do not feel like they are connecting or getting the services they need to prevent families from dropping out of the program.

> If you're not comfortable with the home visitor, you can exchange for a different person. Who wants to sit with somebody and be miserable or not invite them in because you don't want them in your house?
>
> - MIECHV Recipient

Misperceptions

Participants discussed several barriers to enrollment including misperceptions of what family support programs offer, what the agencies can and cannot do, and eligibility requirements. While some participants reported reading about the program in a flyer, others shared their initial misperceptions about family support agencies being connected to or a part of DHS. The stigma associated with DHS is enough to prevent families from enrolling. Several mentioned—prior to enrollment—the belief that participating in family support programs has the potential to have children removed from the home. Some participants reported another barrier to enrollment is fear of having a stranger in the house.

> People see the name of the agency and think badly about it or that it's a part of DHS—at first I did. First thing somebody asks when I talk about the program is are they working with DHS? A lot of people are scared to bring people in the house, fear their kids being taken because of this or that's going on. They don't want that. But I think if somebody explained their job just a little better, what they're there for and how they're willing to help more people would be in the program.
> - MIECHV Recipient

Scheduling Conflicts

Similar to comments discussed about challenges of receiving family support services during the workday, participants discussed inability to attend groups or activities that conflicted with their work schedule or other family commitments. Participants discussed interest in attend group activities to meet other families, however, they reported that only "certain parents or families" can attend due to the timing of groups and activities.

Recommendations

Participants recommended conducting surveys with parents to identify best times to hold group activities or events. Additionally, providing opportunities for activities at differing times will allow more families to attend and improve engagement. Participants reported wanting more group activities with other parents enrolled in the program.

> I think that they should do surveys with the clients on what times are best for parents' groups. I feel like not a lot of parents come to them. It was kind of hard because some of the parents have to work like me, I couldn't make it to most of them because I didn't get off in time.
> - MIECHV Recipient

Scott County // Title V Recipients and Underrepresented Populations

Concern about a Stranger in the Home

This theme was the most frequently discussed topic across all groups with multiple participants reporting the perception that family support services require families to let a "stranger" into their home is a major barrier to enrollment. Participants discussed this theme from multiple angles from and described multiple reasons for concern about allowing a home visitor into their house. Participants reported general distrust of a stranger, regardless of the credentials that are associated with the coordinating agency or service. Additionally, several participants described a fear of judgment, and concerns over how the family support professional would perceive the house. Multiple participants reported being worried that a provider would view their house as too messy or would judge their housing situation.

> Maybe people don't enroll because they don't live in the best conditions or their house is a mess.
>
> - Title V Recipient

Parental Personality

One participant described her attempts to share information with a neighbor about the benefits of family support services. However, the neighbor ultimately did not choose to enroll in the program. Upon reflection, the participant described the neighbor's personality as being shy, introverted, and reclusive. These personality traits might influence perceptions of family support services. The participant concluded that a parent's personality may play a significant role in enrollment, in addition to other factors, especially if the services are perceived as potentially uncomfortable due to the nature of the required interactions.

> I have a neighbor that I told about the program, but I don't think she's ever done it. She is pretty reserved and shy. We go long periods of times without talking because she gets kind of reclusive. I think just that opening herself up to some other people is uncomfortable for her.
>
> - Title V Recipient

Scheduling Conflicts

Several participants perceived family support services to be incompatible with their schedules. Participants reported a combination of work hours and other family related scheduling conflicts, that can often be unpredictable, making the addition of home visits unappealing. Participants reported feeling too busy to add another appointment to their schedule and did not perceive the programs as being beneficial enough to justify the time commitment of participating in the family support program.

> It sounds like a nice program, but I just have a super busy household and I just don't have time. It would not really work for me because I work full time and my schedule is all over the place. It would just be hard to schedule a visit.
>
> - Title V Recipient

Lack of Information

Many participants were not currently receiving family support services due to a lack of information and misunderstanding about the services family support programs can provide to families. In addition to not knowing what programs are available, many participants reported not understanding the purpose, goals, or eligibility criteria for direct service family support programs.

> I would like to get to know what their mission is. It makes it difficult for me to enroll, because I don't know about it. I've never really heard about it until now.
>
> - Father Health Equity Participant

Recommendations

Participants suggested improved advertising strategies in more locations would give programs public visibility. Several participants suggested public advertising, more than fliers left on tables, at other agencies that support families such as local WIC offices, doctors' offices, food banks and other agencies that offer community supports. Advertising should include information about the specific program services and eligibility requirements. One participant recommended programs could send a letter to families of young children that includes all the information about the program, however, other participants commented that they do not consistently read mailed documents.

> I wish they had more advertisement, because what if I never went to that group? What if I never got on that bus? You need a commercial or something. But even flyers in certain places like at the hospital—you just don't see it."
>
> - Title V Recipient

Of the families who were not currently receiving services, several indicated being interested in family support programs based on the description of services provided.

> I'm still young, so if I have another kid, I think it would benefit them because if someone could come in and teach my child at home, I think that would be effective and would be more beneficial to him or her.
>
> - Father Health Equity Participant

Tama County

Strangers in the home

Many families are not comfortable with strangers being in their homes. Participants mentioned that people might not sign up for family support services because they do not want someone coming into their home. They stated various possible reasons including embarrassment or fear because their homes might be messy, as well as distrust and not wanting strangers to know where they lived. They lacked a trusting relationship with a service provider and that they would prefer to meet a family support professional outside of their home.

> For other people, maybe they don't want [home visitors] to see their house. It's messy so they don't want people to come over. They don't want them to know where they live. Trust issues.
>
> - Meskwaki Native American Health Equity Participant

Knowledge of Eligibility Requirements

When families were asked about barriers they may face in signing up with family support services, one participant mentioned not knowing what the eligibility requirements were. If misconceptions exist about the eligibility criteria for receiving family support services, families will be less likely to reach out. Some criteria mentioned included specific types of health insurance or having a specific health diagnosis.

> I don't know the requirements or eligibility. Like, I know, public health you have to have a certain income. There are just certain things... if you didn't have certain insurance, they wouldn't come or you need to have a certain diagnosis. It's not like you can just call and they'll come."
>
> - Meskwaki Native American Health Equity Participant

Wapello County // MIECHV Recipients

Schedules

Finding time between school and work schedules proved to be a difficulty that was echoed by group participants. Reports of "busy lives," "work schedules," and "finding the time" were noted frequently by participants to explain why they had difficulty with accessing services. These issues were reported as internal family system barriers and not a reflection on the programming quality.

> My schedule…during the fall I'll go from school from 8:00 AM until 4:00 [PM] and then, I'll work from 4:00 to 9:00 at night. [I have] a very full schedule and it's difficult to schedule times with family support.
>
> - MIECHV Recipient

Personal Connection

Knowing someone who was already in the program influence some participants' decision to sign up. Hearing about family support through a trusted provider of another program was also common.

> I heard about it through a friend…she said that [her worker] had openings and she told me how to get a hold of her.
>
> - MIECHV Recipient

> I heard about it through another program I participated in. One of the employees told me about it. I think it was through [Iowa State University] Extension.
>
> - MIECHV Recipient

Affordability

The program being no cost was noted by one participant as influential in deciding to participate and other echoed the sentiment during the focus group.

> It was free.
>
> - MIECHV Recipient in response to being asked why they signed up

Supportive Relationship

Program participants often mentioned that a personal connection and rapport with their family support professional impacted their positive feelings about the program. Many participants in this focus group seemed to enjoy telling stories about their experiences and a bit of a game of "who has a better provider" emerged during the back and forth. Simply getting support for someone outside the home ("non-partner" and "non-judgmental") was a key motivator to accessing services. This extra support was "peace of mind" for some participants and for others the adult contact with someone other than their partner was noted as a significant benefit. It was clear these caring relationships had made a significant impact for these individuals.

> Even though it was kind of like service and like she's doing a job, she really kinda came to us more like, she comes off more as a friend.
>
> - MIECHV Recipient

> It gave me peace of mind. It was nice to have someone to talk, for the parents to talk to. Not just about the kids…it was nice to have that focus on you—as a parent—not just the baby.
>
> - MIECHV Recipient

> I'm a stay-at-home dad right now… it's nice that somebody can be like, 'how are you actually doing today?'
>
> - MIECHV Recipient

> [She is] Very non-judgmental. She doesn't mind the crazy that happens in my house… when she would first come, I cleaned my house and now she's just like… family.
>
> - MIECHV Recipient

Support that Comes to You

The ease of not having to travel for a support visit was considered a benefit of the family support program for many.

> Support comes to you—you don't need to pack up everyone and everything to get services.
>
> - MIECHV Recipient

> It's a nice that you don't have to leave the house…you can stay home and they come to you. You don't have to pack up a diaper bag, get my kids in and out of cars, bring snacks all that.
>
> - MIECHV Recipient

Wapello County // Title V Recipients and Underrepresented Populations

Lack of Awareness

Some participants indicated that they simply did not know that family support services were available to them. When asked if they had heard about family support services, one Title V recipient said, "no." The facilitator described what family support services would look like and then asked, "how interested are you in family support services? If I told you today we could sign you up and there would be a person who would come to your home and do some of those things, help you find resources, talked to you about your baby, that kind of thing, would you be interested in something like that?" The participant quickly stated "Yes. 100% interested, just a hundred percent interested." This participant actually signed up for family support services as a result of participating and because the focus group was held at the local MIECHV-funded agency location.

> I don't know anything about [family support services].
>
> - Immigrants/Refugees Health Equity Participant

Privacy

When participants were asked about why they believe someone might decline family support services, they indicated that probing questions from the service providers may give someone pause.

> Not wanting to answer questions [from the home visitor].
>
> - Title V Recipient

More Time to Stay at Home

One Health Equity group participant was interested in family support services because it meant they could spend more time at home.

> I would be happy to participate in that kind of [service]. I [would] have more time to stay at home.
>
> - Immigrants/Refugees Health Equity Participant

Woodbury County

Flexibility of Service Delivery

Several participants discussed initial concern allowing family support professionals to provide services in their house, however, the flexibility of the programs was one of the main reasons' families chose to enroll in services. Participants discussed that having a family support professional who was willing to be flexible and meet with the client in a preferred setting outside the home helped to establish trust. Participants viewed this flexibility as a beneficial aspect of service delivery.

> She is totally fine with meeting at a Starbucks. She was willing to, to not be in the home right away. I told her we'll meet with you but we're going to meet at Starbucks first and then build that relationship.
>
> - MIECHV Recipient

For some women, being a new mother was an isolating experience. Services provided in their home helped to alleviate the emotional strain of not having more social support. Participants discussed the ways that family support professionals tailored services to each family's unique needs, providing emotional support and resources, while in the home made the programs both beneficial and meaningful.

> Having someone come into your home takes away that need to reach out. And when they come to your home, then you are not totally isolated. You get emotional support; you get access to lots of great resources and things that help you provide care for your child.
>
> - MIECHV Recipient

Providing Services when No Other Support was Available

Participants shared the importance of providing services in the home made as the main reason they enrolled. For some families, it was the only option to get the services they needed to support their child. For other families, family support services provided encouragement and help to help support their child's developmental and education needs.

> When my son got out of the NICU, we had to be very careful and I could not take my son anywhere. I actually needed someone to come into my home and I despaired. I thought, 'where am I going to find anybody who's going to come to my home and service my needs?' Nobody will come to your home except [my program]. I was desperate and I didn't know anything about the other advantages of the program. It ended up being the biggest life changing program in me and my son's life ever. - MIECHV Recipient

Essential Parenting and Developmental Education

Participants shared that family support services provided access to essential information and necessary resources to help them raise their children. Participants considered family support services invaluable when they did not have strong enough support from family or friends. Additionally, several participants commented on the challenges of being first time parents and not feeling like they had enough knowledge to feel confident in their parenting ability and choices. Participants reported that participating in family support programs helped them feel more confident as a parent and provided a sense of wellbeing because they always had someone to turn to for help or to answer questions.

> I'm taking advantage of every single thing because I didn't feel like I knew what I was doing. As first-time parents, how would I have known when to put them on cereal? My home visitor pays attention to what I complained about during our visit or said I needed. And then next time she comes, 'Oh I remember you said…' My home visitor is really nice, and she really does care.
>
> - MIECHV Recipient

Barriers to service

Participants reported several reasons why families may not be choosing to participate in family support programs and services. The following themes describe participant perceptions of barriers to service.

Inconsistent Recruitment Strategies

Participants reported learning about family support programs through a variety of different recruitment strategies ranging from fliers to referrals from other agencies. One participant reported she found out about family support services after her son started preschool, but her son was too old to participate, however, her daughter was eligible. Other participants reported seeking services on their own by calling their doctors and requesting information about local resources.

> When my son went to preschool two years ago and that's where his teacher asked me if I wanted the home visiting program for my daughter.
>
> - MIECHV Recipient

Barriers to continued engagement

Several mothers reported frustration with prohibitive program rules that limit the number of children a family support professional can provide services for within one family. Participants discussed the importance of consistency within a family and that once a trusting relationship has developed, they prefer continuity of service providers when receiving services for multiple children.

> I wish my current home visitor can provide services for my baby at the same time as my older child. I asked but they said no. So, when my three-year-old goes to preschool they can start services for the baby. But I have to wait and see if my current home visitor will be available for my baby. If not, I have to get another person.
>
> - MIECHV Recipient

Additionally, programs with age requirements for enrollment can cause frustration when parents find programs beneficial but miss the deadline to enroll or find out about services after their child is already too old.

> I wish that my home visitor could take on my other child, when the child I originally signed up to receive services graduates from the program, I wish my current home visitor could come, but I have to have two separate home visitors because my son will be past three months old. There's like a minimum age that you have to sign up for.
>
> - MIECHV Recipient

Available Program Information

While some participants reported not having enough information to make an informed choice to enroll in the program, others reported that there was too much information provide to families directly after giving birth.

> After you have a baby, you have like 15 people come into your room and say, I'm a part of this program. I'm part of this program. You want to sign up for this? Do you want this? Do you want that?
>
> - MIECHV Recipient

Discomfort Meeting in the Home

Several participants reported feeling uncomfortable with meeting in their homes. Participants' discomfort was exacerbated when there was a lack of knowledge about the program and services being offered. Participants reported they prefer programs that offer flexibility in where to meet.

> The lady called me to set up a visit. But she was very persistent on meeting in the house. And my husband was like, "no." If I can't meet her outside of my house, then we're not doing that.
>
> - Title V Recipient

While one of the benefits of direct service family support that occurs within a client's home is to make scheduling easier for the family, there were participants who did not have consistent housing. Housing insecurity makes enrollment, engagement, and retention challenging.

> It's so uncomfortable because you don't want, I didn't have my own place. Not at the time. I still don't, we know that's what I'm working on. It would be nice if they had like a, you know, if we could meet somewhere like their place.
>
> - Native American Heath Equity Participant

Several participants discussed concern about family support professionals, who they viewed as "strangers", passing judgment. Participants discussed a sense of distrust at allowing someone they did not know to come into their home and challenges being open with someone they do not know. Several participants reported concerns of providers criticizing their parenting choices, cleanliness of their home, and concerns specific to the condition of their housing.

> I don't need you to come into my house and tell me what I'm doing wrong with my child and judging me. I don't know this lady and you want me to open my home to you?
>
> - Title V Recipient

Additionally, participant fears of judgment were compounded when participants viewed family support professionals as "people who might be able to take your kids away." These misperceptions about the nature of programs influenced participants views on enrollment.

> When somebody is coming to your house, you kind of overthink it a little bit and you're like, is this going to be approved? Is this going to be appropriate? Are they going to be concerned about this or judge you and tell somebody else that this is a thing in your house? And then you're basically walking on eggshells the entire time, and you have to worry about the child and then worry about what other people think.
>
> - Title V Recipient

Schedule Conflicts

Participants who had previously received services shared that coordinating schedules was a challenge when trying to find a time to meet with the family support professional. Additionally, the participant reported the provider frequently canceled meetings which frustrated the participant and directly impacted retention.

> We are still busy all the time and we have so much going on that I feel like I would make an appointment for it and then something would come up and I'd have to cancel it. Or like when we did the early head start, the teacher canceled more often than not. So, it was like constantly trying to find a time to reschedule that worked for both parties was always a struggle.
>
> - Title V Recipient

Lack of Information and Misperceptions About Services

Participants reported not knowing about the family support programs available in their area and a general misperception that all family support agencies are associated with DHS. The lack of information about the services provided by family support programs influenced participants interest in enrolling. Several participants had very strong negative views of family support services and did not differentiate direct family support services provided by family support agencies from DHS services associated with child maltreatment. These misperceptions resulted in disinterest in participation in a family support program.

> When I think about DHS coming into my home, it's nothing ever good.
>
> - Title V Recipient

Participants discussed several barriers to enrollment that were impacted by their understanding of services and access to services. One participant reported, despite wanting to enroll in family support services and having a child that would qualify, she did not receive any family support program information during her son's hospitalization.

> When my son was in the PICU at first, and then moved into the NICU, nobody offered me anything.
>
> - Title V Recipient

Several participants acknowledged not knowing anything about available services. In addition to confusion between family support programs and DHS, several participants assumed that children had to have some type of specific medical or developmental need to receive services.

> From my point of view, my child doesn't have any issues that a lot of other kids do. So, I would feel like we were taking services away from somebody else that needed it. I would fall into that category that I don't need services.
>
> - Title V Recipient

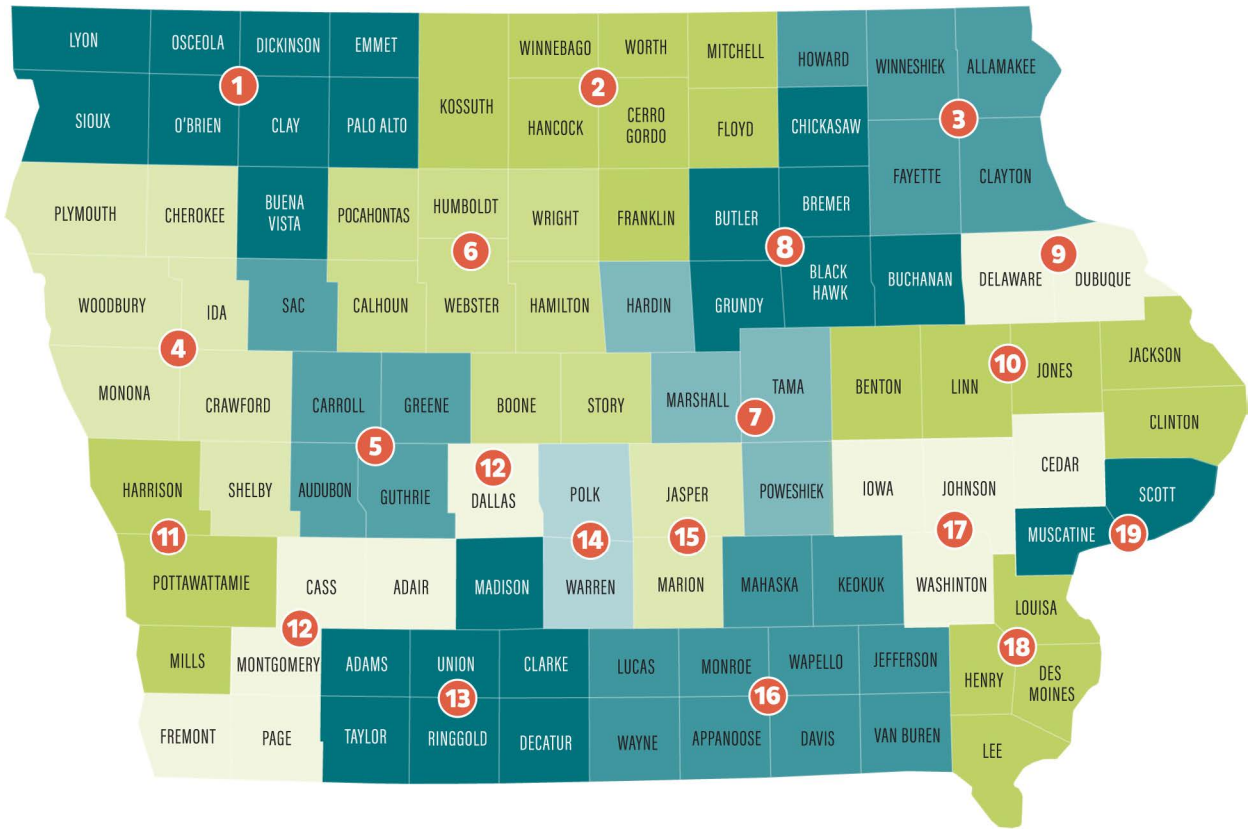
Recommendations

Participants reported the need for more widespread information and access to details of the services programs offer to families in their community. One participant suggested weekly newspaper advertisements and others said having information more readily available in places that families frequently go would help to spread information about the programs to more community members.

> It would be really great if I either got an email or a letter that just briefly described the program with a link to the ".gov" website or "Iowa.org" website that went to it. I don't need mailing packets. I would like to get a letter that tells me where in the state I could go to find it. Whether I can go to my local DHS office and get a packet, or I could go online and look through the list of services.
>
> - Title V Recipient

Appendix H. Integrated Provider Network (IPN) Contractors

Integrated Provider Network (IPN) Service Area Map
Contractors for Substance Use and Problem Gambling Services



The IPN contractors (providers) are funded by IDPH to provide substance use and problem gambling services to eligible Iowans. For more information about the providers listed, click on the provider name or call the phone numbers listed. For more information about other treatment and prevention programs, visit https://yourlifeiowa.org/finder.

January 2020

Table H.1. IPN Contractors for Substance Use and Problem Gambling Services

Service Area	Contractors/Providers	Additional Specialized Treatment Statewide Services*	Counties
1	**Jackson Recovery Centers, Inc., Spencer Phone: 800-472-9018**	n/a	Lyon, Osceola, Dickinson, Emmet, Sioux, O'Brien, Clay, Palo Alto, Buena Vista
2	**Prairie Ridge Integrated Behavioral Healthcare, Mason City Phone: 866-429-2391**	1	Kossuth, Winnebago, Hancock, Worth, Cerro Gordo, Franklin, Mitchell, Floyd
3	**Northeast Iowa Behavioral Health, Decorah Phone: 800-400-8923**	4	Howard, Winneshiek, Allamakee, Fayette, Clayton
4	**Jackson Recovery Centers, Inc., Sioux City Phone: 800-472-9018**	1,2,3	Plymouth, Cherokee, Woodbury, Ida, Monona, Crawford, Shelby
5	**Jackson Recovery Centers, Inc.,Sioux City Phone: 800-472-9018**	1,2,3	Sac, Carroll, Greene, Audubon, Guthrie
6	**Community and Family Resources (CFR), Fort Dodge Phone: 866-801-0085**	1,2,4	Pocahontas, Humboldt, Wright, Calhaun, Webster, Hamiliton, Boone, Story
7	**Substance Abuse Treatment Unit of Central Iowa, Marshalltown, Phone: 641-752-5421**	n/a	Hardin, Marshall, Tama, Poweshiek
8	**Pathways Behavioral Services, Inc., Waterloo Phone: 319-235-6571**	1,4	Butler, Grundy, Chickasaw, Bremer, Black Hawk, Buchanan
9	**Substance Abuse Services Center (SASC), Dubuque Phone: 563-582-3784**	n/a	Delaware, Dubuque
10	**Area Substance Abuse Council, Inc. (ASAC), Cedar Rapids, Phone: 319-390-4611**	1, 2, 3, 4	Benton, Linn, Jones, Jackson, Clinton
11	**Heartland Family Service, Council Bluffs Phone: 712-322-1407**	1, 3	Harrison, Pottawattamie, Mils
12	**Zion Recovery Services, Inc., Atlantic, Phone: 712-243-5091**	1	Fremont, Page, Montgomery, Cass, Adair, Dallas
13	**Crossroads Behavioral Health Services, Creston Phone: 641-782-8457**	4	Madison, Adams, Union, Clarke, Taylor, Ringgold, Decatur
14	**Broadlawns Medical Center, Des Moines, Phone: 515-282-6610**	n/a	Polk, Warren
14	**House of Mercy, Des Moines, Phone: 515-643-6500**	1,3	Polk, Warren
14	**Prelude Behavioral Services, Des Moines, Phone: 515-262-0349**	1	Polk, Warren
14	**UCS Healthcare, Des Moines, Phone: 515-280-3860**	4	Polk, Warren
15	**House of Mercy, Newton, Phone: 641-792-0717**	n/a	Jasper, Marion
15	**UCS Healthcare, Knoxville, Phone: 515-280 -3860**	n/a	Jasper, Marion
16	**Southern Iowa Economic Development Association (SIEDA), Ottumwa, Phone: 800-622-8340**	4	Lucas, Wayne, Monroe, Appanoose, Mahaska, Keokuk, Wapello, Davis, Jefferson, Van Buren

Service Area	Contractors/Providers	Additional Specialized Treatment Statewide Services*	Counties
17	**Prelude Behavioral Services, Iowa City, Phone: 319-351-4357**	1	Iowa, Johnson, Cedar, Washington
18	**Alcohol & Drug Dependency Services (ADDS), Burlington, Phone: 319-753-6567**	1,4	Henry, Louisa, Des Moines, Lee
19	**Center for Alcohol & Drug Services, Inc. (CADS), Davenport, Phone: 563-322-2667**	1	Muscatine, Scott
19	**Robert Young Center, Muscatine, Phone: 563-264-9409**	4	Muscatine, Scott

**Additional Specialized Treatment Statewide Services offered: (1) Adult Residential Treatment, (2) Juvenile Residential Treatment, (3) Women and Children Treatment, (4) Methadone Treatment*

Appendix i. State Licensed Providers

Table i.1. State Licensed Substance Use Disorder Treatment and Problem Gambling Providers by County

County Served	Facility Name	Facility Address	Phone/Fax Number
Appanoose	Community Health Center of Southern Iowa Behavioral Health Services	221 E State Street Centerville, 52544	641-856-6471 (ph) 641-856-2603 (fax)
Benton	Silver Lining Evaluations	185 4th Street S PO Box 114 Walford, 52351	319-241-2230 (ph)
Black Hawk	Access Evaluations and Education	1903 West Ridgeway Avenue Waterloo, 50701	319-252-4631 (ph)
Black Hawk	Allen Recovery Center	1825 Logan Avenue Waterloo, 50703	319-235-3550 (ph) 319-235-3642 (fax)
Black Hawk	Horizons Family Centered Recovery Program Covenant Medical Center	3421 W 9th Street Waterloo, 50702	319-272-8560 (ph) 319-272-2919 (fax)
Black Hawk	Pathways Behavioral Services, Inc.	3362 University Avenue Waterloo, 50701	319-235-6571 (ph) 319-235-6028 (fax)
Bremer	North Iowa Counseling, LLC	506 E Bremer Avenue PO Box 102 Waverly, 50677	319-559-1065 (ph)
Carroll	Manning Family Recovery Center	410 Main Street Manning, 51455	712-655-2300 (ph) 712-655-8241 (fax)
Carroll	New Opportunities, Inc.	23751 Hwy 30 East PO Box 427 Carroll, 51401	712-792-9266 (ph) 712-792-1457 (fax)
Cass	Zion Recovery Services, Inc.	2307 S Olive Street Atlantic, 50022	712-243-5091 (ph)
Cerro Gordo	Mercy Medical Center – North Iowa Mental Health Unit	1000 4th Street SW Mercy Medical Center 5 South Mason City, 50401	641-428-1037 (ph) 641-428-7518 (fax)
Cerro Gordo	Prairie Ridge Integrated Behavioral Healthcare	320 N Eisenhower Avenue, PO Box 1338 Mason City, 50402	866-429-2391 (ph)
Clay	Northwest Iowa Mental Health Center d/b/a Seasons Center for Behavioral Health	201 E 11th Street Spencer, 51301	800-242-5101 (ph) 712-262-3826 (fax)
Clayton	Substance Abuse Services for Clayton County	600 Gunder Road NE Ste 7 Elkader, 52043	563-245-1546 (ph) 563-245-1612 (fax)
Dallas	Assessment Services, Inc.	6150 Village View Drive #102 West Des Moines, 50266	515-327-7036 (ph) 515-875-4895 (fax)
Dallas	Choices Therapy Services, LLC	2829 Buena Vista Drive Clive, 50325	641-745-0499 (ph) 515-987-2390 (fax)
Dallas	Woodward Academy Woodward Youth Corporation	1251 334th Street Woodward, 50276	515-438-3481 (ph)
Delaware	Substance Abuse Services Center (SASC)	909 W Main Ste 1 Manchester, 52057	563-927-5112 (ph) 563-927-3340 (fax)
Des Moines	Adult and Adolescent Substance Abuse Program (ASAP)	400 S Broadway Burlington, 52601	319-752-4000 (ph) 319-758-6650 (fax)
Des Moines	Alcohol and Drug Dependency Services of SE Iowa (ADDS)	1340 Mt Pleasant Street Burlington, 52601	319-753-6567 (ph) 319-753-0703 (fax)
Dickinson	Shade of The Tree	900 Lake Street Spirit Lake, 51360	712-330-9140 (ph) 712-336-9492 (fax)
Dubuque	Hillcrest Community Mental Health	2005 Asbury Road Dubuque, 52001	563-583-7026 (ph) 563-583-7029 (fax)
Dubuque	Mercy Health Center – Turning Point	250 Mercy Drive Dubuque, 52001	563-589-8290 (ph) 563-589-8297 (fax)
Dubuque	Substance Abuse Services Center (SASC)	Nesler Centre 799 Main Street Dubuque, 52001	563-582-3784 (ph) 563-582-4006 (fax)

County Served	Facility Name	Facility Address	Phone/Fax Number
Emmet	Champion State of Mind, PLLC	1820 E Central Avenue PO Box 36 Estherville, 51334	800-592-0180 (ph)
Guthrie	St. Gregory Recovery Center	601 2nd Street Bayard, 50029	515-326-5650 (ph) 631-410-1394 (fax)
Hardin	Central Iowa Detention Evaluation Program	2317 Rick Collins Way Eldora, 50627	641-858-3852 (ph) 641-858-5839 (fax)
Jasper	Capstone Behavioral Healthcare	306 N Third Avenue East Newton, 50208	641-792-4012 (ph) 641-791-0697 (fax)
Jasper	Clearview Recovery, Inc.	501 N Sherman Prairie City, 50228	515-994-3562 (ph) 515-994-3564 (fax)
Jasper	House of Mercy	200 N 8th Avenue E, Newton 50208	641-792-0717 (ph)
Jasper	Integrated Treatment Services, LLC	303 S 2nd Avenue W Newton, 50208	641-275-7533 (ph) 641-792-6251 (fax)
Johnson	Acceptance Recovery Counseling	595 Ashley Court Ste 7 North Liberty, 52317	319-621-2587 (ph)
Johnson	Prelude Behavioral Services	430 Southgate Avenue Iowa City, 52240	319-351-4357 (ph) 319-341-0085 (fax)
Johnson	Resolutions Substance Abuse Services	2030 Keokuk Street Iowa City, 52240	319-351-9760 (ph) 319-331-0994 (fax)
Johnson	University of Iowa Hospitals and Clinics Chemical Dependency Services	200 Hawkins Drive Iowa City, 52242	319-384-8765 (ph)
Linn	A New Leaf – Mental Health & Wellness Center	5925 Council Street NE Ste 117 Cedar Rapids, 52302	319-423-0919 (ph)
Linn	Abbe Center for Community Mental Health	520 11th Street NW Cedar Rapids, 52405	319-398-3562 (ph) 319-398-3501 (fax)
Linn	ANCHOR Center Outpatient Services	Judicial District Department of Correctional Services, 951 29th Ave SW, Cedar Rapids 52404	319-398-3675 (ph) 319-297-3533 (fax)
Linn	Area Substance Abuse Council (ASAC)	3601 16th Avenue SW Cedar Rapids, 52404	319-390-4611(ph) 319-390-4381(fax)
Linn	Cedar Rapids Treatment Center/CRC Recovery Inc.	5005 Bowling Street SW Ste. C Cedar Rapids, 52404	319-531-3824 (ph) 319-531-3840 (fax)
Linn	Mercy Medical Center – Sedlacek Unit	5975 Rockwell Drive NE Cedar Rapids, 52402	319-398-6226 (ph) 319-369-4479 (fax)
Linn	Still Waters Recovery Counseling & Wellness Services	1120 Depot Lane SE Ste 100 Cedar Rapids, 52401	319-350-9444 (ph)
Linn	UnityPoint Health/St. Luke's Methodist Hospital	1030 Fifth Avenue SE Suite 110 Cedar Rapids, 52403	319-363-4429 (ph)
Lucas	Addiction and Recovery Services, LLC	929 Braden Avenue Chariton, 50049	641-217-8264 (ph)
Lucas	Addiction Recovery Center	410 E Robinson Knoxville, 50138	641-842-2813 (ph) 641-842-2632 (fax)
Madison	Turning Point Evaluations, Inc.	113 N John Wayne Drive Winterset, 50237	515-462-5967 (ph) 515-462-5981 (fax)
Marion	Keys to Success	1402 Washington Street Pella, 50219	641-780-1087 (ph)
Marion	Pine Rest Christian Mental Health Services	2611 Washington Street Pella, 50219	641-628-9599 (ph) 641-621-1493 (fax)
Marshall	Substance Abuse Treatment Unit of Central Iowa (SATUCI)	9 North 4th Avenue PO Box 1453 Marshalltown, 50158	641-752-5421 (ph) 641-752-7211 (fax)
Muscatine	Robert Young Center for Community Mental Health	1605 Cedar Street Muscatine, 52761	563-264-9409 (ph)

County Served	Facility Name	Facility Address	Phone/Fax Number
Page	Clarinda Academy	1820 N 16th Street Clarinda, 51632	712-542-3103 (ph) 712-542-2907 (fax)
Plymouth	Plains Area Mental Health Center	180 10th Street SE Ste 201 PO Box 70 Le Mars, 51031	712-546-4624 (ph) 712-546-9395 (fax)
Polk	Alternative Interventions, LLC	3116 Ingersoll Ste 4 Des Moines, 50312	515-778-7989 (ph) 515-987-0884 (fax)
Polk	Avery Comprehensive Services (ACS)	309 Court Avenue Ste 218 Des Moines, 50309	515-875-4880 (ph) 515-875-4881 (fax)
Polk	Bridges of Iowa	1211 Vine Street West Des Moines, 50265	515-414-8049 (ph) 515-209-7081 (fax)
Polk	Broadlawns Medical Center New Connections	1801 Hickman Road Des Moines, 50314	515-282-6610 (ph) 515-282-6620 (fax)
Polk	Center for Behavioral Health Iowa, Inc. (CBH)	1200 University Avenue Ste 106 Des Moines, 50314	515-244-9500 (ph) 515-244-9502 (fax)
Polk	Center for Interpersonal Effectiveness, PC	2525 N Ankeny Boulevard Ste 113 Ankeny, 50023	515-289-9136 (ph) 515-289-9139 (fax)
Polk	Children and Families of Iowa	1111 University Avenue Des Moines, 50314	515-289-2272 (ph)
Polk	Children and Families of Iowa	2331 E 8th Street Des Moines, 50316	515-289-2272 (ph)
Polk	Covert Action	1223 Center Street Ste 22 Des Moines, 50309	515-218-6125 (ph) 515-265-0845 (fax)
Polk	Employee & Family Resources (EFR)	505 5th Avenue Ste 600 Insurance Exchange Bldg, Des Moines, 50309	515-243-4200 (ph) 515-284-5201 (fax)
Polk	Everest Institute, LLC	2500 82nd Place Urbandale, 50322	515-418-7735 (ph) 515-412-5123 (fax)
Polk	Eyerly Ball Community Mental Health Center	1301 Center Street Des Moines, 50309	515-243-5181 (ph) 515-243-2760 (fax)
Polk	Fifth Judicial District Substance Abuse Programs	1000 Washington Avenue Des Moines, 50315	515-242-6600 (ph) 515-242-6656 (fax)
Polk	Fifth Judicial District Substance Abuse Programs - Men's Facility	68 Thayer Street Des Moines, 50315	515-242-6987 (ph) 515-242-6961 (fax)
Polk	Fifth Judicial District Substance Abuse Programs - Women's Facility	1917 Hickman Road Des Moines, 50314	515-242-6325 (ph) 515-242-6328 (fax)
Polk	House of Mercy	1409 Clark Street Des Moines, 50314	515-643-6500 (ph) 515-643-6598 (fax)
Polk	Infinity Assessment &Therapy Services, LLC	100 E Euclid Avenue Ste 131 Des Moines, 50313	515-423-1049 (ph)
Polk	Lloyd's Counseling, Inc.	3832 ½ Douglas Avenue Des Moines, 50310	515-277-2205 (ph) 515-277-2181 (fax)
Polk	Mercy First Step Recovery Center	1750 48th Street Des Moines, 50310	515-271-6075 (ph) 515-271-6060 (fax)
Polk	New Beginnings Counseling Services	6200 Aurora Avenue #102E Urbandale, 52101	515-401-6886 (ph)
Polk	New Sight, Inc.	2340 Euclid Avenue Des Moines, 50310	515-263-0019 (ph) 515-263-0048 (fax)
Polk	Orchard Place Child Guidance Center	925 SW Porter Avenue Des Moines, 50315-0304	515-285-6781 (ph) 515-287-9695 (fax)
Polk	Orchard Place PACE Juvenile Justice Center	620 8th Street Des Moines, 50309	515-697-5700 (ph) 515-697-5701 (fax)
Polk	Powell Chemical Dependency Program	Iowa Lutheran Hospital 700 E University 4th Fl Des Moines, 50316	515-263-2424 (ph) 515-263-2463 (fax)
Polk	Prelude Behavioral Services	3451 Easton Boulevard Des Moines, 50317	515-262-0349 (ph)
Polk	Sober Strategies	2655 100th Street Urbandale, 50322	515-508-0961 (ph)

County Served	Facility Name	Facility Address	Phone/Fax Number
Polk	UCS Healthcare	4908 Franklin Avenue Des Moines, 50310	515-280-3860 (ph)
Polk	Urban Dreams -- S.A.F.E.	1410 6th Avenue Des Moines, 50314	515-288-4742 (ph)
Pottawattamie	Alegent Health, Mercy Hospital	801 Harmony Suite 302 Council Bluffs, 51503	712-328-2609 (ph) 712-328-9257 (fax)
Pottawattamie	Heartland Family Service	515 E Broadway Council Bluffs, 51503	712-322-1407 (ph) 800-422-1407 (ph)
Pottawattamie	Heartland Family Service - Family Service Chemical Dependency Program	2101 S 42nd Street Omaha, NE 68144	402-553-3000 (ph) 402-553-3133 (fax)
Pottawattamie	Heartland Family Service - Iowa Family Works Residential Treatment for Women with Children	1722 Avenue C Council Bluffs, 51503	712-322-1407 (ph) 800-422-1407 (ph)
Scott	Center for Alcohol & Drug Services, Inc. (CADS)	1523 S Fairmount Street PO Box 3278 Davenport, 52802	563-322-2667 (ph) 563-322-3671 (fax)
Scott	QC Family Counseling OWI Program	2485 Tech Drive Bettendorf, 52722	563-355-1611 (ph) 563-355-6617 (fax)
Scott	Rosecrance New Life Outpatient	2322 E Kimberly Road Paul Revere Square Davenport, 52807	563-355-0055 (ph) 563-355-0101 (fax)
Scott	The Abbey, LLC	1401 Central Avenue Bettendorf, 52722	563-355-4707 (ph) 563-355-7647 (fax)
Shelby	Myrtue Medical Center Behavioral Health Department	1303 Garfield Avenue Harlan, 51537	712-755-5056 (ph) 712-755-7143 (fax)
Story	Central Iowa Psychological Services	223 S Walnut Avenue Ames, 50010	515-233-1122 (ph) 515-233-6500 (fax)
Story	Creative Counseling & Intervention Services	214 5th Street Ames, 50010	515-233-1699 (ph) 515-233-2957 (fax)
Story	New Journey Addiction Counseling	208 5th Street Ste 150 Ames, 50010	515-232-1977 (ph)
Story	Youth & Shelter Services, Inc. (YSS)	420 Kellogg Avenue Box 1628 Ames, 50010	515-233-3141 (ph)
Union	Crossroads Behavioral Health Services	1003 Cottonwood Road Creston, 50801	641-782-8457 (ph) 641-782-7048 (fax)
Wapello	First Resources Corporation Treatment and Recovery Services	102 N Hancock Street Ottumwa, 52501	641-682-2800 (ph) 641-682-2826 (fax)
Wapello	Southern Iowa Economic Development Association (SIEDA) Community Action	310 West Main Street PO Box 658 Ottumwa, 52501	800-683-6317 (ph)
Wapello	Southern Iowa Mental Health Center	1527 Albia Road Ottumwa, 52501	641-682-8972 (ph)
Webster	Community and Family Resources (CFR)	726 S 17th Street Fort Dodge, 50501	866-801-0085 (ph) 515-955-7628 (fax)
Webster	YWCA of Fort Dodge	826 1st Avenue N Fort Dodge, 50501	515-573-3931 (ph)
Webster	Children and Families of Iowa	111 Avenue O West Fort Dodge, 50501	515-289-2272 (ph)
Winneshiek	NE Iowa Behavioral Health (NEIBH)	905 Montgomery Street PO Box 349 Decorah, 52101	800-400-8923 (ph)
Woodbury	Family Wellness Associates	1115 5th Street Sioux City, 51101	712-255-0890 (ph) 712-276-6040 (fax)
Woodbury	Jackson Recovery Centers	800 5th Street, Ste 200 Sioux City, 51101	712-234-2300 (ph) 712-234-2398 (fax)
Woodbury	Kulawik Counseling Services	505 5th Street, Ste 520 Sioux City, 51101	712-277-2007 (ph)
Woodbury	Kulawik Counseling Services	822 Douglas Street Ste 201 Sioux City, 51101	402-681-5000 (ph)
Woodbury	Siouxland Counseling Services	409 11th Street Sioux City, 51105	712-522-0947 (ph) 855-864-6105 (fax)
Woodbury	Transitional Services of Iowa, Inc.	1221 Pierce Street Sioux City, 51101	712-255-0204 (ph) 712-255-1120 (fax)

Appendix J. Comparison of High Need Counties

Table J.1: Comparison of High Need Counties from 2010 to 2020

County	Overall Rank 2020	Overall Rank 2010	Change
Appanoose	1	5	higher
Des Moines	2	10	higher
Lee	3	8	higher
Clinton	4	3	lower
Montgomery	5	17	higher
Wapello	6	6	no change
Woodbury	7	4	lower
Pottawattamie	8	1	lower
Marshall	9	13	higher
Black Hawk	10	2	lower
Floyd	11	20	higher
Jefferson	12	16	higher
Webster	13	12	lower
Wright	14	*	higher
Muscatine	15	15	no change
Scott	16	7	lower
Fremont	17	*	higher
Cerro Gordo	18	11	lower
Page	19	14	lower
Buena Vista	20	9	lower
Clarke	21	19	lower
Emmet	22	18	lower
Monona	23	22	lower
Tama	24	*	higher
Fayette	25	21	lower
Osceola	26	*	higher

* These counties were not identified as high need in the 2010 Iowa MIECHV Needs Assessment

2024 Addendum

to the 2020 MIECHV Needs Assessment

In an effort to prepare for potential MIECHV expansion, the Iowa Department of Public Health (Iowa) felt it prudent to update and review the 2020 MIECHV Needs Assessment. Officials were concerned that the Pandemic may have negatively impacted some communities at a disproportionate rate. A secondary reason was to determine the top 50 at risk counties in Iowa. In previous needs assessments, Iowa has focused solely on the top 25 at risk communities for MIECHV services. Expansion funding provides the state with the opportunity to look deeper and reach beyond the top 25 at risk communities.

Iowa contracted with the Integrated Data Systems for Decision-Making (I2D2) team at Iowa State University who assisted in the development of the 2020 Needs Assessment. The update was limited in scope to only the appendices that examine risk factors present in each community (defined as county) as well as ranking risk across all 99 counties. The scope was further limited to only updating available data to 2020 or newer data. If no newer data was available than the data used in the 2020 Needs Assessment was left unmodified.

The methodology used for ranking risk levels of each community remained unchanged. The data points identified in the 2020 Needs Assessment also remained unchanged. Although this was a very minor update to the 2020 Needs Assessment, the rankings have shifted post pandemic.

There are no apparent patterns to why some communities moved up in risk and others decreased in risk. There is no distinct correlation between rural versus urban status. There are new population centers that are in the top 50 at risk communities. There is no clustering of increased or decreased risk in a single geographic location.

Table 1: Four of Iowa's five most populated counties are in the top 50 most at-risk communities in Iowa

County	2024 Population	0-5 Population	% of the 0-5 statewide population	Growth Since 2010	2020 Risk Ranking	2024 Revised Risk Ranking
Polk	517,105	33,723	17%	20.08%	43	40
Linn	237,927	13,945	7%	12.64%	43	37
Scott[1]	178,445	11,259	6%	8%	20	27
Black Hawk[1]	131,164	8,412	4%	.06%	14	8
Statewide	3,193,000	196,485	35%			

[1]*Existing MIECHV community*

Four of Iowa's top five population centers are all identified as at risk communities. All but Johnson are considered in the top 50 most at risk communities. Johnson is home of the University of Iowa and the University of Iowa's Hospital and Clinics which results in a more highly educated populace with a higher than the state average income. Together these four communities represent 35% of the child (0-5) population in Iowa. It would be easy to put more expansion funds in these communities however Iowa has a long history of balancing the needs of rural communities with urban population centers.

Iowa has 25 counties with populations of fewer than 10,000 people. Iowa has found it very challenging to implement an evidence-based home visiting model in a small, rural county that is relatively isolated. There are multiple barriers:

- Lack of available workforce
- Lack of available local implementing agencies for implementation
- Lack of experience with the model at both the implementing agency (LIA) and with community partners.
- Referrals sources (including self-referrals) are made when the program and the LIA is well known, respected and trusted. New programs take years to fully implement.

Where Iowa has experienced success, is by clustering counties into one geographic service area for implementation. Infrastructure and supervision can be provided in a multi-county area successfully. Home visitors must be local or have a manageable service area. Too large of a service area leads to the inability to form trusting relationships with referral partners and the ability to be flexible when scheduling home visits. The presence or visibility of the home visitor is critical in a rural community.

When reviewing the new rankings, some natural clusters of counties do emerge in many parts of the state. There are some communities that remain isolated and therefore difficult to implement a MIECHV funded home visiting program. Some communities such as Polk, Linn and Dubuque are large enough to support a single county approach to MIECHV if they are chosen for expansion.

Table 2: Potential Clusters for a Regional Infrastructure Approach for MIECHV

Region	Rural (R)/Urban (U)	Counties in Geographic Area	Experience with Evidence-based Home Visiting Models	Current MIECHV site?
SW Iowa	R/U	Fremont, Page, Pottawattamie, Cass, Harrison, Monona	PAT, HFA, NFP	Yes (partial)
SW Iowa	Rural	Adair, Clarke, Decatur, Union, Ringgold, Taylor	PAT	No
SE Iowa	R/U	Appanoose, Lucas, Jefferson, Mahaska, Monroe, Wapello	HFA, PAT	Yes (partial)
SE Iowa	Rural	Des Moines, Henry, Lee, Louisa, Van Buren	HFA, PAT in some areas	Yes (partial)
Central	R/U	Hardin, Marshall, Jasper, Tama	HFA, PAT	Yes (partial)
Eastern	R/U	Clinton, Muscatine, Scott	HFA, NFP	Yes
North Central	R/U	Hamilton, Humboldt, Pocahontas, Webster, Wright	HFA, PAT in some areas	Yes (partial)
North Central	R/U	Cerro Gordo, Floyd, Franklin	HFA in some areas	Yes (partial)
NE Iowa	R/U	Black Hawk, Fayette	HFA, PAT in some areas	Yes (partial)

All of Iowa's current MIECHV communities are still in the top 50 most at risk community rankings. There are no current plans to discontinue services in any current MIECHV community. Annually Iowa submits an application for MIECHV formula grant funding to HRSA. Iowa utilizes that opportunity to make any adjustments in planned family capacity based on capacity trends and historical data. Iowa anticipates that shifts in planned family capacity may occur in the future.

Table 3: Current MIECHV Communities Risk Rankings 2020 – 2024

County	2020 Risk Ranking	2024 Risk Ranking	Change
Appanoose	10	12	Declined
Black Hawk	14	8	Increased
Cerro Gordo	15	17	Declined
Clinton	7	14	Declined
Des Moines	4	5	Declined
Fremont	8	26	Declined
Jefferson	23	22	Increased
Lee	2	3	Declined
Marshall	12	9	Increased
Montgomery	1	6	Declined
Muscatine	15	15	No Change
Page	9	10	Declined
Pottawattamie	5	7	Declined
Scott	20	27	Declined
Wapello	2	1	Increased
Webster	11	4	Increased
Woodbury	5	2	Increased

As mentioned earlier, Iowa proposes to identify the top 50 at risk communities in Iowa as eligible for MIECHV funding. Identification as eligible does not constitute any implied promise of future funding awards. Actual determinations will be made by the MIECHV advisory committee after analysis of existing services to fully understand unmet needs. Expansion will be phased in based on community readiness, unmet need, and available funding. All funding awards are based on the results of a competitive request for proposals process that is required by the state of Iowa.

Table Four: Iowa's At Risk Communities

County	Risk Ranking
Wapello	1
Woodbury	2
Lee	3
Webster	4
Des Moines	5
Montgomery	6
Pottawattamie	7
Black Hawk	8
Marshall	9
Emmet	10
Page	10
Appanoose	12
Wright	13
Clinton	14
Muscatine	15
Cass	17
Cerro Gordo	17
Union	17
Hamilton	19
Buena Vista	20
Clarke	20
Jefferson	22
Crawford	23
Decatur	23
Franklin	25

County	Risk Ranking
Fremont	26
Scott	27
Henry	28
Monona	28
Louisa	30
Tama	31
Jasper	32
Lucas	33
Fayette	34
Van Buren	35
Floyd	36
Linn	37
Adair	38
Taylor	38
Polk	40
Mahaska	41
Allamakee	42
Dubuque	43
Pocahontas	44
Ringgold	44
Humboldt	46
Monroe	47
Hardin	48
Harrison	49
Ida	49

Please see the attached updated appendices, which includes indicators, indicator sources, methodology, risk rankings and comparison from 2020 to 2023-24. For a comprehensive review of Iowa's Needs Assessment the complete 2020 Iowa MIECHV Needs Assessment may be found at: **hhs.iowa.gov/media/10179/download?inline**=