Maternal and Child Health Services Title V Block Grant

Iowa

FY 2025 Application/ FY 2023 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

IOWA | Health and Human Services

Shirley Payne, PhD, MPH, Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Service Administration
Room 18-31, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

RE: Title V Maternal and Child Health (MCH) Block Grant

Application for FFY2025 and Annual Report for FFY2023

Dear Ms. Payne:

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

Thank you.

Sincerely,

Erin Drinnin

Erin Drinnin

Director, Community Access and Eligibility Division

Iowa Department of Health and Human Services

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

Assessment of needs, program planning, and performance reporting

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

Beginning in FFY23, Iowa HHS transitioned to Collaborative Service Areas (CSAs) to implement the MCH Title V program. The CSAs create standardized services areas and were designed to ensure a collaborative approach to address the needs of the people who will be receiving services and the infrastructure that enables them to be served, while decreasing fragmentation. The programs included in the CSAs include MCAH, WIC, 1st Five, I-Smile and Title X Family Planning. A full description, including a map, of the CSAs is included in the Overview of the State section of this application.

Population needs and Title V priorities

The 5-year needs assessment cycle guides the development of activities, monitoring, and evaluation. These needs are listed below with descriptions of the corresponding NPMs and SPMs.

Infusing Health Equity within the Title V System

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

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

Access to care for the MCH population

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

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

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

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

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

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

MCAH Systems Coordination

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

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

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

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

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

Explore and research the use of psychosocial assessments provided to adolescents in primary care settings across the state. If gaps in services are identified, Iowa will partner with the Iowa Medicaid Enterprise (IME) to identify billing codes that local Title V agencies can pursue under their purview of their child screening center designation. Monitor the development of the new HHS behavioral health regions to identify connections with Iowa's Title V program in each region.

Dental Delivery Structure of the MCAH Population

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

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

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

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

Safe and Healthy Environments
NPM 5: A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Women who are receiving Title V direct care services will receive safe sleep education based on the mother's needs, taking into account any personal or cultural beliefs the mom or family express, on the following topics: back to sleep, safe sleep environment (crib), no co-sleeping, no extra items in the crib and other recommendations from the AAP and the report from the Child Death Review Team.

SPM 2: Percent of children ages 1 and 2, with a blood lead test in the past year
Local Title V agencies will coordinate blood lead screening with primary care providers, local public health agencies, local Childhood Lead Poisoning Prevention Programs (CLPPPs) and others providing blood lead testing in the community. Educate parents on the importance of blood lead testing at appropriate intervals. Contractors are encouraged to partner with an agency or group serving one of the priority populations to promote blood lead testing in more culturally targeted ways.

SPM 3: Percent of early care and education programs that receive Child Care Nurse Consultant (CCNC) services
Outreach to local early care and education programs regarding the participation in CCNC services. Promote the utilization of CCNCs to provide Health and Safety pre-service/orientation training for child care providers to meet the requirement within the Child Care Development Block Grant.

Access to services, pediatric specialty providers, and care coordination
NPM 11: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.
Child Health Specialty Clinics Regional Centers will continue to provide access to specialty care for CYSHCN and their families, utilizing its existing telehealth infrastructure to increase the number and types of pediatric specialty providers available. Primary care capacity to treat children with complex and/or mental health needs and developmental and intellectual disabilities will be prioritized through provider education opportunities.

Support for making transitions to adulthood
NPM 12: Percent of children with and without special health care needs who receive services necessary to make transitions to adult health care.
Child Health Specialty Clinics Regional Centers will continue to provide gap-filling services to youth with special health care needs. Transition to adulthood resources will be regularly reviewed to ensure that best practices are followed. Transition resources will be enhanced to directly address issues for YSHCN from underrepresented backgrounds.

Support for parenting CYSHCN
SPM 7: Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V
University of Iowa Health Care Division of Child and Community Health will continue to provide support services to Iowa families of CYSHCN, including those with diverse needs. Priority areas will include workforce recruitment and

continuing education for staff on culturally responsive approaches to reduce barriers to family participation in health care. Trainings for families will focus on the development of leadership and advocacy skills among parents of CYSHCN at the individual, community, and policy levels.

Family-Centered Services

Iowa's CYSHCN program leadership includes a full-time Family Partnership Program Manager who works to build the family leadership workforce and assures that the family perspective is represented at all levels of decision-making. Iowa's Title V CYSHCN program includes a Family Advisory Council that meets regularly to provide meaningful input to the planning, development, and evaluation of programs and policies. The CYSHCN program started a Youth Advisory Council in FFY 2021 with emphasis on building youth leadership skills and providing input to the Transition to Adulthood priority area. Each of Iowa's 12 community-based Regional Centers includes at least one member from Iowa's statewide Family Navigator Network to promote the development of family-professional partnerships, provide family support, and ensure that the family voice is heard. In addition, family navigators partner with families in Regional Center Satellite locations serving underserved communities. Family Navigators are paid staff members have experience as primary caregivers of one or more children or youth with special health care needs.

Eliminating Health Inequities

Iowa HHS established the Bureau of Human Rights and Equity as part of the government reorganization in 2023. This bureau has developed initial policies and plans for embedding health equity across internal and external work through accreditation, workforce development, data management, and planning efforts. There are a number of divisions and bureaus that have excelled at developing comprehensive strategies to address health inequities and develop internal strategies to support health equity infrastructure. Iowa HHS is in a position to significantly expand efforts to ensure that all people across the state have the ability to attain their highest level of health. We can accomplish this by explicitly tying a justice-centered approach to identifying and addressing pressing health inequities in historically excluded populations with a specific focus on people of color/indigenous people, people with disabilities, people who identify as LGBTQ+, people who are poor, and people with other demographic characteristics that have been historically excluded from access to opportunities and services to support optimal health.

Iowa has had a long history of participating in the MCH Workforce Development Center cohort programs. Title V staff (including CYSHCN program staff) continue to meet as a continuation of the Accelerating Equity Learning Community (AELC) cohort. The cohort assisted with identifying strategies to ensure family input, particularly families of color. This input will continue to be incorporated into the planning and implementation of Iowa's local Title V structure. Over the last few years the FHB and University of Iowa Division of Child and Community Health have been incrementally increasing internal understanding and capacity to address health equity in programs and services. In 2023, Iowa's Title V program used the Bay Area Regional Health Inequities Initiative (BARHII) to gain an understanding of the internal culture and use of equity. These results are being used to increase the state Title V internal capacity to implement practices and programming that address health inequities, moving from a working knowledge of Health Equity, to the ability to embed equity within all the programs in the Bureau, University of Iowa Health Care Division of Child and Community Health, and Title V in FFY25 and beyond.

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

Within the FHB the Title V Block Grant is the backbone of all programs. The Family Health Bureau is organized within three sections: Reproductive Health, Child & Adolescent Health and Oral Health. Examples of programs under each section include: Early ACCESS, 1st Five, Early Childhood Iowa, Title X Family Planning, Personal Responsibility Education Program, Sexual Risk Avoidance Education Program, Pregnancy Risk Assessment Monitoring System, Hawki Outreach, and EPSDT. Each of these programs contribute directly and/or indirectly to the Title V system.

Like the FHB, the Title V Block Grant provides a strong foundation for all of University of Iowa Division of Child and Community Health CYSHCN programs. Through University of Iowa Health Care, Child and Community Health supports the Regional Autism Assistance Program, Family and Professional Partnership activities, the HRSA funded Pediatric Mental Health Access and Innovations in Care Coordination for Children and Youth with ASD grants, the Iowa Family Leadership Training Institute, provider-to-provider education, telehealth support, outreach to underserved communities, and regional center services including family support, care coordination, and medical services. Title V foundational support allows Child and Community Health to maintain infrastructure and build partnerships with other areas of the University of Iowa, local and regional entities, state agencies, and national partners such as the Association of Maternal and Child Health Programs, and the American Academy of Pediatrics.

III.A.3. MCH Success Story

Oral Health: The Fulfilling Iowa's Need for Dentists (FIND) loan repayment program is an initiative that awards loan repayment funds to dentists who agree to practice in underserved counties in Iowa. FIND uses state and private funding and is administered through Delta Dental of Iowa. A workgroup meets regularly to address opportunities to improve recruitment and retention of dentists and includes the Iowa HHS Oral Health Section, Delta Dental of Iowa, Iowa Area Developmental Group, the University of Iowa College of Dentistry, and the Iowa Dental Association.

Taylor County in southwest Iowa had been without a dentist for several years and efforts to change that had not been successful. But a coordinated, public-private approach recently resulted in the opening of a dental office in the town of Lenox. The collaborations began in 2020 and included the Iowa HHS Oral Health Section (who informed Taylor County Health Department – the Title V contractor – about loan repayment opportunities), Taylor County Public Health (who got support from the Lenox Chamber of Commerce and other community members to recruit a dentist), a local businessman (with a building for purchase), Iowa Area Development Group (who knew the businessman and was familiar with grant opportunities to help with constructing a dental office), Delta Dental of Iowa (who worked with a previous loan repayment awardee in southwest Iowa to determine interest in purchasing the building) and the University of Iowa College of Dentistry (who shared a flyer about the town of Lenox with students and identified a dental student that grew up in southwest Iowa that was interested in loan repayment). Fuller Family Dentistry now has a satellite office in Lenox and Dr. Zach Johnson, who grew up in the neighboring county, is seeing patients in the Lenox dental office, on a path to ownership/partnership, and one of the newest recipients of the FIND dental loan repayment award. FIND recipients have a requirement in the award that they must accept Medicaid clients, this is a large deficit across all of Iowa. This partnership will help continue to provide gap filling services to the most vulnerable citizens in SW Iowa.

Maternal Health: In Spring 2023 Iowa HHS began offering Listening Visit trainings for Healthy Pregnancy Program contractors. The trainings were led by Dr. Lisa Segre, professor in the College of Nursing at the University of Iowa who specializes in the identification and treatment of postpartum depression, particularly among impoverished ethnic-minority mothers. Listening visits are a supportive listening intervention developed in the United Kingdom that utilizes nurses and home visitors to provide gap-filling support for women who score between 12 and 19 on the Edinburgh Postnatal Depression Scale, while they await services with a mental health professional. The sessions focus on listening to the issues and concerns a mother is experiencing in her pregnancy or postpartum, and goal setting to address those issues and concerns. Approximately 30 people were trained at the first session that was offered. Between the first training and the end of FFY23, 27 clients enrolled in the Healthy Pregnancy Program received Listening Visits. Follow-up sessions were held for those that were already trained to help support those providing Listening Visits through any issues they may have encountered, and to share successes and lessons learned. Iowa HHS plans to offer two training opportunities in calendar year 2024, this time offering nursing or social work CEUs for those who participate.

III.B. Overview of the State

Principal Demographics and Geography of Iowa

Iowa is a predominantly rural state with approximately 3.2 million people according to the United States Census Bureau. Ten of Iowa's 99 counties have a population of 65,000 or more and make up more than half of Iowa's population, 23 counties have between 20,000 and 64,999 residents, 64 counties have between 5,000-19,999 residents, and two counties have under 5,000 (State Data Center, 2022 population estimates). Based on metropolitan statistical areas (MSA), sixty-one of Iowa's ninety-nine counties are designated as rural, sixteen are designated as micropolitan, and twenty-two counties are designated as metropolitan. With the state's predominantly rural population, a lack of transportation is one of Iowa's most widespread and persistent concerns with regard to access to health services of all types.

Iowa has typically had a healthy economy with an unemployment rate of 2.9% (March 2024, Iowa Workforce Development), which is significantly below the US rate of 3.8%. The unemployment rate during the COVID-19 pandemic rose to 8% (June 2020, Iowa Workforce Development). While agriculture and related industries are the main sources of commerce, advanced manufacturing, biosciences, insurance, and financial services also contribute to Iowa's economy.

Although Iowa's unemployment rate is low, the 2022 American Community Survey reports the percentage of Iowans living below the federal poverty level (FPL) was 11% compared to 9.1% in 2000. Among female headed households, the percent of those living below the FPL level is more than double that of Iowans overall at 23.5% in 2022, compared to 23.4% in 2000. In both metropolitan (14.6%) and micropolitan counties (14.3%), fourteen percent of women ages 18 to 55 live below the FPL. In rural communities, about 12% (12.8%) of women ages 18 to 54 live below the FPL. State-wide, fourteen percent (14.2%) of females ages 18 to 54 live below the FPL. The percent of females ages 18 to 54 without health insurance also varies by MSA. The highest percent of females without health insurance are those living in rural counties (7.5%), followed by females living in micropolitan counties (6.7%). The lowest percent of females ages 18 to 54 without health insurance reside in metropolitan counties (5.6%). State-wide six percent (6.1%) of females ages 18-54 live below the FPL.

Demographic	2022 Data
Population	3,188,836
Median Household Income	$70,571
Low Income Population **(Population in households with incomes below 2-times the U.S. poverty level)**	159,695

Based upon U.S. Census American Community Survey (ACS) 2022 5-year estimate data as of 12/31/2022

In Iowa, the percent of women of reproductive age (WRA) decreased by 0.9% from the year 2000 to 2022. Ninety-one percent (n=91; 91.9%) of Iowa counties reported a decrease in their percent of WRA from 2000-2022. Eight counties reported an increase (7 metropolitan and 1 rural) of their percent of WRA. The percent increase ranged from 3.5% in Sioux County to 150% in Dallas County. During this same time, Iowa has witnessed the closure of over 40 obstetrical (OB) units. Many of these closures were level 1 community facilities with a low volume of annual deliveries (less than 200). There may not be a direct correlation between the OB unit closures and the reduction and shift in the population of WRA. However, HHS continues monitor access to care by levels of rurality.

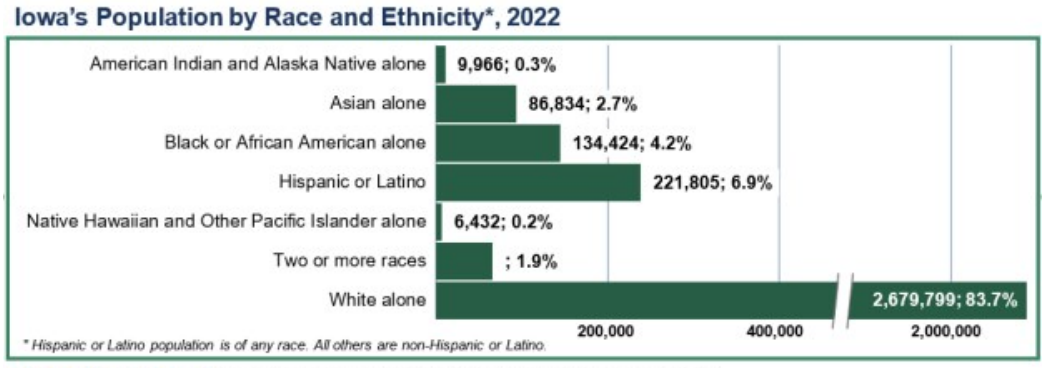
However, state maternal health indicators around health care access and quality have not declined, in spite of the number of closures of L&D units. For example, overall, prenatal care initiation has remained stable over the past 5 years. Staff does note that women living in micropolitan counties compared to those living in metropolitan and urban counties, initiate prenatal care later in their pregnancies. The women of color and those with Medicaid reimbursed births initiate prenatal care later compared to white women and those with private insurance coverage. Accessing

perinatal health care in rural areas is complicated by both patient factors and factors related to the delivery care system itself. Ensuring optimal maternal and neonatal outcomes for rural populations poses unique problems and challenges, including providing basic maternity services to these rural areas. A broad spectrum of provider models, including the use of Certified Nurse Midwives, freestanding birth centers, and the use of additional emotional supports such as doula services, will need to be considered as public health research increasingly supports these options to increase maternal health quality and access, particularly in rural areas and for women of color.

Statewide, 59 counties in Iowa have a Primary Care Health Professional Shortage Area (HPSA). Each Primary Care HPSA also has a Maternal Care Target Area (MCTA). This was added in 2022 to better identify the need and shortage for obstetric services. The total population living in designated HPSAs statewide as of June 2023 is 1,846,164 which is 60% of the total state population.

Overall, Iowa children are in good health. According to the US Census Bureau estimates, 5.8% of Iowa's total population were under the age of five in 2023. The 2023 Kids Count Profile from the Annie E. Casey Foundation, ranks Iowa 6th in the nation in terms of overall child well-being. The report also shows 3% of Iowa children under the age of 18 were uninsured in 2021, this is 2 percentage points below the overall US. In 2022, 12.3% of families with related children under 17 years old were living below the poverty level. According to the combined 2021-2022 National Survey of Children's Health, it is estimated that about 139,000 Iowa children and youth have a special health care need. Access to pediatric specialty health care services remains a challenge for children and youth with special health care needs and their families and many families especially those in more rural areas, need to travel to access services.

Iowa's population reports the following demographics: 83.7% White alone, followed by 6.4% who reported they are two or more races, Black or African American alone comprise 4.2%, Asian alone comprise 2.7%, followed by less than 1% single race each among American Indian and Alaska Natives and Native Hawaiian and other Pacific Islanders. Hispanic or Latino individuals comprise 6.9%. Eliminating disparities in systems such as education, employment, health, income, and other social, economic, and environmental factors will improve overall health in Iowa and increase economic growth.



CDC WONDER Online, Single-Race Population Estimates, U.S. Census Bureau, 2022

Other key demographic data that paint the picture of Iowa includes: in 2022, 28% of families are single parent families. In 2022, the percentage of children in families where the head of household lacks a high school diploma was 8%.

Iowa's MCAH Population

The Family Health Bureau (FHB) Maternal, Child, and Adolescent Health (MCAH) programs promote the health of Iowa's women, mothers, infants, children, youth and adolescents through public and private collaborative efforts. The

FHB contracts with local agencies to serve as the community utility to link individuals and families to care and services in all of Iowa's 99 counties. Agencies eligible to apply to become MCAH providers include private nonprofit and public entities. Most local agencies provide maternal, child, and adolescent health services; however, a small number of agencies provide only maternal health services or only child and adolescent health services, so some counties have two different agencies that work together to ensure that the MCAH population receive services.

Collaborative Service Areas (CSAs)
HHS funds many different activities carried out by local public health, hospitals and community action programs. Several of these areas – WIC, Maternal, Child and Adolescent Health, I-Smile, Title X, and 1st Five – are the focus of an effort to improve health outcomes and enhance program collaboration when providing services.

Previously, in some areas of the state multiple WIC agencies serve a single MCAH agency and vice-versa. There were inconsistencies leading to service issues for program participants. Having multiple service providers/agencies also the competition/switching counties between service areas and programs can negatively impact families who struggle to navigate ongoing changes.

All of the included programs within the new CSA structure have strong desires to improve health outcomes and have identified that in order to meet the needs of clients the programs must pool resources to achieve the goals.

Title V emphasizes the need for evidence-based strategies to address performance measures. WIC emphasizes funding creativity and partnerships. Therefore, the collaboration between these programs, along with the others listed above, will continue to strengthen the evidence-based programming as well as utilizing creativity to achieve the overall goals of the programs.

This was a data-driven process that considered which populations were served by area. Data for the past several years includes:

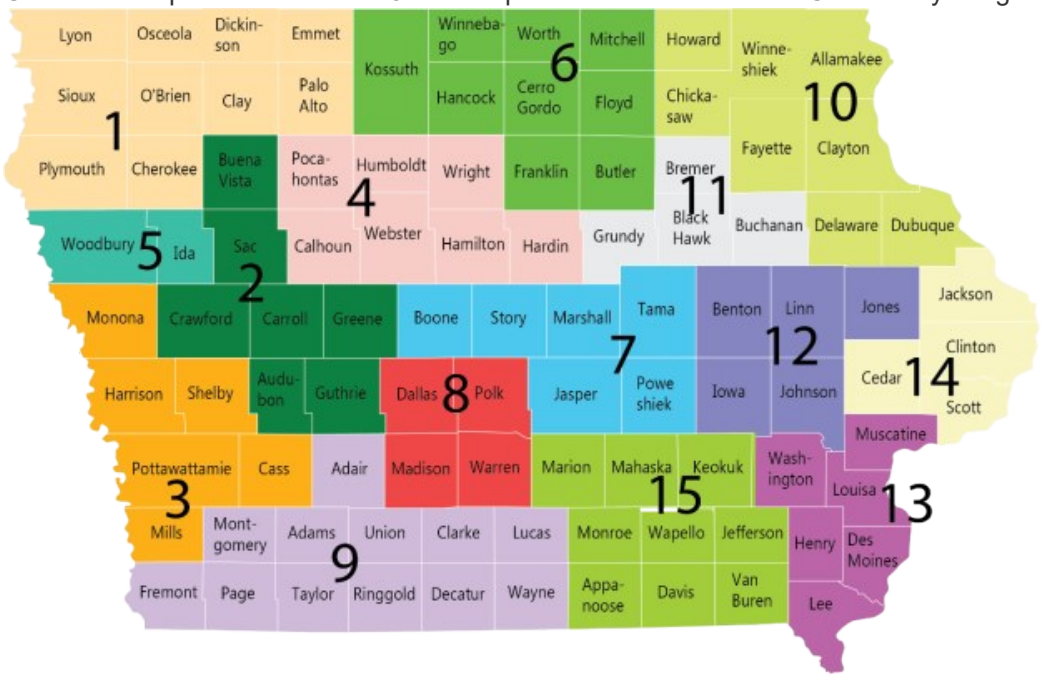
- Population information
- Program utilization information
    - WIC
    - Title V Maternal Health
    - Title V Child and Adolescent Health
    - I-Smile
    - 1st Five
- Medicaid enrollment
- Medicaid births
- Primary care practices

General considerations for all CSAs:

- Goal to keep 0-5 year old population estimate at 7,000 or greater
- No more than 12 counties per CSA to assure the ability to reach all counties each month
- Funding must be adequate to effectively serve the CSA population.
- Most service areas will have competition when applying to be a contractor.
- Maps reviewed to develop the CSA map – Iowa's Public Transit System; Early Childhood Iowa; Mental Health and Disability Service (MHDS) Regions; Iowa Community Action Agencies; Iowa Department of Human

Services; HSS Preparedness Program Service Areas

CSAs were implemented in FFY23. The map below shows the current CSA county assignments by agency:



Women/Maternal/Prenatal/Infant Health:*

In FFY23, 15 local maternal health agencies provided maternal health services to approximately 4,100 low-income pregnant women. A wide range of health education and support services are available to low-income pregnant women, such as risk assessment, psychosocial screening, oral health screening, delivery planning, and presumptive eligibility. The maternal health agencies also provide care coordination to promote early entry into care.

Child and Adolescent Health:*

In FFY23, 14 local child health agencies provided child health services to approximately 78,867 children, ages 0 to 22 years. Through dental care coordination services, the child health programs help families obtain access to dental education and referral through Iowa's I-Smile™ program. Child health agencies may also provide gap filling services, such as immunizations; developmental, nutrition and psychosocial screenings; and laboratory tests including blood lead testing. Child health agencies also provide informing and care coordination services for the Medicaid population.

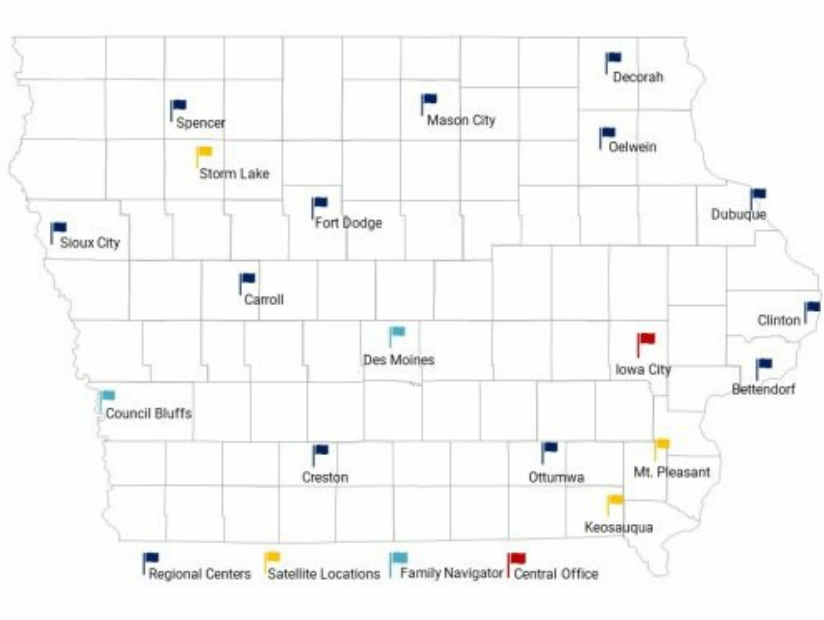
*Service Area maps with local agency information are included in the Attachments.

Children and Youth with Special Health Care Needs:

University of Iowa Health Care Stead Family Department of Pediatrics, Division of Child and Community Health (Child and Community Health) administers Iowa's Title V program for Children and Youth with Special Health Care Needs (CYSHCN), overseeing systems building, enabling, and direct services. Child and Community Health has administrative offices in Iowa City, a network of 12 Child Health Specialty Clinics (CHSC) Regional Centers, 3

satellite locations, and additional family support services across Iowa, employing around 80 public health professionals, clinical providers, and family navigators. Through the Regional Centers, University of Iowa Health Care Division Child and Community Health provides direct clinical care (in-person and via telehealth), care coordination, and family to family support to CYSHCN ages 0–21 and their families. In calendar year 2023, the program provided services and supports to over 7,200 (7212) Iowa CYSHCN and their families.

Child Health Specialty Clinics Regional Center Locations:



The University of Iowa Health Care Division of Child and Community Health vision is to ensure a systems-oriented approach to care for Iowa's children and youth with special health care needs and their families, using the Blueprint for Change Framework, guided by the Standards for Systems of Care for CYSHCN 2.0. The mission is to improve the health, development, and well-being of children and youth with special health care needs in partnership with families, service providers, communities, and policymakers. The current priorities for Iowa's CYSHCN program are 1) access to care, 2) transition to adulthood, and 3) family support. In addition to administering the MCH Title V program for CYSHCN, the University of Iowa Health Care Division of Child and Community Health provides services and supports to Iowa CYSHCN and their families through a number of programs including the Iowa Regional Autism Assistance Program, the Iowa Pediatric Mental Health Care Collaborative, and provides Early ACCESS services as is part of Iowa's Early Intervention program.

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

Access to pediatric specialty care is a challenge for families in Iowa, especially for those with complex medical needs and those living in more rural areas of the state. Most pediatric specialty services are concentrated in only a few of Iowa's 99 counties. According to the 2021-2022 National Survey of Children's Health, over one-third (34%) of children with complex health needs had difficulty or were prevented from receiving specialty health care in the past

year. Iowa ranked in the bottom 20% of states with number of general pediatricians ever certified, aged 70 and under per 100,000 children (American Board of Pediatrics Workforce Data Book, 2017/2018). Iowa has a shortage of developmental specialists to assess, diagnose, and treat CYSHCN including those with Autism Spectrum Disorder and Serious Emotional Disorders.

Iowa currently has seven Home and Community Based Services (HCBS) Waivers that provide funding for services and supports so that individuals who would otherwise require care in a medical institution can live in their own homes and communities. Five of these waivers apply to Iowa CYSHCN: the Health and Disability Waiver, the Intellectual Disability Waiver, the Brain Injury Waiver, the Physical Disability Waiver, and the Children's Mental Health Waiver. Waivers that CYSHCN are eligible for cover about 21,000 Iowans and many of the waivers have long wait lists. University of Iowa Health Care Division of Child and Community Health provides consultation, technical assistance, planning, and care coordination for approximately 715 individuals under the age of 21 with complex and special health care needs who are applying for the Health and Disability (HD) Waiver, are on the waiting list for the HD Waiver, or currently enrolled with the HD Waiver.

Over the past 2 years, HHS has been evaluating and redesigning Iowa Medicaid waiver programs. It is anticipated that when the process is complete, there will be two waiver programs, one for Children and Youth populations, and another for Adult and Aging populations. Eligibility for waiver services will be based on level of care needed, and specific disability categories.

Medicaid In Iowa

In 2016, CMS announced that it approved the launch of IA Health Link (Iowa's Medicaid Modernization initiative). The goals of Medicaid Modernization included improved quality and access, greater accountability for outcomes, and creating a more predictable and sustainable Medicaid budget. Medicaid agencies contract with managed care organizations (MCOs) to provide and pay for health care services.

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

- Wellpoint Iowa, Inc. (formally Amerigroup Iowa, Inc.)
- Iowa Total Care
- Molina Healthcare of Iowa, Inc.

Iowa's Title V program has had a collaborative relationship with Iowa Medicaid Enterprise (IME) for more than 30 years. Medicaid's work with the Title V Maternal, Child, & Adolescent Health program began with a systems change initiative to decrease barriers and assure that pregnant women and children have access to services to which they were entitled. The relationship offered a comprehensive system of care that included outreach, informing newly eligible families of EPSDT services, and care coordination services. Although linkage with established medical and dental homes is a program priority, local Title V contract agencies are also able to bill Medicaid for direct care maternal and EPSDT services through specific provider packages established by Iowa Medicaid. Title V agencies provide EPSDT gap-filling services under Iowa Medicaid's Screening Center provider status, and Title V agencies provide Maternal Health gap-filling services under Medicaid's Maternal Health Center provider status.

The working relationship between Iowa Medicaid and Family Health Bureau programs is solidified each year through a contractual arrangement which is called the Omnibus Agreement. The current Omnibus Agreement is based upon

a collaborative agreement with attachments that address administrative services; EPSDT/MH/OH/1st Five programs; Hawki Outreach; the Healthy Families Line; and a Medicaid match project.

Title V contractors continue to share challenges with billing for direct health care services to the MCOs. Title V staff assist with conversations with the Medicaid Division when the contractors are unable to resolve issues independently.

Iowa Health and Wellness Plan

The Iowa Health and Wellness Plan, Iowa's version of Medicaid expansion, was enacted through bi-partisan legislation to provide comprehensive health care coverage to low income adults. The plan offers coverage to adults age 19-64 with an income up to 133 percent of the Federal Poverty Level (approximately $20,030 for an individual Approximately $27,186 for a family of two (or higher depending on family size). The plan began on January 1, 2014, and currently serves approximately 197,000 Iowans. The Iowa Health and Wellness Plan includes dental services under the Dental Wellness Plan (DWP). Effective July 1, 2017, adult Medicaid members age 19 and older were combined into a single, improved Dental Wellness Program administered by Delta Dental of Iowa and MCNA Dental.

Data Integration

The FHB continues to integrate program data including care coordination, referral management, risk assessment, practice management, billing, and client and population level reporting. The data systems consolidated/integrated to the new system, Iowa Connected (formerly **signify**community).

Development of the new Iowa Connected system was necessary when Signify presented a letter of termination to FHB on September 19th, 2022. In that letter, Signify notified of its intent to sunset the Signify Case Management system on December 31, 2022. At that point numerous discussions took place as to how HHS could replace the entire Case Management system in just over 3 months. Various HHS internal teams along with vendor partners such as AWS and SSG (Strategic Solutions Group) quickly gathered and collaborated on possible resolutions to an overbearing challenge mandated by extremely limited time constraints. Although Signify granted two support extensions (through June 30, 2023) time constraints remained one of the most significant project risks. The new Iowa Connected data system launched June 19, 2023 with minimal issues. Several enhancements have been implemented in the system since launch to make the system more user-friendly and to reduce data entry burden for users.

Public Health Accreditation Board

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

Iowa HHS is currently preparing to apply for reaccreditation in late 2024. In addition to working on reaccreditation, Iowa HHS is available to provide technical assistance to local and Tribal agencies on their accreditation journeys. It is recommended that Iowa's local health departments use the PHAB standards even if not currently seeking accreditation. Use of the PHAB standards will bring more consistency to public health service delivery across our state. Meeting standards and achieved accredited status signifies the role public health plays in assuring a healthy Iowa.

Healthy People 2030 Champion

The Iowa Department of Health and Human Services was designated as a *Healthy People 2030 Champion* by the US Department of Health and Human Service Office of Disease Prevention and Health Promotions. This designation recognizes HSS's commitment to achieve Healthy People's overarching goals and objectives.
HHS programs may use the Healthy People 2030 Champion designation when writing grant applications or for other publications to show HSS's close alignment to the Healthy People 2030 goals of health equity and well-being.

To achieve this designation, HSS met the following eligibility requirements:

- Have a demonstrated interest in, understanding of, and experience with disease prevention, health promotion, social determinants of health, health disparities, health equity, or well-being
- Have an organizational mission that's aligned with the Healthy People 2030 framework or objectives
- Sign a Partnership Agreement and Trademark License with ODPHP that includes details about how the organization supports the Healthy People 2030 vision

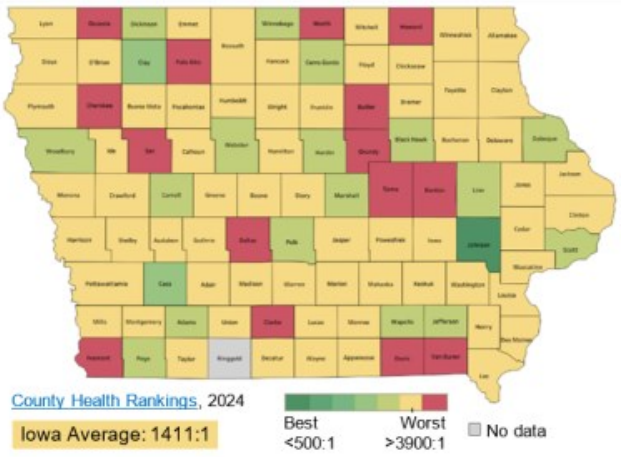
Strengths and Challenges Impacting the MCH Population

Challenges

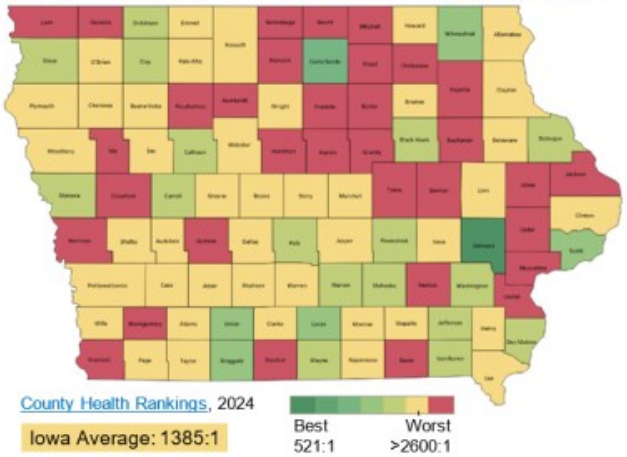
Rural
The rural nature of Iowa presents unique challenges for clients to access services throughout the state. Local Title V MCAH agencies work to ensure needed health services are provided in the rural counties. This is accomplished through building partnerships with health providers and community resources. Likewise, University of Iowa Health Care Division of Child and Community Health provides services for families of CYSHCN in rural areas. FHB staff is currently utilizing contractor agencies to develop Family Engagement and Health Equity advisory groups at the local level to ensure involvement of rural populations in the development and implementation of Title V activities in all 99 counties.

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

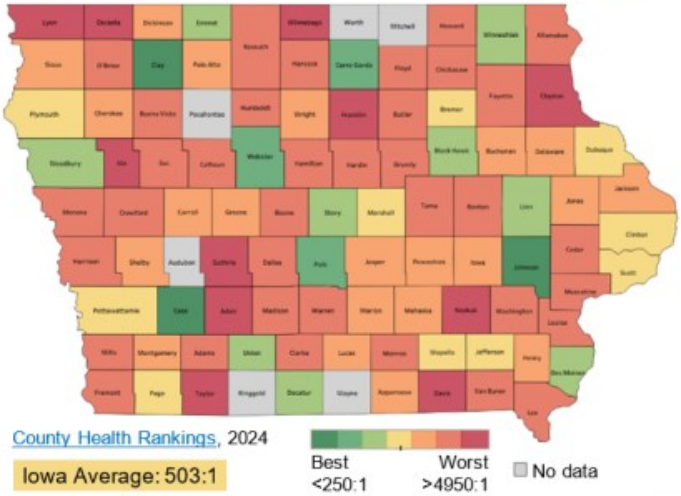
Ratio of Population to Dentists, 2022



Ratio of Population to Primary Care Physicians, 2021



Ratio of Population to Mental Health Providers*, 2023



* Mental health providers include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers that treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care.

Health Equity

The Health Equity Advisory Committee (HEAC) began as a way to focus health equity in Iowa's 2020 Title V Needs Assessment. Initially the committee was used to guide programmatic health equity work, such as the Child and Adolescent Health Request for Proposal (RFP) and subsequent Request for Application (RFA). However, there has been a struggle with continued engagement among this group. The HEAC has lost members throughout the year, and often only two or three members attend meetings, out of a possible 24. Staff have decided to put a pause on the state level committee. In the CAH RFP/RFA are requirements for health equity and family engagement groups. When local groups are fully established representatives from each CSA area will be asked to serve on a state level group or join the Maternal and Child Health Advisory Council.

While it has been a challenge, staff have been trying to find opportunities to make the HEAC more of a fixture in guiding the state's Title V work. Title V would like to begin by shifting the power to the committee, have them guide the direction of the work, and ensure the members have a larger voice in programmatic decision making at the state level. This would allow staff and other programs within FHB to better engage and partner with the HEAC. Staff coordinators are currently looking for ways to structure the advisory committee so the group is truly able to give their insights and knowledge to guide Title V and other MCH-related programs. The HEAC has the beginnings of the framework necessary to achieve this but need to bolster state staff skills and knowledge to be able to successfully implement it. In 2022, Iowa (both MCH and CYSHCN staff) joined the Accelerating Equity Learning Community through the MCH Workforce Development Center. This opportunity has helped focus our efforts, and identify opportunities for growth. Participants in the cohort have been working to shift the culture of health equity within the Title V program by focusing on building health equity skills among Title V staff, not just knowledge. This will also ideally lead to increased support for Title V contractors as they work on their own health equity and community engagement efforts; in a way that does not put undue burden on the committee. Another goal is to shift from knowledge to skills based health equity training to help increase the confidence of Title V staff to assess and offer support to contractors wherever they are in their health equity and community engagement journey.

The Iowa Title V CYSHCN program continues to focus on building capacity for leading systems-level health equity initiatives. Strategic planning for these efforts are led by an internal Health Equity Committee, and the program is committed to providing care to CYSHCN and their families that is culturally and linguistically appropriate, and building capacity to thoughtfully engage diverse families across the state. The CYSHCN program is also working to learn new ways to measure and evaluate the impact of the health equity initiatives.

Strengths

Health Insurance Coverage
In 2022, America's Health Rankings reported that 95.5% of the population in Iowa had some form of medical insurance. Since 2010, children eligible for Hawki and Medicaid have been able to obtain immediate, temporary Medicaid coverage through the Presumptive Eligibility for Children program. All Title V agencies are able to assist families in applying for Medicaid and presumptive eligibility. Iowa's Hawki program also has a dental-only option to increase access to oral health services for families that have medical coverage but lack dental coverage.

Iowans Not Covered by Health Insurance by Race & Ethnicity, 2021

	Iowa %	US %
Overall	**5.1**	**8.9**
American Indian/Alaska Native	14.7	19.9
Asian/Native Hawaiian/Pacific Islander	8.6	5.9
Black or African American	9.9	10.5
Hispanic or Latino*	16.0	17.9
Other Single Race	20.9	20.0
Two or More Races	9.2	13.9
White, not Hispanic/Latino	3.9	5.9

** Hispanic or Latino is of any race.*

US Census Bureau, American Community Survey 1-Year Estimates Public Use Microdata Sample, 2021

Iowa women with medical insurance was reported to be 94% from America's Health Rankings. Iowa is currently one of the most inclusive states in the US in terms of Medicaid income eligibility for pregnant women. Iowa women that make 375% of the Federal Poverty Limit (FPL) or below are eligible for Medicaid assistance during pregnancy and for 60 days postpartum. In 2024, the Iowa Legislature passed a bill to expand postpartum Medicaid coverage to 12 months postpartum. This change resulted in a decrease in the income limit for pregnant and postpartum women to quality for Medicaid coverage, reducing it to 215% of the FPL. All Title V funded local Maternal Health Agencies assist clients in applying for presumptive eligibility, helping women obtain Medicaid coverage early in pregnancy regardless of legal status. Future Title V efforts will focus on providing expanded care to pregnant women beyond the traditional 60 day period.

Maternal Mortality

Iowa's maternal death ratio has followed an upward trend over the past 10 years (2013 – 2022). According to the Iowa Department of Health and Human Services (Iowa HHS) Bureau of Health Statistics (BHS) - Vital Statistics, the Iowa maternal death ratio/100,000 live births has ranged from a low of 8.3 maternal deaths/100,000 live birth in 2020 to a high of 48.9 maternal deaths/100,000 live births in 2021. Iowa's Maternal Mortality Review Committee (MMRC) met several times during the reporting period and will be publishing a report on 2019-2021 maternal deaths in the fall of 2024. Due to small numbers of maternal deaths, multiple years must be combined to ensure data validity.

Iowa HHS launched a new section of the statewide mental health and substance use disorder website, YourLifeIowa that is dedicated to Maternal Mental Health and includes resources and information about perinatal depression including warning signs. The YourLifeIowa website includes a 24/7 call center with texting and chat options and includes updated crisis resources.

The Iowa AIM program implemented the OB Hemorrhage Patient Safety Bundle (PSB) in 2022/2023, and the Severe Hypertension PSB in 2023/2024. The Obstetric Hemorrhage PSB included all 56 obstetrical hospitals, making Iowa one of the first states to achieve HRSA's ambitious goal for 100% of hospitals in the United States (US) to participate in the AIM program. This collaborative was conducted from October 2022 to July 2023 and the full population impact of the work is still being evaluated, however, initial evaluations show that SMM from hemorrhage has declined from historic rates. Improvements in key process measures have also been noted midway through the Severe Hypertension PSB

I-Smile™

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

Each year, Medicaid paid claims are reviewed to measure program impact. Using 2005, data (the year before I-

Smile™ began) as the baseline, data have shown annual improvements for Medicaid-enrolled children (ages 0-12) receiving through this program care. In 2023:

- Over three and a half times more children received gap-filling preventive care from a dental hygienist or nurse through I-Smile™ in a public health setting compared to 2005 (28,782 in 2023; 7,865 in 2005)
- 95% more Medicaid-enrolled children in Iowa were seen by a dentist than in 2005
- 62% of children ages 3-12 years old were seen by dentist, and when including those seen in a FQHC dental clinic, the rate rises to 73% (duplicated)

Iowa Department of Health and Human Services' Current Guiding Principles

Data Driven: HHS makes informed, data-driven, and evidence-based decisions to drive quality and improve results.

Accountability: HHS uses public resources responsibly to improve lives through the programs and services the department provides.

Integrity: HHS generates trust through honest, respectful, and reliable work that all staff can be proud of.

Equity: HHS actively identifies and removes barriers to access and inclusion so that the department can provide all individuals an opportunity to succeed.

Communication: HHS communicates in a thoughtful and coordinated way to ensure individuals are well informed about the department's work.

Collaboration: HHS facilitates meaningful partnerships that focus on the voices of the individuals and communities that are being served.

Iowa HHS Strategic Plan and Operational Plan

In January 2024, Iowa HHS released the agency's new strategic plan, guiding the work of the newly formed health and human service agency. The new strategic plan allows the agency to focus on core operations that guide the way HHS supports Iowans.

The new plan has three strategic priorities:

1. Elevate Organizational Health: Advance and accomplish Iowa HHS initiatives by leveraging responsive leadership, an engaged and motivated team, effective internal communication, innovation and positive work culture.
2. Advance Operational Excellence: Optimize Iowa HHS efficiency, resilience, and effectiveness through the integration of aligned technology and updated policies and processes, with focus on team collaboration and coordination.
3. Help Iowa Thrive. Provide equitable access to health and human services resources helping individuals, families, children and communities thrive.

Divisions and bureaus within Iowa HHS will have the opportunity to contribute to the "Strategic Plan in Action," which outlines pathways and measurement to achieving our strategic priorities.

The Iowa HHS Strategic Plan and Strategic Plan in Action documents can be found here: https://hhs.iowa.gov/about/performance-and-reports/strategic-plan

Wellness and Preventive Health Division Strategic Planning

The Wellness & Preventive Health (WPH) Subdivision of Iowa HHS contains the agency's maternal and child health work, including maternal and reproductive health, oral health, child and adolescent health, WIC, and healthy eating and physical activity work. This section of teams and bureaus was created in the fall of 2022 and continues to form its identity and fully understanding its scope and space within Iowa HHS. WPH staff conducted an accelerated strategic planning process utilizing existing plans from across programs within WPH. The majority of the teams in WPH have recently published strategic plans or are currently using work plans from their grants. In lieu of starting from scratch and creating a new WPH strategic plan, the WPH leadership pulled together the existing plans into a clear, coherent strategy. Steps taken in this accelerated process include:

- A robust review of action plans, work plans, strategic plans, and other goals, objectives, and strategies being used across the WPH section by WPH leadership.
- The review of existing plans among WPH teams, lead by team leaders, to check for accuracy, appropriateness, and alignment with existing strategy.
- The coding and sorting of all WPH goals into four themes by WPH leadership.
- The review of teams' plans by other teams within WPH to check for areas of existing collaboration and opportunities for new partnerships across teams.
- A check across all teams for upcoming external trends and opportunities for inclusion in the strategic plan.

University of Iowa Health Care Division of Child and Community Health Strategic Plan

University of Iowa Health Care Division of Child and Community Health developed a five-year strategic plan in 2017, which was updated in 2021. Funding through the Title V program serves as foundational support for all CYSHCN activities. The strategic plan includes the following goals:

- Care Coordination and Clinical Services
    - Title V funding supports the Regional Center structure and allows resources to be combined so services can be provided through a community-based approach, even in the most rural areas of the state.

- Family Professional Partnerships
    - Title V funding is combined with other state and federal funding sources to build a robust system of family-centered care and shared decision making at all levels.

- Advocacy and Policy
    - Strengthened by the designation as Iowa's Title V program for CYSHCN, University of Iowa Health Care Division of Child and Community Health provides a leadership role in pediatric advocacy and policy efforts at the local, state, and national levels.

- Health Equity
    - The promotion of health equity and honoring diversity among Iowa children and youth with special health care needs and their families is a primary goal in the University of Iowa Health Care Division of Child and Community Health strategic plan. Leadership support is funded through the Title V CYSHCN program.

Other State Statutes and Regulations that Impact Title V Programs:

Iowa Administrative Code Chapter 641.76 Summary

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

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

Other sections of Iowa Code that impact Title V:

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

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

Red Tape Review

Governor Kim Reynolds signed Executive Order 10 on Tuesday, January 10, 2023, putting a moratorium on administrative rulemaking and instituting a comprehensive review, or red tape review, of all existing administrative rules.

The order directs that each rule chapter effective on January 1, 2023 be reviewed by the department according to a schedule established by the Administrative Rules Coordinator (ARC). Upon completion of this review, the department will submit a rule report to the ARC detailing a list of rules to repeal and a list of rules HHS proposes to re-promulgate. For those HHS will re-promulgate, a new rulemaking is to be initiated.

The Executive Order directs a comprehensive evaluation and rigorous cost benefit analysis of all existing and proposed rules to evaluate their public benefits, whether the benefits justify the cost, and whether there are less restrictive alternatives to achieve their intended goal. Each new rule chapter finalized by the department must reduce

the overall regulatory burden, or remain neutral, as compared to the previous rule chapter.

Iowa HHS expects the review of all administrative rules to be completed by the end of 2024.

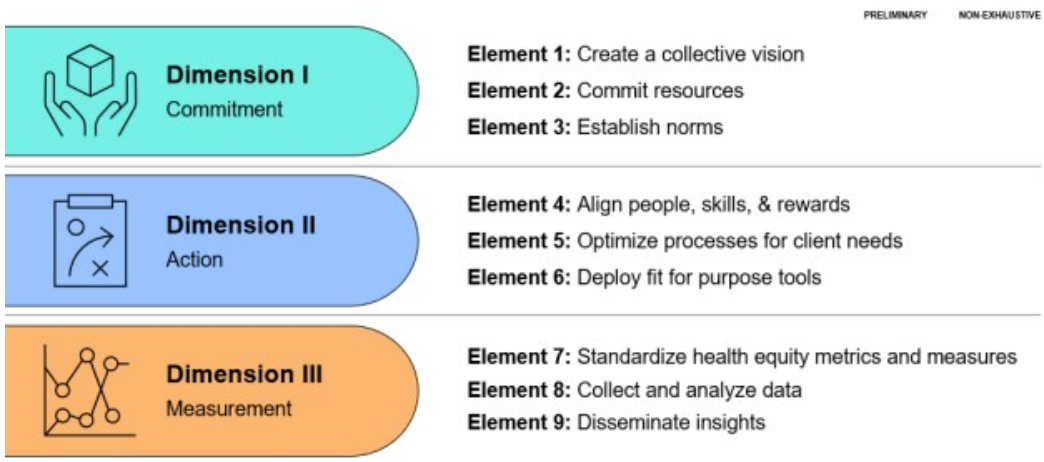
III.C. Needs Assessment
FY 2025 Application/FY 2023 Annual Report Update

Iowa's Title V program continues to evaluate programs and processes, and strives to include family input into all activities, including the assessment of needs and priorities. Iowa's Title V Family Delegate was a core member of the Needs Assessment team. The Title V plans and Needs Assessment process are presented for feedback from the Maternal and Child Health Advisory Council (MCH Advisory Council) which includes multiple youth and family representatives. Additionally, the University of Iowa Health Care Division of Child and Community Health Family and Professional Partnership Program provides regular feedback to ensure that the strategic plans for the Family Partnership program and the Title V CYSHCN program are aligned with the needs articulated by Iowa families. The Family Advisory Council (FAC) provides review of the block grant initiatives and members of Title V CYSHCN program and FAC leadership are trying to strengthen the role of family advisors in providing input to all Title V CYSHCN program activities, including the Title V Block Grant.

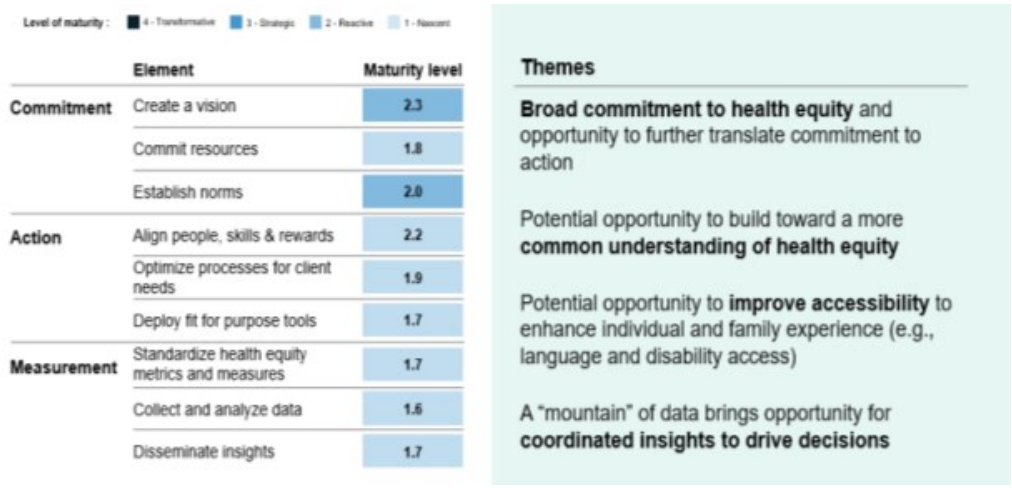
Iowa HHS Health Equity Assessment

Iowa HHS conducted a health equity assessment that consisted of an internal analysis of current health equity initiatives and current capacity of the workforce to address health equity. This assessment included a thorough review of documents, an all-staff survey, staff focus groups, and key informant interviews with leadership. The needs assessment also analyzed Iowa HHS capacity and need for specific areas necessary for health equity work, such as community engagement and data methodology. The final report will identify opportunities for improvement and expansion and will include actionable roadmaps for programs to embed health equity into their work. The Bureau of Health Equity will utilize findings to create additional trainings to address these skills gaps, which may include: disaggregating data, data equity in communications, authentic community engagement, or other key topics.

The all-staff assessment focused on the three dimensions below:



Initial results before final report is completed and released have been shared through a Department-wide All Staff meeting. Below are the overall results on each of the elements outlined above:



Level of maturity : 4 - Transformative 3 - Strategic 2 - Reactive 1 - Nascent

	Element	Maturity level
Commitment	Create a vision	2.3
	Commit resources	1.8
	Establish norms	2.0
Action	Align people, skills & rewards	2.2
	Optimize processes for client needs	1.9
	Deploy fit for purpose tools	1.7
Measurement	Standardize health equity metrics and measures	1.7
	Collect and analyze data	1.6
	Disseminate insights	1.7

Title V staff have had a strong commitment to Health Equity for many years. Title V staff are prepared to work with the Bureau of Health Equity to share existing programmatic successes/strategies as well as learn new innovative approaches Iowa's Title V program can embed Health Equity at both the state and local levels.

Maternal Health

Iowa systematically reviews population and programmatic data for each population domain. Based on these reviews, Iowa HHS updates state action plans and ESMs to best address the most current data. The next section provides an update to the maternal health population needs assessment based on the national and state focus on maternal health initiatives.

Iowa is a predominantly rural state with approximately 3.2 million people according to the US Census Bureau. Agriculture and related industries are the main sources of employment. Based on metropolitan statistical areas, **sixty-one of Iowa's ninety-nine counties are designated as rural**, sixteen are designated as micropolitan, and twenty-two are designated as metropolitan.[1] Although Iowa's unemployment rate is generally low, the 2022 American Community Survey reports the percentage of Iowans living below the federal poverty level (FPL) was 11%, an increase from 9.1% in 2000. **Nearly one-quarter (23.5%) of female-headed households in Iowa live below**

the FPL. There are currently 56 hospitals in Iowa providing maternity services and there were 34,558 births in 2022. Table 1 provides an overview of the birthing population in the state by key social and health characteristics.[3] **Iowa's birthing population also has a high prevalence of chronic and pregnancy-related diseases** that make pregnancy and childbirth high risk, including overweight and obesity, hypertensive conditions, and diabetes.

Iowa's 2019 *MHI* award was highly successful in development of pipelines for training new obstetrical providers including rural-focused OBGYNs, FM-OBs, and CNMs in Iowa. The IMQCC was established and a diverse board of stakeholders were recruited to form Iowa's Maternal Health Task Force. Iowa joined the AIM program, conducted several successful AIM QI collaboratives, and initiated a mobile simulation-based education program that primarily serves rural and low-volume facilities to maintain preparedness for obstetrical emergencies.

However, like many states, Iowa is experiencing shifts in population health that make pregnancy and childbirth increasingly high-risk, creating a further demand to elevate care and services to the birthing population. Simultaneously, the obstetrical workforce, particularly in rural areas, remains vulnerable to shortages and inexperience that make units vulnerable to closure.

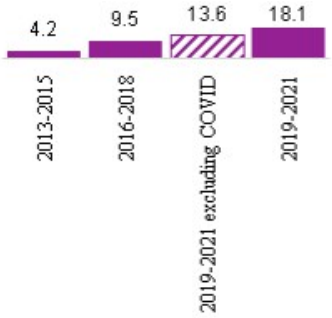
Table 1: Characteristics of Iowa's 2022 birth cohort

Race	Number (Percentage)
White	28,497 (82.5)
Black	2,566 (7.4)
American Indian/Native American	193 (0.6)
Asian	1,034 (3.0)
Native Hawaiian/Other PI	330 (1.0)
Multi race	865 (2.5)
Other/Unknown	1,073 (3.1)
Ethnicity	
Non-Hispanic	30,554 (88.4)
Hispanic	4,002 (11.6)
Age (years)	
15-19	1,296 (3.8)
20-24	6,149 (17.8)
25-29	11,363 (32.9)
30-34	10,554 (30.5)
35 or older	5,194 (15.0)
Primary language	
English	31,506 (91.2)
Not English	3,049 (8.8)
Maternal county of residence	
Metropolitan	22,072 (63.9)
Micropolitan	4,965 (14.4)
Rural	7,521 (21.8)
Medicaid reimbursement for delivery	
Not Medicaid	20,075 (58.1)
Medicaid	14,483 (41.8)
Births by location	
Hospital with less than 250 annual births	3,763 (10.9)
Hospital with 250-500 annual births	2,234 (6.5)
Hospital with 501-1000 annual births	8,775 (25.4)
Hospital with 1001-2000 annual births	5,826 (16.9)
Hospital with greater than 2000 annual births	13,243 (38.3)
Home births (community births)	743 (2.0)

Through the process of developing and implementing these programs, additional opportunities to improve the quality and safety of maternity care and support the rural obstetrical workforce have been identified.

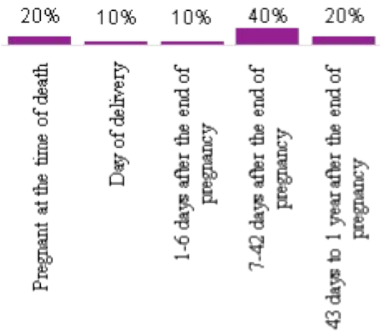
Challenge #1: Increasing pregnancy-related morbidity and mortality, disparities, and social determinants of health experienced by Iowa's birthing population.

Figure 2: The Pregnancy-Related Mortality Ratio (PRMR, deaths per 100,000 live births) in Iowa, 2019-2021



Iowa was historically a state with good health outcomes for mothers and children, however, **there has been an increase in pregnancy-related maternal mortality**, which is not entirely attributable to deaths from COVID-19 infection, as shown in Figure 2.[2] Furthermore, **95% of recent cases were thought to have been preventable or possibly preventable** by the MMRC**.** 58% of those of died from pregnancy-related causes were insured under Medicaid for their pregnancy care, reflecting an economic disparity as only 42% of pregnancies are covered by Medicaid in the state. The distribution of timing of pregnancy-related deaths in Iowa between 2019-2021 is shown in Figure 3, demonstrating a high proportion of postpartum deaths.

Figure 3: The timing of Pregnancy-Related Deaths in Iowa, 2019-2021.



Maternal deaths reflect systemic challenges and for every person who dies of pregnancy-related causes, many more suffer severe complications. **Iowa has higher rates of SMM than the US and there are significant disparities by race, ethnicity, primary payment source, and where people live**. For nearly all groups, SMM was higher in 2020-2022 than in 2017-2019, suggesting an ongoing need to elevate the quality of care being received across the state and particularly for rural residents, those with public insurance (Medicaid), and racial minorities (Figure 4).[3]

Infection (including COVID-19), cardiovascular disease, thrombotic embolism, hemorrhage, and mental health conditions were the leading causes of pregnancy-related mortality in Iowa from 2019-2021. Of note, an additional 11% of pregnancy-associated, but not related, deaths were attributed to mental health conditions. Similarly, disseminated intravascular coagulation (a late complication of hemorrhage), respiratory distress syndrome, shock, heart failure, eclampsia, and sepsis are the leading SMM indicators. While statewide implementation of AIM PSBs focused on reducing harm from obstetric hemorrhage and severe hypertension (including preeclampsia and eclampsia) in pregnancy has been successful, **there is a continuing need to improve care to address additional leading morbidity and mortality indicators in the state.**

Challenge #2: New destination communities of non-English speaking people are receiving less adequate prenatal care and are vulnerable to SMM and mortality.

Figure 5: Portion (%) of births to non-English speaking individuals by zip code in Iowa, 2018-2022 births.[3]

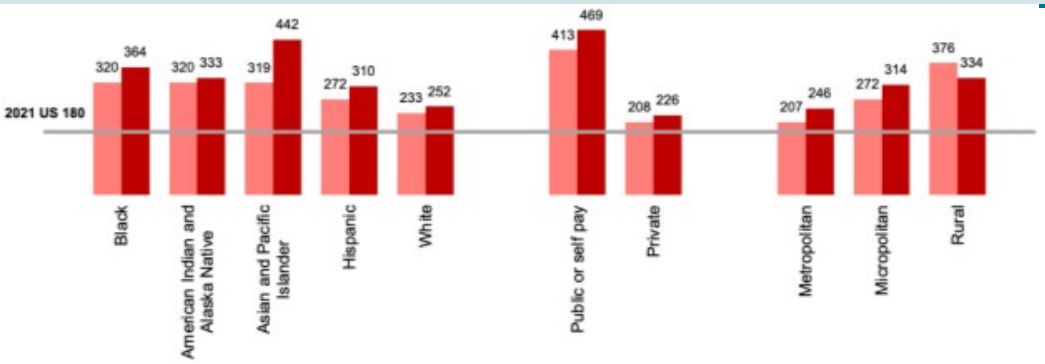
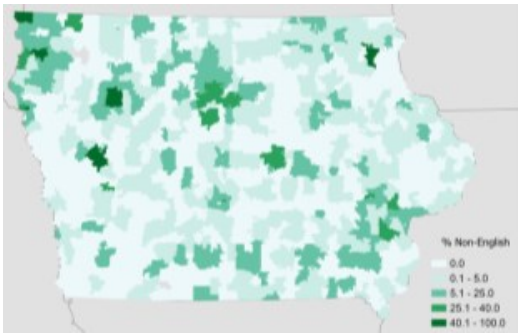


Figure 4: Trends and disparities in SMM by race and ethnicity, primary source of payment, and place of residence in Iowa, 2017-2019 and 2020-2022 as compared to the US overall for 2021. Reported as cases per 10,000 births.

Rural states in the Midwest and US South have been described as "new destinations" for immigrants. Immigration to Iowa was primarily driven by Latin American migration in the 1990s and early 2000s, and now includes immigration from Africa, southeast Asia, Pacific Islands and beyond. Migration to rural communities is centered around agricultural processing or light manufacturing, creating conditions for "microdiversity" where small communities become home to people of dozens of nationalities. One Iowa community, home to a pork processing plant, recently reported having **32 different languages** spoken among students in their small school district. Statewide, 8.8% of births occur to people who do not identify English as their primary language; these births are primarily concentrated in specific areas, Figure 5.[2]



While small communities may rely on immigrant labor to keep industries afloat, they frequently struggle to meet the healthcare needs of immigrants and their families. Perinatal care is a vital need for immigrant communities as many are of reproductive age and may have risk factors for high-risk pregnancies. However, migrant birthing parents face numerous challenges to accessing timely and appropriate perinatal care such as financial, linguistic, cultural, and transportation barriers. **In Iowa there is significantly higher rates of inadequate prenatal care among non-English speaking parents**, Table 2.[4]

Prenatal care adequacy	Primary language is not English	Primary language is English
Adequate plus	28%	38%
Adequate	41%	49%
Intermediate	7%	5%
Inadequate	24%	9%

Table 2: Prenatal care adequacy by primary language, English or non-English, 2018-2022. [3]

Health disparities experienced by migrant populations are affected by structural barriers within the healthcare system, such as lack of cultural humility, lack of access to insurance, and mistrust between patients and providers. For 12% of Iowa's recent pregnancy-related deaths, the MMRC cited communication (either language or cultural differences) as directly contributing to the death. With immigrant populations on the rise in Iowa, **there is a critical need to equip health systems across to meet the needs of our increasingly diverse communities**, especially counties where there is a large proportion of immigrant families. In the absence of these critical improvements, immigrant families will continue to experience inequitable access to quality maternal healthcare, leading to a disproportionate burden of adverse maternal health outcomes.

Challenge #3: Rural facility closures and unique challenges for low-volume facilities threaten to further worsen outcomes for rural residents.

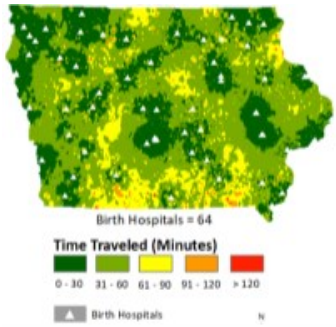
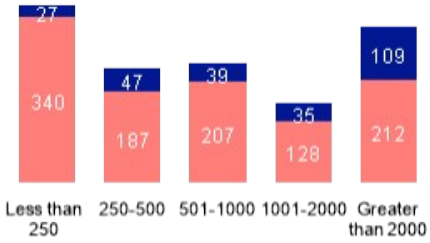


Figure 6: Actual time traveled to give birth in Iowa, 2019.

Iowa has experienced the closure of over 40 obstetrical units since 2000 and the March of Dimes currently classifies 33 of Iowa's counties are maternity care deserts.[5] The actual distance traveled to give birth has increased in several areas, and there are regions where the average travel time to give birth exceeds 60 minutes, Figure 6.[6] Since 2019, an additional five obstetrical units have closed in Iowa. **Of the 56 remaining facilities, nearly half (25) have fewer than 250 annual births.** The distribution of hospitals by annual delivery volume is shown in Table 1. As a largely rural state, there is an inherent tradeoff between geographic access to care and hospital volume. Facilities with low volume are vulnerable to closure due to challenges with staffing, finances, and maintaining staff experience to provide safe care. The minimum volume for a facility to provide safe care and remain financially viable is unknown but has been estimated by rural hospital administrators to be at least 200.[7]

Statewide QI collaboratives, as are offered here in Iowa for AIM PSBs and are occurring around the country, are effective at improving population health outcomes and reducing disparities.[8] In many states these collaboratives focus on high-volume, urban centers as that is where most births occur. **Iowa is unique in that nearly half of the births in the state (43%) occur in facilities with fewer than 1000 annual births** that are mostly located in rural and micropolitan communities (Table 1). **The lowest volume hospitals also have higher rates of SMM**, primarily driven by rates of blood transfusion suggesting vulnerability to hemorrhage and its sequela, Figure 7. This illustrates

Figure 7: SMM, transfusion and non-transfusion (SMM 20), by hospital annual delivery volume in Iowa, 2020-



the need to support safe practices in lower volume facilities.

Lower volume facilities face unique challenges in performing QI activities. Frequently nurse managers of these units are “working managers” meaning they spend a large portion of their time staffing the unit and there are rarely dedicated educators or QI personnel. These leaders are less likely to have advanced degrees or formal training in nursing education, project management, or QI. In several facilities the manager of the maternity unit does not actually have maternity care experience. The cumulative effect of these factors is that many small facilities face challenges in educating their staff and performing unit-level QI. **To reduce SMM, mortality, and health disparities in Iowa it is essential to support building capacity among the staff at the lowest volume facilities to perform QI.**[9]

Challenge #4: The obstetrical workforce in Iowa’s rural communities is shrinking.

Iowa’s obstetrical workforce continues to shrink, threatening the viability of facilities and access to care. Specifically, number of delivering physicians overall and per capita is declining, Table 5.[10] OBGYNs attended the most births in our state (71%), followed by FM-OBs (14%), and CNMs (12%), however the distribution of providers varies significantly by rurality. **FM-OBs attend most births in rural counties (64%)** and the fewest in metropolitan counties (5%). OBGYNs attend most births in metropolitan counties (82%) and fewer in rural counties (27%). CNMs attend more births in metropolitan counties (14%) but do attend 9% of rural births.

A growing problem in our rural obstetrical workforce is the declining practice of obstetrics by FM physicians. FM physicians practicing obstetrics are critical to the vitality of many rural hospitals. One of the reasons cited for discontinuation of obstetrical practice is inability to maintain skills with a low-volume practice, leading to fear of adverse events and lawsuits.[11]

Year	Delivering Physicians per capita	OBGYNs per capita	Number of OBGYNs	Number of FM-OBs	Number of CNMs
2021	9.1	3.8	231	269	92
2020	8.8	3.8	232	247	83
2019	9.6	4.0	243	294	90
2018	10.7	4.2	252	324	91
2017	10.5	4.1	244	311	76

Table 3: Delivering physicians and OBGYNs per capita and count of delivering providers by specialty in Iowa.

In addition to declining physician providers, **rural areas struggle to maintain robust nursing staff with experience in perinatal care.** In low-volume facilities nurses, like providers, have a multi-specialty practice, covering adult, pediatrics, operative, and maternity services, which poses challenges in maintaining expertise and skills. Individually and collectively, participating in fewer births results in limited exposure to obstetrical emergencies, making those that occur at high risk for preventable harm. The simulation program is one key strategy employed to support these teams in gaining experience with obstetrical emergencies, however **ongoing training and education is necessary to ensure staff remain competent and prepared.**

Challenge #5: Increasing community (home) birth in Iowa potentially threatens safety.

Community birth, also referred to as home or out of hospital birth, is increasing nationally and in Iowa. From 2019 to 2022, the number of community births in Iowa by CNMs increased by 66%. Births by unlicensed midwives have also increased and are expected to rise more with the passage of legislation that provides a pathway for Certified Professional Midwife (CPM) licensure in Iowa along with a mandate for insurance coverage of community birth, both of which will take effect in July 2024. Until 2012, births by unlicensed providers were considered a felony which kept this provision of care outside of the traditional healthcare system for pregnant Iowans. With the removal of that

barrier, hospitals are now seeing an increase in the number of intrapartum and postpartum transfers from home to hospital. Statewide, hospital staff have reached out to IMQCC expressing safety concerns with the transfer process for planned community birth and reports of SMM events. Similarly, many community birth providers report experiences of hostility when transferring patients into the hospital, which may result in delayed transfer in emergencies, poor communication to the receiving team, and other unnecessary barriers. Models in other states suggest an opportunity for collaboration to achieve safe, patient-centered care.

Children and Youth with Special Health Care Needs

The Iowa Title V CYSHCN program assesses needs through the framework of the Blueprint for Change, guided by National Standards for Systems of Care for CYSHCN. The National Survey of Children's Health is an ongoing source of population-based, family-reported data for Iowa's Title V CYSHCN program. Other needs assessment activities include the annual Youth Services Survey for Families, sent to a sample of families who receive direct and enabling services through University of Iowa Health Care Division of Child and Community Health, conversations with members of the Family Navigator Network and the Family Advisory Council, and a review of ongoing activities of partner organizations such as the Developmental Disabilities Council, and internal programs such as the Regional Autism Assistance Program.

Changes in health status and need:

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

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

The COVID-19 Public Health Emergency exacerbated the need to address all of these priority areas, especially access and parent support. Iowa's Title V program including CYSHCN continued to provide support in all of these areas, including expanded access to in-home telehealth direct services and supports for families. For a large portion of 2020 and 2021, many Title V local and state program staff provided this care while working from home, or in reduced density work environments. Although day-to-day activities have resumed, the impact of this public health emergency lingers for staff and for families in Iowa.

The Iowa Title V CYSHCN program collects information from the Family Navigator Network about changes in issues and needs from families they are working with. The Family Advisory Council also provides information about the needs of families of CYSHCN. Mental health issues continue to be an issue for Iowa's CYSHCN and provider shortages make access to care especially challenging, especially for children and youth in more rural areas of Iowa.

A family survey is part of the annual process for this 5-year Title V cycle for Child and Community Health programs. The Youth Services Survey for Families is a questionnaire that includes 26 questions with a 5-level Likert-type response scale ranging from 'Strongly Agree' to Strongly Disagree.' Respondents are also given the option 'Does not apply.' The items in the questionnaire are grouped into 6 domains that pertain to the direct and enabling services provided through University of Iowa Health Care Division of Child and Community Health: Access, Participation in

Treatment, Cultural Sensitivity, Satisfaction, Outcomes, and Social Connectedness. Domains contain between 2 and 6 questions, which are combined into a mean domain score. Additional questions cover basic demographic information: Gender, age-category, and race/ethnicity. Additionally, there are 3 open-ended questions, asking 1) What has been the most helpful thing about the services you and your child received as a result of services? 2) What would improve services for families who need support? and 3) Any other comments? The survey is administered annually in the spring. The table below shows the results from the 2021,2022, 2023, and 2024 surveys. A review of the data showed that scores were relatively high overall and have remained steady over time.

Youth Services Survey for Families, mean domain scores,2021, 2022,2023, and 2024 surveys

Domain	2021	2022	2023	2024
Access	4.4	4.2	4.2	4.4
Participation in treatment	4.4	4.4	4.4	4.5
Cultural Sensitivity	4.7	4.6	4.6	4.7
Satisfaction	4.4	4.2	4.2	4.4
Outcomes	3.8	3.8	3.8	3.9
Overall (above domains)	**4.3**	**4.2**	**4.2**	**4.3**
Social Connectedness	4.4	4.2	4.2	4.3

Iowa Title V CYSHCN program staff are in the early planning stages for the 2025 Needs Assessment. During FFY2023, program staff worked with AMCHP to develop a comprehensive evaluation plan for the Family Navigator Network. Implementation of this plan is currently underway.

Changes in capacity and MCH systems of care

Essential services for MCH priority populations were influenced in several ways during the 2024 Iowa legislative session.

There are a number of major changes anticipated by families of children and youth with special health care needs in the next few years. Over the past 2 years, Iowa HHS, primarily at the direction of Iowa Medicaid program leadership, has been seeking feedback from consultants, families, self-advocates, providers, and communities about Iowa's Medicaid Home and Community-Based Services (HCBS) waiver programs. This process has been intentional and although the process is not yet complete, state leadership has provided a thoughtful vision about a waiver program overhaul.

University of Iowa Health Care Division of Child and Community Health has had a number of opportunities to provide comments and input into the waiver redesign process. Because the needs of children and families differ greatly from the needs of adults, program staff, along with a number of other groups, have emphasized the need to separate out child from adult waivers, with attention paid to ensuring smooth transitions from child to adult waivers. The new waiver redesign is not yet complete, but the most recent proposal shows a move from the 7 current waivers to 2 new waivers, one for Children & Youth ages 0–20 years, and another called Adults & Aging for ages 21 years or over.

Another major change is in the way special education services will be delivered. Iowa currently has 9 Area Education Agencies (AEAs) that have provided special education and other services to Iowa's public and accredited private schools. During this year's legislative session, the AEA system was overhauled with changes scheduled for implementation during the 2024–2025 school year. Although lawmakers were mindful of the impact of these changes

on special education services, many families have expressed uncertainty about how these and other services such as technology distribution and crisis counselling will be delivered during the upcoming and future school years.

Breadth of Partnerships with other entities that serve the MCH population

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

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

Operationalizing the 2021 Needs Assessment

FHB is currently in the process of reviewing and rewarding the FY2023 Title V Request for Applications (RFAs) The Title V Block Grant State Action Plans directly affect and dictate the development of requirements and activities outlined in the funding opportunity. Staff continue to use and update the 2021 Needs Assessment to ensure the needs of Iowa's population are continuing to be met and continue to reduce barriers faced by families.

In order to further operationalize the Needs Assessment state Title V staff are continuing to utilize the findings to inform and programmatic changes including but not limited to the Maternal Health Strategic Plan and the CSAs discussed previously.

University of Iowa Health Care Division of Child and Community Health updated their strategic plan in 2021 with a focus on alignment between the needs of CYSHCN and families and the work that is carried out. Title V Priority areas are used as a basis to direct efforts within the program as well as to provide input to other organizations with shared goals.

Changes in organizational leadership

Iowa's Title V for CYSHCN program is housed within University of Iowa Health Care Carver College of Medicine Stead Family Department of Pediatrics, Division of Child and Community Health.

Vanessa Curtis, MD, *Title V CYSHCN Director*, *Division Director, Child and Community Health and Child Health Specialty Clinics,* began leading University of Iowa Health Care Division of Child and Community Health in January 2024. In addition to leading the Division, Dr. Curtis is a practicing pediatric endocrinologist with over 13 years of

experience treating children and youth with special health care needs. Dr. Curtis's role includes teaching trainees and she served for the 5 years as Director of Iowa's Pediatric Endocrine and Diabetes Fellowship program. In addition to clinical and teaching activities, she has been previously funded by NIH, industry, and national networks/foundations; her current research focuses on comparing the oral micro-biome in healthy obese adolescents to obese adolescents with metabolic syndrome.

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[1] State Data Center. *Business & Industry*. Accessed March 1, 2024. https://www.iowadatacenter.org

[2] Iowa Department of Health and Human Services. Maternal Mortality Review Information Application (MMRIA, or "Maria") is a data system designed to facilitate MMRC functions through a common data language. CDC, in partnership with users from the committees and other subject matter experts, developed the system. It is available to all MMRCs. Data used in this narrative is from the Iowa MMRC.

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[4] Kotelchuck M. An evaluation of the Kessner adequacy of prenatal care index and a proposed adequacy of prenatal care utilization index. *Am J Public Health*. 1994;84(9):1414-1420. Doi:10.2105/ajph.84.9.1414.

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[6] Carrel M, Keino BC, Ryckman KK, Radke S. Labor & delivery unit closures most impact travel times to birth locations for micropolitan residents in Iowa. *J Rural Health*. 2023;39(1):113-120. doi:10.1111/jrh.12643

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[8] Main EK et al. Reduction in racial disparities in severe maternal morbidity from hemorrhage in a large-scale quality improvement collaborative. *Am J Obstet Gynecol.* 2020;223(1):123.e1-123e14. Doi:10.1016/j.ajog.2020.01.026.

[9] Anglim AJ, Radke SM. Rural Maternal Health Care Outcomes, Drivers, and Patient Perspectives. *Clin Obstet Gynecol*. 2022;65(4):788-800. doi:10.1097/GRF.0000000000000753

[10] Iowa Department of Health and Human Services - Bureau of Family Health. Access to Obstetrical Care in Iowa: A Report to the Iowa State Legislature – Calendar Year 2021. Des Moines: Iowa Department of Health and Human Services, 2023.

[11] Roberts RG, Bobula JA, Wolkomir MS. Why family physicians deliver babies. *J Fam Pract.* 1998 Jan;46(1):34-40..

Click on the links below to view the previous years' needs assessment narrative content:

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,512,681	$4,781,161	$6,549,016	$3,259,555
State Funds	$6,334,543	$6,737,444	$6,255,937	$6,703,793
Local Funds	$0	$0	$0	$0
Other Funds	$8,847,074	$6,874,675	$8,947,232	$7,125,809
Program Funds	$480,000	$480,000	$850,000	$517,116
SubTotal	$22,174,298	$18,873,280	$22,602,185	$17,606,273
Other Federal Funds	$12,046,998	$11,768,542	$11,648,481	$11,589,161
Total	$34,221,296	$30,641,822	$34,250,666	$29,195,434

	2023		2024	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$6,549,016	$3,829,937	$6,611,198	
State Funds	$5,916,685	$6,754,112	$6,285,103	
Local Funds	$0	$0	$0	
Other Funds	$8,925,468	$6,978,676	$8,373,752	
Program Funds	$850,000	$1,206,326	$850,000	
SubTotal	$22,241,169	$18,769,051	$22,120,053	
Other Federal Funds	$16,824,943	$16,145,906	$6,400,880	
Total	$39,066,112	$34,914,957	$28,520,933	

	2025	
	Budgeted	Expended
Federal Allocation	$6,611,198	
State Funds	$6,234,520	
Local Funds	$0	
Other Funds	$8,328,679	
Program Funds	$1,026,032	
SubTotal	$22,200,429	
Other Federal Funds	$5,093,879	
Total	$27,294,308	

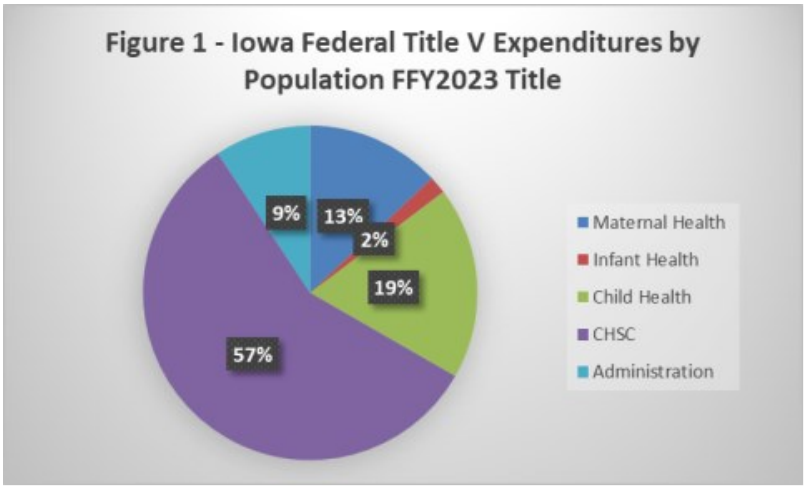
III.D.1. Expenditures

Form 2, MCH Budget/Expenditure Details, shows $3,829,937 in federal Title V fund expenditures. See the Expenditure workbook attachment for a detailed breakdown of expenditures for the Federal/State Partnership.

Form 3a, Budget and Expenditures Detail by Types of Individual Served, reports federal-state partnership expenditures for FFY23 in the amount of $18,412,342 excluding admin funds. Of this amount, $3,473,228 was funded by federal Title V. The state match expenditure is reported at $6,754,112. This exceeds both the state match requirement of $4,883,780 and the maintenance of effort requirement of $5,035,775.

Figure 1 displays the distribution of Title V expenditures by population served. Federal Title V funds expended for child health primary and preventive care was $712,949 or approximately 19 percent of the total Title V expenditures. At the time of submission, expenditures remain to be claimed in the Preventive and Primary Care for Children budget category; This category is fully obligated. HHS anticipates this budget category to be fully expended by the end of the budget period and will meet the minimum 30% requirement as indicated in the budget.

The federal Title V expenditure for children and youth with special health care needs is reported at $2,198,201 or 57 percent of the federal block grant funds expended for the year at the time of submission. Administration expenditures of $356,709 represent 9 percent of the federal Title V expenditures to date. At time of submission this amount reflects charges to administrative costs (MCH Director salary, travel, and other expenses) for the Title V Block Grant. The final indirect costs will be pulled prior to closeout based on actual expenses and will not exceed the 10% maximum.

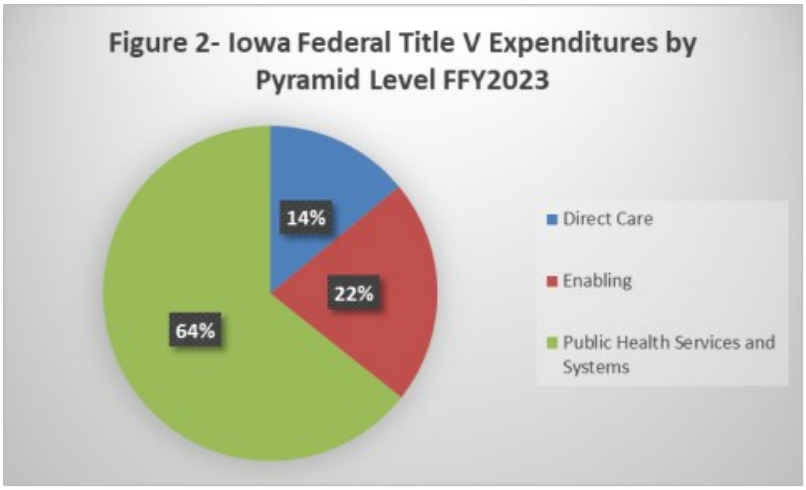


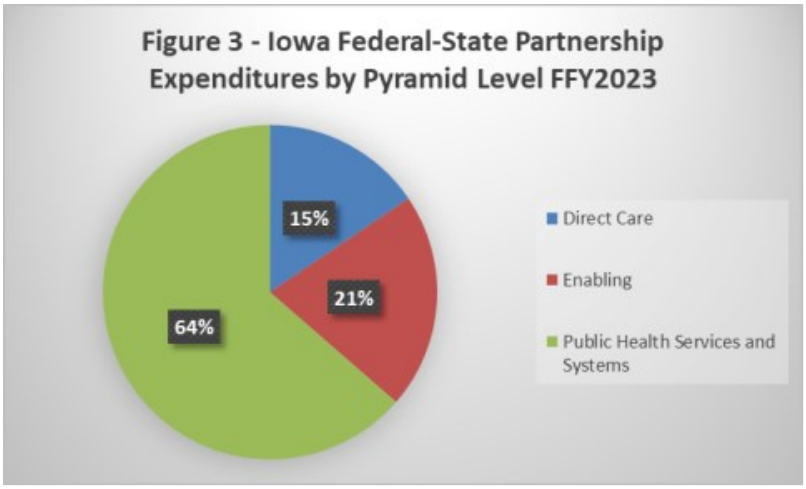
Current expenditures are based on the expenditures reported on 3/31/2024. All funds are obligated and are on target to be fully expended by the end of the budget period. For FFY23 funds, Iowa HSS continues to use

considerable Title V funds to build in required functionality into the new Iowa Connected data system. Nearly $1M in Title V funding is obligated to this project. The Iowa Connected project was built on a deliverable-based budget and Iowa rolled out the new system's minimally viable product June 19, 2023. Iowa HHS continues to work with the vendor to build out additional functionality to meet the documentation and reporting needs of the Title V program. Expenses for continued development will be included in the close out for FFY23. Additionally, funding is obligated to local Title V MH and CAH agencies through the end of September 2024.

Form 3b, State Title V Program Budget and Expenditures by Types of Services, shows resources dedicated to Public Health Services and Systems continue to increase for MCH compared to the proportional of funds directed to direct services. Continued improvement has been achieved in reporting on expenditures by pyramid level. Family engagement and health equity activities are spread throughout the pyramid levels.

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





As shown in the Expenditure report attachment, Iowa's Title V program is a blend of Title V funds, state match, program income and other federal/state funds.

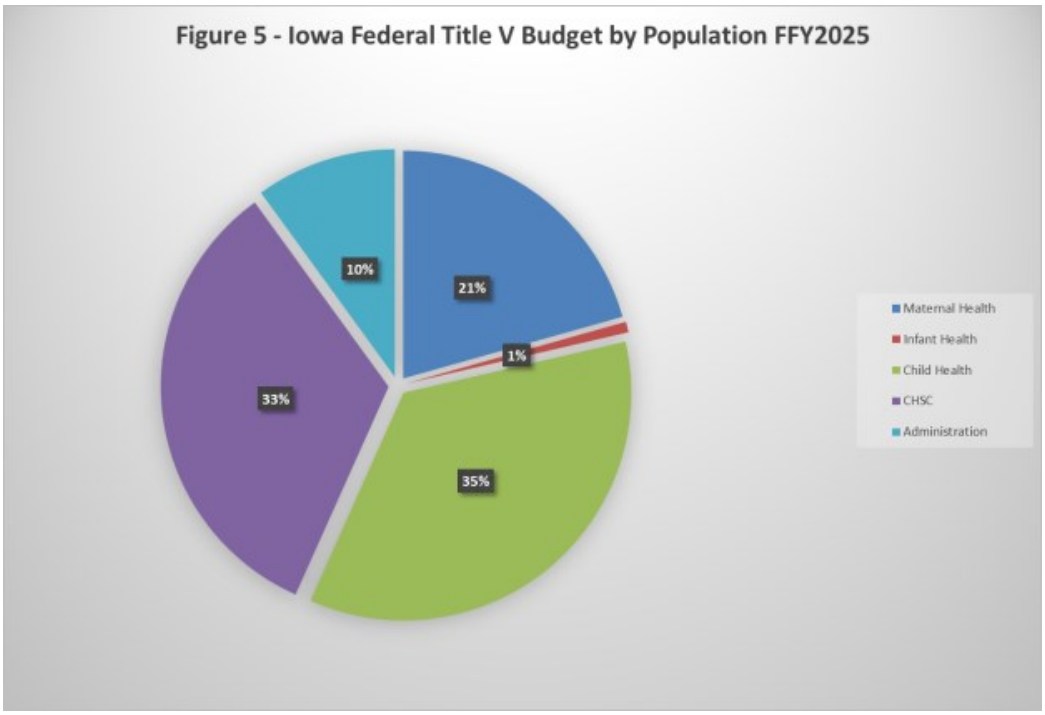
Through the Title XIX/Title V MOU, Iowa's local Title V contractors are designated a Medicaid provider status (Screening Center and/or Maternal Health Center) by virtue of their Title V application. These contractors are required to bill Medicaid for services for clients enrolled in Medicaid. Title V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

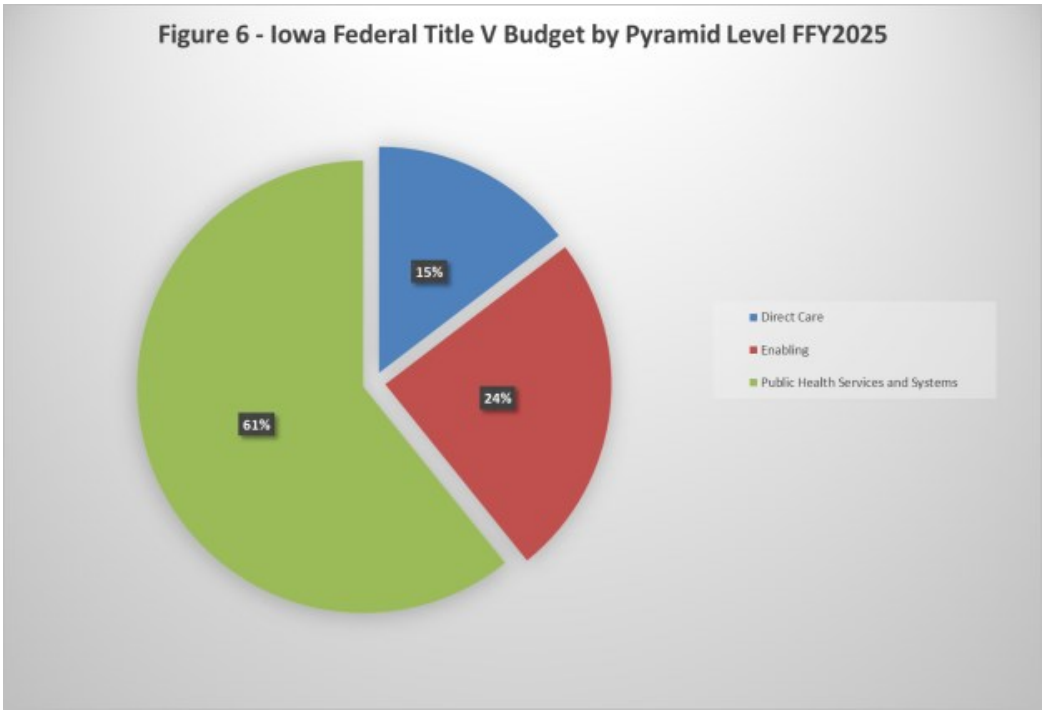
The audit of Iowa's Title V, Maternal and Child Health Block Grant expenditures is included in the State of Iowa Annual Comprehensive Financial Report. The audit is conducted by the state Auditor's Office under the requirements set forth in the Single Audit Act of 1984, the Single Audit Amendments of 1996 and Title 2, US Code of Federal Regulations, Part 200, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Federal Awards (Uniform Guidance). The most recent report is for the period July 1, 2020 to June 30, 2021. The Iowa Department of Public Health had no findings in the 2021 State of Iowa Single Audit Report for the Title V program, AL Number 93.994. The report is submitted to the federal clearinghouse by the Department.

III.D.2. Budget

The FFY25 Title V appropriation is projected to be $6,611,198, based on the current Notice of Grant Awards received. As itemized in the budget included in the attachments section, this expected allocation is budgeted as follows: $1,364,097 (21%) for maternal health services; $50,051 (1%) for infant health services; $2,334,401 (35%) for child health services; $2,201,529 (33%) for services to children with special health care needs; and $661,119 (10%) for program administration. Budgeted items for preventive and primary care for children, children with special health care needs, and administration satisfy federal legislative requirements. Figure 5 below illustrates the budget plan for Title V allocation by population served. Figure 6 represents the Title V allocation by levels of the pyramid.

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

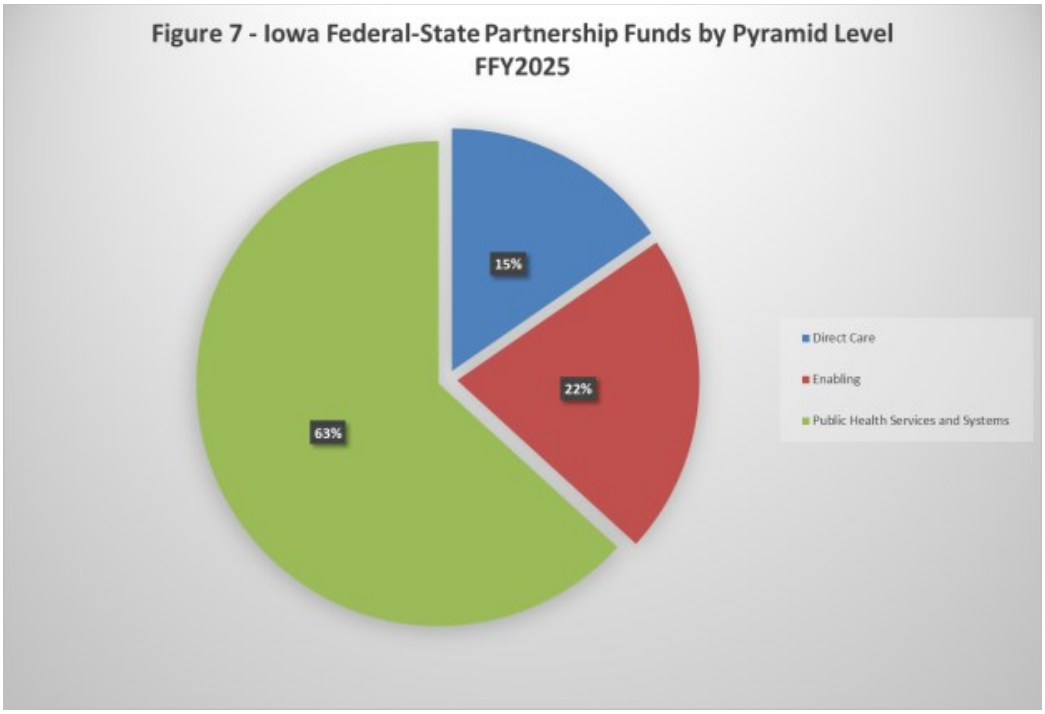




The projected state match is $6,234,520. Iowa continues to exceed the state maintenance of effort of $5,035,775, established in 1989 and exceeds the required match of $4,958,399. This amount has increased from previous years.

The total budget for the federal-state partnership is projected to be $22,200,429. Figure 7 illustrates the allocation of funds by level of service for the total partnership budget.

The attachment provides budget details by level of servi ce, as well as population group served. The Federal/State Partnership Budget supports the activities proposed within the State Action Plan for each population domain.



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

Public Health Services and Systems

Estimated budget for continuing development of core public health functions and system development are $14,034,672 or 63 percent of the total federal state partnership budget. This amount includes support services and salaries for maternal infant health, child health, and EPSDT. This category includes 36 percent of the funding for local child health agencies and 23 percent of local maternal health funds. In addition, it will include contract services with the University of Iowa, Departments of Pediatrics, Perinatal Review Team, Healthy Child Care Iowa, EPSDT dental and HHS 1st Five Initiative. CHSC's budget for public health services and systems is estimated at $2,758,111 (45 percent of the CYSHCN budget).

The 15 local maternal health agencies and 14 local child and adolescent health services use Title V funds to support health equity and family engagement activities in all 99 counties across Iowa. Activities include the convening of a family engagement/health equity committee, health promotion activities, and improving internal infrastructure to meet the needs of community members.

Enabling Services

The federal-state partnership budget for continuation of enabling services are estimated at $4,751,121 representing 21 percent of the partnership budget. This category includes 50 percent of the funding for local child health agencies

and 47 percent of local maternal health funds. Healthy Families toll free information and referral line, TEEN Line, Hawki Outreach, EPSDT, STD testing, immunization, lead poisoning prevention, and birth defects and audiological services are included in this category. CHSC's budget for enabling services is estimated at $2,064,590. CYSHCN services in this category include EPSDT III and Handicapped Waiver Services.

Local MCAH agencies provide care coordination, presumptive eligibility and informing services to ensure that clients are able to access medical and dental services. Agency action plans include specific activities for the priority populations identified in the FFY21 Needs Assessment. Agencies also were required to have people with lived experience review communication materials and outreach materials to ensure they are meeting the needs of their communities and reduce health inequities.

Direct Health Care Services

The federal-state partnership budget for continuation of direct care services are estimated at $3,414,635. This represents approximately 15 percent of the partnership budget. The amount includes 14 percent of the funding for local child health agencies and 30 percent of local maternal health funds. In addition, this category includes Birth Defects Institute and Regional Genetics Services; dental treatment, and dental sealant projects; and child vision screening. CHSC projects a direct care budget of $1,314,276 or approximately 21 percent of the CYSHCN budget.

For individuals that do not have access or limited access to regular medical and dental services through a medical/dental home, local MCAH agencies provide gap-filling direct health care services to meet the needs of members of their communities.

Other State/Federal Funds

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

Other federal funds directed toward MCH include:

State Systems Development Initiative (HRSA/MCHB)
Title X Family Planning
Early ACCESS (IDEA, Part C)
Personal Responsibility Education Program--PREP (ACF)
Pregnancy Risk Assessment Monitoring System (PRAMS) (CDC)
ERASE Maternal Mortality (CDC)
Perinatal Quality Care (CDC)
Alliance for Innovation on Maternal Health (AIM) Capacity (CDC)

Sexual Risk Avoidance Education Program (ACF)
Care Coordination for ASD/DD (HRSA)
EPSDT – HCBS IS (HRSA)
Peer Support MHDS (HRSA)
Pediatric Mental Health Care Access (HRSA)
Maternal Health Innovation (HRSA)

III.E. Five-Year State Action Plan

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

State: Iowa

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

Through legislation and Iowa Administrative Code Chapter 641.76 the Iowa Department of Health and Human Services (HHS) is designated as the entity to apply for Title V Block Grant funding and administer Iowa's Maternal and Child Health services. The Family Health Bureau, within the Wellness and Preventive Health Subdivision, is designated as the lead to apply for funding and to enter into contracts with selected private, nonprofit or public agencies for the assurance of access to prenatal and postpartum care for women, preventive and primary child health care services, and services to children and youth with special health care needs.

The HHS Oral Health Section collaborates within the FHB to develop programs to reduce barriers to oral health care and reduce dental disease through prevention.

The CYSHCN program is administered by Child Health Specialty Clinics (CHSC), which is part of University of Health Care, Stead Family Department of Pediatrics, Division of Child and Community Health (Child and Community Health). HHS contracts with CHSC to provide services for CYSHCN including infrastructure building activities, clinical services, care coordination, and family support. Iowa legislation requires that 37% of Title V Block Grant funds are allocated to CHSC.

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

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

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

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

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

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

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

Maternal and Child Health Advisory Council

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

Iowa Statewide Perinatal Care Program

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

Title V MCAH RFP/RFA Work Group

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

Family Advisory Council

In 2014, University of Iowa Health Care Division of Child and Community Health created a Family Advisory Council (FAC) to provide feedback regarding the planning, development, and evaluation of programs and policies that will assure a systems-oriented approach to care for Iowa CYSHCN. Members are family members of CYSHCN or self-advocates and represent a broad cross-section of families that served across the state. The FAC participates in activities that promote support for CYSHCN with members of the Iowa Legislature. In 2021, a Youth Advisory Council was started, with dual purposes of developing youth leadership skills and providing input into the transition to adulthood programs.

RAP Expert Panel Advisory Committee

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

Partners and collaborators

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

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

Iowa's Title V program has strong collaborations with other programs and initiatives that improve outcomes for children and families. The following list provides an overview of those partnerships:

Title XIX
Iowa's Title V MCH program and Iowa Medicaid have had a mutually beneficial relationship for nearly three decades. The foundation for this relationship is the contract established each year between the legacy Departments of Public Health and Human Services specifically, Iowa Medicaid Enterprise (IME). This agreement is for six years and renewed annually through an amendment to address program updates. This contract, known as the Omnibus Agreement, does not include services for CYSHCN. With the merger of the two departments it will be determined how this agreement will be carried out.

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

1st Five Healthy Mental Development
1st Five is a state funded public-private partnership bridging primary care and public health services in Iowa. 1st Five supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children 0-5 years and coordinates referrals, interventions and follow-up. Currently, 1st Five covers 88 of the 99 counties in Iowa. 1st Five collaborates with local Title V contractors to decrease duplication of developmental screenings and for referrals.

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

The Regional Autism Assistance Program (RAP)
The Iowa Department of Education (DE) has contracted with University of Iowa Health Care Child and Community Health for over 30 years to support the statewide Regional Autism Assistance Program (RAP). RAP aligns with authorizing legislation, Iowa Code 256.35, to "coordinate educational, medical, and other human services for persons with autism, their parents, and providers of services to persons with autism." Title V CYSHCN resources along with support from DE and HHS to provide a comprehensive System of Care for children and youth with Autism Spectrum Disorder (ASD) and their families.

Title X Family Planning Program
Iowa's MCH program works closely with the Title X Family Planning program. In Iowa, there are two federal grantees for Title X, Iowa HHS and the Family Planning Council of Iowa (FPCI). At HHS, Iowa's maternal health program shares staff with the Title X program, which ensures strong collaboration with the program. Those staff work closely with the FPCI programs to ensure that all women enrolled in the maternal health program have access to family planning services.

Maternal, Infant and Early Childhood Home Visitation (MIECHV)
Iowa's MIECHV program moved from the Family Health Bureau to the Bureau of Early Intervention and Supports Bureau during the government restructuring in 2023. Iowa's MIECHV program provides evidence-based home visiting in high need counties and serves as an important support to pregnant women and families of young children. Iowa's Title V and MIECHV programs have a strong history of collaboration, referral and program planning.

Iowa HHS Division of Behavioral Health
Iowa's Title V program has long established relationships with staff within the Division of Behavioral Health, especially focused on the mental health and substance use needs of pregnant women. The two bureaus have regular checkpoints to ensure collaboration and reduce duplication. The Bureau of Family Health partnered with Your Life Iowa, HHS's online resource for mental health, substance use, gambling and suicide, to build out specific resources related to maternal health mental health in 2024. Other projects include training on SBIRT and screening/referral resources for Title V staff. The Title V Director serves on the Children's Behavioral Health Board, serving as an advisory committee to the Governor and HHS Director regarding Iowa's children's behavioral health system.

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

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

Iowa's Title V Maternal and Child Health System is implemented through a community utility model and strives to improve access to care for pregnant women, children and families. At the state level there are a total of 11.75 FTEs directly funded by Title V. Within the Family Health Bureau there are 35 professional staff and 5 support staff that work on behalf of the Title V program. Iowa has a diverse staff that work within the Title V program, including registered nurses, social workers, maters of public health degrees, human service experiences, epidemiologists, among others. This diversity of staff provides a variety of experiences and education to guide the work within the Family Health Bureau.

Currently, Iowa has 14 CAH and 15 MH local agencies spanning all 99 counties. Local Title V agencies are chosen through a competitive RFP process. These agencies have an approximate combined workforce of 278 FTEs, funded through the federal/state/local partnership. Iowa's Title V workforce is competent in delivering core services, understanding the needs and issues of the vulnerable population they serve and developing partnerships with other community service providers.

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

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

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

Title V has engaged families in needs assessments to identify needs and are implementing strategies to improve families in the implementation of services. The Maternal Health and Child & Adolescent Health RFPs for Title V services were released with family engagement as a cornerstone of the work locally. Iowa HHS continues to develop long-term goals for state-level work, program planning, and contract management.

Iowa HHS has a long history of providing opportunities for students to gain valuable experience through internships, research projects and participation in grant activities. The Title V program's strongest relationship is with the University of Iowa's Master of Public Health program, although have also worked with Des Moines University, Iowa State University and the University of Northern Iowa. Each semester, the Department works with faculty in the program to identify opportunities for research or internships. The Title V program presents annually to MPH students on the Title V program, which helps with recruitment and interest in the opportunities. Iowa's Title V Director serves on the steering committee for St. Louis University's HRSA funded MCH Center of Excellence. In this role, he helps direct activities of the Center of Excellence, including continuing education programs, internship opportunities and curriculum development. The MCH Internship Program (formerly paired practicum) organized through the MCH Workforce Development Center has been another strong resources utilized by Iowa's Title V program. These interns have been extremely well prepared and are able to excel in the projects that have been assigned.

The Iowa Title V CYSHCN program operates through University of Iowa Health Care, and includes 12 Child Health Specialty Clinics Regional Centers. These community-based centers are located across the state. Currently, there are a total of 34 employees/6.18 FTEs directly funded by Title V and a total of 76 total employees.

The Division of Child and Community Health relies on University of Iowa Health Care for Human Resources activities, including recruitment and retention. Because the nature of the Child Health Specialty Clinics Regional Center structure is to provide gap-filling services, many areas struggle to find qualified candidates. While recruitment of qualified candidates can be challenging at times, offers of employment with a generous benefit package in rural communities is a helpful recruiting tool. The Health Equity Committee has focused on creating an intentional plan for expanding the racial and ethnic diversity of the workforce. Staff have reviewed and changed information and qualifications of job listings to place more emphasis on lived experience when appropriate to the position.

University of Iowa Health Care Division of Child and Community Health staff continually evaluate workforce development needs. As an organization that has operated from geographically diverse areas across the state, program staff already had capability and experience to facilitate remote trainings, even before COVID-19. University of Iowa Health Care Division of Child and Community Health facilitates many staff development opportunities and includes opportunities to earn continuing education credits. The Family Navigator Network provides monthly learning opportunities for Family Navigators. Trainings include offerings such as updates on statewide organizations, evidence-based resources, family advocacy, positive work environments, updates in waivers and social security, mandatory reporting, stigma and children's mental health, mobile crisis units, resilience, and professional ethics.

Opportunities are provided for the broader CYSHCN workforce across the state. Through foundational support from Title V and more direct support through HRSA funded grants and state funded contracts, the Iowa Title V CYSHCN program provides learning opportunities directed to primary care providers throughout the state. Opportunities from the past year have included Shared Decision Making, Gender Affirming Care, Eating Disorders, Anxiety Disorders, Treatment for Behavioral Issues, Suicide Risk, and others. On average, over 100 people attended each of the webinars that were offered.

University of Iowa Health Care Division of Child and Community Health offers pre-service learning opportunities for students through Iowa's Leadership Education in Neurodevelopmental and Related Disabilities Program (LEND), including telehealth shadowing, seminars on shared decision making, and mentoring for family advocates. Child and Community Health also routinely hosts student practicum experiences from the University of Iowa College of Public Health's Master of Public Health (MPH) program.

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

Iowa's Title V program sees the value and need for family and client involvement in the development and implementation of all state MCH activities. While the CYSHCN program has established protocols in place, the other population domains have struggled to successfully involve families and clients. Staff have networked with Region VII and other state Title V Directors to discuss strategies for this involvement; however, this remains a challenge across the region and nation for all populations outside of CYSHCN. Title V staff are implementing strategies identified through participation in the Accelerating Equity Learning Community through the MCH Workforce Development Center to address this challenge moving forward.

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

CAH Family Engagement
Iowa's Title V program understands that efforts to reduce disparities and promote health equity should be built into the intent, structure and function of programs and organizations. The CAH program is utilizing a tiered approach in promoting family-centered systems and services in Iowa by supporting parents/caregivers in engaging with their children, shaping services and programs to be family-centered, and shaping systems and policies to be family-centered. The 2023 Child and Adolescent Health RFP required a commitment from contractors to engage members of their communities in decision making. Contractors are required to outline how they would engage diverse participant voices in program planning, decision making and implementation, and how they would build partnerships with organizations designed for, and involved with priority populations, using evidence-based/informed community engagement and collective impact strategies.

The 2023 RFP required contractors to develop and implement a family engagement group using prescribed steps and methods. While the plans for building and utilizing the groups were rooted in best practice ideals, most contractors were unable to create a team of clients and community members that met the expectations of the RFP. They faced recruitment challenges they were unable to overcome, and in many situations, progress was stalled as a result. In response to the feedback provided by contractors, and in order to encourage forward movement in this area, the decision was made to modify some member requirements, allow contractors to utilize their family engagement group during the building phase, and to allow partnership with existing groups within communities. The FY24 and FY25 RFAs will reflect these changes to the requirements, which was warmly received by contractors. It's anticipated that there will be an immediate impact on the family engagement groups and in turn, the improvement of programs and services.

In the 2023 RPF and subsequent RFAs, contractors were also charged with focusing partnership and engagement strategies on designing program policies, materials, and services that would improve the health outcomes for identified priority populations, across the NPMs, SPMs and core Title V services. Each contractor was assigned one priority population from a predetermined list of eight, identified from the needs assessment. They were also allowed to select a second priority population from the same list. Clients or parents/primary caregivers from the priority populations are required to be included in the development of policies and procedures. Contractor events or meetings are to be designed to include participation from members of the priority populations and/or recruit for

representation on boards and coalitions. Agencies are encouraged to actively recruit and retain staff from the priority populations, they are required to provide annual training to all staff related to serving priority populations, and they are to create partnerships with community organizations or agencies designed for and involved with priority populations, prioritizing those led by members of the priority population. Title V staff meet with contractors regularly to review and update family engagement and health equity workplans and to provide technical assistance.

IMQCC Community Advisory Board
The IMQCC Community Advisory Board was developed in the fall of 2020 and is composed of community members from around the state of Iowa with lived birthing experiences. Members participate in both recurring monthly, and one-off meetings to provide feedback on their experiences and their suggestions for improvement in patient care.

CYSHCN
Iowa's Title V CYSHCN program has a long history of developing and supporting family partnerships. University of Iowa Health Care Division of Child and Community Health employs a full-time Family and Professional Partnership Program Manager who has lived experience as the primary caregiver of a child with special health care needs. The program manager is responsible for assuring family partnership across all levels. The Division has a nine-member Strategic Operations Team, including the Family and Professional Partnership Program Manager and the coordinator of the Family Navigator Network, who also has experience as the primary caregiver of a child with special health care needs. The Family Partnership program works to build the family leadership workforce and ensure that the family perspective is represented at all levels of decision-making. This structure also allows the family perspective to be included in recommendations to program leadership regarding policy-level decisions. Family Support and Engagement was one of four main goals of the Health strategic plan created in 2017. A revision of this plan occurred in 2021, and this goal was renamed Family Partnership.

University of Iowa Health Care Division of Child and Community Health has a long history of employing family support professionals, now known as Family Navigators. Iowa's first Family Navigator, Julie Beckett, was hired by Child Health Specialty Clinics in 1984. Ms. Beckett worked with state and federal officials to develop the "Katie Beckett Waiver," which was passed into federal law in 1982. Since that time, Iowa has continued to build infrastructure for family-centered care and partnerships.

University of Iowa Health Care Division of Child and Community Health has developed a robust, statewide Family Navigator Network. Currently, there are 22 Family Navigators in the Network. All Regional Centers include at least one trained Family Navigator who is a paid staff member and the parent or primary caregiver of a CYSHCN. Family Navigators provide family-to-family support, systems navigation, and connections to community resources. Family Navigators assure that the family voice is heard. All families receiving direct services have access to a family navigator. In addition, family-centered goal setting still occurs in all clinical visits. Goals are documented in the Electronic Medical Record, so all providers understand family goals and preferences. Goals for their child are regularly reviewed with the parents to track progress and address any barriers to achieving those goals. The Iowa Title V CYSHCN program is currently evaluating ways to strengthen family and professional partnerships through shared decision making for providers statewide.

In October 2020, the Family Navigator Network was introduced as an Emerging Practice in the Association of Maternal and Child Health Programs (AMCHP) MCH Innovations Database. The handout associated with this practice can be found here: https://amchp.org/database_entry/family-navigator-network/. Program staff worked with AMCHP in FFY2023 to develop a comprehensive evaluation plan for the Family Navigator Network, and implementation of the evaluation is currently underway.

In 2014, University of Iowa Health Care Division of Child and Community Health created a Family Advisory Council (FAC) to assist with the planning, development, and evaluation of programs and policies that impact the System of Care for Iowa CYSHCN. Members come from both rural and urban regions across the state. A recent process review with the FAC identified new approaches to optimally utilize the the FAC by providing a balance of content education and meaningful input from members. In 2021, program staff implemented a Youth Advisory Council in order to help develop youth leadership skills and advise on activities, especially for the transition to adulthood priority area. This activity is ongoing

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

Iowa's CYSHCN program has a relationship with Iowa's Family Voices affiliate, ASK Resource Center (ASK), which collaborates with Iowa Family Leadership Training Institute. Recognizing Everyone's Strengths by Peace building, Empathizing, Communicating and Trust building (RESPECT) trainers from ASK helped to shape the communication and conflict management curriculum for the Iowa Family Leadership Training Institute (IFLTI).

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

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

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

Dr. Kane has worked extensively with data linkages, vital records data, Iowa's Barriers to Prenatal Care Survey data, Medicaid paid claims data, the Iowa Hospital Discharge data file, and Title X data. She has provided data analysis to support and guide numerous programs and initiatives, most recently, Iowa's AIM project and data dashboard. Dr. Kane's research interests include women's reproductive health, access and barriers to health care, and the use of data to promote public health action. More recently, Dr. Kane has been representing the Bureau of Family Health on the Syndromic Surveillance Team. In this role she is developing a business case for the Bureau's involvement in Syndromic Surveillance and developing and testing relevant case definition in ESSENCE. Dr. Kane's recent peer-reviewed publications include:

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

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

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

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

Dr. Kane's 2023 prepared and disseminated several communication products for partners and stakeholders:

Curated customized data reports for 10 external partners (e.g., counties, community-based organizations, and Title V Maternal Health agencies). These reports were used to complete successful grant applications, conduct county level needs assessments, provide education to medical students, help community-based organizations' set priority areas, and to address disparate teen pregnancy rates in selected counties.

Created and distributed customized data reports to the University of Iowa researchers and their partners. These reports were used to examine the effect of obstetrical access to care following Medicaid privatization in 2016, to conduct an evaluation of the AIM bundle to reduce NTSV c-sections, to guide technical assistance, to examine trends in stillbirth rates from 2005 to 2021, to support quality assurance activities for the Statewide Perinatal Care Program Team as they visit hospital OB units, and activities for the Office of Statewide Clinical Education Programs. The Office of Statewide Clinical

Education will use the report to assess distribution and monitor delivering clinicians in Iowa.

Produced seven required annual reports including the state and CDC Termination of Pregnancy surveillance report, the OB workforce report which is used by the legislature to conduct surveillance of the distribution of delivering clinicians, outcome measures reported to the Centers of Medicaid and Medicare services by the Iowa Division of Medicaid, and the annual report to the Division of Medicaid. The report to the Division of Medicaid is used to monitor selected maternal and newborn outcomes by Medicaid reimbursement status using the linked file of the birth certificate linked to paid claims.

Developed and provided presentations to key stakeholders including the FSB - MCHEP Assignee Capacity Building Presentation, DRH SMM Workgroup Meeting, ASTHO-Risk appropriate care collaborative group – Storytelling with Data - Iowa Secondary Analysis – Maternal Transfers, Medicaid Maternal Health Task Force (data briefs and factors associated with preterm birth), Title V Maternal Health Monthly Contractor Call - Data briefs, the University of Iowa, College of Public Health MPH students, and presented the Iowa Quality Measures to Wellness and Prevention Branch leadership. Dr. Kane also developed and provided a presentation to the Reproductive Health Team to guide questionnaire revisions for Iowa Prenatal Care survey and the Title X Family Planning team to guide future data visualizations for presentations stakeholders.

Dr. Kane conducted analysis and provided ongoing and updated data for the Iowa Maternal Quality Care Collaborative (IMQCC) hospital accessible website and data dashboard. The IMQCC hosts three dashboards. One presents birth outcomes and access to care variables. It has been viewed over 7,500 times in 2023. A second dashboard reports quarterly NTSV rates and related process measures. This dashboard has been viewed over 4,700 2,000 times in 2023. The third dashboard, rolled out in November of 2022, presents quarterly transfusion and hysterectomy counts and has been nearly 400 times since its rollout.

Iowa has made progress in its efforts to recruit and retain program level epidemiologists. Prior to 2021 the State of Iowa did not have a job classification for Epidemiologists. Title V staff at the federal level as well as past reviewers have highlighted this fact as a challenge. As a result of the new classification, two epidemiologists have been added to the FHB.

Cassidy Hanson has been providing epidemiologic support as both the PRAMS and Oral Health Epidemiologist since 2023. Cassidy received a Bachelor of Arts in Public Health Education from the University of Northern Iowa in 2021 and her Master of Public Health Degree in Epidemiology from the University of Arizona in 2023. Prior to becoming an Epidemiologist at the Iowa Department of Health and Human Services, Cassidy worked as a research assistant for the Arizona Prevention Research Center (AzPRC) Participatory Evaluation Institute. Additionally, Cassidy has interned with the Epidemiology, Surveillance and Preparedness team at Olmsted County Public Health Services in Rochester, Minnesota and with the Childhood Lead Poisoning Prevention Program at the Iowa Department of Public Health.

In her current role, Cassidy uses her data collection, analysis, visualization, and program evaluation skills to aid in understanding oral health and pregnancy outcomes, behaviors, and accessibility among Iowa populations and share them with others. She has worked extensively with various datasets including PRAMS, I-Smile and other oral health program data, Medicaid Paid Claims data, the Behavioral Risk Factor Surveillance System, and Iowa Hospital Discharge data. Cassidy is passionate about using data to understand health concerns across the state and promote public health action.

Victoria Popp received her Bachelor of Science from Florida State University, where she continued her academic studies and went on to receive her Master of Public Health in 2022. Victoria recently joined Iowa’s Department of Health and Human Services in October of 2022. Prior to joining the Department, Victoria worked for the Florida Department of Health as an Enteric Disease Case Investigator. She also interned for the Association of Maternal and Child Health Programs (AMCHP) working alongside epidemiological staff in South Dakota.

Since October 2022, Victoria serves the Child and Adolescent Health team by providing epidemiological support and leading continuous quality improvement initiatives. As Victoria also serves as the epidemiologist for the Iowa WIC team and the Violent Death Review Team, she is able to foster collaboration across multiple teams to best serve the people of Iowa.

Victoria also serves as epidemiological support for the Child Death Review team. Victoria provides survey development, data analysis, and data visualization for many teams, as well as the production of annual reports. Victoria's research interest includes safe sleep, childcare regulations, suicide rate reduction among adolescents, and child development.

The Iowa Department of Health and Human Services successfully recruited a CSTE Applied Epidemiology Fellow (AEF) for a 2-year fellowship beginning in July of 2023. Daniela Rochez joined the MCH Epi team on July 5, 2023. Ms Rochez has taken a leadership role to complete an analysis of maternal mortality data and to write the MMRC report covering years 2019-2021. She is using the Maternal Mortality Review Information App (MMRIA) into which cases reviewed by the Maternal Mortality Review Committee are entered. In addition to this primary project she has taken a leadership role in supporting collaboration and information exchange between the numerous groups providing doula services. Ms. Rochez has participated in numerous team and agency activities as she learns the role of an applied epidemiologist.

The CSTE AEF is designed to support the nation's need for an applied epidemiology workforce capacity through the 2-year program. The program uses a mentorship and competency-based approach similar to the CDC Epidemic Service (EIS) program and is supported by CDC funding. AEF CSTE core concepts are to create and train a core group of public health epidemiologists, provide service to the sponsoring agency, and to strengthen applied epidemiological capacity.

The Iowa Title V CYSHCN program does not employ dedicated epidemiologists; however, staff have significant expertise in data management and analysis. A total of 0.6 FTE is dedicated to data analysis, which includes time from two Program Managers, a Program Coordinator, and an Electronic Medical Records Specialist. With an MPH in Public Health Policy and Administration, emphasis in Family and Child Health from the University of Michigan, Jean Willard, manages the Title V CYSHCN program and brought 17 years of professional experience in research, evaluation, data collection, and analysis prior to joining University of Iowa Health Care Division of Child and Community Health in 2013. Ms. Willard's experience includes health policy data analysis for statewide programs including Medicaid and CHIP, and the Iowa Child and Family Household Health Survey (2000, 2005, 2010). Jennifer Cook, Associate Director of Child and Community Health, has an MPH in Community and Behavioral Health from the University of Iowa and has primary responsibilities for evaluation activities. Over the past 10 years, Ms. Cook has managed evaluations for numerous projects funded through SAMHSA, HRSA, and state entities including the Iowa Department of Human Services. Qualitative data analysis is provided by an experienced Program Coordinator with an MPH in Community and Behavioral Health. Program data activities rely heavily on data retrieved through Electronic Medical Records. Extracting data from Electronic Medical Records in a format that is useful for data analysis purposes is provided through invaluable support and expertise from Deanna Wahl.

Additionally, the program is part of the University of Iowa, and has regular access to biostatisticians from the University of Iowa Department of Biostatistics when additional support or advice is necessary. The CYSHCN program has a relationship with the College of Public Health and over the past several years has sponsored MPH Practicum students, including students through the Department of Biostatistics. With the full support of departmental faculty, these students provide expertise and analysis for specific data analysis projects. Recent projects include multivariable analyses of data from the National Survey of Children's Health regarding family stress for families of children with medical complexity, food insecurity, and health equity for CYSHCN. Most recent projects include an analysis of health insurance claims data to evaluate prevalence of mental health diagnoses for children and youth in Iowa, and the use of claims data to evaluate the use of developmental screenings for young children by primary care providers. This relationship serves to increase the capacity of the CYSHCN program, as well as helping add to the MCH quantitative analysis workforce.

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

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

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

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

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

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

The following tables outlines the progress made towards the selected goals and objects during this project period.

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data driven programming
Objective 1. 1 Iowa's Title V agencies will review, update, and report on the evidence-based/evidence-informed strategy measures (ESMs) that will be linked with the relevant national performance measures (NPMs) and state performance measures (SPMs) and establish performance objectives for all measures.
Progress Made: Both the Title V Leadership team and SSDI program staff continue to monitor and evaluate the selected ESMs to ensure they are still relevant to the needs of Iowans and align with the NPMs/SPMs selected. SSDI staff continue to evaluate the availability and accuracy of data sources and utilize the data for inclusion in the annual Title V application.
Objective 1. 2 Iowa's Title V agency will identify priority needs and evaluate the previously selected National Performance Measures (NPMs) and State Performance Measures (SPMs) to ensure that the needs identified in Iowa's Title V MCH Needs Assessment are being addressed.
Progress Made: The Title V Needs Assessment is underway. Staff developed data detail sheets and are assessing the ability to address priority needs.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability
Objective 2. 1 Ensure Iowa's capacity to report on all of the elements within the minimum/core data set.
Progress Made: Iowa continues to report on the minimum and core data set on a timely manner. Relevant data is shared with the MCH epidemiologist, Title V leadership, and local agency staff. Data was used to inform the Title V block grant application. Data sharing agreements continue to be analyzed and updated as needed.
Objective 2.2 Enhance Iowa's MCH data capability by developing and supporting syndromic surveillance efforts
Progress Made: SSDI staff and the MCH Epidemiologist continue to advocate for developing a syndromic surveillance system and are working towards identifying a data champion.
Objective 2.3 Ensure Iowa's capacity to link information between key MCH datasets by continuing to develop and enhance the integrated MCH data system.
Progress Made: The SSDI coordinator and MCH epidemiologist continue to meet and discuss capacity and barriers to data linkages. These challenges are also frequently discussed with a larger internal data community of practice group. The SSDI coordinator is engaged in a departmentwide project identifying maternal & reproductive health data & projects.

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming
Objective 3.1 Develop and implement a standard data analysis plan through a health equity lens
Progress Made: The SSDI Coordinator continues to work with Title V leadership, the MCH Epidemiologist and the Health Equity team to identify data sources and data needs in regards to social determinants of health and health equity in Iowa. Staff continue to seek out trainings and best practices regarding health equity data analysis.

Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.
Objective 4.1 Identify data needs and develop products (e.g. reports, fact sheets) that will support surveillance systems development related to COVID-19.
Progress Made: Staff continue to monitor the status of COVID-19 in Iowa. New COVID-19 questions were included in the PRAMS Phase 9 Questionnaire and are currently being developed for the 2025 Barriers to Prenatal Care Survey.
Objective 4. 2 Monitor emerging MCH health issues to provide support for additional surveillance systems development when needed.
Progress Made: Staff continue to meet with reproductive/maternal health staff and stakeholders to identify trends and emerging MCH issues. Staff are also encouraged to regularly attend conferences, meeting and webinars to increase knowledge of emerging trends and issues.

Plans for Upcoming Budget Year

Plans for the upcoming year is outlined in the table below.

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data driven programming		
Objective 1. 1 Iowa's Title V agencies will review, update, and report on the evidence-based/evidence-informed strategy measures (ESMs) that will be linked with the relevant national performance measures (NPMs) and state performance measures (SPMs) and establish performance objectives for all measures.		
Timeline	**Activity**	**Staff/Group Responsible**
Complete annually in January	Evaluate evidence-based/evidence-informed strategy measures (ESMs) for relevance to current needs.	Title V Leadership
Complete annually in January	Use ESMs to monitor Iowa's progress towards improvements in the selected SPMs and NPMs.	SSDI Coordinator, Title V Leadership
Complete annually in March	Evaluate availability and relevance of data sources for selected performance measures and identify new sources as needed.	SSDI Coordinator
Complete annually in May	Report on ESMs developed to support the NPMs and SPMs.	SSDI Coordinator, Title V Leadership
Complete annually in May	Assist in development of Title V application and reports by providing data related to NPMs and SPMs.	SSDI Coordinator, Title V Leadership
Complete annually in June	Use Plan-Do-Check-Act cycles to update MCH logic models to address evolving needs of Iowa's MCH population.	SSDI Coordinator, MCH Regional Consultants, MCH RFP Team
Complete annually in July	Monitor performance objectives based on current NPMs, SPMs, and ESMs outlined to facilitate improvement.	Title V Leadership
Complete annually in July	Continue to contribute to Title V annual reporting.	SSDI Coordinator, Title V Leadership
Ongoing	Develop communication mechanism for reporting findings related to NPMs and SPMs.	SSDI Coordinator, MCH Regional Consultants
Ongoing	Continue the development and enhancement of the integrated MCH data system.	SSDI Coordinator, Data Integration Team
Objective 1. 2 Iowa's Title V agency will identify priority needs and evaluate the previously selected National		

Performance Measures (NPMs) and State Performance Measures (SPMs) to ensure that the needs identified in Iowa's Title V MCH Needs Assessment are being addressed.		
Timeline	**Activity**	**Staff/Group Responsible**
Complete annually in May	Develop Data Detail Sheets to create a snapshot of Iowa's MCH population.	Title V Needs Assessment Core Team
Complete annually in June	Conduct focus groups and key informant interviews or relevant data sets with MCH clients statewide to understand the effectiveness of Iowa's Title V programs from a client perspective.	Title V Needs Assessment Core Team
Complete annually in June	Assess capacity at state and local levels for addressing identified priority needs.	Title V Needs Assessment Core Team
Complete annually in June	Based on Data Detail Sheets and qualitative data obtained in the focus groups, identify priority needs related to Iowa's MCH population.	Title V Needs Assessment Leadership Team
Complete annually in June	Based on priority needs and state and local capacity, evaluate previously selected NPMs and SPMs to ensure needs are being measured and addressed.	Title V Needs Assessment Leadership Team
Ongoing	Determine the data needs for SPMs, including data sources, analyses plan and identify any practices that would benefit from a Plan-Do-Check-Act cycle.	SSDI Coordinator, Title V Leadership, MCH Regional Consultants

Goal 2: Strengthen access to, and linkages of, key MCH datasets to inform MCH Block Grant programming and policy development, and assure and strengthen information exchange and data interoperability		
Objective 2. 1 Ensure Iowa's capacity to report on all of the elements within the minimum and core datasets.		
Timeline	**Activity**	**Staff/Group Responsible**
Complete annually in March	Review current capacity to report on all minimum and core dataset elements.	Title V Needs Assessment Core Team
Ongoing	Continue to collect data elements of the minimum and core data set.	Title V Needs Assessment Core Team
Complete annually in July	Use minimum and core data set to inform the Title V needs assessment.	Title V Needs Assessment Core Team
Ongoing	Develop or update formal data sharing agreements between Family Health Bureau and data holders where needed.	SSDI Coordinator
Complete annually in March	Review priority core data set elements to ensure appropriate evaluation Iowa's Title V MCH programs.	Title V Needs Assessment Core Team
Ongoing	Develop or update formal data sharing agreements between Family Health Bureau and data holders where needed.	SSDI Coordinator
Objective 2. 2 Enhance MCH data capability by developing and supporting syndromic surveillance efforts		
Timeline	**Activity**	**Staff/Group Responsible**
Ongoing	Develop or update formal data sharing agreements between Family Health Bureau and data holders where needed.	SSDI Coordinator
Objective 2. 3 Ensure Iowa's capacity to link information between key MCH datasets by continuing to develop and enhance the integrated MCH data system.		
Timeline	**Activity**	**Staff/Group Responsible**
Complete annually in March	Evaluate Iowa's capacity to link data sets and identify potential barriers to data linkage. Document information in a shared file to be updated on an annual basis.	SSDI Coordinator, MCH Epidemiologist
Complete annually in March	Review Iowa's capacity to facilitate access to data related to the minimum and core data sets.	SSDI Coordinator, MCH Epidemiologist
Ongoing	Invest in infrastructure to support cost benefit analysis related to selected data within the core and minimum data sets.	Family Health Bureau

Goal 3: Enhance the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming		
Objective 3.1 Develop and implement a standard data analysis plan through a health equity lens		
Timeline	**Activity**	**Staff/Group Responsible**
4/2025	Train MCH staff on best practices regarding data analysis in regards to advancing health equity	SSDI Coordinator, Title V Leadership, MCH Epidemiologist

Goal 4: Develop systems and enhance data capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats, such as COVID-19.		
Objective 4.1 Identify data needs and develop products (e.g. reports, fact sheets) that will support surveillance systems development related to COVID-19.		
Timeline	**Activity**	**Staff/Group Responsible**
6/2025	Analysis of newly developed questions related to COVID-19.	SSDI Coordinator, MCH Epidemiologist
Complete annually in July	Create and provide fact sheets to be placed on the Iowa HHS website and shared with providers and community stakeholders (at minimum once per year).	SSDI Coordinator, MCH Epidemiologist
Objective 4.2 Monitor other emerging MCH health issues to provide support for additional surveillance systems development when needed.		
Timeline	**Activity**	**Staff/Group Responsible**
Ongoing	Regularly consult with the FHB staff to determine if SSDI has the capacity to provide support for additional emerging MCH issues (at minimum 4 times per year).	SSDI Coordinator
Ongoing	Attend conferences, community meetings, and events in order to increase knowledge and awareness of emerging MCH issues.	SSDI Coordinator
As needed	Identify data sources relevant to newly identified emerging MCH issues in Iowa.	SSDI Coordinator, MCH Epidemiologist
As needed	Produce materials for programs working on newly identified emerging MCH issues.	SSDI Coordinator, MCH Epidemiologist

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

Iowa's Barriers to Prenatal Care Project

Ongoing since 1992, the purpose of this project is to obtain brief, accurate information about women delivering babies in Iowa hospitals. Specifically, the project seeks to learn about women's experiences getting prenatal or delivery care during their current pregnancy. Other information is included which may be pertinent to health planners or those concerned with the systematic development of health care services.

This project is a cooperative venture of all Iowa's maternity hospitals, the University of Northern Iowa Center for Social and Behavioral Research, and the Iowa Department of Health and Human Services. The Robert Wood Johnson Foundation funded the first three years of this project. The current funding is provided by the Iowa Department of Public Health. The Director is Dr. Mary Losch, University of Northern Iowa Center for Social and Behavioral Research. The Coordinator for the project is Rodney Muilenburg.

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

The present yearly report includes an analysis of large Iowa cities, a trend analysis of the last ten years, a frequency analysis of COVID-19 questions, and a frequency analysis of all variables included in the 2022 questionnaire. Data presented in the report are based upon 2022 questionnaires received to date (n = 17,986). All analyses reflect unweighted percentages of those responding.

PRAMS

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

Iowa PRAMS has identified 8 research priorities based on the maternal and child health priorities as determined through the Title V and Title X needs assessment processes for Iowa, as well as Healthy People 2030 objectives.

- Enhance data collection and dissemination efforts to promote evidence-based decision making in planning, policy, evaluation, allocation and accountability
- Reduce infant morbidity and mortality through improving safe sleep practices
- Improve pregnancy planning and spacing and prevent unintended pregnancy
- Incorporate mental health into relevant preventive health efforts within MCH programs
- Improve rates of breastfeeding
- Explore the prevalence of maternal substance use, including alcohol use, binge drinking, tobacco and electronic cigarette use, opioid use, and illicit drug use
- Improve access to preventive and restorative dental care for low-income pregnant women
- Reduce racial disparities in maternal and child health outcomes

BRFSS

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

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

Iowa Connected

The FHB continues to integrate program data including care coordination, referral management, risk assessment, practice management, billing, and client and population level reporting. The programs consolidated/integrated to the system, Iowa Connected, are Child and Adolescent, Maternal Health, Family Planning, 1st Five and Oral Health. Iowa HHS transitioned to the new system on June 19, 2023. Prior to this date, Iowa utilized **signify**community as the integrated data system for these programs.

The objective of the Iowa Connected project is to provide a case management system that allows for continued support of MCH related programs. Iowa Connected is used by programs within the FHB and by outside agencies/providers partnered with the Bureau to provide and coordinate services for individuals across Iowa. It also drives reporting, performance management, and billing across those programs and agencies.

Iowa's Integrated Data System for Decision Making (I2D2)

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

What is I2D2?

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

I2D2 Commits to Priorities for the Long-Term

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

Enhancing Effectiveness and Efficiency for Decision-Makers

- I2D2 gives agencies the power to improve policies and programs with cross-system data.
- I2D2 standardizes legal processes to ensure all protections are in place and reduce the need to revisit

comprehensive data sharing provisions with each use.
- I2D2 prioritizes data security by minimizing data sharing and enforcing strict user-based role access protocols.
- I2D2 fosters collaboration and maximizes efficiency by relieving the burden on agency staff to coordinate cross-agency responses to data requests.

I2D2 brings together the rigor and strength of our nation's first land-grant institution, Iowa State University, with the policy experience and insight of Early Childhood Iowa – a statewide organization dedicated to providing early care, education, health, and human services for children zero through five. Through this partnership, I2D2 puts the state's most informed, passionate, and data-driven resources to work ensuring all Iowa children are successful from birth.

Iowa Violent Death Reporting System

Iowa is funded by the Centers for Disease Control & Prevention to collect data on violent deaths for the National Violent Death Reporting System. Using data from death certificates, medical examiner reports, and law enforcement reports, the Iowa Violent Death Reporting System (IAVDRS) gathers information on cause of death and contributing circumstances, and enters it into a national database. Iowa HHS contracts with the University of Iowa Injury Prevention Research Center (UI IPRC) to implement IAVDRS. Violent death includes death by homicide, suicide, law enforcement intervention, unintentional firearm injury, undetermined intent, and terrorism. An advisory committee that consists of data providers and community partners working to prevent violent deaths guides the program. Community partners and researchers can use IAVDRS data to contribute to a better understanding of violent deaths in Iowa and develop strategies to prevent them.

Iowa data collection started for deaths that occurred beginning in calendar year 2015. In 2015, data was collected from the seven most populous counties (Black Hawk, Johnson, Linn, Polk, Pottawattamie, Scott and Woodbury). Statewide data collection began in calendar year 2016. Data collection is on average 18 months delayed, ie: 2022 data was closed out in April 2024.

Iowa Maternal Mortality Review Committee

The Iowa Maternal Mortality Review Committee is part of an ongoing quality improvement cycle. The committee leads understanding of the drivers of maternal death and determination of what interventions will have the most impact at patient, provider, facility, system and community level to prevent future deaths. The committee determines: if the death was pregnancy-related? What was the underlying cause of death? Was the death preventable? What are the contributing factors to the death? What specific and feasible actions might have changed the course of events? This important work is intended to move from data collection about maternal deaths to prevention activities.

The Iowa MMRC is hosted by Iowa HHS staff as the lead agency and collaborates with the Iowa Medical Society. The two organization work together to select committee members, provide orientation for new members, coordinate communication with members, schedule meetings, distribute case summaries and ensure a complete CDC MMRC decision form is completed for each maternal death case presented. Committee members include Maternal Fetal Medicine, Obstetrics and Gynecology, Family Medicine, Nurse Midwifery, Mental Health Provider, Addiction Medicine, Violence Prevention, Anesthesiology, Forensic Pathology, Law Enforcement and Health Start Director.

National MMRC information - The link below has an interactive map, you can link to profiles for state level MMRC's across the nation including Iowa.

- https://www.reviewtoaction.org/tools/networking-map

Challenges in MCH Data

The main barrier to improving the use of maternal and child health data centers around HIPAA data privacy regulations. These data privacy regulations represent outdated policies that limit care coordination, prevent timely

access to data, and do not keep up with technological changes, all of which pose an undo administrative burden.

The balancing act that takes place between an individual's right to data privacy and protection with the need for care coordination and with technological advancements can pose a challenge. Both maintaining HIPAA compliance and protecting individuals' protected health information (PHI) from exposure are paramount at Iowa Health and Human Services. Although there have been minimal changes to HIPAA rules and regulations since 2013, there has been a call nationally to loosen some administrative regulations to facilitate better care coordination across covered and noncovered entities. The 2019 request for information (RFI) represented a step towards lessening the administrative burden that HIPAA can pose on covered entities. This is crucial regarding facilitating patient care coordination across not only a complex healthcare system, but also throughout an individual's life course. Time and time again, it has been shown that coordination throughout a multifaceted approach to care produces improves outcomes for individuals, which is why care coordination has been highlighted as such an effective intervention in population and individual health. Administrative processes and regulations surrounding HIPAA should aim to make compliance less of a burden, while still maintaining patient privacy and upkeeping the protection of individuals' protected health information. Without changes to these policies and procedures, care coordination cannot take place at the level required to see population level health changes.

In addition to limiting the ability to coordinate care, HIPAA regulations also make it difficult to keep up with ever advancing technological changes. Technology changes at such a rapid pace, it is as difficult as it is important for policies and procedures to keep up. It is clear that HIPAA cannot remain the same as technology and its impact on privacy laws continue to evolve quickly. The way in which technology, healthcare, and HIPAA are intertwined was furthered by the COVID-19 global pandemic. The pandemic quickly changed the way healthcare is delivered and the benefit of technology within the healthcare system is now undeniable. To overcome data challenges while still respecting data privacy, applicable laws such as HIPAA must be revised to keep up with changes in technology and promote care coordination.

Technological improvements have created innumerable novel opportunities to collect and analyze data. One of the key challenges to utilizing maternal and child health data effectively is that there are a multitude of barriers to obtaining timely data. In addition to the time that's needed to properly collect, measure, and clean data, data privacy requirements also pose an undue burden when it comes to the timely analysis and dissemination of data. Access to accurate, reliable and timely information enables leaders to make the most informed decisions. As technology continues to evolve and connect individuals to care, data privacy policies need to change too. Updating HIPAA data privacy laws would improve the utilization of MCH data by alleviating some undo administrative burden, by keeping up with technological changes in a post-pandemic world, and by improving timely access to data.

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

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

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

Child Care Nurse Consultants follow the national Child Care Health Consultant (CCHC) Competencies. CCHC Competency 10A states that the CCHC/CCNC Helps programs prepare for, respond to, and recover from emergencies and disasters.

CCNCs work collaboratively with Early Care and Education (ECE) programs to develop written emergency preparedness, response, and recovery plans including plans for responding to emergency situations or natural disasters that may require evacuation, lock-down, or sheltering in place. The CCNC also helps ECE programs develop relationships with relevant community partners to support emergency preparedness, response, and recovery.

Healthy Child Care Iowa (HCCI) and local CCNCs are written into the Iowa Statewide Child Care Emergency Preparedness and Response Plan. HCCI and CCNCs help to provide Iowa specific resources, communications, guidance documents and reference materials related to public health federal or state policy; environmental hazards, communicable disease outbreaks and other resources. CCNCs also represent the needs and concerns of child care providers and parents around emergency response and disaster impact on the child care infrastructure with county boards of public health, county emergency managers, and HHS.

The Iowa Title V CYSHCN program is housed within University of Iowa Health Care, which is the largest tertiary care center in the state and includes Iowa’s most comprehensive Children’s Hospital. UI Health Care has adopted the National Incident Management System (NIMS) and the Hospital Incident Command System (HICS) as standardized organizational and operational structures for responding to disasters and major emergencies. The UI Health Care Emergency Management Subcommittee includes representatives from the Stead Family Children’s Hospital to ensure that the needs of children and youth, including those with special health care needs, are recognized. Among other things, this subcommittee maintains relationships and participates in county, state, and federal programs related to emergency management.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Iowa HSS and University of Iowa Health Care Division of Child and Community Health maintain many formal and informal partnerships benefiting Iowa families. This leveraging of resources to plan and implement MCH, including CYSHCN, programs results in a strong statewide network.

MCHB Investments: Iowa HHS manages several MCHB projects, including the State System Development Initiative; Maternal, Infant, and Early Childhood Home Visiting; Pediatric Mental Health Care Access Initiative; Innovations of Care Coordination for Children and Youth with ASD, Early Hearing Detection and Intervention (EHDI) and Maternal Health Innovation. Other projects include participation in the National MCH Workforce Development Center and other TA opportunities. The Iowa Title V program has a partnership with Iowa's Leadership Education in Neurodevelopmental and Related Disorders Training Program (LEND) through the University of Iowa.

Federal Investments: HSS and Child and Community Health manage and/or work closely with other federal agency programs that include the PREP, SRAE, Title X Family Planning, Infant and Child Death Review, Early Intervention, and Head Start. Projects through the Centers for Disease Control and Prevention include an Oral Disease Prevention grant, ERASE Maternal Mortality, AIM Capacity, Perinatal Quality Collaboratives, a MCH Epidemiologist (CDC assignee), the Pregnancy Risk Assessment Monitoring System, EHDI and Learn the Signs. Act Early. Strong collaborations exist with the US Department of Agriculture's Special Supplemental Nutrition program for Women, Infants, and Children.

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

State and Local MCH Programs: HSS contracts with local health departments and private, non-profit agencies for MCH program activities. In addition to families, local MCH contractors work with each county board of health, including participation in regular community health needs assessments and health planning. Projects rely on local coordinators to facilitate partnerships and referrals with medical and dental offices and community organizations. Other state and local partnerships include programs in adolescent health, mental, developmental, and behavioral health programs and the Regional Autism Assistance program.

HSS Programs: The MCH program has strong linkages within HSS Bureaus of Immunizations, Chronic Disease Prevention and Management, as well as Vital Records & Health Statistics, and Substance Abuse Prevention and Treatment programs.

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

Public Health and Health Professional Educational Programs and Universities: Iowa has long-standing collaborations with public health and health professional education programs, including UI Colleges of Nursing, Medicine, Public Health, and Dentistry; the University of Northern Iowa; Des Moines University; and community colleges. Activities include education and training for students within health provider training programs, training for MCH contractors about depression screening and Listening Visits, and assistance developing standards of care and evaluating quality of care to reduce mortality and morbidity of infants. Collaborations also include the Iowa LEND program and the University Center for Excellence in Developmental Disabilities (UCEDD).

Family/Consumer Partnership and Leadership Programs: Some of the ways that HSS and University of Iowa Health Care Division of Child and Community Health hear family and consumer viewpoints are through focus groups, advisory councils, the Access for Special Kids Resource Center, and Family Voices.

State and Local Public and Private Organizations that Serve the State's MCH Population: HSS and Child and Community Health have many public-private partnerships with organizations such as Delta Dental of Iowa Foundation, the Iowa Chapter of the AAP, ChildServe, Blank Children's Hospital, the Iowa Primary Care Association, the National Alliance on Mental Illness Iowa Chapter, and Common Good Iowa. Opportunities range from funding for school-based dental sealant programs, participation on health advisory councils, and evaluating program data. Child and Community Health is part of the University of Iowa Health Care, which includes the Stead Family Children's Hospital, Iowa's only comprehensive children's hospital.

Family/Consumer Partnerships: The Iowa Title V CYSHCN program employs a Family and Professional Partnerships Program Manager. This position assures family partnership at all levels and requires lived experience caregiving for a CYSHCN. Feedback from families is integrated into all levels of activities. The CYSHCN program also has an active Family Advisory Council. Both family navigators and members of the FAC receive training on MCH core competencies. In 2022, University of Iowa Health Care Division of Child and Community Health Youth Advisory Council held its first meetings. The council builds leadership and self-advocacy skills and is working toward a model that allows it to provide guidance to the program's transition to adulthood activities. In addition University of Iowa Health Care Division of Child and Community Health works diligently to expand the workforce for family partnerships through the Family Peer Support program and the Iowa Family Leadership Training Institute.

HSS maintains family partnerships through the MCAH contract agencies that work directly with families within the Collaborative Service Areas, providing care coordination, referral assistance, and gap-filling preventive health services. Families are represented on the Title V MCH Advisory Council (MCHAC) and on local health coalitions and similar types of councils.

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

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

HSS works through local Title V MCH contractors to assure health services for families, which include helping clients

become better consumers and navigators of the health care system. Contractors report that the majority of family issues they address are related to medical/dental appointments and health issues and services. Contractors also work with families to find assistance with transportation, translation, food, clothing, and housing as well as referrals to other programs.

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

Iowa's Title V program and the Iowa Medicaid program have a strong working relationship through an established contract. The current contract is for three years, with an option to renew for an additional three years (for a total of 6 years). This contract, the Omnibus Agreement, does not include services for children with special health care needs.

The Omnibus Agreement addresses cooperation between Title V, Title X, WIC, Title XIX, and Title XXI programs. Roles of Medicaid and Title V are identified, and program descriptions are included. The purpose of each component and their impact on the Medicaid core measures is as follows:

- Attachment A - Informing and Care Engagement Administrative Services: This establishes parameters for Title V local contract agencies to provide and receive payment for the following:
    - Informing families of new Medicaid eligible children ages 0 to 21 years of the benefits and services within the EPSDT program.
    - Providing medical care coordination services for pregnant women and children on Medicaid who are not enrolled in a Medicaid MCO.
    - Providing dental care coordination for any Medicaid enrolled pregnant woman or child. This allows clients to be linked to oral health services provided by a dentist and coordinate oral health care services.
    - Providing presumptive eligibility for low income pregnant women. This service is open to the uninsured – both citizens and non-citizens. The pregnant woman is able to receive Medicaid covered maternal health services right away and establish an OB provider.
- Attachment B - Child and Adolescent Health, EPSDT: This defines staffing for program support for the following:
    - Provides staff support for quality monitoring of EPSDT services provided by Title V contract agencies. FHB staff provide training, consultation, technical assistance, and quality review of local contract agencies (e.g. chart audits).
- Attachment C - Maternal Health: This defines staffing for program support for the following:
    - Provides staff support for quality monitoring of maternal health services provided by Title V contract agencies. FHB staff provide training, consultation, technical assistance, and quality review of local contract agencies (e.g. chart audits).
- Attachment D - **I-Smile™**: This defines staffing for program support for the following:
    - Provides Title V staff support for implementation of the I-Smile™ dental home initiative to improve access to Medicaid dental prevention and treatment services for children and pregnant women. Title V staff provide training, consultation, technical assistance, and quality review of local contract agencies.
    - Provides funding for local agencies to connect children and families with dental, medical and community resources. This includes infrastructure work to increase the provider networks that will see Medicaid enrolled clients.
- Attachment E - 1st Five Children's Healthy Mental Development: This defines staffing for program support for the following:
    - Provides FHB staff support for quality monitoring of 1st Five sites located within Title V contract agencies in 88 of Iowa's 99 counties.
    - Provides funding for local 1st Five sites to increase the number of providers performing

developmental screening utilizing a validated, reliable tool at the EPSDT recommended intervals. This funding does not pay for care coordination services.

- Attachment F – MCH and Hawki Outreach Services: This attachment provides support for the following:
  - MCH Outreach Services: Supports the toll-free 1-800 phone line so that women, youth, and families can receive information and referral for questions relating to prenatal care and well child services in addition to other services the family may need.
  - Hawki Outreach: Provides support for a state level Hawki Outreach Coordinator and funding for local Title V CAH contract agencies to conduct Medicaid and Hawki outreach activities to promote enrollment.
- Attachment G – Medicaid and Vital Records Linked Data: Provides support for linking vital records data files and Medicaid paid claims data to evaluate health outcomes related to Medicaid services provided for pregnant women and children. Through this attachment, FHB funds the MCH Epidemiologist, through an agreement with the CDC.

Program outreach and enrollment

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

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

Health Care Financing

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

Waiver Programs

Iowa currently has seven Home and Community Based Services (HCBS) Waivers that provide funding and individualized supports to allow eligible members to live in their own homes and communities. Many waivers have long waitlists. Five of the current waivers apply specifically to Iowa CYSHCN: the Health and Disability Waiver, the Intellectual Disability Waiver, the Brain Injury Waiver, the Physical Disability Waiver, and the Children's Mental Health Waiver. Through a contract with Iowa Medicaid, the University of Iowa Division of Child and Community Health provides consultation, technical assistance, planning and care coordination activities for some waivers. Over the past 2 years, HHS has been evaluating and redesigning Iowa Medicaid waiver programs. It is anticipated that when the process is complete, there will be two waiver programs, one for Children and Youth populations, and another for Adult and Aging populations. Eligibility for waiver services will be based on level of care needed, and specific disability categories.

Joint Policy Level Decision Making

Over the years, the Title V Director has experienced many opportunities to meet with Iowa's Medicaid Director on

joint policy issues and problem resolution. Examples include working together to implement the informing and care coordination program; shifting care management from ‘targeted case management’ to ‘administrative care coordination’ based upon federal clarification; including interpretation for PE, informing, and care coordination as a service paid by FHB to local MCAH agencies through HHS/Medicaid funding; increasing Medicaid’s reimbursement rate for certain services based upon Cost Analyses completed by local Title V MCAH contract agencies; establishing third party billing policies; and resolving some instances of lack of payment to local contract agencies from the MCOs.

Approximately 13 staff from various programs within the Family Health Bureau and Oral Health Center meet monthly with the IME Maternal Health Center & Screening Center Project Manager, IME Oral Health Project Manager, and IME Contract Manager. The meetings provide an opportunity for staff to pose questions and concerns, provide input, and receive updates from IME on Medicaid policy and current issues. Challenges that local MCAH agency contractors have experienced are presented and discussed. FHB shares information on progress within MCAH and other programs of mutual interest.

Medicaid Core Set Measures

States are required to report on several Medicaid Health Care Quality Measures to monitor and improve the quality of care provided to Medicaid beneficiaries. These measures are part of efforts to ensure that Medicaid programs across the country are meeting certain standards of care.

The following tables display the Medicaid Health Care Quality Measures that Iowa's Title V program impact directly or indirectly through our work of the Omnibus agreement and Title V NPMs and SPMs.

2025 Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set):

2025 Mandatory Child Core Set Measures

Measure Name
Primary Care Access and Preventive Care
Childhood Immunization Status (CIS-CH)
Well-Child Visits in the First 30 Months of Life (W30-CH)
Immunizations for Adolescents (IMA-CH)
Developmental Screening in the First Three Years of Life (DEV-CH)
Child and Adolescent Well-Care Visits (WCV-CH)
Lead Screening in Children (LSC-CH)
Maternal and Perinatal Health
Live Births Weighing Less Than 2,500 Grams (LBW-CH)
Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)
Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)
Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)
Low-Risk Cesarean Delivery: Under Age 20 (LRCD-CH)»
Dental and Oral Health Services
Oral Evaluation, Dental Services (OEV-CH)
Topical Fluoride for Children (TFL-CH)
Sealant Receipt on Permanent First Molars (SFM-CH)

2025 Provisional Child Core Set Measures

Measure Name
Postpartum Depression Screening and Follow-Up: Under Age 21 (PDS-CH)
Prenatal Immunization Status: Under Age 21 (PRS-CH)
Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)

2025 Core Set of Maternal and Perinatal Health Measures for Medicaid and CHIP (Maternity Core Set):

2025 Mandatory Maternity Core Set Measures

Measure Name
Live Births Weighing Less Than 2,500 Grams (LBW-CH)
Well-Child Visits in the First 30 Months of Life (W30-CH)
Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)
Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)
Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)
Low-Risk Cesarean Delivery: Under Age 20 (LRCD-CH)[b]

2025 Voluntary Maternity Core Set Measures

Measure Name
Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD)
Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)
Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)
Low-Risk Cesarean Delivery: Age 20 and Older (LRCD-AD)[b]
Prenatal Immunization Status: Age 21 and Older (PRS-AD)[c]
Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP-AD)[c]

2025 Provisional Maternity Core Set Measures

Measure Name
Postpartum Depression Screening and Follow-Up: Under Age 21 (PDS-CH)
Postpartum Depression Screening and Follow-Up: Age 21 and Older (PDS-AD)
Prenatal Immunization Status: Under Age 21 (PRS-CH)
Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)

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

State Action Plan Introduction

State Action Plan Introduction

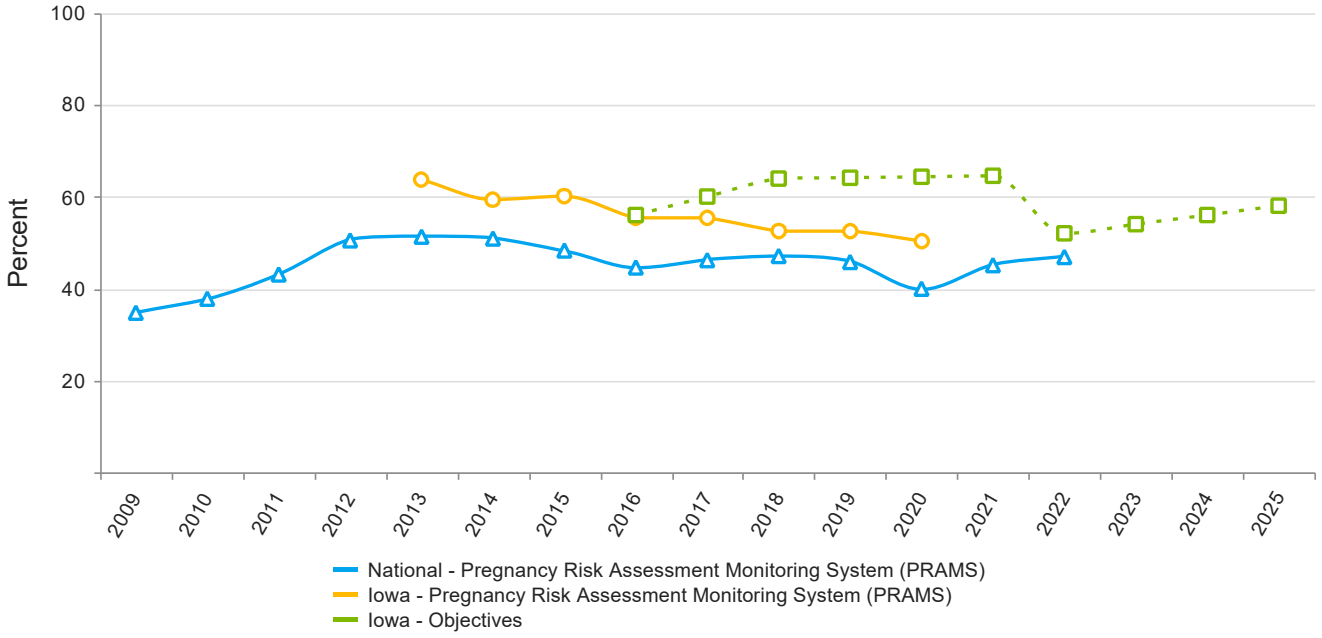
Iowa's Title V programs promote the development of systems of health care for children (with and without SHCN) ages 0-21 years, pregnant women, and their families. Iowa strives for services that are collaborative, comprehensive, flexible, coordinated, culturally competent, developmentally appropriate,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

The State Action Plan and Annual Reports highlight the planned activities for FFY2025, ongoing activities, and accomplishments of FFY2023. The State Action Plan is broken into the Population Domains selected by HRSA.

Women/Maternal Health

National Performance Measures

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	64.1	64.3	64.5	52	54
Annual Indicator	55.3	52.4	50.3	50.3	50.3
Numerator	19,796	18,294	16,828	16,828	16,828
Denominator	35,811	34,942	33,461	33,461	33,461
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	56.0	58.0

Evidence-Based or –Informed Strategy Measures

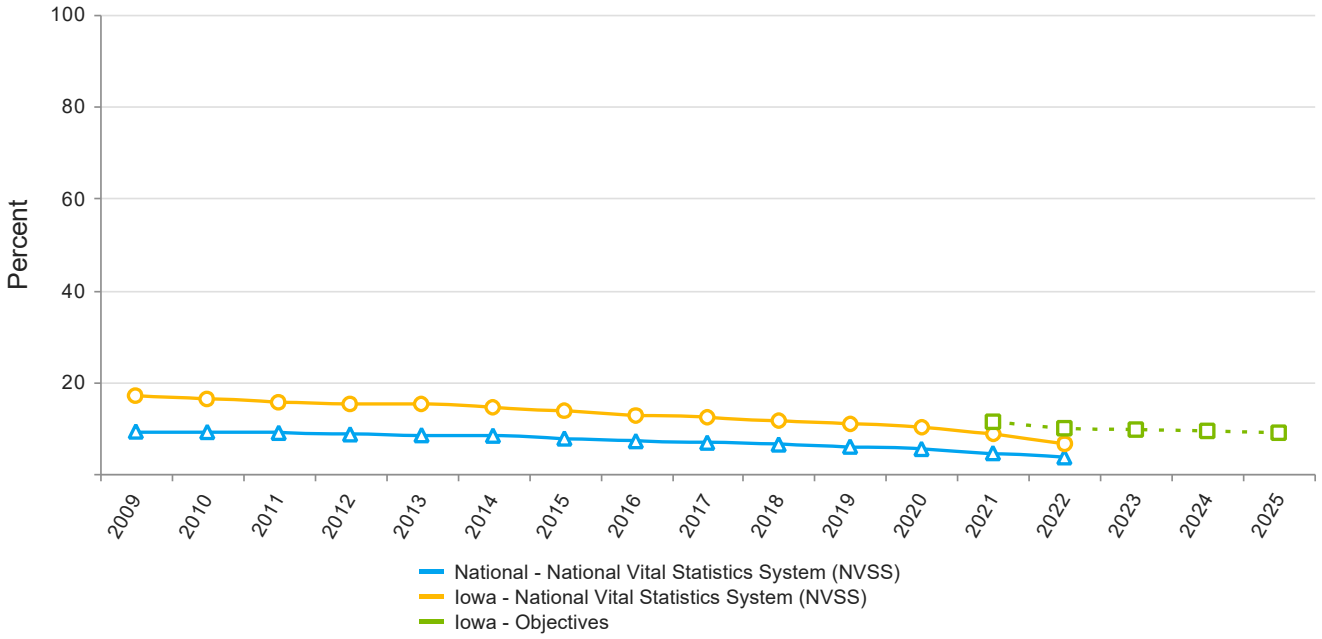
ESM PDV-Pregnancy.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	355	400	400	400	400
Annual Indicator	397	397	365	370	343
Numerator					
Denominator					
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	400.0	400.0

NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			11.4	10	9.7
Annual Indicator	11.6	11.0	10.3	8.7	6.7
Numerator	4,388	4,120	3,713	3,214	2,456
Denominator	37,751	37,613	36,085	36,805	36,477
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	9.4	9.0

Evidence-Based or –Informed Strategy Measures

ESM SMK-Pregnancy.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			50	75	76
Annual Indicator			73.6	52.9	69.3
Numerator			53	2,287	219
Denominator			72	4,324	316
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	77.0	78.0

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV
Indicators and Annual Objectives

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally available Data (FAD) for this measure is not available/reportable.

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally available Data (FAD) for this measure is not available/reportable.

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			9	8.9	8.8
Annual Indicator		9.4	9.4	9.4	9.4
Numerator					
Denominator					
Data Source		Iowa's Maternal Mortality Review Committee (IMMRC)	Iowa's Maternal Mortality Review Committee (IMMRC)	Iowa's Maternal Mortality Review Committee (IMMRC)	Iowa's Maternal Mortality Review Committee (IMMRC)
Data Source Year		2019	2020	2019-2021	2019-2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	8.7	8.6

State Action Plan Table

State Action Plan Table (Iowa) - Women/Maternal Health - Entry 1	
Priority Need	
Dental Delivery Structure of the MCAH Population	
NPM	
NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	
Five-Year Objectives	
By 2025, increase the percent of women who had a preventive dental visit during pregnancy to 65.3%	
Strategies	
Build and enhance partnerships with community organizations and health care providers	
Oral health promotion for expectant parent and baby	
Outreach to dental and medical providers including birthing centers	
Care coordination and referrals	
Partner with community organizations to promote health equity	
Gap-filling preventive services	
Collect race and ethnicity data to help identify gaps in services	
ESMs	**Status**
ESM PDV-Pregnancy.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator	Active
NOMs	
NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	

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

Priority Need

MCAH Systems Coordination

NPM

NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy

Five-Year Objectives

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

Strategies

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

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

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

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

Local Title V agencies provide individualized health education to all maternal health clients on the importance of tobacco cessation and provide referrals to resources to support cessation

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

ESMs	Status
ESM SMK-Pregnancy.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer	Active

NOMs

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

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

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Priority Need

Access to care for the MCAH Population

NPM

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

By 2025, will increase the rate of attendance at postpartum visits to 93%

Strategies

- Educate on the importance of postpartum visits and offer at least one postpartum visit to all maternal health clients
- Black and African American Maternal Health Clients who receive Doula services will receive up to three postpartum visits
- Title V agencies will ensure staff are appropriately trained on postpartum visits and warning signs
- Title V agencies will refer clients to a lactation counselor when appropriate

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

State Action Plan Table (Iowa) - Women/Maternal Health - Entry 4

Priority Need

MCAH Systems Coordination

SPM

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

Five-Year Objectives

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

Strategies

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

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

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

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

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

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

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

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

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

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

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

According to PRAMS data, although the current FAD is 50.3% from 2020, 2021 data shows an increase to 54.6% of women with a preventive dental visit during pregnancy. This aligns with Iowa's annual objective of 54% for 2023.

This increase can likely be contributed to increased dental care coordination and services provided by Maternal Health contractors to pregnant women and a return to pre-pandemic dental office capacity for preventive dental care. Additionally, the 2020 rate may have been low due to COVID and its impact on public health services and dentistry.

Despite efforts to increase oral health education by MH and CAH contractors, many pregnant women remain unaware of the safety and importance of receiving dental services during pregnancy. This, along with the decreasing number of dentists willing to accept Medicaid-enrolled patients and limited availability of dentists willing to treat pregnant women, may negatively affect future rates.

The Iowa Department of Health and Human Services' (HHS) Oral Health Section staff continued efforts to increase oral health messaging for pregnant and soon-to be-pregnant women throughout FFY23. The I-Smile Dental Home Initiative Facebook page provided multiple oral health messages each week, some of which focused on good oral health during pregnancy. A partnership with the Maternal Health, Family Planning and WIC programs resulted in a radio commercial promoting oral health before, during and after pregnancy. The messaging aired 4,154 times on 92 different radio stations, reaching over 635,000 individuals, and was streamed 442,053 times on various streaming services.

Iowa's Title V service area landscape changed beginning October 1, 2023 as a result of the need to better align service areas for the various programs and contracts offered by Iowa HHS. At that time, the Maternal Health program issued a Request for Proposal (separate from Child and Adolescent Health) to contract with entities who were equipped and desired to provide maternal health services. To ensure local collaboration about oral health, improve oral health and birth outcomes, and ensure optimal oral health for infants, Oral Health Section staff began requiring quarterly meetings between the CAH I-Smile Coordinator and Maternal Health Director within each service area . I-Smile Coordinators were also required to provide oral health training to Maternal Health program staff that provide preventive dental services (e.g., oral screening, fluoride varnish application, and counseling) to Maternal Health clients. They also trained Maternal Health staff on dental care coordination to help clients overcome barriers related to social determinants of health. These trainings ensured staff understood the role of oral health in overall health and were updated on current recommendations, policies, and procedures.

I-Smile Coordinators made in-person visits with all Obstetrics and Gynecology (OB/GYN) offices, or women's health centers if no OB/GYN offices available in a county, within their service area. During these visits they shared educational materials, posters, and fliers to promote the importance of preventive dental care for mothers and their babies before, during, and after pregnancy. I-Smile Coordinators were also required to conduct a promotion initiative highlighting the importance of oral health for women of reproductive age. Examples of this promotion included distribution of new mom and baby care bags to women who had recently delivered which included oral health supplies and educational information and community baby showers. In FFY23, MH clients received more than 1,600 dental screenings and 986 dental care coordination calls to connect them with the dental and medical services they needed.

An ongoing collaboration continued with Count the Kicks, a program dedicated to preventing stillbirths by promoting healthy habits throughout pregnancy. Count the Kicks received grant funding, which facilitated the purchase of

supplies and promotional materials for oral hygiene kits which were then distributed to expectant mothers by direct service staff as they provided oral health education.

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

Iowa continues to have higher rates of maternal smoking than the national rate, however the percentage does continue to consistently trend down. Title V and the Tobacco program collaborated to reduce smoking rates for many years, and the consistent messaging and support through the Quitline program have likely helped reduce this rate over the years.

Local Title V agencies were required to continue to connect with their local Tobacco Community Partnership grantees. Agencies are required to develop coalitions to address maternal health, and agencies whose service area reflects a higher rate of smoking will be encouraged to include local tobacco program staff in the coalition, and to identify local strategies the coalition can implement to reduce smoking in pregnant women. During FY2023 all awardees held at least one coalition meeting and will continue to bring people together in their CSA to address the Maternal Health needs in their area.

Title V nurses at local agencies are required to complete the Treating Tobacco Use During Pregnancy training (formally known as Ask, Advise, Refer) and to utilize this process when working with clients who smoke. During chart audits and data reviews, Iowa HHS Title V staff review documentation to ensure all clients who report smoking during pregnancy are provided education on smoking cessation and a warm referral to Iowa's Prenatal Quitline program. This program includes an incentive, which clients will be educated on.

State MH staff worked with MH agencies to provide training and technical assistance to support their work in addressing each Title V NPM and SPM. A tobacco lunch and learn was held for all contractors and included specific training on tobacco resources for pregnant women.

State staff have continued to engage with the Iowa HHS Tobacco Use Prevention and Control program to identify innovative strategies to reduce smoking and ensure opportunities for collaboration continue to be explored

Local MH agencies provide direct services to Medicaid enrolled and uninsured pregnant women. During the reporting period, a total of 4,339 clients were seen, with 2,671 receiving enhanced health education,2.633 clients were screened for tobacco use, 2,829 clients were screened for depression, 3,684 were screened for domestic violence and 2,636 were screened for substance use, and 47 participated in a lactation class. All clients receiving health education are required to receive education on topics related to the Title V National and State Performance Measures, including breastfeeding, tobacco cessation, oral health, safe sleep, and topics related to recommendations from Iowa's Maternal Mortality Review Committee (MMRC). Clients that report tobacco use are referred to Iowa Quitline.

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

During the reporting period, Iowa held 3 Maternal Mortality Review Committee (MMRC) meetings, a schedule that resulted from seeing an increase in maternal deaths within one year postpartum. As a result of these increased efforts, Iowa is on track to have all cases reviewed within 2 years of the maternal death. Iowa continues to implement strategies based on the most recent MMRC report findings, including AWHONN's POST-BIRTH Warning Signs and seatbelt safety education. Local MH agencies provide tailored nursing and social work services to pregnant and

postpartum women based on the MMRC recommendations, including enhanced health education and substance use and mental health screenings.

The Iowa AIM program implemented the Obstetric Hemorrhage Safety Bundle during the reporting period, resulting in a 5.1% decrease in Iowa's near-miss events of severe maternal morbidity from hemorrhage within 9 months of implementation. Multiple statewide learning sessions were held in FFY2023, and Iowa's AIM QI Coaches met regularly with the 56 participating birthing hospitals. Toward the end of the reporting period the Iowa AIM program began implementation of the Severe Hypertension Safety Bundle, which will continue through the next reporting period.

Iowa HHS MH staff developed new requirements for RFP applicants to address the National and State Performance Measures (NPM/SPMs) to implemented during FY2023. Significant changes included a new requirement to develop a coalition to address maternal and reproductive health issues in each CSA, and a strong emphasis on family engagement. All applicants were required to establish strong community partners and regularly engage with families to continue to provide education on safe sleep best practices to clients and partners. During FY2023 all awardees held at least one coalition meeting and will continue to bring people together in their CSA to address the Maternal Health needs in their area, several of which have chosen to focus on addressing Maternal Mortality.

Women/Maternal Health - Application Year

Universal Postpartum Visit NPM: A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components

In calendar year 2021, PRAMS data indicated that the rate of attendance at postpartum visits was 90.7%. Iowa has focused on postpartum follow up for several years due to recommendations from the Maternal Mortality Review Committee and will continue these efforts into future years.

Postpartum care is important, not only to ensure that the mother's body is healing well, but to ensure that that there are no physical or emotional complications or issues that have arisen since birth. This visit also serves as an opportunity to educate on topics such as breastfeeding and safe sleep now that the baby is born, as well as to offer support and referrals for any issues or stressors that have appeared since birth.
Title V Maternal Health clients already receive one postpartum visit; with a preference for a postpartum home visit. Postpartum visits include education around POST-BIRTH warning signs, if the client had not been seen during their pregnancy, they would be referred to services such as WIC to support them beyond the Healthy Pregnancy Program. Iowa HHS will continue to support local agencies' efforts to provide postpartum visits and education. All client educational materials will be reviewed and approved by Iowa HHS staff to ensure proper education is provided to clients to serve their needs postpartum.

Iowa HHS Title V MH staff will include all requirements for local agencies specified in the strategies in the agency contract and will review implementation during site visits.
African American and Black identifying maternal health clients in four Iowa counties are offered Doula services. Doula clients receive up to 6 weeks of post-delivery support consisting of 3 visits. These visits include infant feeding education and support, breastfeeding consultation, referrals, postpartum care and recovery, and Infant health and well-being. This is a pilot project that will run through the FY25. This program allows Black and African American Title V maternal health clients to receive postpartum support and connection with someone who understands their perspectives and experiences.

During the 2024 legislative session, the Iowa legislature passed to expand Medicaid to provide postpartum coverage up to 12 months for mothers up to 215% FPL. The Title V program is working to identify what this would entail for our program's coverage, and what Medicaid would cover for different postpartum visits. The timing of when Medicaid expansion would become enacted is still pending but may impact our FY25 plans and goals depending on what we are able to have our Title V Maternal Health agencies offer. The change in FPL eligibility will also be a discussion that may impact our numbers on this performance measure moving forward. Iowa's Title V program is fortunate to have a strong relationship with the Medicaid program and is included in the preparation and planning for implementation of the Medicaid state plan amendment.

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

According to PRAMS data, although the current FAD is 50.3% from 2020, 2021 data shows an increase to 54.6% of women with a preventive dental visit during pregnancy. This aligns with Iowa's annual objective of 54% for 2023.

This increase can likely be contributed to increased dental care coordination and services provided by Maternal Health and Child Health contractors to pregnant women and a return to pre-pandemic dental office capacity for

preventive dental care. Additionally, the 2020 rate may have been low due to COVID and its impact on public health services and dentistry.

Despite efforts to increase oral health education by MH and CAH contractors, many pregnant women remain unaware of the safety and importance of receiving dental services during pregnancy. This, along with the decreasing number of dentists willing to accept Medicaid-enrolled patients and limited availability of dentists willing to treat pregnant women, may negatively affect future rates.

The Dental NPM will be addressed by Iowa HHS Oral Health (OH) staff and through the I-Smile (Child and Adolescent Health) and Maternal Health (MH) programs. Oral Health education and access to dental services will be maintained or increased for women of child-bearing ages through HHS partnerships with the following programs/organizations: Count the Kicks (MH/OH promotion), Delta Dental of Iowa Foundation (funding opportunities), Iowa Primary Care Association (FQHC referrals), Oral Health Iowa coalition (advocacy), Molina Healthcare (Medicaid benefits), Title X/Family Planning (OH education and services), Iowa HHS Division of Behavioral Health (Tobacco/OH education), University of Iowa College of Dentistry (current science and research), and WIC (OH services for clients).

An HHS OH staff member has recently been assigned to serve as the MH/OH liaison. She will oversee and strengthen relationships with the MH and Title X/Family Planning programs to ensure optimal oral health remains a priority for women of child-bearing age. The MH/OH liaison will also strengthen the partnership with Count the Kicks, a program using evidence-based strategies to save babies and prevent still births, to ensure promotional materials and messaging remain relevant and useful. OH staff will continue to ensure Count the Kicks messages are shared through I-Smile oral health promotions and social media and that educational materials are distributed to MH clients and medical and dental offices while providing outreach.

The MH/OH liaison will oversee a statewide effort to increase the number of MH program participants receiving OH preventive services in partnership with the I-Smile program in FFY25. Efforts are currently underway to research promotional items and educational materials that will incentivize clients to receive OH services from the MH programs around the state. In addition, OH staff will interview I-Smile coordinators who have demonstrated success in serving MH clients to then develop a ‘best practices’ guide to share with other I-Smile coordinators.

In FFY2025, a pilot project begun in 2024 to provide enhanced oral health education within a Title X/Family Planning clinic will continue. OH staff will develop scripts for Title X clinic staff to use to provide oral health education to women who indicate they would like to be pregnant within the next year or are unsure if they want to be pregnant within the next year. Education will focus on optimal oral health before, during and after pregnancy, regular dental visits, and/or oral care for the newborn. Feedback from this project will be used to finesse protocols and messaging to ensure the maximum benefit for Title X staff and clients.

OH staff will maintain a new partnership with Molina Healthcare to increase oral health services for prenatal women and MH clients. As a Managed Care Organization for Medicaid services in Iowa, Molina offers value-added benefits for their clients to encourage optimal healthcare. Although Molina does not provide dental benefits, they are able to incentivize clients to participate in the MH program, which offers oral screenings and oral health education to encourage overall health and wellbeing during pregnancy.

I-Smile coordinators will continue to meet with the MH director for their Collaborative Service Area (CSA) on a quarterly basis to ensure local collaboration regarding improving oral health and birth outcomes for low-income women and to ensure optimal oral health for their infants. I-Smile coordinators will also be required to provide training on preventive services and dental care coordination for MH staff that provide these services to MH clients. The

training ensures MH staff comprehend the significance of oral health in overall well-being and that they are equipped with the most current recommendations, policies and procedures.

In FFY25, I-Smile coordinators will make in-person visits to all dental offices in their service areas to develop positive relationships that support referrals. They will also visit all obstetrics/gynecology offices to promote optimal oral health as part of overall health. For counties that do not have an obstetrics/gynecology office, the coordinators must visit family planning clinics and/or women's health clinics. At the dental and medical office visits, coordinators may share educational posters, promotional items and/or written educational materials to inform providers and clients on the importance of preventive dental care for the mother and baby, promote referrals to dentists and the I-Smile program, and provide education on the importance of preventive dental care before, during and after pregnancy.

Coordinators will be required to develop a health promotion initiative targeting women of child-bearing age. An example of this in past years was developing packets of materials (educational fliers, adult and infant toothbrushes, I-Smile coordinator and contact information) for medical offices to distribute at prenatal appoints to ensure the importance of oral health care during pregnancy.

OH staff will enhance the use of MH program data in FFY25 to address health equity and to better understand where targeted technical assistance or other interventions may be needed. The MH/OH liaison will use the strengthened partnership with Title X/Family Planning to identify gaps and needs throughout the state to equitably provide OH services. The data and its findings will be shared and discussed with MH contractors at annual in-person site visits and with Iowa HHS MH program staff.

Smoking NPM: A) Percent of women who smoke during pregnancy

The percent of women who smoke during pregnancy has declined. Iowa HHS has had a strong focus on maternal tobacco use over the past ten years due having a higher rate of maternal smoking than the national average (8.7 vs. 4.6, respectively). An emphasis on Iowa's Quitline program for pregnant women and general education and screening for tobacco use likely contributed to the decline. Unfortunately, it is also possible that the reduction in smoking is in part due to an increase in other forms of tobacco, particularly vaping and other "smokeless tobacco" options that the public may have misperceptions about the safety of those products in pregnancy.

Local Title V agencies will be required to continue to connect with their local Tobacco Community Partnership grantees. Agencies are required to develop coalitions to address maternal health, and agencies whose service area reflects a higher rate of smoking will be encouraged to include local tobacco program staff in the coalition, and to identify local strategies the coalition can implement to reduce smoking in pregnant women. Title V nurses at local agencies will be required to complete the Treating Tobacco Use During Pregnancy training (formally known as Ask, Advise, Refer) and to utilize this process when working with clients who smoke. During chart audits and data reviews, Iowa HHS Title V staff will review documentation to ensure all clients who report smoking during pregnancy are provided education on smoking cessation and a warm referral to Iowa's Prenatal Quitline program. This program includes an incentive, which clients will be educated on. State staff will continue to engage with the Iowa HHS Tobacco Use Prevention and Control program to identify innovative strategies to reduce smoking and ensure opportunities for collaboration continue to be explored.

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

2021 maternal deaths have been reviewed, but the data is still being analyzed. The Maternal Mortality Review

Committee are also unable to draw any conclusions from changes in the rate over the years due to small numbers, however continue to utilize recommendations from previous maternal mortality reviews. Due to many strategies implemented to reduce maternal deaths since Iowa adopted this performance measure, staff anticipate the rate to decrease over the years. Anecdotally, following a mass campaign on seatbelt safety, the most recent maternal mortality review cases did not include a single motor vehicle death where the pregnant or postpartum woman was unrestrained. While numbers of maternal deaths are too small for this to be statistically significant, the hope is to see a continued reduction in motor vehicle deaths where the woman was not wearing a seatbelt.

In FFY24, Iowa completed two Maternal Mortality Reviews for 2021 deaths. Results from these reviews will be available prior to FFY2025, and Iowa HHS MH staff will utilize recommendations from the committee to update direct care requirements for local Title V agencies. Local MH agencies will continue to provide postpartum home visits and include screening, education, and physical assessments based on the 2021 MMRC recommendations. A new requirement in FFY2023 was for local agencies to develop coalitions for their service area specific to maternal health, agencies will continue their coalitions in FFY2025. Agencies will share the new recommendations with their coalition and work on community-driven strategies to reduce the maternal mortality rate.

Local MH agencies were also required to identify a Maternal Health Director, who is at a minimum 0.5 FTEs. In FFY2025, Iowa HHS MH staff will work with the MH Directors to develop their skills in leading their coalitions to make changes in their community and to utilize local data to drive the change. Training and professional development opportunities will be shared with the MH Directors, and a minimum of one in-person meeting will be required to discuss ways to build up infrastructure at the local level to support pregnant and postpartum women and reduce maternal mortality.

Iowa HHS will continue to have a strong focus on health equity as a strategy to reduce maternal mortality, particularly disparities in Black and African American identifying pregnant and postpartum women. Iowa's Title V Community Based Doula Project for African American Families will be implemented in the current four counties (Polk, Black Hawk, Dubuque, and Scott), with a focus on increasing the workforce and assisting Iowa Medicaid in implementing payment for doula services for Medicaid beneficiaries. In addition to general training on utilizing local program data, MH Directors will receive support in disaggregating their local agency data to identify disparities in their community, and will work with their coalitions to identify strategies to address any identified disparities.

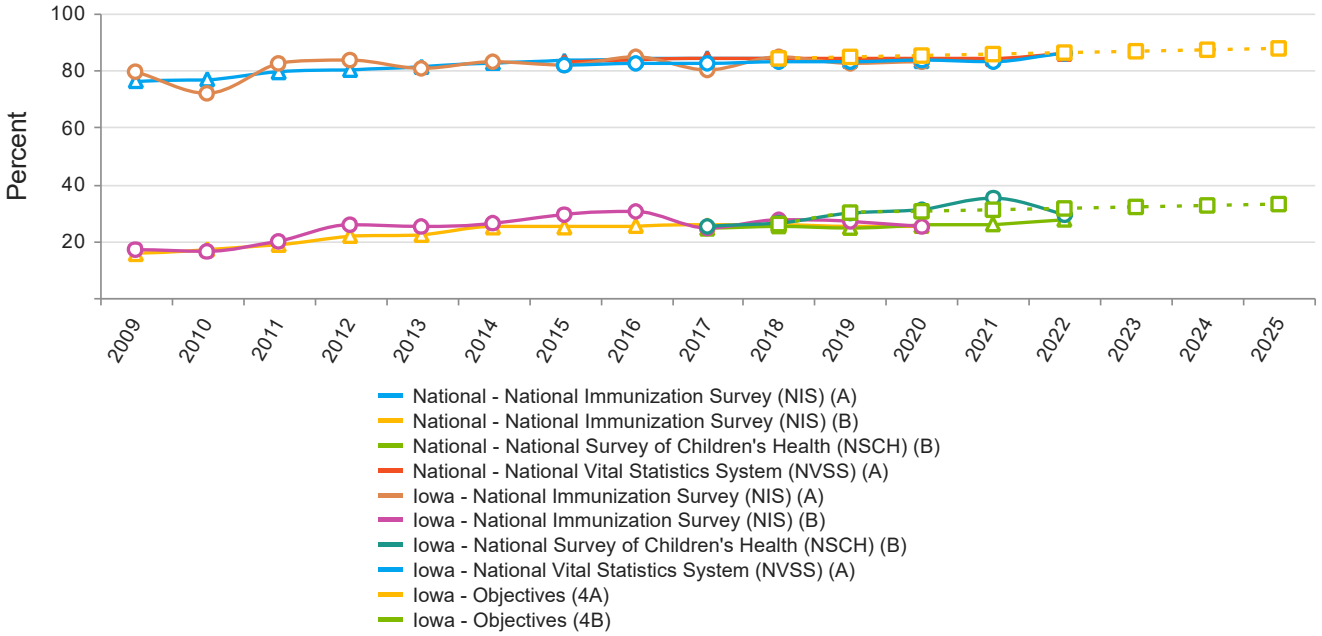
Iowa HHS Maternal health will also be expanding their postpartum visits through one-year postpartum, to align with Medicaid Expansion. The details of what these expanded offerings will look like is still pending the Governor's signature and Medicaid reimbursement guidance.

Title V MH staff will continue participating on the Iowa Maternal Quality Care Collaborative to receive updates on state level maternal health best practices as well as to share updates on Title V work. Staff will continue to collaborate with ERASE MM staff to implement statewide initiatives to address maternal mortality.

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF
Indicators and Annual Objectives



NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	84.5	85	85.5	86	86.5
Annual Indicator	84.5	80.2	84.7	82.4	82.7
Numerator	27,589	28,001	29,640	27,149	25,443
Denominator	32,646	34,927	34,980	32,950	30,761
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	86.5
Annual Indicator	85.8
Numerator	30,706
Denominator	35,768
Data Source	NVSS
Data Source Year	2022

Annual Objectives		
	2024	**2025**
Annual Objective	87.0	87.5

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	30	30.5	31	31.5	32
Annual Indicator	30.5	24.8	27.3	27.0	25.0
Numerator	9,785	8,458	9,169	8,547	7,539
Denominator	32,069	34,057	33,621	31,621	30,105
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	32
Annual Indicator	29.3
Numerator	29,078
Denominator	99,115
Data Source	NSCH
Data Source Year	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	32.5	33.0

Evidence-Based or –Informed Strategy Measures

ESM BF.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age

Measure Status:	Inactive - Replaced				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			23	46	25
Annual Indicator			17	19	28
Numerator					
Denominator					
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected and Year End Report
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

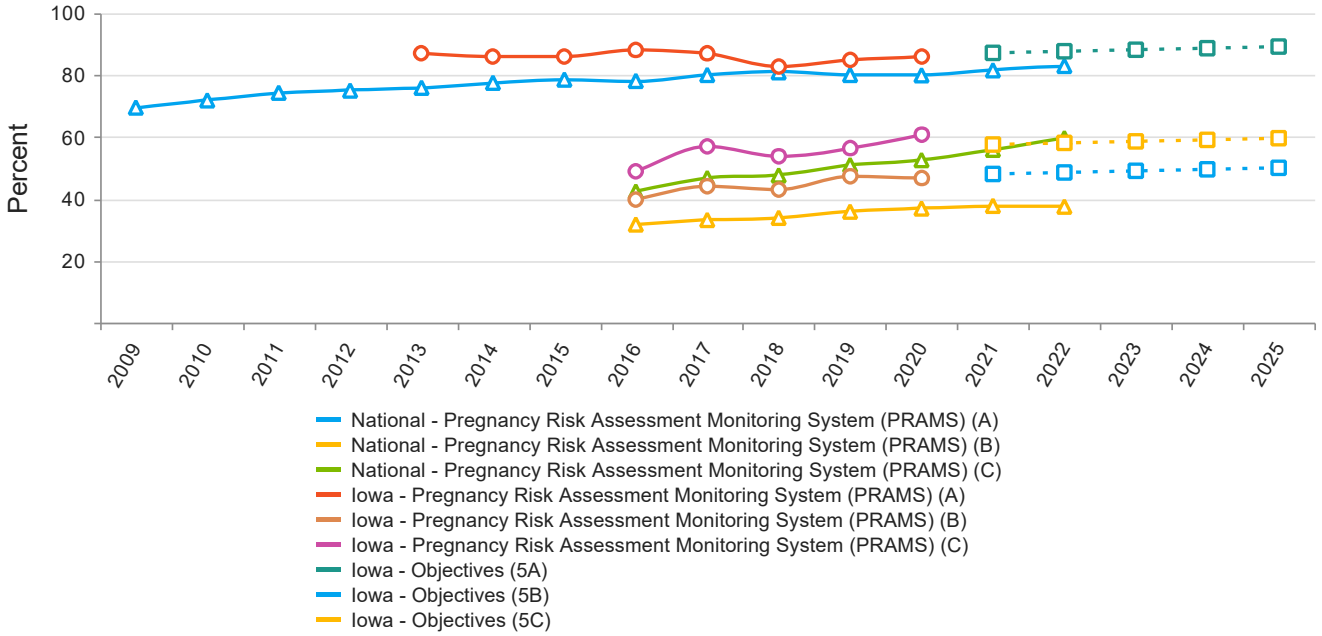
ESM BF.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			30	65	85
Annual Indicator			64.7	81.5	69
Numerator			1,591	3,522	2,221
Denominator			2,460	4,324	3,219
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	73.0	75.0

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS
Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			87	87.5	88
Annual Indicator	86.7	84.8	85.7	85.7	85.7
Numerator	30,649	29,197	28,106	28,106	28,106
Denominator	35,356	34,418	32,785	32,785	32,785
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	88.5	89.0

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			48	48.5	49
Annual Indicator	44.2	47.5	46.5	46.5	46.5
Numerator	15,044	15,850	14,684	14,684	14,684
Denominator	34,022	33,343	31,570	31,570	31,570
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	49.5	50.0

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			57.5	58	58.5
Annual Indicator	57.0	56.1	60.8	60.8	60.8
Numerator	19,594	18,702	19,376	19,376	19,376
Denominator	34,396	33,309	31,865	31,865	31,865
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	59.0	59.5

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			12	14	
Annual Indicator			6	34	60
Numerator					
Denominator					
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	65.0	70.0

State Action Plan Table

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

ESMs	Status
ESM BF.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age	Inactive
ESM BF.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work	Active

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

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

Priority Need

Safe and Healthy Environments

NPM

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Five-Year Objectives

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

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

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

Strategies

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

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

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

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

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

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

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

ESMs	Status
ESM SS.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year	Active

NOMs

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

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

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

Breastfeeding rates fell slightly from 2018 to 2019 for infants ever breastfed (84.7% - 82.4%) and for infants breastfed exclusively for 6 months (27.3% - 27.0%). Iowa's local Title V Maternal Health agencies focused heavily on breastfeeding initiation and duration during this time period, and agencies worked with families to provide support for breastfeeding. Iowa has continued efforts to increase breastfeeding rates since before 2018, and we anticipate seeing these rates increase, although we do anticipate that the COVID-19 pandemic has caused a dip that we are working to overcome.

Iowa HHS Maternal Health posted the Request for Proposal (RFP) for local Title V Maternal Health (MH) agencies in FFY2022, for work beginning FFY 2023. RFP requirements were determined based on the outcomes of the FFY2020 Title V Needs Assessment, which prioritized maternal mortality, maternal smoking, breastfeeding, safe sleep, and maternal oral health.

Iowa HHS MH staff developed new requirements for RFP applicants to address the National and State Performance Measures (NPM/SPMs). Significant changes included a new requirement to develop a coalition to address maternal and reproductive health issues in each CSA, and a strong emphasis on family engagement. All applicants were required to establish strong partnerships with birthing hospitals and WIC agencies in their service areas, which will ensure enhanced support for breastfeeding for Title V clients. Applicants were required to continue or initiate relationships with hospital and community lactation consultants, as well as to develop new infrastructure-building strategies to address breastfeeding in their service areas. All awardees held at least one coalition meeting in FY2023, many build their own coalitions, some merged with existing coalitions, such as a breastfeeding coalition, to ensure they were not duplicating efforts and to capitalize upon an engaged audience.

Iowa's CDC MCH Epidemiologist developed CSA-level data reports for each service area. Applicants were required to utilize the data provided to identify populations and geographical areas to target based on the data provided, and were also required to conduct a gap analysis of the entire service area to determine how local MH services could complement and improve upon existing services, and fill gaps in access to services. Data elements provided included breastfeeding rates at hospital discharge for each county in the service area as well as breastfeeding rates for the CSA as a whole.

Iowa HHS MH staff continued to work with MH agencies to provide training and technical assistance to support their work in addressing each Title V NPM and SPM. MH staff participated in workgroups for Iowa's Breastfeeding State Plan and contributed to the state plan in collaboration with Iowa's WIC program.

Local MH agencies provide direct services to Medicaid enrolled and uninsured pregnant women. During the reporting period, a total of 4,339 clients were seen, with 2,671 receiving enhanced health education and 47 participating in a lactation class. All clients receiving health education are required to receive breastfeeding education.

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

The percent of infants placed to sleep on their backs and placed to sleep without soft objects or loose bedding both

increased from 2019 to 2020, however the percent of infants placed to sleep on a separate approved sleep surface declined slightly. While Iowa remains higher than the national rate for each indicator, there is a clear need to focus on increasing the percentage of infants placed to sleep on a separate approved sleep surface. It is likely the pandemic impacted these rates, where it appears to have had a protective impact on infants sleeping on their back and without soft objects or blankets, and a negative impact on bed-sharing and other unsafe sleep surfaces such as swings, pillows, or rock and plays. This could have been impacted by limited childcare options and more parents working from home with their children present, and placing them to sleep in more convenient locations. 2020 is still the most recent nationally available data, so we cannot speak to whether or not this trend has changed in recent years.

Iowa HHS MH staff developed new requirements for RFP applicants to address the National and State Performance Measures (NPM/SPMs) to implemented during FY2023. Significant changes included a new requirement to develop a coalition to address maternal and reproductive health issues in each CSA, and a strong emphasis on family engagement. All applicants were required to establish strong community partners and regularly engage with families to continue to provide education on safe sleep best practices to clients and partners. During FY2023 all awardees held at least one coalition meeting and will continue to bring people together in their CSA to address the Maternal Health needs in their area.

Iowa's CDC MCH Epidemiologist developed CSA-level data reports for each service area. Applicants were required to utilize the data provided to identify populations and geographical areas to target based on the data provided, and were also required to conduct a gap analysis of the entire service area to determine how local MH services could complement and improve upon existing services and fill gaps in access to services. Data elements provided included intended infant sleep practices at hospital discharge, such as using blankets and co-sleeping.

Iowa HHS MH staff worked with MH agencies to provide training and technical assistance to support their work in addressing each Title V NPM and SPM. Iowa HHS provides funding to the Iowa SIDS Foundation to conduct statewide education on safe sleep and to facilitate Iowa's Safe Sleep Workgroup. Workgroup participants discussed findings from Iowa's Child Death Review Team and shared resources and updates on activities related to promoting safe sleep and preventing infant deaths. During the reporting period, the SIDS Foundation worked with Iowa HHS to identify internal areas of possible policy change that could effect Safe Sleep in the State.

Local MH agencies provide direct services to Medicaid enrolled and uninsured pregnant women. During the reporting period, a total of 4,339 clients were seen, with 2,671 receiving enhanced health education. All clients receiving health education are required to receive safe sleep education.

Perinatal/Infant Health - Application Year

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

Breastfeeding rates have declined for both measures between 2018 and 2020 (84.7% - 82.7% and 27.3% - 25%). Despite concentrated efforts to increase breastfeeding rates at the state and local level, it is likely the pandemic impacted rates in 2020. Hospitals implemented restrictive policies at the beginning of the COVID-19 Pandemic such as separating mothers and newborns when the mother tested positive, and not allowing additional birth support workers such as doulas and lactation consultants to enter patient rooms in an effort to reduce the spread of COVID. This may have negatively impacted the success of new mothers in initiating their breastfeeding journey and in return, reduced the rate of mothers who sustained breastfeeding beyond six months. Staff are hopeful the trend improves as more emphasis is placed on the importance of lactation support immediately following delivery and throughout the postpartum period. Access to breast pumps for Medicaid and WIC beneficiaries has varied over the past few years due to multiple changes in Medicaid policy related to breast pumps. As Iowa's Title V, WIC, and Medicaid policy staff continue to collaborate, staff anticipate the duration of breastfeeding beyond six months to increase. As workplace culture shifts to be more family-centered, Title V staff are optimistic that more working moms in Iowa will be able to sustain breastfeeding once they return to work. Iowa has a very high rate of households where both parents are working, so ensuring policies and workplace culture are supportive of breastfeeding will be extremely important in raising this rate in Iowa.

Iowa HHS Title V MH staff will include all requirements for local agencies specified in the strategies in the agency contract and will review implementation during site visits.

Local agencies identify a minimum of one birthing hospital to collaborate with and increase referrals to and from lactation consultants. In areas where the birthing hospital does not have a lactation consultant, the agencies are required to identify resources and build a strong referral system between the birthing hospital and other organizations with lactation consultants such as their own Maternal Health program, WIC, and other local resources. Iowa HHS staff will provide support to agencies in connecting with their local birthing hospital, if needed, by linking with the hospital's staff participating in the Iowa AIM program. Iowa HHS Maternal Health staff working in the AIM program have developed strong relationships with the hospital OB unit staff and can make connections with local Title V agencies as needed. Another area of opportunity to strengthen referrals to community resources is through the Iowa Breastfeeding Database. This new initiative within Iowa HHS aims to increase lactation accessibility and connect Iowans to resources in their community. Iowa HHS Maternal Health staff will explore the utilization of the database within Title V clinics, including submitting their referral lists to be included in the database.

Local agencies are required to identify an employer to work with in improving their support to breastfeeding employees. During agency site visits and contractor meetings, strategies for connecting with employers and supporting them outside of providing basic information about Iowa laws will be shared.

All agencies will be required to verify participation in their local breastfeeding coalitions, verify local resource lists for breastfeeding support and document all staff training related to breastfeeding support. Communication regarding policies around breast pump access within WIC and Medicaid MCOs will be sent out regularly to all agencies.

All client educational materials will be reviewed and approved by Iowa HHS staff to ensure proper education is provided to clients. Iowa HHS staff will work with agencies to increase access to lactation classes provided by Title V agencies, including supporting developing workflows, outreach, and marketing for classes and assistance with billing.

Title V agencies included in the Title V Doula Pilot project will be encouraged to train doulas as Certified Lactation Consultants. Clients working with participating doulas will receive culturally congruent breastfeeding support.

State Title V MH staff will meet regularly with state WIC staff to identify areas for improved collaboration at the state and local level and to identify gaps in lactation support between the two programs. Identified gaps will be addressed through TA, training, and contract management of local agencies.

Iowa HHS recently hired a Breastfeeding Coordinator to oversee breastfeeding related activities in the Division, mainly focusing on efforts between WIC, SNAP-ED, and Title V. Title V will work on identifying opportunities for cohesive breastfeeding activities to reach more of Iowa's population. Efforts will begin by identifying areas of duplicative work that can be streamlined, as well as identifying gaps in Iowa's approach to breastfeeding initiation and duration. State Title V MH staff will continue collaborating with the WIC program to implement Iowa's Statewide Breastfeeding Strategic Plan which is in effect through 2026. The Breastfeeding Strategic Plan has 4 goals to address different areas of opportunity related to breastfeeding. Goal 1 focuses on building collaborative partnerships

to improve coordination of maternal and child health breastfeeding programs. Goal 2 looks to improve access to adequate and quality lactation services across Iowa. Goal 3 is examining how to increase community-based support for breastfeeding. Finally, Goal 4 focuses on improving awareness, support and access to donor breastmilk. Currently State Title V staff serve on goal 1 which focuses on developing a statewide referral system to improve access to maternal and child health breastfeeding services.

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

Data related to infant sleep practices has remained relatively stable since 2012. Iowa continues to provide education to new parents and providers in a variety of ways, however influencing behavior change in parents and unregistered child development homes has proven difficult. Anecdotally from qualitative data sources, parents seem to know the recommendations related to infant sleep practices, but in the moment do not follow them. Contributing factors to these behaviors may be lack of support to new parents, substance use (legal and illegal), and misperceptions that it won't happen to their infant.

The percentage of infants placed to sleep on an approved safe sleep surface slightly decreased from 2019 - 2020, while the other two measures increased (asleep on their back and without soft bedding). It is possible the pandemic played a part in this issue, with many individuals' employment and financial situations changing substantially. This may have impacted families' access to safe sleep items, such as cribs and pack and plays. In addition, many individuals started working from home, which may have increased the number of individuals placing their infants in unsafe sleep situations. Iowa has also had past initiatives that provided cribs to families in need, and as these grant opportunities and funding sources change or go away, fewer families may have had access to safe sleep items at that time. The fourth measure of the percent of infants room sharing with an adult during sleep is new, so we have not been tracking this measure previously. However, room sharing is part of the safe sleep education that the Title V program provides.

Iowa HHS Title V MH staff will include all requirements for local agencies specified in the strategies in the agency contracts, and will review implementation during site visits. Local agencies will identify one community organization, healthcare organization, or retailer that serves parents, prospective parents, or caregivers such as grandparents, to provide safe sleep education and outreach that underscores the importance of babies sleeping on their backs, on an approved surface, without soft objects or loose bedding, in the same room as an adult.

All agencies will be required to maintain a safe sleep resource directory, provide client education and ensure all direct service staff have received training on safe sleep. Iowa HHS will provide a minimum of one training opportunity on safe sleep best practices and ways to incorporate cultural humility into their education on safe sleep.

All client educational materials will be reviewed and approved by Iowa HHS staff to ensure proper education is provided to clients.

Iowa HHS Title V MH staff will review charts and agency data annually to ensure all clients receive individualized education on safe sleep practices, and that providers utilize Iowa's Safe Sleep Field Guide for education. Training will be provided to all Title V MH nurses on safe sleep best practices and how to support families in making the safest choice when putting their infants to sleep.

State Title V MH staff will continue to collaborate with partners on the HHS Safe Sleep Workgroup. This workgroup is informed by the Child Death Review Team and will implement new strategies to address sleep-related infant deaths as new information becomes available. Strategies may include developing new resources for families and/or providers, providing training to identified groups, or implementing social media campaigns to promote safe sleep practices. A child death review report is due to be released in 2024, which will be reviewed for potential strategies to address safe sleep.

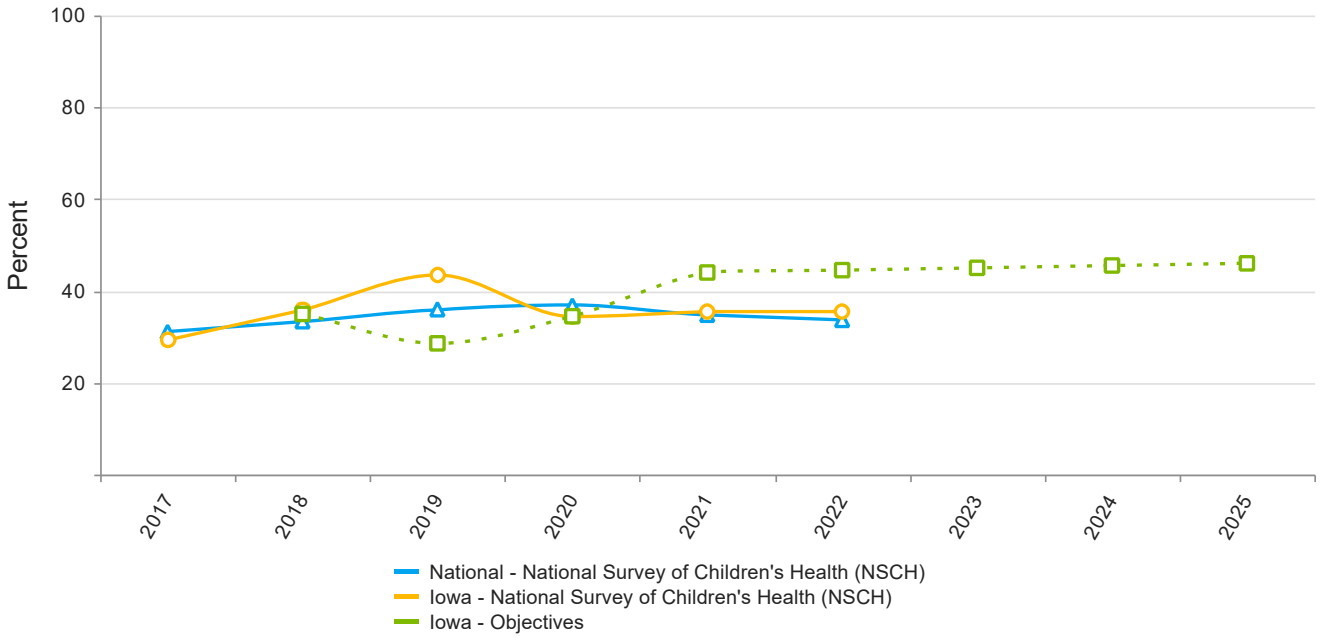
Iowa HHS will continue to include a flier on safe sleep practices with each birth certificate. Iowa HHS will work with Iowa birthing hospitals to encourage them to conduct safe sleep audits. Iowa HHS will share an audit tool with all of Iowa's birthing hospitals and encourage them to use the tool to increase staff awareness of the recommended safe sleep environments in the hospitals' newborn nursery.

Child Health

National Performance Measures

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

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28.6	34.5	44	44.5	45
Annual Indicator	34.2	43.2	34.0	35.0	35.6
Numerator	32,539	43,907	35,273	31,234	31,113
Denominator	95,266	101,539	103,777	89,276	87,348
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	45.5	46.0

Evidence-Based or –Informed Strategy Measures

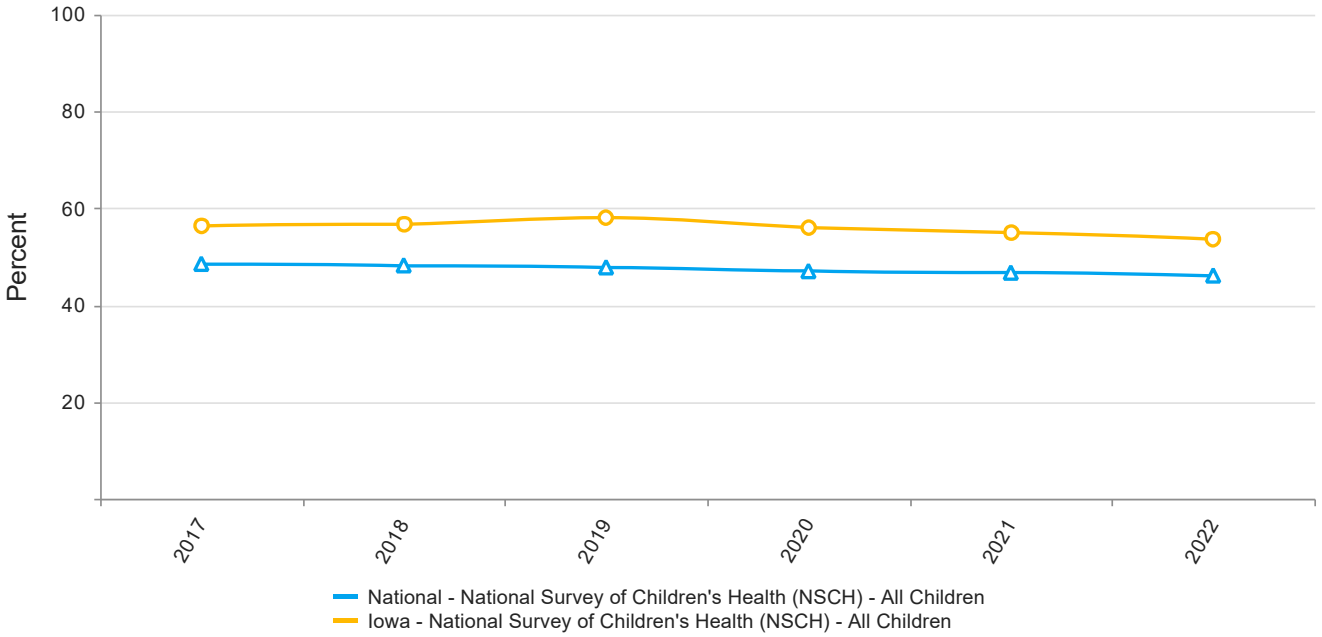
ESM DS.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	2	2.5	2.2	2.3	6
Annual Indicator	1.9	2	4.5	5.6	5.5
Numerator	1,076	2,537	5,240	6,606	6,554
Denominator	56,307	125,164	116,112	117,017	118,759
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2018	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	5.7	5.9

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	53.7
Numerator	389,805
Denominator	725,963
Data Source	NSCH-All Children
Data Source Year	2021_2022

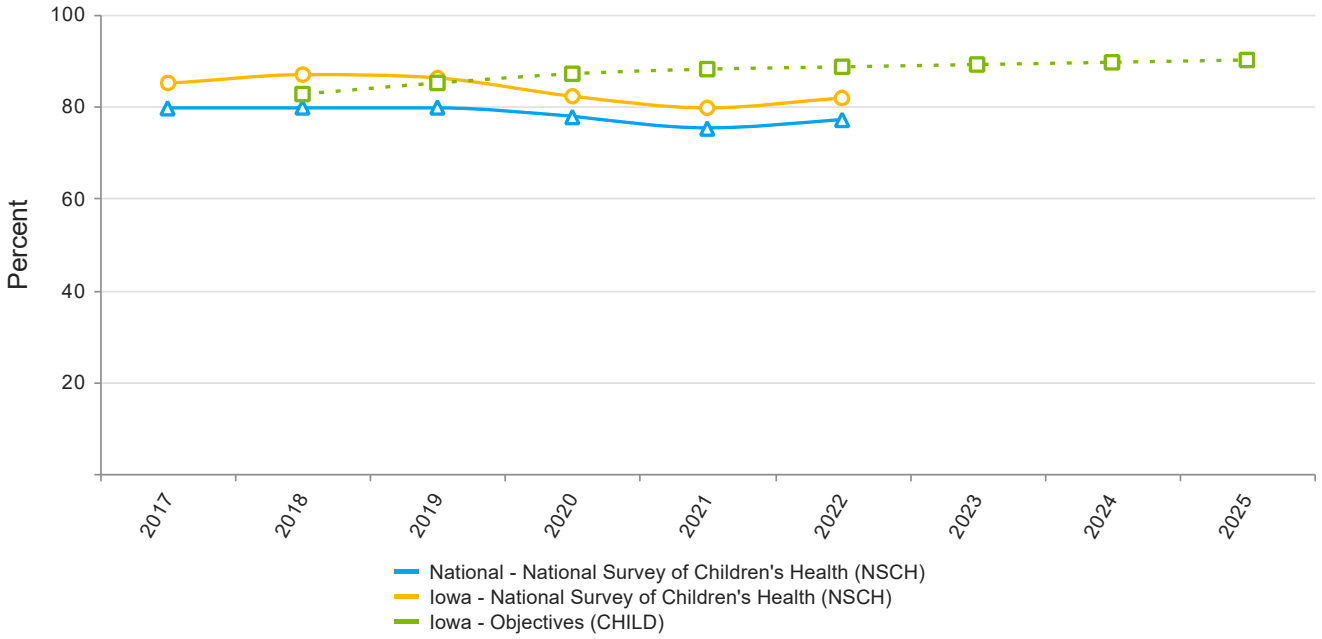
Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of telehealth visits through Child Health Specialty Clinics

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			3,150	4,000	3,400
Annual Indicator	3,115	4,464	4,397	3,377	3,431
Numerator					
Denominator					
Data Source	Program Data	Program Data (EHR)	Program Data (EHR)	Program Data (EHR)	Program Data (EHR)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	3,450.0	3,500.0

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child
Indicators and Annual Objectives



NPM PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	85	87	88	88.5	89
Annual Indicator	86.7	86.1	82.0	79.5	81.6
Numerator	585,814	583,397	553,776	538,939	559,852
Denominator	675,638	677,662	675,147	677,742	685,800
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	89.5	90.0

Evidence-Based or –Informed Strategy Measures

ESM PDV-Child.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	385	400	400	400	400
Annual Indicator	397	397	365	370	343
Numerator					
Denominator					
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	400.0	400.0

State Performance Measures

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			70	72	74
Annual Indicator		68	70	71.4	75.4
Numerator					
Denominator					
Data Source		IDPH Lead Report Card	IDPH Lead Program Data System (HHLPSS)	IDPH Lead Program Data System (HHLPSS)	Lead Program Data System (HHLPSS)
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	76.0	78.0

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	36	38	43	55	57
Annual Indicator	37.2	42.1	53.8	56.3	55.7
Numerator	1,563	1,759	2,153	2,117	2,023
Denominator	4,201	4,183	3,999	3,763	3,632
Data Source	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	59.0	60.0

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			1,100	1,800	2,700
Annual Indicator	873	1,080	1,710	2,634	2,488
Numerator					
Denominator					
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	2,550.0	2,612.0

State Action Plan Table

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

NOMs

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Priority Need

Dental Delivery Structure of the MCAH Population

NPM

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Five-Year Objectives

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

Strategies

Local Title V agencies build partnerships with organizations and health care providers
Local Title V agencies conduct outreach to dental and medical providers
Local Title V agencies partner with community organizations to promote health equity through oral health promotion
Local Title V agencies provide oral health care coordination and referrals for all clients
Local Title V agencies collect race and ethnicity data to help identify gaps in services
Local Title V agencies provide gap-filling preventive services

ESMs	Status
ESM PDV-Child.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.	Active

NOMs

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

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

Priority Need

Access to care for the MCAH Population

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

By 2025 will increase the percent of children without special health care needs who have a medical home to 54%.

Strategies

Local Title V agencies will assess medical home status of all clients at every interaction

Development of referral sources for clients without medical home

Provide care coordination for clients without a medical home

Provide culturally and linguistically appropriate well child visit reminders for children who are Title V clients and children enrolled in Medicaid Fee For Service

Local Title V agencies may provide gap-filling direct care services for children based upon an assessment of need within the service area

ESMs	Status
ESM MH.1 - Number of telehealth visits through Child Health Specialty Clinics	Active

NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

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

Priority Need

Safe and Healthy Environments

SPM

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

Five-Year Objectives

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

Strategies

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

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

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

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

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

State Title V and Childhood Lead Poisoning Prevention Program collaboration and coordination of programming

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

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

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

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

Priority Need

Safe and Healthy Environments

SPM

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

Five-Year Objectives

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

Strategies

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

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

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

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

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

Annual CCNC performance measure data is published, posted on the HCCI website and shared with partners and stakeholders

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

State Action Plan Table (Iowa) - Child Health - Entry 6

Priority Need

Dental Delivery Structure of the MCAH Population

SPM

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

Five-Year Objectives

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

Strategies

State Title V staff will maintain and develop state and local partnerships

Local Title V agencies provide outreach and training for medical providers to promote fluoride varnish application during well visits

Local Title V agencies provide outreach to dentists to educate on fluoride varnish application during well visits

State Title V staff will work towards integration of dental hygienists in medical clinics

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

Iowa's rate has remained stable and generally kept pace with national rates for several years. Although efforts to increase rates of screening have been continued, the system also continues to experience challenges such as staff turnover and burnout in health care, stagnant funding, and new economic pressures of inflation. When considering the significant changes in Iowa's Health and Human Services delivery system, staff remain hopeful for increased success through improved strategies and enhance program evaluation.

During Iowa's shift to Collaborative Service Areas (CSAs), Iowa's 1st Five Healthy Mental Development Initiative (1st Five) experienced a delay due to technical considerations with the scoring of applications and a need to re-bid the local delivery of 1st Five services. This was significant for NPM 6 because 1st Five is one of Iowa's primary strategies for progress with this measure. Because of the delay, Iowa was not able to start new contracts until January 2023 instead of July 2022. This delay resulted in higher-than-usual rates of turnover among Developmental Support Services (DSS) staff (care coordinators). Local contractors pulled back on contact with referring primary care practices, and this may have impacted screening rates.

New contracts beginning January 2023 included work plans that focused on the new Levels of Engagement (LOE) structure. The shorter time frame than planned for implementation left little opportunity to observe quantitative impacts. Program evaluation efforts included a survey of participating primary care practices; however, response rates were low. This was addressed by adding telephone outreach which increased the response rate somewhat. Responses indicated that continued effort is needed to provide marketing materials to providers and that providers are very open to technical assistance from 1st Five. Since the LOE framework is well-suited to provide these supports, Iowa HHS looks forward to pursuing these improvements via the LOE framework.

Quarterly virtual check-in workshops with local contractors to support their progress and milestones were continued in FFY23. These workshops improved relationships between Iowa HHS consultants and local contractors and increased understanding of performance improvement strategies.

The newly-developed strategy to use local physicians as peer consultants was successful. It resulted in increased use of peer consultation as a resource to support primary care practices in the use of screening tools.

The 1st Five program determined a need to change the performance measure in local contracts from a focus on making/maintaining contact with parents/caregivers to a measure related to LOE strategies. This was due to changes from one technology system to another for the support of Developmental Support Services (care coordination) functions. Due to the timing of the technology change, it was not possible to assure that baseline data and trend data would reliably reflect performance progress regarding Referral Outcomes. Instead, the performance measure was shifted to the development of lists of primary care practices that included an assessment of their LOE along with updated contact information. The lists were useful on a number of levels from increasing awareness that local site coordinators had about the status of their practices to paving the way for ease of contact with practices for program evaluation and other needs.

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

According to the NSCH, the percentage of children ages 1-17 who had a preventive dental visit in the past year increased slightly, from 79.5% in 2020-2021 to 81.5% in 2021-2022, but did not meet Iowa's annual objective target of 89% set for 2023. This increase aligns with Iowa Medicaid Paid Claims data, which reveals that in 2023, 55.4% of Medicaid-enrolled children ages 1-17 had a dental visit compared to 49.1% in 2020, 51.4% in 2021, and 54.1% in 2022.These increases may be attributed to children returning to the dentist for preventive dental care, as well as the ability to reach more children with preventive care through I-Smile in public health settings, following a decline during the COVID-19 pandemic.

If rates of children accessing preventive dental visits continue to rise, it is likely National Outcome Measure (NOM) 14 - *reduce the percent of children and adolescents who have dental caries or decayed teeth* - will be positively affected. Since oral health is a critical component of overall health, a decrease in poor oral health outcomes would similarly have positive effects on NOM 19 - *increase the percent of children or adolescents with excellent or very good health*.

Even with the relationships built between I-Smile coordinators and dental offices/dentists, only 870 dentists billed Medicaid in 2023 for services provided to children ages 1-17, compared to 961 in 2022. A continuing decline in the number of dentists seeing and treating Medicaid-enrolled individuals may hinder Iowa's progress in meeting its objectives and adversely affect future rates. Efforts to address and improve access to dental services for Medicaid beneficiaries are crucial to ensuring the continued success of initiatives like the I-Smile program and improving the oral health of both children and pregnant women.

The Iowa HHS Oral Health Section staff continued efforts to increase oral health messaging for children and their families throughout FFY23. A National Children's Dental Health Month promotion provided statewide oral health and I-Smile program education through postcards for state legislators, contractor-specific newspaper ads and program advertisements on Facebook, Instagram and Google. The 'Brush, Floss, I-Smile' themed promotion also included an FM radio and Spotify advertisement broadcast throughout the state for more than 60 days and reached 308,600 people. In FFY23, one promotion activity was required of each I-Smile Coordinator to address early childhood oral health and included billboard and radio advertisements, distribution of educational kits and social media and digital marketing campaigns.
Program policy regarding I-Smile Coordinator responsibilities and hours were changed in FFY23 to require coordinators spend 32 hours each week building local public health system capacity and ensuring population-based oral health services. As part of the increased capacity building efforts of the I-Smile Coordinator, a new required position, the Dental Direct Service Planner, was created to manage planning and purchasing for direct services and data entry for each CAH service area. This change allowed I-Smile Coordinators additional time to build and advance partnerships, promote oral health best practices and to provide in-person outreach visits to dental and medical practices to help clients and families receive dental care. I-Smile Coordinators shared information about the I-Smile program, the referral network, educational materials, and partnership opportunities as part of each visit.

Throughout FFY23, Oral Health Section staff assisted with the transition from a software-as-a-service Title V MCH data system to an Iowa HHS owned and maintained system, Iowa Connected. Data dashboards were developed within Iowa Connected to provide relevant and timely data about the contracted agencies. Oral Health Section staff met quarterly to discuss Medicaid and program data, contractors' progress toward meeting goals and reducing oral disease, and to identify technical assistance needs per contractor.

Oral Health Section staff continued to meet with I-Smile Coordinators quarterly to ensure program consistency, provide information on current standards and to share best practices. Meeting topics in FFY23 included: Life Course theory, I-Smile program requirements and policies, principals of Community Water Fluoridation, and the essential services of public health. Staff made site visits to all Maternal Health and Child Health contractors to discuss

progress toward meeting program requirements.
Partnerships with Iowa Medicaid and the Prepaid Ambulatory Health Plan (PAHP) carriers, including Delta Dental of Iowa and Managed Care of North America, remained strong in FFY23. Oral Health Section staff developed referral processes to provide information to the PAHPs when client needs were identified but a provider could not be found to provide treatment. They also provided ongoing assistance to I-Smile Coordinators navigating PAHP billing issues and questions. I-Smile Coordinators continued to encourage dentists to accept and provide services to Medicaid-enrolled patients. Despite 79 fewer dentists seeing Medicaid-enrolled children in SFY2023 than in 2022, the percentage of Medicaid-enrolled children ages 0-12 receiving care rose from 46.7% to 48.5%.

Dental care coordination is essential to help individuals and families overcome social determinants to health to help achieve a lifetime of health and wellness. Contractors continued to provide dental care coordination to connect children with necessary dental and medical services. More than 8,900 children and their families received a dental care coordination phone call, text message or email.

The I-Smile program provided dental screenings and other preventive services, including silver diamine fluoride, to 25,006 children under age 21 in various settings, including childcare and Head Start centers, preschools, public health agencies, and WIC clinics in FFY23. In addition, 13,587 students received services from I-Smile @ School, which provided preventive dental services to children in elementary and middle schools across the state with 40% or higher Free and Reduced Price Lunch rate. All children were referred to a dentist and care coordination was provided as appropriate following service provision.

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

Iowa's Title V program is encouraged that efforts to address past challenges in blood lead testing, especially the pandemic and supply chain disruptions, have resulted in now-positive testing trends. The collaboration between Iowa Health and Human Services (Iowa HHS), Title V staff and the Childhood Lead Poisoning Prevention Program (CLPPP) has continued to be vital for identifying priority populations and improving testing rates. The increase in blood lead testing rates from 2021 to 2022 is a positive trend. Work will continue to ensure testing rates stay at optimal levels for children aged 12 to 24 months; and reach optimal levels among children aged 24 to 36 months. The data highlighting the significant testing gaps in certain counties for blood lead testing among children aged 12 to 24 months is a concern. It's crucial to address these disparities to ensure all children receive timely testing and intervention if needed.

The data regarding blood lead testing rates in Iowa offered a comprehensive view of the state's progress and challenges in addressing childhood lead exposure. In 2022, there continued to be a positive uptick in testing rates, with 75.37% of children aged 12 to 24 months receiving a blood lead test. Testing rates for children aged 24 to 36 months were 39.8%. While there was an increase in testing rates from 2021 to 2022, improvement is still needed with children aged 24- to 36-months. Also, we must be diligent to continue to test children aged 12- to 24-months at higher rates and not allow rates to decline. Although the trend is increasing in both age groups, the drop-off in testing rates for children aged 24 to 36 months, where only 39.8% received a blood lead test, is a concern. Nevertheless, collaborative efforts between Title V staff and the Childhood Lead Poisoning Prevention Program (CLPPP) were notable. Efforts continued to increase testing for enrolled children.

Continued collaboration, outreach, and education efforts targeting both parents and healthcare providers will be essential for sustaining and further increasing blood lead testing rates. With a continued emphasis on the importance of routine testing at ages 12 and 24 months, progress can be made to mitigate childhood lead exposure and its

associated health risks.

State Title V staff identified strategies to help the Title V contract agencies increase the percentage of blood lead testing in Iowa in FFY2023. Strategies embraced by the agencies included assuring children in their service area received age and interval appropriate blood lead testing through the provision of direct testing, referral to another agency, or referral to the child's primary care provider. The Title V contract agencies used the results of an environmental scan of their service areas to identify healthcare providers and systems that provided blood lead testing (both venous and capillary). This environmental scan assisted the agencies in identifying gaps in service, education, and testing schedules which they worked to correct. With this information, agencies coordinated the provision of blood lead testing in their service area where gaps in care were assessed. They assured access, avoided duplication, provided education to families, and they partnered with groups and individuals to increase culturally appropriate access, outreach and education on lead poisoning prevention and lead testing.

FHB began efforts this year to partner with the CLPPP to distribute needed LeadCare II machines and supplies to contractors who need them to increase blood lead testing for children under the age of six. Collaboration also began to provide Title V contractors with access to the Healthy Homes and Lead Poisoning Prevention System (HHLPPS) system to allow timely review of blood lead testing results.

In an effort to increase communication, Title V contract agencies included focused language on the importance of lead testing and the recommended intervals for families through their age-appropriate informing scripts and informing packets. A weekly Title V email newsletter distributed to local Title V agencies was used to distribute articles on blood lead testing and how to successfully partner with local CLPPPs.

Title V staff continued to work closely with CLPPP staff to provide continuity of recommendations, provision of screening and distribution of educational tools. The two programs worked to have agreements in place to allow for greater data sharing and evaluation between the programs. In addition, agreements are in place with local contract staff, which allowed for increased identification of areas of need. The Title V Child and Adolescent Health Program will continue to work with Medicaid on data sharing agreements to augment Title V and CLPPP data, to allow for greater exploration of areas of need and to create data-driven plans for the future. Title V CAH staff and DHS staff will continue to work on the appropriate reimbursement of lead screening for Child Health Screening Centers with the aim of increasing reimbursement to assist with testing completion at all the recommended age levels.

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

In FY23, Iowa continued at 56% of Early Care and Education (ECE) programs participating with their local child care nurse consultant (CCNC). 95% of ECE programs who received CCNC services demonstrated improvement in health and safety as a result of the service.

The FY23 Child and Adolescent Health (CAH) RFP included a requirement for contractors to provide CCNC services throughout their service area. In prior MCAH RFPs, CCNC services were an optional activity. For almost 25 years CCNC services have been provided through braided funding with limited CAH funding. In the past 5 years, there has been an increase in local funding for CCNC services and in FY23 there was an increase in CAH gap fill funding provided through Child Development Block Grant federal funds Iowa Health and Human Services receives.

The new Iowa Quality For Kids® (IQ4K) released in April, 2022 has a requirement for ECE programs applying for levels 2-5 to have onsite visits with their local CCNC. 38% of ECE programs are participating in Iowa’s quality rating system.

State staff anticipate a continued increase in ECE programs requesting CCNC services, with a goal of 60% participation by FY25. However, CCNC services are not a regulatory requirement for ECE programs, so it is unlikely that 100% participation is possible.

In Iowa, 75% of families with children under age 6 have all parents in the workforce. Title V CAH agencies incorporate public health principles and practices in ECE programs by providing CCNC services. Healthy Child Care Iowa (HCCI) provides structure and fidelity for CCNCs at the local level. CCNCs are registered nurses with specialized early childhood training including:

- Knowledge of child care practices, rules and regulations
- Integrating health into early learning systems
- Helping ECE programs understand infant and early childhood development and a range of health topics
- Assessing the health and safety needs of the early care and education program

CCNCs incorporate principles of health equity when working with ECE programs providing consultation, training, technical assistance, information and referral as well as care planning for children with special health needs. The CCNC program is evidence-based and helps to ensure that children have access to healthy and safe care. Research indicates that child care health (nurse) consultants support healthy and safe early care and education settings and protect and promote the healthy growth and development of children and their families.

Iowa continues to see an increase in the number of children in ECE programs who have health needs that require special care by the ECE staff. CCNCs have the skill and expertise using an equity lens to assist ECE providers and families ensuring children with special health needs have a care plan in place. When working with ECE providers, CCNCs collect data on the number of children in care with special health needs by category (asthma, allergy, diabetes, seizures, etc.). CCNCs work with the child's parents, medical providers and the ECE director to assist in the development of care plans and provide training and technical assistance for ECE staff to aid in understanding the care plan including any medications that may need to be administered while the child is in their care. The number of children identified with special health care needs has increased in the past few years (FY22=827, FY23= 1424). This increase follows national trends post pandemic.

HCCI health and safety trainings are essential in helping ECE professionals gain needed knowledge to implement health and safety best practices. In FY23 CCNCs held both face-to-face and virtual trainings to accommodate the needs of the ECE professionals. A total of 382 trainings on a variety of health and safety topics such as safe sleep, special health needs, injury prevention and other health related topics were provided to 3020 participants with 95% reporting increased knowledge as a result of the training.

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

After a substantial increase in 2022, the number of Medicaid-enrolled children ages 0-35 months who received a fluoride varnish application from a medical provider decreased in 2023 from 2,634 to 2,488 and did not meet Iowa's annual objective of 2,700. This decrease occurred despite 22 more medical providers applying fluoride varnish to Medicaid-enrolled children ages 0-35 months in 2023 (130) than in 2022 (108), suggesting that while more providers are providing fluoride varnish, it is being applied to fewer children per provider. The decline may be linked to the reduced participation of Medicaid-enrolled children in their routine well-child visits. Data from CMS-416 EPSDT reports reveal a 10% decrease in the attendance of Medicaid-enrolled children ages 0-20 at well-child visits in 2023

(43%) compared to 2022 (53%). Notably, children aged 1-2 experienced an even larger decline from 80% to 65%. Also, with the initiation of the Oral Health Iowa (OHI) coalition, the Cavity Free Iowa (CFI) workgroup was less active in the past year due to its integration into the coalition. This transition may have also negatively affected SPM 5. Oral Health Section staff continue to investigate other potential reasons for this decline and adjust activities accordingly.

Despite the efforts and successes of CFI in previous years, a continued decrease in the number of children receiving a fluoride varnish by a medical provider poses a significant risk to the National Outcome Measure (NOM) 14 - *reduce the percent of children and adolescents who have dental caries or decayed teeth*. This decline could lead to a rise in tooth decay cases and poor oral health outcomes. Given the link between oral health and overall well-being, a rise in poor oral health outcomes could also adversely affect NOM 19 - *increase the percent of children or adolescents with excellent or very good health*.

During FFY23, I-Smile Coordinators provided outreach to pediatric and family practice medical offices in their service areas to promote oral health as a component of overall health. These outreach visits involved training and educating physicians and medical staff to incorporate the EPSDT-required oral screening and preventive fluoride varnish application into well-child medical appointments for children 0 to 5 years old. The training toolkit, developed and maintained by Iowa HHS Oral Health Section staff, included guidelines for outreach, fliers, brochures, I-Smile dental screening guides, EPSDT periodicity schedules, and a presentation about the importance of oral health in overall health.

Cavity Free Iowa (CFI), the workgroup focused on integrating oral screenings and fluoride varnish into well-child medical appointments, is championed by a central Iowa pediatrician. The pediatrician continued to train to other medical staff and students, enabling them to implement what they learn in their future practices. Oral Health Section staff organized and created ‘CFI kits’ to give to families. They were distributed to medical offices where physicians, nurses and other office staff had received a customized CFI training from their I-Smile Coordinator. Each kit consisted of a cellophane bag containing a parent education card, toothbrush, toothpaste and fluoride varnish. The kit was opened during the medical appointment to remove and apply the fluoride varnish and then resealed and sent home with the family.

A Des Moines University Masters of Public Health student completed an Integrative Learning Experience project on improving oral health in Iowa through the use of fluoride varnish in primary care settings. The student thoroughly researched fluoride varnish and its use, along with the CFI toolkit. The research concluded that fluoride varnish as part of well-child exams is beneficial, but primary care providers generally remain hesitant to apply fluoride varnish due to time constraints, lack of training and lack of parent understanding. The student provided recommendations, including the appointment of a program coordinator within each medical clinic to monitor processes and maintain communication with CFI workgroup leadership, creating templates to integrate fluoride varnish application within electronic medical record systems and updating training and educational materials to target mid-level providers in their respective training programs.

At the conclusion of FFY23, I-Smile Coordinators had trained 686 medical staff within 47 counties to provide oral screenings and apply fluoride varnish. Direct service dental hygienists and nurses for CAH contractors also continued to provide preventive dental services and education to young children in a variety of locations, including childcare centers, preschools, public health agencies, WIC clinics and other locations.

Child Health - Application Year

Universal Medical Home NPM: Percent of children without special health care needs, ages 0 through 17, who have a medical home

The medical home is an approach to providing primary health care services to women, children and their families that is team-based; focuses on the whole person; and is comprehensive, ongoing, coordinated and patient-centered. The American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association have jointly defined the medical home as “a model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care. The physician-led care team is responsible for providing all the patient’s health care needs and, when needed, arranges for appropriate care with other qualified physicians.” State and local Title V MCH programs are key partners in many of these efforts.

Iowa’s Title V CAH program utilizes a medical home model to help children and adolescents receive quality care from primary care providers (doctors, nurse practitioners, physician assistants, etc.) who are responsible for both acute and preventive care (sick and well care). Iowa Administrative Code Chapter 641.76 defines “medical home” as a team approach to providing health care that originates in a primary care setting; fosters a partnership among the client, the personal provider, and other health care professionals, and where appropriate, the client’s family; utilizes the partnership to access all medical and nonmedical health-related services needed by the client and the client’s family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.157.

Iowa’s Local Title V CAH agencies are required to assure medical home for all clients enrolled in Title V, clients during the Presumptive Eligibility period, all clients receiving a direct care service, all clients during the Informing process (informing newly eligible Medicaid clients of their benefits and what is included) and clients enrolled in Medicaid Fee for Service.

The community-based agencies must have referral networks with primary care providers to increase access to medical homes for clients. When clients are identified as not having a medical home the CAH agency must provide care coordination for all clients. CAH agencies are required to have plans for the process of providing care coordination to predetermined priority populations as identified through the previous Title V Needs Assessment.

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

The rate for developmental screening remains about the same with a slight increase. As HHS has transitioned to our new Collaborative Service Areas (CSAs), the 1st Five local Site Coordinators have gained familiarity with the changed service areas over the past year, and in a couple of areas, the Title V and 1st Five contractors are entirely new organizations or new Site Coordinators in the 1st Five role. Some contractors were impacted by challenges with the CSA transition, and in those cases, they are stabilizing and building referral numbers back to the levels they had been prior to the transition. With focus on both, referral numbers and screening in the coming year, staff are optimistic that a continued slow improvement in the overall measure will be seen.

A primary strategy for increasing rates of developmental screening in Iowa is the 1st Five Healthy Mental Development Initiative. Like Title V, 1st Five is delivered through contracts with local public and non-profit agencies serving a majority of the CSAs (1st Five is available in 88 of Iowa’s 99 counties, some CSAs are not covered or are partially covered). 1st Five is a public-private partnership bridging primary care and public health services in Iowa.

The four-part model used for this initiative supports health providers in the earlier detection of social-emotional and developmental delays and family risk-related factors in children birth to age 5 (up to a child's fifth birthday) and coordinates referrals, interventions and follow-up. The basics of 1st Five include:

- Targeting the population of children birth to age five (up to a child's fifth birthday)
- Increasing use of surveillance and standardized developmental screening by partnering with (engaging) primary care providers
- Providing a one-step referral resource for primary care providers.
- Connecting referred children (and their parents/caregivers) to existing services in their local communities.
- Keeping primary care providers informed about children's progress.
- Supporting healthy social, emotional and cognitive development.

Participation in the 1st Five Initiative is voluntary on the part of primary care providers and referred clients and their parents/caregivers.

As part of the Title V federal-state partnership, the 1st Five Initiative is funded primarily through an appropriation of state funds provided to the Department. In addition, some of the activities performed by contractors are eligible to draw matching funds from the Medicaid Division. These funds are tied to activities that support the Early and Periodic Screening Diagnostic and Treatment (EPSDT) benefit that is part of Medicaid. Specifically, they support the primary care provider network in the use of developmental surveillance and standardized developmental screening tools. The work occurs through direct support and training for primary care practices along with maintaining a strong network among community partners to address referral needs when developmental screening shows concerns.

During FFY25, local agencies will be focused on increasing the overall number of referrals and on increasing or maintaining the percentage of referrals that are based on a developmental screen. FY23 program evaluation results indicated that 1st Five has a need for consistent communication tools and an increase in name recognition of the program. 1st Five will focus on consistency in the visual presentation of materials used. After a shift in FHB data system to a new vendor during FY24, 1st Five will focus on data consistency in FFY25. The program looks forward to results of contextual inquiry being conducted as part of the program evaluation in FY24 to learn what improvements might benefit the referral and data entry processes (Developmental Support Services).

The work in FFY25 will continue to use the 1st Five Levels of Engagement framework for moving primary care practices to full implementation of screening and referral. The Department's 1st Five program has identified and developed a scale of three Levels of

Engagement to categorize levels of partnership with 1st Five participating primary care practices. The goal of the local agencies is to first encourage primary care practices to participate in some Level of Engagement for the 1st Five program, and then to assist the practices, as much as they desire to increase the Level of Engagement.

FFY25 will include agency subcontracts with local primary care physicians who have reached the third Level of Engagement. Level 3 engagement includes universal screening of children at recommended periodicity schedule intervals along with making referrals to 1st Five on an ongoing basis. Subcontracts with the local primary care physicians will include the expectation that they provide peer consultations with other primary care physicians in the CSA to support their adoption of developmental screening. As appropriate, continuous improvement activities and results will be used to improve this resource based on the previous year's results.

Title V Child and Adolescent Health contract agencies will continue to perform developmental screening as a gap filling direct health care service. CAH contract agencies will continue to partner with Early ACCESS, ensuring children found not eligible for early intervention services are monitored and rereferred if necessary.

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

According to the NSCH, the percentage of children who had a preventive dental visit in the past year increased slightly, from 79.5% in 2020-2021 to 81.5% in 2021-2022, but did not meet Iowa's annual objective target of 89% set for 2023. This increase aligns with Iowa Medicaid data, which reveals that in 2023, 48.5% of Medicaid-enrolled children had a dental visit compared to 44.7% in 2020, 46.8% in 2021, and 46.7% in 2022. These increases may be attributed to children returning to the dentist for preventive dental care, as well as the ability to reach more children with preventive care through I-Smile in public health settings, following a decline during the COVID-19 pandemic.

If rates of children accessing preventive dental visits continue to rise, it is likely National Outcome Measure (NOM) 14 - reduce the percent of children and adolescents who have dental caries or decayed teeth - will be positively affected. Since oral health is a critical component of overall health, a decrease in poor oral health outcomes would similarly have positive effects on NOM 19 - increase the percent of children or adolescents with excellent or very good health.

Even with the relationships built between I-Smile coordinators and dental offices/dentists, only 809 dentists billed Medicaid in 2023 for services provided to children, compared to 888 in 2022 and 1,035 in 2021. A continuing decline in the number of dentists seeing and treating Medicaid-enrolled individuals may hinder Iowa's progress in meeting its objectives and adversely affect future rates. Efforts to address and improve access to dental services for Medicaid beneficiaries are crucial to ensuring the continued success of initiatives like the I-Smile program and improving the oral health of both children and pregnant women.

The I-Smile program, which connects children and families with dental, medical, and community resources to ensure a lifetime of health and wellness, will be used to address this Dental NPM, in addition to the work of Iowa HHS OH staff. OH staff will convene quarterly I-Smile coordinator meetings to ensure program consistency, cultivate leadership abilities, explore new opportunities, and promote current standards and procedures. Meeting topics include current oral health events and topics, health equity and inclusion, trainings, and data use. Each meeting includes an open forum for I-Smile coordinators to discuss concerns, successes and best practices among their peers.

As the local oral health subject matter experts, I-Smile coordinators are charged with for ensuring the success of the I-Smile program. Coordinators are required to spend 32 hours each week building local public health system capacity and ensuring enabling and population-based oral health services. In FY25, each coordinator will form, build or continue partnerships with at least five partners within their CSA to benefit families served by I-Smile. Partners may include businesses, civic and/or faith-based organizations and must increase awareness about the importance of oral health and seek to achieve mutual benefit. Some of the planned partnerships for FFY25 include libraries, YMCA centers and food banks.

Promoting oral health remains an important element to program success. I-Smile coordinators will be required to conduct oral health promotion that includes the benefits of I-Smile, including one initiative focusing on early childhood oral health. Proposed promotions for FFY25 include infant oral health packets containing an infant toothbrush, infant toothbrushing instructions and educational fliers about the importance of age 1 dental visits.
OH staff will continue to develop and maintain stock of educational materials that I-Smile coordinators use with the clients and families they serve. These materials provide instruction and guidance using Plain Language Act principles to ensure all materials are easy to understand. Four OH staff will alternate developing messages for the I-Smile Facebook page; a fun and educational resource for parents about oral health. The OH website will be updated

by HHS staff in FFY25 to incorporate materials and information that had been on the former I-Smile website to ensure it is a valuable resource for medical and dental providers, school staff, parents/guardians, and the public.

OH staff will work with I-Smile coordinators on a variety of quality assurance initiatives in FFY25. I-Smile coordinators and staff that provide direct dental services will be required to complete medical record audits to ensure quality of service documentation. Coordinators will also submit quarterly activity and progress reports to HHS outlining how they are achieving contractually required I-Smile activities, including: trainings, partnerships, outreach, and promotions. OH staff will hold two site visits with each I-Smile coordinator and CAH project director annually; one site visit will be in-person to discuss work plan activities and troubleshoot concerns and one site visit will be virtual (or optional in-person) to discuss local and state data, data trends and data stratified by age, race and ethnicity.

I-Smile coordinators will ensure the provision of gap-filling direct services, tailored to the specific needs identified in community need assessments. Coordinators will have oversight of a Direct Dental Service Planner (DDSP), a new required position that is responsible for scheduling, setting up service sites, procuring supplies, distributing and collecting forms, and ensuring accurate data entry of dental services (oral screenings, fluoride treatments, sealant applications, silver diamine fluoride, and counseling/education). Gap-filling services must be available for children aged 0-2 years and those in 2nd and 3rd grades attending elementary schools with a free/reduced lunch rate participation of 40% or higher (as part of I-Smile @ School).

As part of Iowa's Oral Health Workforce Grant through HRSA, OH staff will work with at least two contractors to incorporate the Oral Disease Preventionist (ODP) project within I-Smile. The ODP project uses public health dental hygienists within medical offices to provide oral screenings, fluoride applications, education and counseling, and assist with referrals for dental care.

OH staff are currently applying for the Centers for Disease Control and Prevention's (CDC) State Promotion of Strategies to Advance Oral Health competitive application. This funding opportunity focuses on increasing access to water from optimally fluoridated water systems; disseminating data about the relationships between the oral health of people living with diabetes, overall health and use of and access to medical and dental care; increasing access to I-Smile @ School (school-based dental sealant program) services; and increasing awareness of CDC's infection control and prevention resources. Funding secured from this opportunity will allow for continued statewide I-Smile @ School services for at-risk students in schools with high free and reduced meal rates.

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

During the year 2022, 75.37% of Iowa's children (ages 12<24 months) received a blood lead test, meeting the state goal of 75%. This is a 4% increase from the previous year. Approximately 11% of Iowa's counties have 60% or less of their children ages 12<24 months receiving at least one blood lead test, which is a 9% improvement from 2021. Both of these positive changes indicate that the challenges faced during the COVID-19 pandemic are no longer applicable. In addition, the supply chain issue relating to the LeadCare II machines and kits also recovered and is no longer a barrier. These rebounds in testing are very encouraging. However, coverage for lead testing still significantly decreases when looking at children ages 24<36 months. As of 2022, 39.8% of children ages 24<36 months received a blood lead test.

The Child and Adolescent Health (CAH) program is currently in the 2nd contract year of a 4-year competitive Request for Proposal (RFP) grant cycle. 14 community-based contractors provide public health services at the community level for CAH services. This RFP includes blood lead testing promotion and testing services for children. Data analysis revealed that 8 of Iowa's 99 counties have higher than average rates of children in Title V's Health Equity priority populations, which include Hispanic/Latinx and African American, Black or African, without blood lead

tests. A requirement was placed into the RFP to focus on lead testing in these specific populations in these 8 counties. In addition, RFP requirements include providing blood lead testing to 1 year old children in 55 of our 99 counties which have less than the state goal of 75% of children testing in the county with a blood lead test; and for 2 year old children 61 of our 99 counties who had less than the state goal of 40% of children residing in the county with a blood lead test. Title V believes by continuing to target priority populations and requiring blood lead testing for 1- and 2-year-olds in more than half of our counties, Iowa will be able to continue to get more children tested at the proper ages and intervals. Additionally, the RFP requires contractors to set both single year and 5-year goals for both 1- and 2-year-old children to increase blood lead testing in their service area. These goals will allow staff to more closely measure each agency's impact on the blood lead testing of children in their area.

The CAH program will continue to work collaboratively with the Iowa HHS Childhood Lead Poisoning Prevention Program (CLPPP). The two programs continue to work to determine data sharing and meaningful use of the data collected, targeting interventions for populations, and improved testing strategies for Iowa's children. The CLPPP has recently issued 10 LeadCare II machines for Title V contractors to utilize to make testing of children under 6 years of age easier and more convenient.

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

Participation with Child Care Nurse Consultant (CCNC) program through Healthy Child Care Iowa (HCCI) remained at 56%. The new Iowa Quality For Kids® (IQ4K) has a requirement for ECE programs applying for levels 2-5 to have on-site visits with their local CCNC. 38% of ECE programs are participating in Iowa's quality rating system. With Iowa's focus and support for high quality child care, Iowa HHSanticipates a continued increase in ECE programs requesting CCNC services, however CCNC services are not a regulatory requirement for ECE programs, so it is unlikely that 100% participation is possible.

HCCI and the CCNC program has a 28 year history. In recent years both the state structure and the role of the CCNC has changed as the national focus on the importance of child care has changed. National research demonstrates that health and safety policies and practices improve when ECE programs have the services of child care health (nurse) consultants, and overall program quality increases as a result of those services. Iowa data has shown increased rates of ECE programs accessing CCNC services.

In Iowa, 75% of families with children under age 6 have all parents in the workforce. Of those in care, there are children who have health needs that require special care by the Early Care and Education (ECE) program. Child Care Nurse Consultants (CCNCs) have the skill and expertise using an equity lens to assist ECE providers and families ensuring children with special health needs have a care plan in place. When working with ECE providers, CCNCs collect data on the number of children in care with special health needs by category (asthma, allergy, diabetes, seizures, etc.). CCNCs work with the child's parents, medical providers and the ECE director to assist in the development of care plans and provide training and technical assistance for ECE staff to aid in understanding the care plan including any medications that may be administered while the child is in their care. The number of children identified with special health care needs has increased in the past few years (FY22=827, FY23= 1424). This increase follows national trends post pandemic.

IQ4K has a requirement for ECE programs applying for levels 2-5 to have on-site visits with their local CCNC. CCNCs provide IQ4K visits and training for the following:

Training:

- IQ4K Levels 2 - 5 Medication Administration Skills Competency (course and skills test out)
- Med Admin Skills Competency 2-hour course may be taken online (on-demand) or Face to Face for HHS child care regulatory training credit
- Initial test-out of medication skills competency is a 1-hour visit with the CCNC for HHS child care regulatory training credit
- 2-year reassessment of skills is a 1-hour visit with the CCNC however no HHS training credit is given

Visits:

- IQ4K Levels 3 - 5 Health and Safety Checklist for Early Care and Education Programs
- Requires a minimum of 2 on-site visits
- The ECE provider develops an Action Steps plan for Continuous Quality Improvement

The plan for FFY25 is to continue with the success of the Healthy Child Care Iowa Child Care Nurse Consultant program with quality supports, program fidelity, equitable funding, and consistent data collection and reporting.

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

After a substantial increase in 2022, the number of Medicaid-enrolled children ages 0-35 months who received a fluoride varnish application from a medical provider decreased in 2023 from 2,634 to 2,488 and did not meet Iowa's annual objective of 2,700. This decrease occurred despite 22 more medical providers applying fluoride varnish to Medicaid-enrolled children in 2023 (130) than in 2022 (108), suggesting that while more providers are participating in providing fluoride varnish, it is being applied to fewer children per provider. The decline may be linked to the reduced participation of Medicaid-enrolled children in their routine well-child visits. Data from CMS-416 EPSDT reports reveal a 10% decrease in the attendance of Medicaid-enrolled children at well-child visits in 2023 (43%) compared to 2022 (53%). Notably, children aged 1-2 experienced an even larger decline from 80% to 65%. Also, with the initiation of the Oral Health Iowa (OHI) coalition, the CFI workgroup was less active in the past year due to its integration into the coalition. This transition may have also negatively affected SPM 5. OH staff plan to investigate other potential reasons for this decline and adjust the work plan and activities accordingly.

Despite the efforts and successes of CFI in previous years, a continued decrease in the number of children receiving a fluoride varnish by a medical provider poses a significant risk to the National Outcome Measure (NOM) 14 - *reduce the percent of children and adolescents who have dental caries or decayed teeth*. This decline could lead to a rise in tooth decay cases and poor oral health outcomes. Given the link between oral health and overall well-being, a rise in poor oral health outcomes could also adversely affect NOM 19 - *increase the percent of children or adolescents with excellent or very good health.*

Children are recommended to see a dentist before their first birthday. However, many dentists are not comfortable seeing children this young and/or many children from low-income families have difficulty being seen in dental offices. To address this, Iowa HHS OH staff will address SPM 5 through outreach by I-Smile Coordinators with medical offices and through Iowa HHS collaboration with the Cavity Free Iowa workgroup and Oral Health Iowa coalition. The Cavity Free Iowa (CFI) workgroup that includes partners from Delta Dental of Iowa Foundation, I-Smile coordinators, Broadlawns Hospital, and MercyOne Pediatrics. Iowa HHS staff began CFI in 2017 as a medical-dental initiative to increase the number of children who receive preventive fluoride varnish at well-child medical appointments and d referrals for dental care. In FFY25, CFI will transition to be part of the Oral Health Iowa coalition, which will allow a broader message and larger reach. HHS staff and I-Smile coordinators are members of the Oral Health Iowa coalition and will continue to participate. Iowa HHS will also continue to provide training materials for I-

Smile coordinators to use for medical office trainings as part of CFI.

In FFY25, I-Smile coordinators will be required to visit all pediatric medical offices within their service areas to promote oral health as part of overall health. If a county does not have a pediatric medical office, coordinators must visit all family practice medical offices within that county. Outreach visits will include offering CFI trainings for physicians and medical office staff to incorporate oral health education and fluoride varnish into well visit appointments for children birth to age five. The training toolkit (guidelines for outreach, fliers, brochures, I-Smile dental screening guides, and periodicity schedules) was developed and is maintained by HHS staff, and includes a presentation on the importance of oral health in overall health and a hands-on demonstration and observation sessions. Assistance may also be provided to troubleshoot any issues that may occur from billing fluoride varnish to the Medicaid managed care organizations. Participating offices receive a certificate after training has been completed and a plaque after six months of continued fluoride varnish applications

HHS OH staff will share the decline in the performance measure with Oral Health Iowa coalition members to discuss opportunities to see positive trends in future years. Discussion may include ways to ensure fluoride varnish is being billed to Medicaid's Managed Care Organizations and ideas for promotions to re-energize and/or incentivize medical offices to ensure fluoride varnish is provided. A new partnership with Molina Healthcare (discussed in the Dental NPM), one of Iowa Medicaid's three Managed Care Organizations, will be engaged to determine a possible Value-Added Benefit to ensure oral health is part of overall health.

In FFY25, OH staff will seek input from I-Smile coordinators and CFI pediatrician champions about changes needed for toolkit materials, then work to revise the CFI toolkit, including updated referral forms and resources and current Iowa HHS branding. HHS OH staff will also continue to work with partners at the Delta Dental of Iowa Foundation to update and distribute CFI certificates and plaques as part of the ongoing partnership.

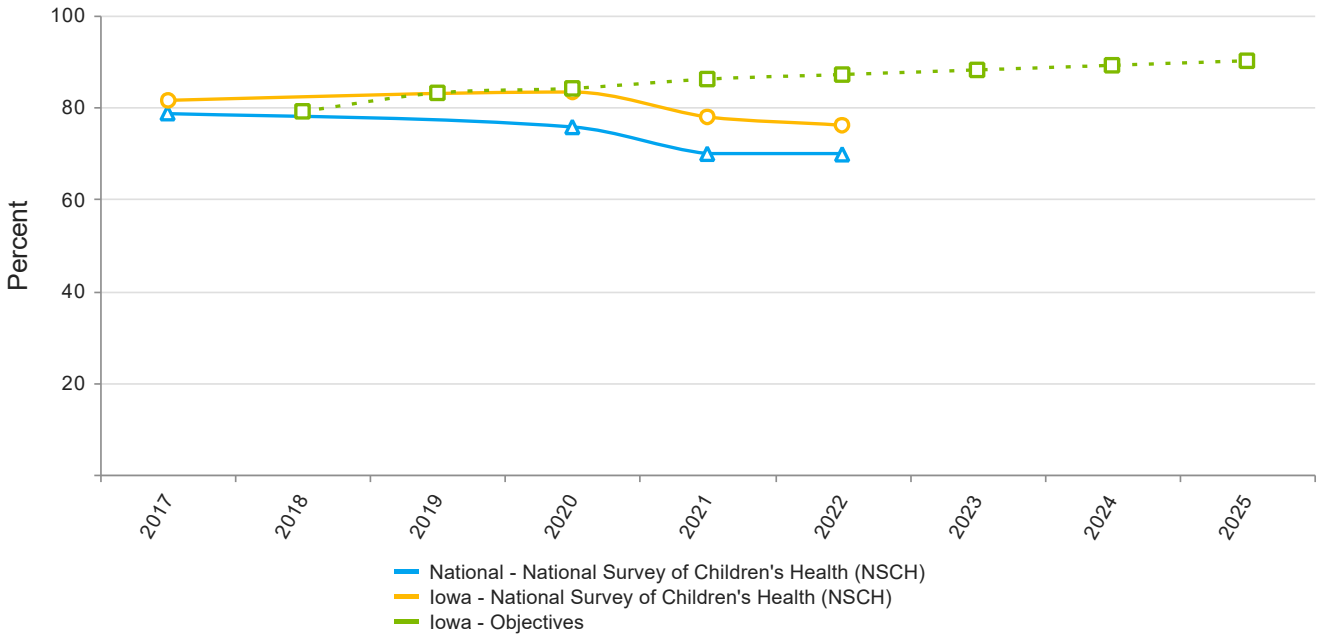
Federally Qualified Health Centers (FQHCs) in Iowa are supported by a longtime partner, Iowa Primary Care Association (IPCA). OH staff will meet with IPCA to discuss the number of FQHCs using dental hygienists in medical clinics to provide oral health education and direct services, and their success and challenges of that model. Lessons learned from conversations will be shared with the CFI workgroup.
Those lessons learned will also be used as part of an Iowa HHS HRSA grant initiative, the Oral Disease Preventionist (ODP) project. In the next year, Iowa HHS OH staff will work with contractors to implement the ODP project within I-Smile, as part of Iowa's Oral Health Workforce grant. The ODP project uses public health dental hygienists as Oral Disease Preventionists within medical offices to provide oral screenings, fluoride applications, education and counseling, and referral assistance. The project will be particularly beneficial for medical offices that have not successfully incorporated oral screenings and fluoride varnish into their well-child visit services, but are interested in dental disease prevention.

In FFY25, OH staff will analyze data from Iowa Connected, Iowa's Title V data system, to better determine the actual number of children aged birth to two receiving fluoride at a physician's office. A new setting type, Physician's Office', was added to the data system in FFY24 to capture the number of children receiving fluoride varnish in a physician's office by a dental hygienist working with I-Smile. The performance measure currently uses just the fluoride varnish services provided by a physician in a medical office.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV
Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	83	84	86	87	88
Annual Indicator	81.1	88.5	83.2	77.7	76.1
Numerator	191,475	195,697	191,890	185,686	188,931
Denominator	236,185	221,185	230,603	239,022	248,333
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	89.0	90.0

Evidence-Based or –Informed Strategy Measures

ESM AWV.2 - Percent of children 10 through 20 years of age enrolled in Medicaid with a well visit in the past year

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	35	29
Numerator		
Denominator		
Data Source	Iowa Medicaid CMS 416	Iowa Medicaid CMS 416
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	30.0	31.0

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			25	25	24.5
Annual Indicator		25	30	30	30
Numerator					
Denominator					
Data Source		Iowa Youth Survey	Iowa Youth Survey	Iowa Youth Survey	Iowa Youth Survey
Data Source Year		2018	2020	2021	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	29.0	28.5

State Action Plan Table

State Action Plan Table (Iowa) - Adolescent Health - Entry 1	
Priority Need	
Access to care for the MCAH Population	
NPM	
NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV	
Five-Year Objectives	
By 2025, increase the percent of adolescents ages 12 through 17 with a preventive medical visit in the past year to 85%	
Strategies	
Local Title V agencies will educate parents of adolescents on the importance of annual well visits during the Informing process	
Provide culturally and linguistically appropriate annual well visit reminders for adolescents who are Title V clients and for adolescents enrolled in Medicaid Fee For Service	
Bureau of Family Health staff will explore possible collaborations with Iowa Medicaid Enterprise, Department of Human Services, Department of Education, Managed Care Organizations, the University of Iowa EPSDT physician group, and provider associations, to assure adolescents receive annual well visits	
Peer to Peer PCP education and outreach on the importance of adolescent well visit this will include: Incorporating pre-participation physicals into the well visit; Maximizing pre-participation physicals, med checks, acute visits into well visits; Coding and billing the well visit appropriately; Adolescent friendly care; Elements of the well visit	
Health Equity Advisory Committee input on increasing adolescent well visits	
Agencies may provide gap-filling direct care services for adolescents based upon an assessment of need within the service area	
Family Engagement group involvement in increasing adolescent well visits	
ESMs	**Status**
ESM AWV.1 - Partner with at least two other organizations or agencies, including but not limited to family planning, substance abuse, youth serving organizations, parent and family organizations, universities, and/or community colleges to promote adolescent well	Inactive
ESM AWV.2 - Percent of children 10 through 20 years of age enrolled in Medicaid with a well visit in the past year	Active

NOMs

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

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

Priority Need

MCAH Systems Coordination

SPM

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

Five-Year Objectives

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

Strategies

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

Provide adolescent mental health training for local Title V agencies

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

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

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

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

Re-engage the state Adolescent Health Collaborative

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

Adolescents continue to be a priority population for outreach efforts and targeted informing efforts to work to encourage and educate on the importance of the adolescent well visit, immunizations, and other screenings specific to the 12-17 year old population in a medical home setting. According to the NSCH, there was a small decrease in the rate of well care visits from 77.7% (2021) to 77.1% (2022) which was an expected possibility with the continuance of the COVID-19 Pandemic and delaying of well visit type appointments.

Federal Medicaid data (CMS 416) from the 2022 Child and Adult Health Care Quality Measures shows a significant discrepancy between the number of children with a health care provider coded well visit and the NSCH survey parent report of a well visit. CMS-416 reported the percentage of adolescents aged 12-17 receiving at least one well care visit as 58.8%. This is a continued focus for NPM 10 and the state action plan objective of 85% by 2025. This will be a continued high priority need in encouraging and re-engaging families after the COVID-19 pandemic to return to annual well care exams with a primary health care provider.

Challenging and continued issues are the decreased number of pediatricians in the state with Iowa ranking 44th out of 50 states with pediatricians per capita according to the American Board of Pediatrics 2023 State and County Distribution of US-Based General Pediatricians.

Local Title V CAH contractors hold the responsibility of providing well-child reminders, assisting families in linking with providers, assisting with making appointments, and providing follow-up to help parents assure that their children received the recommended periodic well-child exams through the EPSDT program. In addition, CAH contractors promote adolescent immunizations at schools, back to school events, and immunization clinics. A main focus is to get adolescents and their families connected with a medical home. Equally important is the education of families and adolescents themselves on the difference between limited sports-type physicals, services provided at back to school events and/or immunization clinics and comprehensive well visits at an established medical home.

Although the CAH agencies have been working diligently to inform and implement strategies to improve adolescent health through well visits, the statistics are still alarming in that 58.8% of adolescents ages 12-17 receiving a well care visit is well below the state goal of 85% by 2025. In order to address this, Iowa HHS has been in the process of seeking out requests for proposals for projects focusing on adolescent well visit and adolescent mental health.

Local contractors continue to work with primary medical care services and dental care providers to coordinate needed referrals, appointments and services for adolescents and children who are not covered under a Medicaid Managed Care Organization, in order to ensure that the family is linked to a medical home thus improving health outcomes for this population. Local Title V agencies are required to complete a community needs assessment annually identifying gaps in local services for all Iowans, in all ninety-nine counties. CAH and the Oral Health staff provided consultation through analyzed surveillance and technical assistance as needed, to support the Title V agencies as they tell the story of their communities. The Title V agencies collaborate with local stakeholders, medical and dental providers, schools and use client experience to promote access to care and assure that children and adolescents have EPSDT services

During FY23 contracted agencies continued work on targeted health equity efforts around family

engagement and inclusion of priority populations in multiple child and adolescent health objectives. Agencies continued to build family engagement groups with priority populations to gather insight and feedback on local service provision, outreach and informing materials, and input into the procedures and policies of local agencies to be more family friendly and accessible.

Other programs that support the Adolescent Well Visit NPM:

- Iowa's Sexual Risk Avoidance Education (SRAE) program continues to implement evidence-based curriculum that promotes the positive development of adolescents through curriculum-guided, interactive group discussions; positive adult guidance and support; and community service learning.

- Iowa's Personal Responsibility Education Program (PREP) is an adolescent development initiative that provides comprehensive sexuality education to assist youth in reducing their risk of unintended pregnancy, HIV/AIDS, and other STIs while addressing life skills to prepare youth for a successful adulthood.

- Iowa HHS enters into a contract with Iowa State University (ISU) Extension each year to operate the Healthy Families Line (HFL) and Teen Line. ISU Extension staff provide information and referral for the Care for Kids program. Callers reach the HFL at 1-800-369-2229 or through a toll-free TTY number. Families who call to obtain information about Care for Kids can be connected directly to the EPSDT Coordinator in their local community.

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

Since 2018, there has been a notable rise in the proportion of teenagers reporting experiencing intense feelings of sadness or hopelessness for extended periods, leading them to disengage from their usual activities. The upward trend in these percentages is concerning. According to the IYS special topics report issued in March 2022 (the last report available), the percentage of 6th graders reporting such feelings increased from 19% to 27%, while 8th graders saw an increase from 24% to 29%, and 11th graders from 33% to 36%. Although the COVID-19 pandemic is contained, research has indicated that this trend is still moving upwards indicating that longer term effects from stressors of the pandemic may be persisting. Our objective is to gradually decrease the overall percentage across the three grades by 0.5% annually, beginning in 2024. The next IYS was conducted in the fall/winter of 2023 and results are not available at the time of this report.

Currently, Iowa's Title V contractors have provided minimal services pertaining to adolescent mental health. Contractors seldom directly serve the adolescent population, often referring individuals to local mental health specialty providers when available.
In an effort to explore how the state Title V program could better address adolescent health and well-being, the Child and Adolescent Health Team brought together a group of interested participants including Iowa HHS staff, outside agencies such as the Iowa Primary Care Association, and Iowa high school students to discuss the direction that should be taken to help address adolescent mental health. Iowa HHS has been in the process of seeking out requests for proposals for projects focusing on adolescent well visit and adolescent mental health.

Iowa's Title V Program is represented at the Iowa Children's Behavioral Health System State Board, which convenes regular meetings six times a year. Additionally, advancing systems building to promote universal behavioral health screening and assessments, education, prevention, and access to mental health consultation

services is a contractual requirement for all Title V child and adolescent health contractors.

State Title V staff collaborated with the Iowa High School Athletic Association to expand the Iowa Athletic Pre-Participation Physical Examination form that all participants must complete. The expansion included adding questions pertaining to the client's mental health in the form of the PHQ-4. The PHQ-4 is a self report questionnaire to screen for depression and anxiety over the last two weeks.

Contractors are continuing to collaborate with various organizations, including local chapters of Mental Health America and the National Alliance on Mental Illness (NAMI), County Mental Health and Disability Services, Mental Health Regions, mental health coalitions, school districts, healthcare providers, youth organizations, and organizations serving immigrants and refugees.

Adolescent Health - Application Year

Adolescent Well Visit NPM: Percent of adolescents, ages 12 through 17, with a preventive visit in the past year

In the National Survey of Children's Health (NSCH) 2021-2022 data showed that 76.1% of Iowa's adolescents ages 12-18 received a well child visit per parent report. The previous rate available is 2019-2020 data at 83.2%. Based on these rates, Iowa's five-year goal was to reach 85% by 2025. However, due to the COVID-19 pandemic, the rates of well child visits significantly decreased. National and state reports indicate that all families accessed less preventive care in 2020 and 2021 with a rate of 77.7%. Due to this dip in preventive care rates, our 2025 goal has been adjusted to 80%.

The CMS 416 data shows a significant discrepancy between the number of children with a health care provider coded well visit and the NSCH survey parent report of a well visit. The CMS 416 Medicaid data of adolescents with a well visit enrolled in Medicaid showed 52% for 10–14-year-olds and 45% for 15–18-year-olds in 2019. The COVID-19 pandemic adversely impacted the number of adolescents accessing well visits in 2020 and 2021. These percentages decrease to 46% for 10–14-year-olds and 40% for 15–18-year-olds in 2020. The numbers rebounded a little in 2021 with 50% for 10–14-year-olds and 43% for 15–18-year-olds. In 2022, the numbers decreased again with 48% for 10–14-year-olds and 41% for 15–18-year-olds. 2023 has shown to decrease once again at 41% for 10–14-year-olds and 33% for 15–18-year-olds. This downward trend is concerning, especially since the rates have continued to decrease even after recovery from the pandemic.

Public health professionals have been watching closely to see if families will return to preventive care at the same rate as pre-pandemic or if the pandemic will have a lasting effect on preventive care. It appears that the pandemic may have a lasting effect on preventive care, prompting more urgent and targeted intervention strategies for this performance measure.

Historically, Iowa HHS has contracted with local Title V agencies to work on all the Iowa selected NPMs and SPMs across the state with the 2015 & 2020 MCAH needs assessments demonstrating a need for additional focus on adolescents. Contractors have spent decades partnering with WIC and early care and education programs as the primary ways to find and serve pregnant clients, infants, and young children. After years of trying to make this model successful for adolescents, and gathering the feedback of contractors, stakeholders, and families, Iowa HHS removed the adolescent well visit and adolescent mental health performance measures from the CAH RFP in FFY 2023, with the exception of well visit reminders for adolescents enrolled in Title V and Fee-For-Service Medicaid, and outreach during the Informing service. Local Title V contractors will still have the option to provide direct health care services and screenings as a gap-filling service, with demonstrated need through their Screening Center Provider Status with Medicaid.

Child and Adolescent Health program responsibilities are reflected in local contractor work plans. Requirements that contribute to increasing adolescent well visits:

- Working with local Boards of Health in the counties served
- Addressing health equity
- Outreach for Medicaid and Hawki, including providing presumptive Medicaid eligibility determinations for children and adolescents
- Assisting families in understanding and using medical and dental insurance coverage, transitioning between coverage, and navigating the health care system
- Age appropriate scripts and resource directories to encourage adolescent well visits during the Medicaid Informing process.

- Promotion of adolescent immunizations at schools, back to school events and immunization clinics.
- Provide culturally and linguistically appropriate annual well visit reminders for adolescents who are Title V clients (underinsured or uninsured) and adolescents enrolled in Medicaid Fee For Service.
- Promoting access to well-child exams, with particular focus on the uninsured, underinsured, and Medicaid fee-for-service populations not served by a Medicaid Managed Care Organization
- Providing needed interpretation services and linking to transportation resources

Hawki Outreach builds and strengthens local infrastructure through local partnership development, engagement and promotion and distribution of Hawki materials. Local contractors provide presumptive eligibility determinations for children and adolescents, which allow immediate access to Medicaid covered medical, dental, and pharmacy services until a formal Medicaid eligibility or Hawki eligibility determination is made. Contractors provided outreach activities in their communities to three required populations: schools, priority populations and employees without access to employer-sponsored health insurance. Providing outreach to schools at the local level continued to be important in reaching uninsured, eligible adolescents.

Local Title V contractors are required to have family engagement activity(ies) to gather input and recommendations to increase the quality of the program as a whole. One of the topics expected to be discussed through these efforts is strategies to increase adolescent well visits from family members with adolescents eligible for Title V services. State level Title V staff are exploring partnering with the State of Iowa Youth Advisory Council (SIYAC). The purpose of the youth advisory Council is to foster communication among a group of engaged youth and the Governor, general assembly, and state and local policymakers regarding programs, policies, and practices affecting youth and families; and to advocate for youth on important issues affecting youth.

Through the Personal Responsibility Education Program (PREP) and the Sexual Risk Avoidance Education (SRAE) Program, program facilitators have access to materials to promote the adolescent well visit with the youth they serve. Many facilitators provide lessons on health and wellness. Additional topics include but are not limited to; personal responsibility, self-regulation, goal setting, healthy decision-making, a focus on the future, and the prevention of youth risk behaviors such as drug and alcohol use.

Senate File (SF) 496, an education bill, was signed into law by Governor Kim Reynolds on May 26, 2023. Although SF496 is an education bill, some of the language pertains to contractors working in Iowa schools. Currently, the majority of PREP and SRAE contractors provide programming in a school-based setting. PREP and SRAE contractors must follow a school district's policies, procedures, and guidance regarding the school district's obligations under SF 496. This includes the school district's obligations to obtain written consent from a student's parent or guardian for surveys (pre/post-tests) and questionnaires and to prohibit instruction on sexual orientation and gender identity to students in kindergarten through sixth grade. The agency has seen a 56% decrease in the number of youth completed curriculum surveys and 57% decrease in the number of youth completed federal performance measure surveys. The collection of data performance measures is required by the Family and Youth Services Bureau, and therefore, may require PREP and SRAE contractors to look for community-based settings for program implementation.

Iowa HHS is currently in the process of creating a specific funding opportunity to advance adolescent health in Iowa. The original goal of the funding opportunity included two focuses: 1) to increase the quality and availability of adolescent well visits in the medical home and 2) to increase the ability of Primary Care Providers to manage adolescent mental health in the primary care setting. The funding opportunity focus group included youth, family members and primary care providers as part of the team to ensure the needs of each affected population are included. Unfortunately, two Requests for Proposal (RFP) were issued with no applicants. Due to this, Iowa HHS will utilize the funds available, in part, to administer an assessment of need throughout the state. This assessment will examine the barriers that exist in all facets of the state, rural and urban, and in all population groups. The results of

this assessment will help guide a more targeted approach and more specific needs of primary care providers throughout the state in order to increase adolescent well child visits in Iowa.

Moving adolescent health to its own funding opportunity will move it to contractors with expertise in adolescent health. The intent is to focus on building the capacity of medical homes to serve adolescents expertly through well visits and management of frequent mental health needs in the primary care setting. Primary Care Provider to Primary Care Provider and/or Mental Health Clinician to Primary Care Provider consultation, education and peer support is an evidence-based practice and a method primary care providers are comfortable using.

Contractors of Iowa Medicaid working on EPSDT gather quarterly to work on initiatives to improve EPSDT services and implementation in Iowa, including the University of Iowa, Iowa Medicaid, Bureau of Family Health/Title V and the Managed Care Organizations.

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

From 2018, there has been a significant increase in the percentage of adolescents that report that during the past 12 months they were feeling so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing usual activities. The increase in the percentages is alarming. In the IYS special topics report released in March 2022 the percentage of 6th graders reporting on this measure increased from 19% to 27%. The percentage of 8th graders increased from 24% to 29% and the 11th grade percentage went from 33% to 36%. The IYS report also highlighted the disproportionate percentage of students who identify as LGBTQ+ reporting that 67% had experienced feelings of sadness or hopelessness as compared to 25% of heterosexual students. A reasonable deduction for the increase in percentages during that timeframe can be attributed to the COVID-19 pandemic. It is likely the closure of schools and halt of extracurricular activities may have exacerbated teens feeling lonely and isolated. The COVID-19 pandemic also brought other struggles for families. With the closure of schools and other activities halted, more families were home together. This brings an increase in emotional and physical abuse of children and adolescents as well as other stressors such as job losses and financial stress. In addition, many children and families have difficulty accessing mental health resources such as mental health medication management, specialty advanced practice mental health providers, and adolescent outpatient group therapy options due to a statewide shortage of these specialists and services, along with extensive wait lists in some areas.

Public health officials are watching for the 2023 IYS data to be released to see if rates are decreasing after the pandemic or if rates may be affected by ongoing unmet mental health needs and recent legislation around DEI, gender identity and orientation discussion, and allowable books in school libraries.

Iowa HHS is currently in the process of creating a specific funding opportunity to advance adolescent health in Iowa. The original goal included increasing the ability of primary care providers to manage adolescent mental health in the primary care setting. The funding opportunity focus group included youth, family members and primary care providers as part of the team to ensure the needs of each affected population were included. Unfortunately, two Requests for Proposal (RFP) were issued with no applicants. Due to this, Iowa HHS will attempt to secure a contractor to help fulfill the intent of the funding opportunity by issuing a sole source contract to a community partner. Part of this process will be to meet with varying community partners and to create a plan to meet our goal of increasing the ability of primary care providers to manage adolescent mental health in the primary care setting.

Providing specific funding for adolescent health will move it to contractors with expertise in adolescent health. The intent is to focus on building the capacity of medical homes to serve adolescents expertly through well visits and

management of frequent mental health needs in the primary care setting. Primary Care Provider to Primary Care Provider and/or Mental Health Clinician to Primary Care Provider consultation, education and peer support is an evidence-based practice and a method primary care providers are comfortable using.

Title V local contractors have provided some depression screens, substance abuse screening with brief intervention and referral, and intimate partner violence screens over the past decade, however there are additional mental health services that are included as part of the Screening Center Provider package. These services include mental health assessment, mental health therapy, psychosocial screenings, and nutrition counseling. With the growing need for mental health support, Title V can expand the capacity and services that Screening Centers are able to provide to address some of these gaps. State Title V staff are working with Iowa Medicaid to build out these codes through selecting screening tools and resources, providing training and providing support for implementation.

Adolescent Health staff serve on the Youth Risk Behavior Survey (YRBS) advisory committee. On January 27, 2023, the committee received notice from Dr. Robert Kruse, State Medical Director, that the Agency will not be participating in the CDC's YRBS in 2023 in order to focus efforts on maximizing the state administered Iowa Youth Survey (IYS) and improving survey participation Iowa joins seven other states that will not participate in YRBS in 2023, including Colorado, Idaho, Minnesota, Oregon, Florida, Washington, and Wyoming. School participation in both IYS and YRBS has continued to decrease, so by consolidating our approach into one youth survey, we hope to stabilize and eventually increase school participation. YRBS data provides a statewide summary, whereas IYS allows us to analyze and report data at multiple jurisdiction levels (county, judicial district, Area Education Agencies), making the IYS a valuable resource for making decisions at a local level. The lack of data specific to adolescents is a significant concern for programs.

Staff serve on the Statewide Advisory Committee for Adolescent Health. Prevent Child Abuse Iowa (PCA Iowa) provides statewide administrative support services for legacy Department of Human Services (DHS) and is responsible for the coordination of the advisory meetings. Membership includes state-level representatives from legacy Department of Human Services, legacy Department of Public Health, Department of Education, and the legacy Department of Human Rights (DHR), the Division of Criminal & Juvenile Justice Planning (CJJP). A staff person from the Polk County Public Health Department serves on the advisory committee.

Another project in which Iowa HHS Title V staff is participating is the re-examining of Iowa's School Based Medicaid Services. A collaborative goal is to create infrastructure in schools to support the availability of mental health services to adolescents in the school setting. Creating a system that is easily accessible will provide another access point for Iowa's youth to receive support in the area of mental health.

New funding through Iowa's Pediatric Mental Health Care Access award has allowed HHS and the Division of Child and Community Health to establish a relationship with the University of Iowa's Scanlan Center for School Mental Health. In FFY2025, this relationship will continue. In addition to a focus on increasing the capacity to provide appropriate services for mental health diagnoses for school-aged youth, DCCH will also work with the Scanlan Center to provide evidence-based therapy trainings for mental health providers and suicide prevention trainings for school staff.

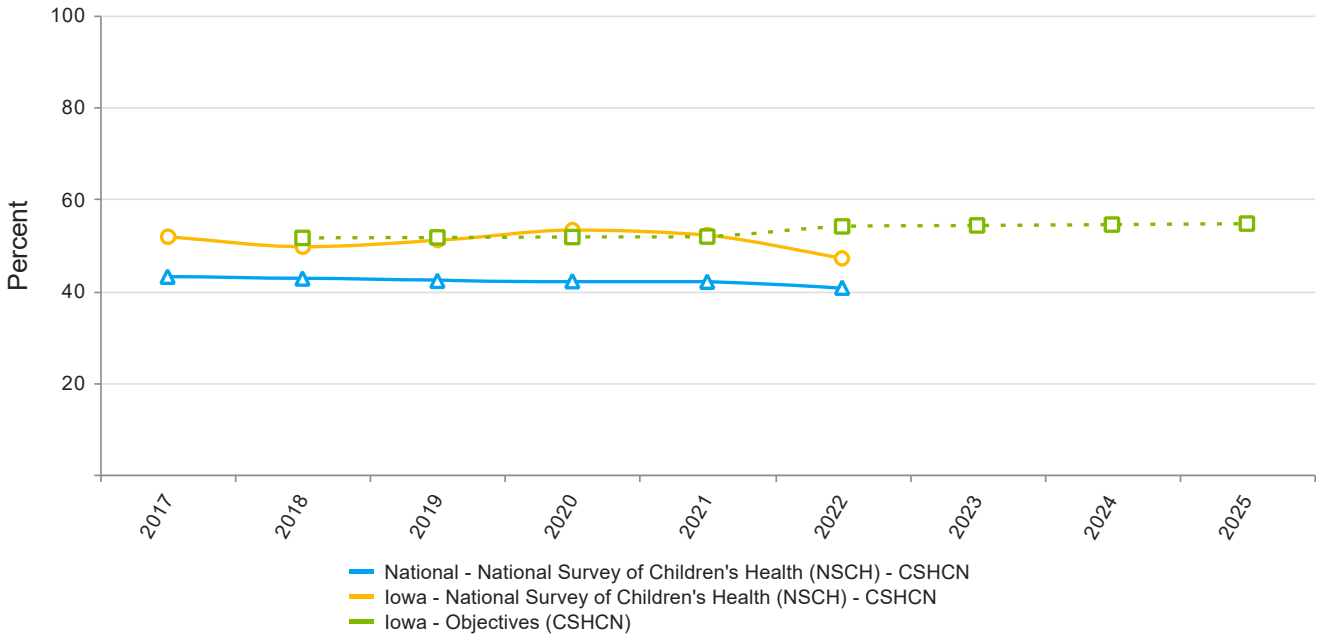
Title V and PMHCA staff will work to expand and publicize a new resource that is being developed through the partnership with the University of Iowa Scanlan School for Mental Health. Welltrack Connect is a HIPAA and VPAT-compliant online referral service to help individuals seeking mental health services locate and connect with a provider who best fits their mental health needs. The Scanlan Center has partnered with Welltrack Connect to build a statewide network of mental health and psychiatric medical providers to increase access to services across the state, including rural areas where access to care is limited. Providers create or claim a profile that includes

information about their practice location, clinical specialties, provider demographics, whether telehealth is offered, forms of payment (including insurance) accepted, and current availability. This platform is available to all Iowans statewide at no cost to mental health providers or prospective clients.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	51.6	51.7	51.8	54	54.2
Annual Indicator	51.0	52.3	53.8	52.5	47.1
Numerator	74,037	75,172	79,550	78,926	65,535
Denominator	145,140	143,725	147,830	150,375	139,096
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	54.4	54.6

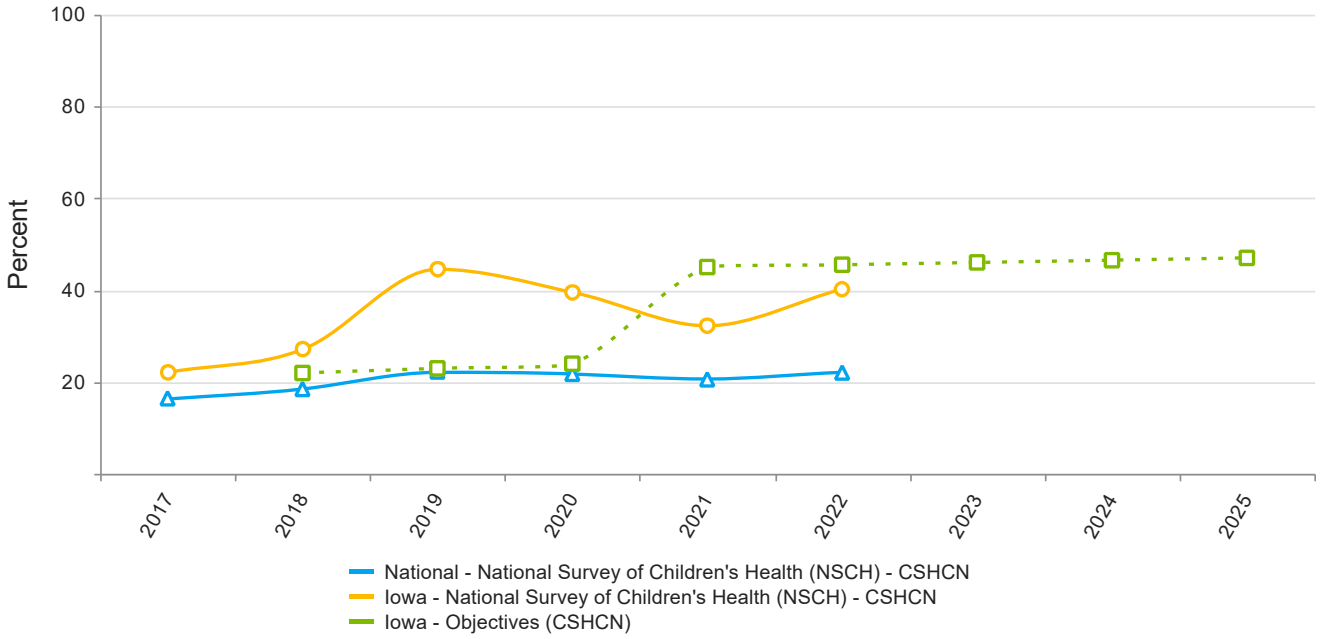
Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Number of telehealth visits through Child Health Specialty Clinics

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			3,150	4,000	3,400
Annual Indicator	3,115	4,464	4,397	3,377	3,431
Numerator					
Denominator					
Data Source	Program Data	Program Data (EHR)	Program Data (EHR)	Program Data (EHR)	Program Data (EHR)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	3,450.0	3,500.0

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR Indicators and Annual Objectives



NPM TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	23	24	45	45.5	46
Annual Indicator	27.2	44.5	40.8	32.3	40.1
Numerator	20,601	30,962	29,858	24,358	27,274
Denominator	75,605	69,559	73,204	75,316	67,971
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	46.5	47.0

Evidence-Based or –Informed Strategy Measures

ESM TR.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			64	66	98
Annual Indicator	62.1		92.2	97.8	94.7
Numerator	218		200	220	230
Denominator	351		217	225	243
Data Source	Program Data (EHR)		Program Data (EHR)	Program Data (EHR)	Program Data (EHR)
Data Source Year	2019		2021	2022	2023
Provisional or Final ?	Final		Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	98.0	98.0

State Performance Measures

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			88	88.5	89
Annual Indicator	87.4		83.2	86.5	87.6
Numerator	97		5,399	3,598	3,887
Denominator	111		6,486	4,160	4,437
Data Source	Youth Services Survey for Families		Youth Services Survey for Families	Youth Services Survey for Families	Youth Services Survey for Families
Data Source Year	2016		2021	2022	2023
Provisional or Final ?	Final		Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	89.5	90.0

State Action Plan Table

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Access to community-based services and supports, pediatric specialty providers, and coordination of care	
NPM	
NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	
Five-Year Objectives	
By 2025, increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home to 53.4%	
Strategies	
Provide access to specialty care through Child Health Specialty Clinics (CHSC), including attention to culturally and linguistically appropriate care	
Strengthen infrastructure and increase opportunities for pediatric specialty care through Telehealth	
Increase Primary Care capacity to treat children with complex and/or mental health needs, and developmental and intellectual disabilities	
ESMs	**Status**
ESM MH.1 - Number of telehealth visits through Child Health Specialty Clinics	Active
NOMs	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	
NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	
NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC	

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 2

Priority Need

Access to support for making necessary transitions to adulthood

NPM

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR

Five-Year Objectives

By 2025, increase the percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care to 24.6%

Strategies

Work with youth and families in the transition to adult health care

Ensure appropriate transition resources for families accessing CHSC Regional Center services

Ensure appropriate resources for youth and families from underrepresented backgrounds who are transitioning from pediatric to adult health care

ESMs	Status
ESM TR.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist	Active

NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

State Action Plan Table (Iowa) - Children with Special Health Care Needs - Entry 3

Priority Need

Support for parenting Children and Youth with Special Health Care Needs

SPM

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

Five-Year Objectives

By 2025, increase the percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V to 90%

Strategies

Provide family support services to Iowa families of CYSHCN, including recruiting and supporting ethnically diverse staff including cultural liaisons

Increase appreciation of strengths and understanding of barriers to family participation and care for direct services staff statewide

Ensure caregiver confidence and capacity to advocate for CYSHCN on all levels (personal/family, community, and policy), including family training to underserved/underrepresented populations

Children with Special Health Care Needs – Annual Report

Families of Iowa's CYSHCN continued to face challenges navigating complex systems of services and supports in Federal Fiscal Year 2023. Barriers to finding in-home care, respite services, and school-based services continued to be a challenge for many families. While there have been some changes in policy at the legislative level to help alleviate some issues tied reimbursement rates and provider shortages, families are uncertain about the impacts of major changes in Home and Community Based Waiver Services, and the special education system. Access to emotional, behavioral, and developmental evaluation and services is improving, but is still a primary concern statewide, and especially in rural areas.

For Federal Fiscal Year 2023, Child and Community Health and the Child Health Specialty Clinics (CHSC) Regional Centers have continued to focus on the three priority areas identified in the 2020 5-Year Needs Assessment. These priority areas are: 1) Access to community-based services and supports, pediatric specialty providers, especially mental health providers, and coordination of care; 2) Access to support for making necessary transitions to adulthood; and 3) Support for parenting Children and Youth with Special Health Care Needs (CYSHCN). CYSHCN program staff are in the early data collection stage for the 2025 5-Year Needs Assessment.

Priority Need
Access to community-based services and supports, pediatric specialty providers, especially mental health providers and coordination of care (Oct 1, 2022 – Sept 30, 2023)

NPM 11. Percent of children with and without special health care needs having access to a medical home

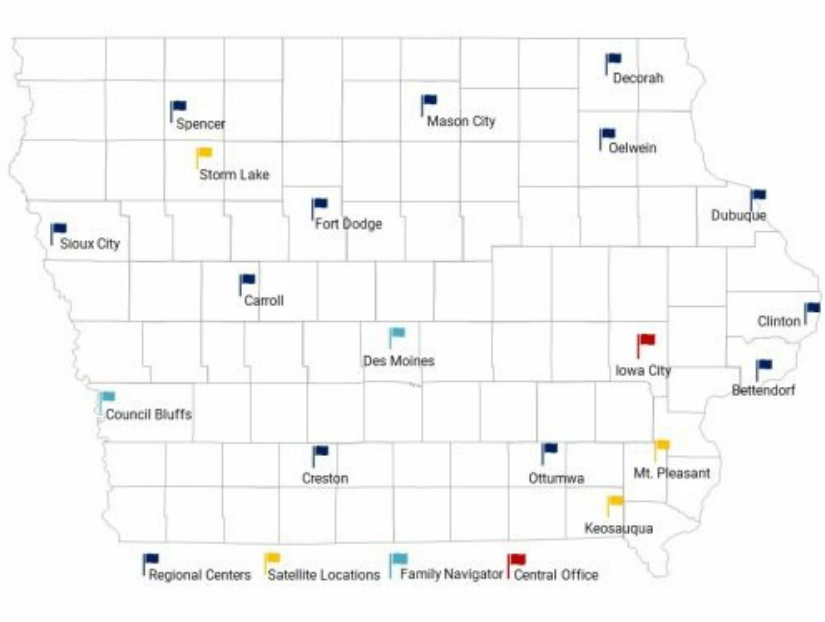
The Access to Care priority area included three main strategies: 1) providing access to specialty care through Child Health Specialty Clinic Regional Centers and satellite locations, 2) strengthening existing infrastructure and increasing opportunities for specialty care through telehealth, and 3) supporting workforce development and integration opportunities for pediatric and sub-specialty providers for serving children with complex and/or mental health needs, developmental and intellectual disabilities, and their families.

The provision of gap-filling direct services included: 1) providing specialty care to families, including enhanced, culturally responsive supports; 2) a focus on family-centered goal setting; and 3) assessing best practices for trauma informed and culturally responsive care coordination that aligns with community needs.

Providing Access to Specialty Care
Iowa's Title V program for CYSHCN can provide services and supports for children with special health care needs ages 0–21 years regardless of diagnosis. Child and Community Health includes 12 permanent Regional Centers that are open either 4 or 5 days per week depending on community needs and available resources. Title V Block Grant funding provides foundational support for the Regional Center infrastructure, with braided funding from other federal and state resources. Some funding is also generated through program income from public and private health care payer reimbursement.

All Regional Centers include registered nurses, family navigators, and clerical staff. Most Regional Centers include an advanced registered nurse practitioner (ARNP), and some have social workers, dietitians, or other program staff. Services are also provided through satellite locations where staff provide services once or twice a month, and locations with only family navigators who provide family-to-family support.

All Regional Centers are equipped with modern telehealth equipment, providing families with access to pediatric specialty health care services from University of Iowa Health Care providers. Gap-filling direct services are provided to families through the Regional Center infrastructure, primarily in rural areas of the state, or where specific gaps exist. The map below shows the distribution of regional centers, satellite clinics, family navigator-only locations, and the central administrative offices.



Map 1 Child Health Specialty Clinics locations

In FFY2023, Child and Community Health directly served 8415 children and their families. Examples of programs that leverage funding in addition to Title V dollars are listed in the following table; a handful of patients were seen by multiple programs due to eligibility changes within the year.

Examples of Child and Community Health programs that receive funding in addition to Title V foundational support:

Regional Autism Assistance Program (RAP) 43% of patients were served through the Regional Autism Assistance Program (RAP). RAP coordinates educational, medical, and other services and supports for children and youth who have ASD or are suspected of having ASD, their parents, primary caregivers, other family members, and providers of services to persons with ASD. With foundational funding from the Title V block grant, Child and Community Health combines funds from the Iowa Department of Health and Human Services (Iowa HHS) and the Iowa Department of Education (IDOE) to administer RAP.
Health and Disability Waiver and Waitlist Services (HDM) 8% of patients were served through the Medicaid Health and Disability Waiver program or its waitlist. Nurses and Family Navigators help locate and organize resources enabling these children to grow up with other family members and participate in normal community activities. The HDM team helps families access health, education, and social support services and provides care coordination to help children with special health needs remain at home and in their communities. Title V supplements funding provided through Iowa HHS and Iowa Medicaid.
Pediatric Integrated Health Home (IHH) 11% of patients were served through the Pediatric Integrated Health program (IHH). This program provides care coordination and family support services to Iowa children and youth who are eligible for Medicaid and have mental or behavioral health diagnosis. Child and Community Health provided IHH services to children and families through four regional centers in northeastern Iowa. Title V supplemented funding provided through Iowa HHS and Iowa Medicaid.
Community Circle of Care (CCC) 3% of patients were served through the Community Circle of Care (CCC). CCC was a regional System of Care program providing care coordination for community-based services and supports to non-Medicaid children and youth with serious behavioral or mental health needs in northeast Iowa. CCC served children and youth up to 21 years old through four regional centers in northeastern Iowa. Title V supplemented funding provided through Iowa HHS.

In FFY2023, Child and Community Health also provided service coordination to about 300 children, nutrition services to almost 500 children, and health assessments to around 50 children with enrolled children 0–3 years old through Early ACCESS, Iowa's Part C Early Intervention program.

All families who receive services through Child and Community Health have access to support from family navigators. Family navigators are staff members who are also the parent or primary caregiver of a child with special health care needs. They work with families to provide emotional support, systems navigation, and connections to community resources. In FFY2023, family navigators provided over 32,136 contacts with or on behalf of over 5426 children and their families.

Family Navigator (FN) Contacts

	FFY2023	FFY2022
Total contacts	32,136	33,467
CYSHCN (unduplicated) with FN contacts	5426	4901

Child and Community Health employed eight ARNPs and one pediatrician who provided developmental and behavioral screenings and assessments, mental health care, medication management, medical care coordination, and other medical supports in Regional Centers. The Ottumwa Regional Center uniquely houses both an ARNP and a pediatrician, who began to provide services at the end of FFY2022. In FFY2023, these providers completed 3758 in-person visits with 1957 children. The COVID-19 pandemic created an opportunity for some gap-filling ARNP visits to occur via telehealth. Telehealth visits with Regional Center nurse practitioners increased from FFY2022. In FFY2023, there were a total of 565 ARNP telehealth visits: 259 into homes, and 306 into Regional Centers that do not have an ARNP on-site.

Access to culturally and linguistically appropriate care

Child and Community Health staff have worked to be inclusive across underrepresented populations in the state, employing 2 Spanish speaking family navigators and one Marshallese-speaking family navigator, from within the communities they serve. Child and Community Health works within the broader University of Iowa Health Care system to ensure that interpreters are available during telehealth and in-person visits. In FFY2023, interpreters were provided during in-person and telehealth visits through Child and Community Health for families who preferred visits in another language. Most interpretation was provided through University of Iowa Health Care interpreters or through their contracted service provider, Cyracom. Of patients served, 5.3% had a primary language other than English listed. Of those 5.3%, almost 70% were Spanish speaking. Primary languages are listed below.

Language	Percent of all Patients	Percent of non-English Language Patients
Spanish	3.6%	67.1%
Tigrinya	0.4%	7.9%
French	0.2%	4.3%
Oromo	0.2%	3.0%
Somali	0.1%	2.4%
Hmong	0.1%	1.8%
Karen	0.1%	1.8%
Arabic	0.1%	1.8%
Pohnpeian	0.1%	1.8%
Vietnamese	0.1%	1.8%
Marshallese	0.1%	1.2%
Burmese	0.1%	1.2%
Unknown	0.1%	1.2%
Laotian	0.0%	0.6%
Swahili	0.0%	0.6%
American Sign Language	0.0%	0.6%
Micronesian	0.0%	0.6%

Family-centered goal setting

Family-centered goal setting continued to be a priority in FFY2023. Regional Center staff initiate, review, and document family goals at each clinical visit. Family goals are documented within the Epic Electronic Medical Record used by the University of Iowa Health Care system through a workflow developed in FFY2020. Since FFY2020, the family goal setting workflow has adjusted to adapt to clinic and family needs, such as incorporating goal setting activities within telehealth visits. Goal setting activities included weekly and monthly review of documentation by

program staff, and monthly consultations with Regional Center staff to celebrate successes and identify areas of opportunity. FFY2023 continued to emphasize formal family goal setting, as demonstrated in the reported data. In FFY2023, the percentage of visits where new goals were initiated was 95%, compared to 94% in FFY2022; the percentage of visits where current goals were reviewed was 93%, compared to 92% in FFY2022.

Goal Setting Data FFY2021 – 2023

	FFY2021	FFY2022	FFY2023
Percent of visits where new goals were initiated	84%	94%	95%
Percent of visits where current goals were reviewed	92%	92%	93%

Program staff participate in monthly consultations with Regional Center staff to identify areas for staff development. FFY2023 consisted of working closely with staff including ARNPs, RNs, and administrative staff, to reevaluate clinic workflows to continue prioritizing family goal setting. All Child and Community Health provider disciplines received additional training on family goal setting workflows during at least one of their monthly meetings in FFY2023.

Child and Community Health Advanced Registered Nurse Practitioner (ARNP) Visits

	FFY2023	FFY2022
In-person	3758	2887
Telehealth in clinic	306	240
Telehealth into home	259	216
Total ARNP visits	4323	3343

Strengthening Telehealth Infrastructure

University of Iowa Health Care, located in east central Iowa, is Iowa's only comprehensive pediatric tertiary care center. For many families this is their only access to specialty services within the state. Child and Community Health has been providing access to pediatric specialty services through in Regional Centers across the state for decades, and continues to build on this infrastructure and add new specialties to increase the number of CYSHCN who can access services each year.

In FFY2023, Child and Community Health continued previous efforts to expand and enhance telehealth services, especially in the areas of child and adolescent psychiatry, behavioral and developmental pediatrics, as well as adding additional medical specialties. In FFY2022, a Tele-Autism Spectrum Disorder pilot and a Psychotherapy Clinic began serving patients, with efforts continuing through FFY2023. In August 2023, a Pediatric Nephrology Hypertension Clinic pilot began in the Bettendorf Regional Center, with plans to continue into FFY2024 based on community needs. FFY2023 also included introducing an additional adolescent psychiatry provider to expand psychiatric telehealth services.

In FFY2023, Child and Community Health provided telehealth services from University of Iowa Health Care providers to 1082 patients. Of those, psychiatrists saw 651 patients through nearly 2000 visits in FFY2023.

Psychiatry visits facilitated by Child and Community Health

	FFY2023	FFY2022
Telehealth in clinic	1694	1702
Telehealth into home	295	290
Total Psychiatry visits	1989	1992

Additional visits were provided in the areas of nutrition by registered dietitians, developmental and behavioral pediatrics, pediatric genetics, pediatric neurology, pediatric endocrinology, genetics, and psychology. Dietitians also provided some services in-person during clinic visits.

Other pediatric specialty visits facilitated by Child and Community Health

	FFY2023	FFY2022
In-person	51	53
Telehealth in clinic	95	44
Telehealth into home	782	885
Total other pediatric specialty visits	928	982

Iowa's Evidence Based Strategy Measure for the Access to Care priority area focused on the number of telehealth visits facilitated through Child and Community Health: ESM 11.1: Number of telehealth visits through Child Health Specialty Clinics. In FFY2023, Child and Community Health facilitated 3431 telehealth visits. This is slightly higher than the number of visits in FFY2022 (3377). Since the return of in-person visits due to the pandemic in 2021, there has been an overall decrease in telehealth visits due to the availability of in-person visits.

Activities focused on increasing the infrastructure to support telehealth continue to result in increased access for families to specialty services. This included efforts to: 1) build partnerships with specialty providers including those from other states and institutions; 2) investigate mechanisms for funding and reimbursement of facility and staff time for telehealth; and 3) evaluate staffing needs to prepare for increasing telehealth opportunities.

Increasing Workforce Capacity

In FFY2023, Child and Community Health continued to provide opportunities to increase provider capacity to treat CYSHCN, with an emphasis on targeting Primary Care Providers (PCPs). PCPs were offered access to continuing education opportunities through webinars, facilitated through foundational funding from Title V in addition to funding from the Health Resources and Services Administration (HRSA) Pediatric Mental Health Care Access (PMHCA) Program. Program activities also included collaborations with the primary care medical community and training programs across the state. These programs and trainings have been developed with the assistance of the PMHCA Advisory Council whose members included representatives from the University of Iowa Health Care Physician Assistant program, psychiatrists, general pediatricians, the Iowa Department of Health and Human Services Title V MCH program and 1st Five Healthy Mental Development Initiative, the Iowa Chapter of the American Academy of Pediatrics, the Iowa Association of Nurse Practitioners, the Iowa Primary Care Association, and family leadership.

Child and Community Health presented 10 training webinars in FFY2023, covering the following topics:

Date	Webinar Topic	Presenter(s)*	Total Attendees	Primary Care Provider/Support Staff
13 Oct 22	Detecting and Managing Suicide Risk in Pediatric Primary Care Settings – Part II	**Lisa Horowitz**, PhD, MPH, National Institute of Mental Health, NIH	86	12
27 Jan 23	Behavior Basics: When to Worry, What to Do	**Burgundy Johnson**, DO, Child and Adolescent Psychiatry Carle Bromenn Medical Center **Todd Kopelman**, PhD, Department of Psychiatry **Kelly Pelzel**, PhD, Department of Psychiatry	111	18
24 Feb 23	Depressive Disorders in Children and Adolescents	**Burgundy Johnson**, DO, Child and Adolescent Psychiatry Carle Bromenn Medical Center	99	16
16 Mar 23	Ways to Help Picky Eaters and Their Families	**Linda Cooper-Brown**, PhD, Division of Developmental and Behavioral Pediatrics	104	13
25 Apr 23	Helping Parents Manage Common Behavior Problems: A Deeper Dive into Behavior Basics	**Kelly Schieltz**, PhD, Division of Developmental and Behavioral Pediatrics	142	16
26 Jun 23	Helping Parents of Children with Toileting Fears	**Laura Fuller**, PhD, ABPP, Department of Psychiatry **Kari Gjerde Kempf**, PhD, Postdoctoral Fellow, Department of Psychiatry	60	9
19 Jul 23	Bioethical Aspects of Gender Affirming Care in Youth	**Burgundy Johnson**, DO, Child and Adolescent Psychiatry Carle Bromenn Medical Center	73	9
8 Aug 23	Assessment and Interventions Strategies for Individuals at Risk for Psychosis: PIER Program	**Amanda McCleery**, PhD, Department of Psychological and Brain Sciences	73	2
1 Sept 23	Nothing About Me Without Me: Shared Decision Making in a Clinic Setting	**Diane Brenneman**, DMin, FPSS, Division of Child and Community Health **Megan Sprecher**, ARNP, FNP-MC, Division of Child and Community Health	34	3
19 Sept 23	It's More Than Just Food Labels: Psychosocial Impact of Pediatric Food Allergy	**Lisa Woodruff**, RD, LD, Division of Child and Community Health	35	1
		Total	**817**	**99**

*Presenters were from the University of Iowa Health Care Carver College of Medicine except where otherwise noted.

Additional collaborations formed through the Health Resources and Services Administration (HRSA) Pediatric Mental Health Care Access (PMHCA) Program included the development of the Pediatric Psychiatry Roundup: Reviewing Up-to-Date Child Psychiatric Information for a Post-Pandemic World Virtual Conference. This conference was planned in partnership with Carle Health, with the target audience including primary care providers, social workers, mental health counselors, and other health care professionals. The virtual conference was on May 5, 2023, with a total of 378 participants. This virtual learning experience included the following sessions:

- Family Mental Health in the Post Pandemic World
- Mini Child Psychiatry Topics: Tips and Tricks in Evaluating and Treating ADHD, Mood Disorders, and Trauma/PTSD
- Pediatric Sleep: Normal or Not and What to Do About It
- Supporting Attachment Relationships
- When the Child is the Trigger: The Plight of the Parent with a History of Childhood Abuse
- Autism: Screening, Diagnosis, and Beyond!
- In Case of an Emergency, Dial A-A-P: An Overview of AAP Mental Health Initiatives

Through a partnership with Iowa's Project LAUNCH, 280 professionals registered, which included 135 health care providers, for a virtual learning experience. Child and Community Health participated on the planning committee, arranged for the provision of Continuing Medical Education credits, created marketing materials, and assisted with marketing efforts. This virtual learning experience included the following sessions for health care professionals:

- Healing Iowa: Reshaping Our Systems and Communities for Iowa's Children to Thrive in Response to ACES
- Perinatal Depression and Anxiety
- Biopsychosocial Causes and Treatments to Troubling Behaviors in Autism
- Therapy with Babies: Exploring the Meaning of Infant Mental Health
- The Impact of Abuse, Neglect, and Social Experience on Behavior and Neurodevelopment: A 30-Year Perspective

Priority Need

Transition to adulthood for children and youth with special health care needs (Oct 1, 2022 – Sept 30, 2023)

NPM 12. Percent of adolescents with and without special health care needs, ages 12–17 who received services necessary to make transitions to adult health care

Activities within the Transition to Adult Health Care priority area focused on three areas in FFY2023: 1) continuing to provide clinic-based transition to adult health care services to families of transition-aged youth, 2) working alongside families and youth to plan for the transition to adulthood, and 3) ensuring appropriate transition resources for families accessing CHSC Regional Center services.

Clinic-Based Services

Providing clinic-based transition to adult health care services and supports continued to be a priority in FFY2023. In FFY2023, program staff, in collaboration with clinic staff, continued to evaluate clinic workflows to streamline processes for documenting transition plans. Regional Center staff have continued to initiate, review, and document transition plans at each clinical visit. Transition planning is initiated with the completion of a family and youth-drive Transition to Adult Health Care Checklist, developed by program staff and based on Got Transition® and other resources. The form is available on electronic tablets for in-clinic use, on MyChart (UI Health Care's patient portal), and as a hard copy. A Spanish language version is available, and for families who speak other languages, interpreters are available. The checklist highlights 12 distinct aspects of transition to adulthood, with a space at the end for identifying additional concerns. The 12 aspects are as follows:

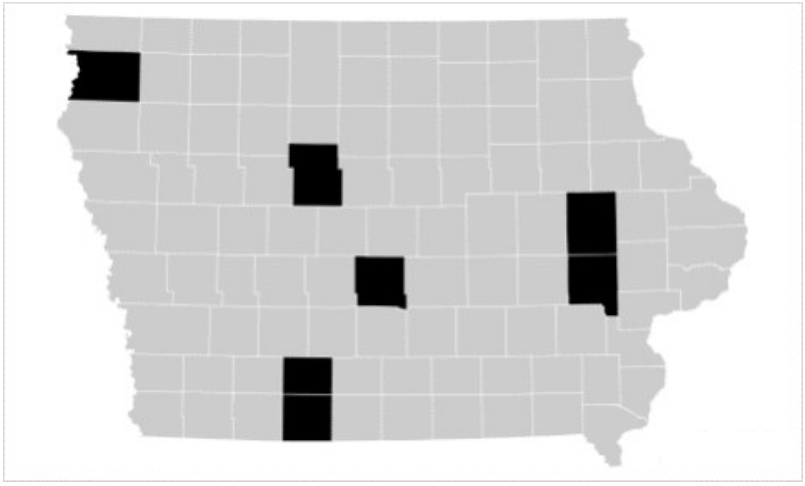
1. Learning about my health needs, medicines, or allergies
2. Learning how my health care privacy changes at age 12 and again at age 18
3. Planning for a health emergency

4. Learning how to fill out medical forms
5. Making healthy choices about food, friends, relationships, or alcohol, tobacco, and drugs
6. Learning how to make my own appointments, check myself in, or talk with my doctor/nurse
7. Planning how to get to my doctor or nurse's office
8. Learning where my pharmacy is and how to refill my medications
9. Understanding health insurance
10. Finding primary care providers or specialists that serve adults
11. Deciding whether I will need help making decisions after I turn age 18
12. Finding out which services I use now that will end at age 18 or 21 and how to sign up for new programs as an adult

Transition plans are documented in the Epic Electronic Medical Record used by University of Iowa Health Care. Program staff complete a monthly review of transition plan documentation data, with monthly consultations with Regional Centers to review data and identify areas of opportunity. In FFY2023, was a continued effort to ensure that all transition-aged youth seen at Regional Centers have transition plans, which is evident in the consistently high percentage of visits where transition plans were either initiated or reviewed. In FFY2023, the percentage of visits where transition plans were initiated was 86%, compared to 93% in FFY2022, while the percentage of visits where transition plans were reviewed was 91%, compared to 94% in FFY2022. The decrease from 2022 to 2023 is due to changes for telehealth psychiatry providers. CHSC is in the process of evaluating the best way to include telehealth specialty providers from outside of CHSC in our transition to adulthood planning program. ESM 12.1 is "the percentage of youth ages 12–21 served by Child Health Specialty Clinics who have completed a transition checklist". In FFY2023, CHSC providers saw 243 transition-aged youth with special health care needs in the clinical setting. Of those, 230 have completed a transition to adulthood checklist (95%).

Working Alongside Families and Youth

In FFY2023, the Transition to Adulthood program hosted the second year of its Youth Advisory Council, aiming to engage youth with special health care needs in an advisory capacity. The FFY2023 council consisted of 4 youth self-advocates, 4 siblings of youth with special health care needs, 1 Young Adult Ally, 1 Master of Public Health graduate student assistant, and 1 staff-level program coordinator. Council members were 14–22 years old, while the Young Adult Ally was a young adult self-advocate who served as a mentor to council members and as part of the council's programmatic leadership team. Council members were distributed throughout the state and represented both rural and more urban areas. The map below shows the locations of youth advisory council members.



Map 2 Youth Advisory Council member locations

There were 5 virtual council meetings from April 2023 to August 2023. Each council meeting began with 15-minutes of “social time” for youth to connect with one another and with the Young Adult Ally and staff. Both the council members and Young Adult Allies were compensated for attending meetings. Council meeting topics were largely driven by the identified needs of council members, who strongly leaned toward building their leadership and advocacy capacity to better prepare them to provide feedback in an advisory capacity. Youth provided the following feedback on the transition to adult health care program:

- Youth with special health care needs require intentional leadership and advocacy skills building to successfully provide programmatic feedback.
- Youth younger than 18 years old tend to be unfamiliar with what the transition to adult health care entails.
- Youth need structured discussions, an appropriate amount of time, and supports with making decisions related to the transition to adult health care.
- Transition to adult health care resources need resources tailored to youth, rather than their just their parents/caregivers. Council members reviewed and provided feedback on the updated transition to adult health care resources, which launched in late FFY2023.

A toolkit detailing the process of starting a youth advisory council was developed in FFY2023, and this project was presented in an AMCHP Workshop session at the 2023 AMCHP conference.

FFY2023 also included a formal evaluation of the transition to adult health care program. The program evaluation was conducted for a Master of Public Health (MPH) student’s Applied Practice Experience, in collaboration with program staff. The goal of the evaluation was to 1) identify how clinic-based transition to adulthood services are working within Regional Centers, 2) identify strengths of the transition to adult health care program, and 3) identify key areas of improvement. The evaluation consisted of two components:

1. A survey of staff on their perceptions of current transition to adulthood practices
2. Key informant interviews with parents and caregivers of transition-aged youth that recently received clinical services through Regional Centers

In total, 10 key informant interviews were conducted in March 2023. Interviews were led by the student and analyzed with assistance from program staff. Key informant interviews revealed:

- Families of transition-aged youth value the support they receive from staff, specifying ARNPs, RNs, and family navigators. These close relationships allow families to be connected to the necessary resources to support their youth as they enter adulthood.
- While resources on the health care transition are necessary and appreciated, more resources on additional areas of the transition to adulthood are necessary. This includes information about school and community-based services, skills for daily living, and building community as an adult with special health care needs.
- Families of youth with special health care needs require an intentional and direct introduction to the transition to adult health care to properly support their youth and young adults.
- Transition-aged youth need more targeted and accessible information on the transition to adult health care, especially as health care privacy changes as they age.
- Families of youth with complex medical needs and increased needs as they become adults struggle to find appropriate transition to adulthood resources for their families.

An analysis of the survey completed by program staff yielded the following the results:

- Families utilize the Transition Checklist to identify transition to adult health care topic areas they want to discuss with their provider.
- Families and youth tend to struggle to grasp the concept of transition to adult health care, especially for youth under 18 years old.
- Clinic workflows regarding the initiation of transition planning tend to work well, but there are times of confusion with what staff member is responsible for certain aspects of the documentation process.

Recommendations from the transition to adulthood program evaluation began to be implemented at the end of FFY2023. Most notably, an updated transition to adult health care resource library debuted in September 2023. This update included brand new resources, following guidance from Got Transition® and other resources. The updated resources included information written for the following audiences: parents/caregivers, youth/young adults with special health care needs, and parents/caregivers of youth with medical complexities. Program staff received feedback from Regional Center staff, as well as the Youth Advisory Council and Family Advisory Council prior to the new product launch. Transition to adulthood resources are available at all clinic appointments, as well as on the CHSC website: https://chsciowa.org/transition-resources. The implementation of additional improvements, such as updating the transition to adult health care workflow within the Epic Electronic Medical Record, will continue into FFY2024.

Ensuring Appropriate Transition to Adulthood Resources

In addition to the launch of the updated transition to adulthood resource library, FFY2023 also included an increased focus on tailoring transition to adulthood information to better support the needs of YSHCN. In late FFY2022, program staff identified that there was a need for training on supporting families and YSHCN as they go through puberty and concerns surrounding sexual health. The transition to adulthood program staff collaborated with the Family Navigator Network leadership team to provide a four-part webinar series for Child and Community Health staff, including internal and external speakers. Continuing education credits were provided for eligible staff members. Additionally, a sexual heath resource kit specific to YSCHN was developed and sent to every Regional Center to share with families as needed.

Sexual Health Webinar Series: Transition to Adulthood Program

Date	Webinar Topic	Speakers	Number of Attendees
5 Oct 22	Preparing for Puberty with CYSHCN	**Danielle Wendel**, ARNP, Division of Child and Community Health	32
19 Oct 22	The Birds and the Bees for CYSHCN	**Judy Warth**, BBA, Center for Disability and Development, **Self-Advocate Panel**	36
2 Nov 22	How to Partner with Parents to Support their Children's Sexual Development: A Workshop for Professionals	**Laura Holland**, MS, LMT, Elevatus LLC	42
8 Nov 22	Staff In-Service: Debriefing Session	**Family Navigator Network Leadership**, Division of Child and Community Health	40

Priority Need

Support for parenting children and youth with special health care needs (Oct 1, 2022 – Sept 30, 2023)

SPM 7. Percent of caregivers of children and youth with special health care needs who report overall satisfaction with support services received through Title V

Strategies for supporting families were centered around three key areas: 1) providing family-to-family support to Iowa families of CYSHCN, 2) increasing the advocacy skillset of capacity of Iowa families and providing opportunities for provider workforce development, and 3) building the infrastructure for strengthening family leadership capacity statewide. These activities are carried out through the Child and Community Health Family and Professional Partnership program.

Youth Services Survey for Families
The Youth Services Survey for Families (YSS-F) was the basis of the questionnaire used to quantify the performance measure for SPM 7. The results of this survey found that in calendar year 2023, 88% of CYSHCN had families who reported overall satisfaction with services. The 2023 performance target for this measure was 89%.

The survey was sent to families of 2847 children. Responses were received from 281 families for an 9.0% response rate, which is approximately 3% of families served by Child and Community Health.

The YSS-F includes 26 questions with a 5-level Likert-type response scale ranging from 'Strongly Agree' to 'Strongly Disagree.' The items in the questionnaire are grouped into 6 domains: Access, Participation in Treatment, Cultural Sensitivity, Satisfaction, Outcomes, and Social Connectedness. The Satisfaction domain includes 6 items:

-Overall, I am satisfied with the services I received
-The people helping my child stuck with us no matter what
-I felt my child has someone to talk to when he or she was troubled
-The services my child and family received were right for us
-My family got the help we wanted for my child
-My family got as much help as we needed for my child

The state performance measure looks at the percent of families for whom the mean score for these items was over 3.5 on the 5-point scale

Providing Family-to-Family Support

In FFY2023, family navigators provided support services to over 5400 families of CYSHCN, an increase from the 4901 families served in FFY2022. As of September 2023, Child and Community Health employed 22 family navigators across the state. This included two family navigators who specialize in working with Spanish-speaking families, and one who specializes working with families from Marshallese communities. Due to the increased need for family-to-family support services in French-speaking African communities in Iowa, Child and Community Health increased an existing family navigator’s FTE to provide concentrated outreach and engagement efforts to this community. This effort continued into FFY2024, with plans to expand outreach and support services based on community needs.

Family Partnership and Workforce Development

Members of the Family Navigator Network participate in monthly 60-minute in-service presentations, which allow them to earn continuing education units to maintain state Family Peer Support Specialist certification. In-service topics for FFY2023 included:

Date	In-Service Topic
11 Oct 22	Making the Best Use of Supervision
8 Nov 22	Staff Debrief: Resources and Lived Experience with CYSHCN Sexual Education
13 Dec 22	Iowa Legislative Forum Advocacy Training
10 Jan 23	How to Get the Most Out of Your Performance Review
14 Feb 23	Extended School Year Services
14 Mar 23	Introducing Molina Health Care Iowa
11 Apr 23	Best Practices for HIPAA Compliance and Documentation
9 May 23	Resources from Easterseals
13 Jun 23	I-Smile and Oral Health Resources
26 Jun 23	Helping Parents of Children with Toileting Fears
11 Jul 23	Statewide Services: Disability Rights Iowa and Iowa Compass
8 Aug 23	Iowa Medicaid Hope and Opportunity in Many Environments (HOME) Project
12 Sept 23	Best Practices for Documentation

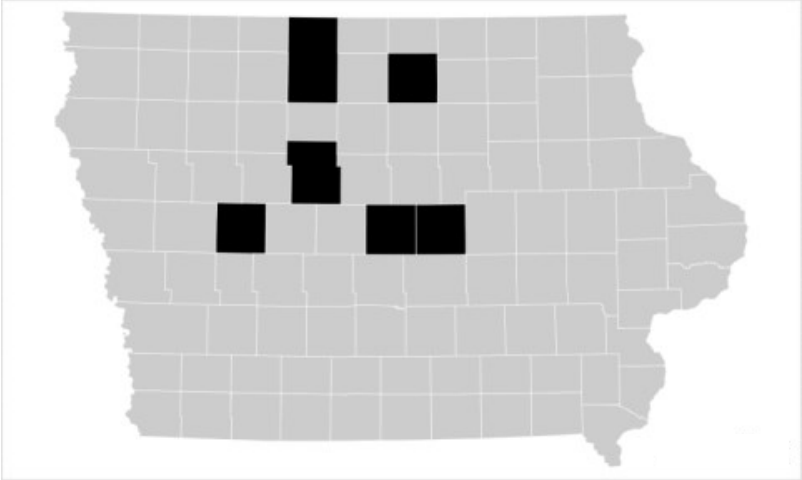
Family Advisory Council

The Family Advisory Council continued into FFY2023, with 11 members from across the state and meetings held primarily via teleconference. The Family Advisory Council met 5 times during FFY2023, including the March “Day on the Hill” at the statehouse in Des Moines where council members were able to communicate needs of families and children and youth with special health care needs with policymakers. The Family Advisory Council also met with the Iowa Department of Health and Human Services Director and the Iowa Medicaid Director in April 2023 to provide feedback and share lived experiences on the topics of waiver services and resource gaps across the state. In FFY2023, the Family Advisory Council also provided feedback on the Iowa Family Leadership Training Institute and the Transition to Adulthood program evaluation.

Strengthening Family Leadership Capacity

Child and Community Health prioritizes family partnership as foundational to all of its work. As part of this foundation, programs build advocacy skills for families and strengthen family advocacy networks.

The Iowa Family Leadership Training Institute began in 2016 to provide parents and caregivers the opportunity to develop leadership and advocacy skills. Sessions for the 2023 cohort ran from March to June and included over 80 hours of trainings plus work with a mentor. This cohort comprised eight family leaders, and participants came from both rural and urban areas of the state. The map below shows the locations of family advisory council members.



Map 3 Locations of family advisory council members

As part of this training, a community service project is developed. In 2023, projects included:

- Social Emotional Learning for Childcare Providers
- Project Inclusion- school playground communication boards and fencing
- All-Star Allies: Heroes, Together in Sports
- Be the Change, Weighted Blanket Project
- Pioneering for Special Youth- educating youth about careers in OT, SLT, and ABA
- Killian & Ko-- providing augmentative alternative communication
- Activities for All- event planning
- My Great Life- promoting soft skills for employment

More information about these projects, and historic IFLTI community service projects are collected in a lookbook that can be accessed here:

https://chsciowa.org/sites/chsciowa.org/files/resource/files/iflti_lookbook.2023.pdf

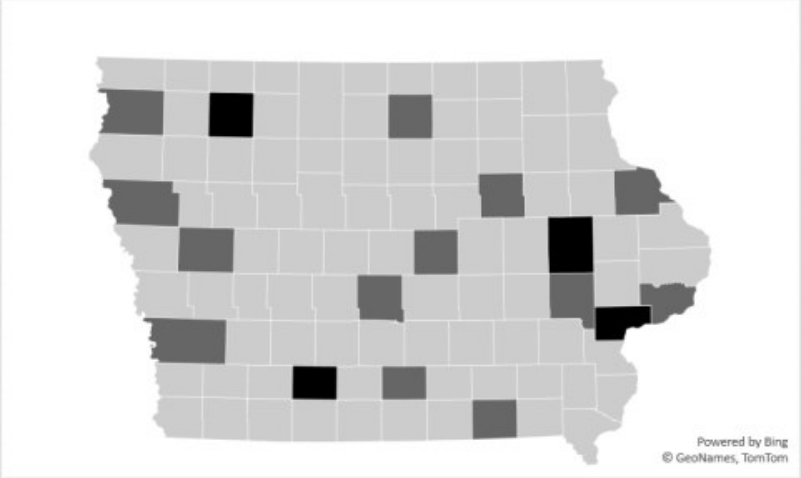
IFLTI graduates often use their leadership skills to promote systems of care for CYSHCN. Participants have gone on to do great things, and while IFLTI can't take all of the credit, it certainly contributed to family leadership capacity to advocate for CYSHCN. Participants have gone on to:

- Serve on family advisory councils,
- Serve on a school board: https://www.wsr.k12.ia.us/page/school-board
- Participate in a PBS documentary: https://www.youtube.com/watch?v=NNijL1r3bCI
- Contribute to books: https://www.amazon.com/Looking-Up-Truth-About-Syndrome/dp/B09K1XKKT5
- Participate on statewide boards: https://thearcofiowa.org/board
- Open a café to provide work experience for young adults with disabilities, https://www.iccompassion.org/copyof-global-food-project
- Run for public office

Storytelling for family leaders is a family leadership capacity building training offered through the Family and Professional Partnership program. Storytelling for Family Leaders is a virtual training developed with the Iowa Department of Education based on the Parents as Presenters program. The training includes an in-person

orientation, online modules, and virtual sessions for peer coaching to help families develop a 10-minute story to be used as part of their advocacy efforts. The training was offered from September 2023 to November 2023 and included 4 participants.

In addition, the Family and Professional Partnership program contributed to Family Peer Support Specialist (FPSS) trainings. FPSS draw on their own experience as a parent or primary caregiver of a child with an emotional, behavioral, or mental health need and work to empower families by teaching skills that assist them in finding their own voice. FPSS are employed at social service agencies, clinics, residential programs, and other community-based organizations, and serve on a variety of advisory boards and committees at local, state, and national levels. In past years, Family and Professional Partnership program staff developed the curriculum for the FPSS trainings and helped facilitate the efforts to create an FPSS certification through the Iowa Board of Certification. Currently, this partnership is administered through the National Resource Center for Family Centered Practice in the University of Iowa School of Social Work. The program is still involved with this program and provides trainings on Shared Decision Making. In FFY2023, 23 family peer support specialists were trained across the state. More information about Family Peer Support Specialists and trainings can be found here: https://iowapeersupport.sites.uiowa.edu/family-peer-support#training. The map below shows the distribution of FPSS trained in 2023.



Map 4 Distribution of FPSS trained in 2023

In April 2023 (FFY2022) and October 2023(FFY2023), the Family and Professional Partnership program facilitated Advocacy Trainings tailored to families of CYSHCN from Marshallese backgrounds. These trainings were designed by Family and Professional Partnership program staff, including a staff member from the Marshallese community. The goal of these trainings were to 1) empower families to recognize their strengths, 2) understand the family role as an expert on their child, 3) empower families to ask providers for what they need, and 4) understand the purpose and benefit of health screenings for children. The trainings took place in-person with 6 participants in Dubuque, IA, and about 20 in Ottumwa, IA.

Children with Special Health Care Needs – Application Year

Due to the change in leadership for the CYSHCN program as well as the upcoming needs assessment, new priorities and approaches are expected in FFY2026. For FFY2025, Child and Community Health activities will primarily focus on maintaining many of the activities from the previous few years.

Priority Need

Access to community-based services and supports, pediatric specialty providers, especially mental health providers and coordination of care (Oct 1, 2024 – Sept 30, 2025)

NPM 11. Percent of children with and without special health care needs having access to a medical home

FFY2025 will include the implementation of plans based on the comprehensive needs assessment completed in 2020. During FFY2025, Child and Community Health will 1) provide access to specialty care through Child Health Specialty Clinics Regional Centers and satellite locations, 2) strengthen infrastructure and increase opportunities for specialty care through telehealth, and 3) support workforce development and integration opportunities for pediatric and sub-specialty providers for serving children with complex and/or mental health needs, and developmental and intellectual disabilities, and their families.

Access through Regional Centers

In FFY2025, Child and Community Health's existing Child Health Specialty Clinics (CHSC) Regional Centers and satellite locations will continue to provide family-centered care coordination, family support, systems navigation, and gap-filling clinical services. The current framework incorporates multiple care delivery models, including in-person visits, telehealth and telephone visits, and communication through MyChart, a component of the Epic Electronic Medical Record used by all of University of Iowa Health Care, including Child and Community Health. All Regional Centers include Family Navigators, Nurses, and Administrative Staff, with some centers also housing Nurse Practitioners and Dietitians. CHSC Nurse Practitioners provide gap-filling services that complement services provided by local primary care providers while simultaneously maintaining a medical home approach to care. Early ACCESS (Iowa's Part C Early Intervention Program) provides funding for CHSC Dietitians to provide services through telehealth, while Title V funds supplement dietitian hours to provide access to dietitians for CYSHCN statewide who need this type of service. CHSC Regional Centers will continue utilizing interpretation and translation services provided through University of Iowa Health Care infrastructure for all necessary clinical visits to increase family access to services regardless of language spoken.

In FFY2025, Child and Community Health will begin to align family goal setting activities with a more comprehensive workforce development approach based on shared decision-making and family centered care principles. A structured family goal setting process began with the HRSA-funded Enhancing a System of Care for Children with Special Health Care Needs project that ended in 2017. Since that time, Regional Center staff have continued to formally initiate, review, and document goals at each clinical visit. Child and Community Health is currently performing a review of goal setting activities, and an anticipated outcome of this review is a more comprehensive approach for practicing shared decision-making principles with families. This approach will include workforce development and quality improvement activities focused on shared decision-making, with less emphasis on formal documentation of goal setting activities at every clinical visit. This review of the goal setting process is in response to Regional Center staff concerns about limited staff time and lack of family buy-in to the formal goal setting process.

Telehealth

Child and Community Health facilitates a state-wide telehealth network to support the care of CYSHCN in Iowa, especially those living in rural areas throughout the state. The Child and Community Health telehealth structure allows families to attend telehealth visits at Regional Centers where there are clerical staff, family navigators, and registered nurses available to help support the visit. Child and Community Health also supports in-home telehealth visits, which is especially important for visits with dietitians.

In FFY2025, Child and Community Health will continue to align telehealth processes with the broader health care system to improve and streamline workflows. In FFY2024, Child and Community Health transitioned to an Epic-to-Epic workflow that allows for the integration of telehealth visits into the University of Iowa Health Care electronic medical record. This shift has standardized the workflow for providers, making it easier to connect with patients through the Regional Centers.

In FFY2025, staff will explore ways of utilizing this improved telehealth infrastructure and workflow to collaborate with providers in and out of the University of Iowa Health Care system to increase access to specialty care providers throughout the state. To address the limited access to pediatric specialty providers in Iowa, Child and Community Health will continue to explore new opportunities for expanding pediatric specialty care services through the telehealth network. Child and Community Health is currently piloting a pediatric nephrology hypertension clinic in one Regional Center and will explore plans to expand services to additional centers in FFY2025. Pediatric specialty care through telehealth will continue to be expanded based on patient need and provider capacity.

For several years, Title V funding has been supplemented with funding from the HRSA Pediatric Mental Health Care Access (PMHCA) award. This has allowed Child and Community Health to improve access to telepsychiatry services for children and youth with ongoing mental health care needs. Child and Community Health has received funding through the PMHCA competitive renewal process and will continue efforts to build on the existing telepsychiatry infrastructure in Iowa by expanding workforce and additional providers or additional telehealth time for existing providers.

During FFY2025, Child and Community Health will continue to monitor changes to telehealth flexibilities authorized during federal emergency declarations put into effect during the COVID-19 pandemic. As these declarations change, Child and Community Health will ensure that telehealth workflows and procedures comply with updated policies.

Health Care Provider Workforce Development
Activities for FFY2025 will continue to support Child and Community Health's commitment to providing primary care workforce development opportunities that will strengthen medical home approaches to care for Iowa CYSHCN. Child and Community Health will continue providing opportunities for health care providers to increase their capacity for treating CYSHCN within community-based practices.

Iowa's only comprehensive pediatric tertiary care provider, University of Iowa Health Care, provides pediatric specialty provider clinic notes for their referred patients through the Epic Care Everywhere service. Primary care providers statewide have access to this system, including CHSC provider notes that are documented in Epic. The availability of provider-to-provider documentation supports both community and specialty providers in accessing real-time accurate information and is a valuable communication resource.

Workforce development initiatives for providers will be provided online, but there may be opportunities for in-person trainings. Child and Community Health will build upon its existing partnerships to collaborate on workforce development initiatives, including with the Iowa Chapter of the American Academy of Pediatrics, the Iowa Association of Family Practitioners, the Iowa Physician Assistant Society, and the Iowa Chapter of the National Association of Pediatric Nurse Practitioners.

New funding through the Pediatric Mental Health Care Access award has allowed Child and Community Health to establish a relationship with the University of Iowa's Scanlan Center for School Mental Health. In FFY2025, Child and Community Health will continue this relationship. In addition to a focus on increasing the capacity to provide appropriate services for mental health diagnoses for school-aged youth, Child and Community Health will also work with the Scanlan Center to provide evidence-based therapy trainings for mental health providers and suicide prevention trainings for school staff. This funding will also allow Child and Community Health staff to work with the University of Iowa College of Public Health to study pediatric mental health diagnosis prevalence using claims data from a private insurer.

Priority Need
Transition to adulthood for children and youth with special health care needs (Oct 1, 2024 – Sept 30, 2025)

NPM 12. Percent of adolescents with and without special health care needs, ages 12–17 who received services necessary to make transitions to adult health care

The FFY2023 evaluation of the Child and Community Health program for transition to adult systems of care revealed that youth with special health care needs and their families continue to be concerned with the process of transitioning from pediatric to adult systems of care. During FFY2025, Child and Community Health will continue to 1) provide clinic-based transition to adult health care services for transition-aged youth and their families, 2) work alongside youth and families to plan for the transition to adulthood, and 3) ensure appropriate transition to adulthood resources for Iowa's youth with special health care needs and their families.

Clinic-Based Services
In FFY2025, CHSC Regional Center staff will continue the systematic initiation, review, and documentation of the Child and Community Health transition checklist for every child 12 years of age or older seen in the Regional Centers. Program staff will conduct monthly reviews of transition documentation, located within the electronic medical record, and participate in monthly consultations and data sharing with Regional Center staff.

FFY2025 will include ongoing workforce development opportunities for staff, including an increased effort to providing training on shared decision-making and family- and youth- centered care. Child and Community Health will continue to gather formal and informal feedback from clinical and family support staff through surveys and attending discipline-specific meetings to tailor workforce development opportunities to fit needs being seen within Regional Centers. Efforts to connect with other disciplines such as the Family Navigator Network to provide workforce development opportunities will continue through FFY2025. Transition to adulthood workflows will continue to be regularly reviewed and streamlined to ensure consistency throughout Regional Centers and satellite locations. Efforts will include reviewing workflows for serving families with enhanced support needs, such as those using interpretation services during clinical visits.

Working Alongside Families and Youth
In FFY2025, Child and Community Health will continue to strategically implement recommendations from the evaluation of transition to adulthood programming, including efforts to explore innovative ways to engage transition-aged youth and their families.

In FFY2025, Child and Community Health will continue to explore ways to engage youth in an advisory capacity. Child and Community Health implemented it's first Youth Advisory Council in FFY2022, which continued into FFY2023. In FFY2024, strategies for engaging youth shifted from a formal council structure to a Youth Advisor model. This shift is

expected to improve youth engagement efforts by reducing the time commitment and requesting feedback in additional, more youth-centered ways. Youth Advisors are youth ages 14-22 years old with special health care needs that provide guidance on Child and Community Health programming, while also receiving opportunities to develop the leadership and advocacy skills necessary to transition to adult health care systems. Plans for FFY2025 will include activities to refine the Child and Community Health youth engagement strategies to offer beneficial experiences for youth, while also incorporating youth feedback as a standard for program development and implementation.

Child and Community Health will continue efforts to engage families and youth in all aspects of transition planning. These efforts will include soliciting feedback from the Family Advisory Council and Youth Advisory Council and using family- and youth- centered best practices during in-clinic transition planning.

Access to Appropriate Resources
The focus on updating and enhancing transition to adulthood resources for youth with special health care needs and their families will continue into FFY2025. The Child and Community Health transition to adulthood program uses Got Transition® as a guide for working with families. One of the recommendations from the program evaluation was the need for more updated and specific transition resources for youth with special health care needs and their families. In late FFY2023, Child and Community Health developed and launched updated transition to adulthood resources, based on the Got Transition® Six Core Elements of Transition. Updated resources were based on program evaluation data, feedback from Child and Community Health staff and families served, and best practices as outlined by Got Transition®. The updated resources are now more comprehensive and include transition resources tailored for youth with special health care needs, and their parents, including parents of youth with more complex care needs and medical complexities.

All of the updated resources were also translated into Spanish, with plans to expand the library of translated resources based on community needs. Program staff will continue to regularly review transition resources from content experts, such as Got Transition®, and incorporate best practices into the Child and Community Health transition resource library. FFY2025 includes plans to continue bringing transition resources to a state-wide audience, with the goal of serving as a systems-level resource for the transition from pediatric to adult health care systems. There will also be efforts to continue streamlining the transition to adulthood workflow, such as integrating the updated resources within the Epic electronic medical record system.

Priority Need
Support for parenting children and youth with special health care needs (Oct 1, 2024 – Sept 30, 2025)

SPM 7. Percent of caregivers of children and youth with special health care needs who report overall satisfaction with support services received through Title V

Iowa's comprehensive needs assessment was completed in 2020 and identified family support as a significant need within the CYHSCN population domain. Strategies in FFY2025 will build on past activities to address this need by 1) providing family-to-family support to Iowa families of CYSHCN; 2) building appreciation for strengths and challenges for families across the state through advocacy and provider workforce development; and 3) building the infrastructure for strengthening family leadership capacity statewide. FFY2025 activities will continue to emphasize support for families from underrepresented backgrounds.

The Family Advisory Council is supported by the Tile V CYSHCN program. The role of the Council is to provide guidance on all Child and Community Health activities, including family support. In FFY2025, the Family Advisory

Council will meet on a quarterly basis and agendas will emphasize: 1) leadership education for family advisors; 2) providing early input to newly planned Child and Community Health initiatives; and 3) providing feedback for existing programs. In addition to serving in an advisory capacity, members of the Council have several opportunities to participate in advocacy activities on behalf of Iowa's families of CYSHCN. The Family Advisory Council holds a bipartisan legislative forum during one of their quarterly council meetings, in which council members can advocate for issues impacting Iowa's CYSHCN. Additionally, the Council is invited to participate in a state "Day on the Hill" and legislative forum, which is designed as a bipartisan effort in partnership with Iowa's Developmental Disabilities Council (DD Council). These advocacy opportunities are intended to provide council members with an opportunity to visit with state policy makers during the legislative session. Additionally, activities in FFY2025 will explore opportunities to elevate the Family Advisory Council into a more advisory role, including an exploration of opportunities to contribute to a more structured advocacy agenda.

Family-to-Family Support
Family-to-family support activities will continue through the existing Child and Community Health Family Navigator Network, which currently includes 23 Family Navigators. Family Navigators are all parents or caregivers of CYSHCN with additional training that enables them to provide emotional support, connect families to community resources, and assist families in navigating complex systems of care. Since 2020, all Family Navigators have been required to receive Family Peer Support Services certification through the Iowa Board of Certification. The Family Navigator Network is a key strategy for the Iowa CYSHCN program's commitment to including family voice at all levels of decision making.

Iowa families of CYSHCN can access Family Navigators through any Child and Community Health CHSC Regional Centers. All families of CYSHCN ages 0–21 in Iowa are eligible to receive family navigation services. Referrals to the Family Navigator Network are made through a number of different channels including Early ACCESS, Iowa's Regional Autism Assistance Program, primary care and specialty providers, and word of mouth. Family Navigator Network leadership staff will continue to explore ways of managing high referrals to best support families seeking care from the network.

Family Navigator Network leadership will continue to provide virtual monthly professional development opportunities to increase Family Navigator capacity to address more complex referrals, such as those for children and youth with challenging mental and behavioral concerns. Monthly professional development sessions will also focus on updating navigators on system-level changes that will impact families.

In FFY2025, there will be an effort to provide topical learning opportunities to families through quarterly webinars. Child and Community Health will continue to explore opportunities to raise awareness about the availability of Family Navigators.

Family Navigator Network leaders will continue to work closely with the Child and Community Health Health Equity Committee to strengthen activities that will identify and support parents from underrepresented backgrounds. Activities from the Health Equity Committee's strategic plan specific to the Family Navigator Network include: 1) developing partnerships within diverse communities and increasing family support services to underserved populations; and 2) building financial and structural resources for recruiting and supporting racially and ethnically diverse staff and exploring the use of cultural liaisons to inform programmatic activities. In FFY2025, Child and Community Health will continue efforts to use data to inform community outreach and recruitment efforts.

In FFY2020, the Family Navigator Network was identified as an Emerging Practice in the Association of Maternal and Child Health Program's (AMCHP) Innovation Hub and in FFY2023 Child and Community Health collaborated with AMCHP to develop an evaluation plan for the Family Navigator Network. Implementation of the evaluation plan

began in FFY2024. Evaluation efforts are expected to continue through FFY2025, and results from the evaluation will be utilized to guide efforts to strengthen the structure and operations of the network. Results will also be used in the upcoming Title V 5-Year Needs Assessment.

Advocacy and Family Support: Workforce Development
In FFY2025, Iowa's CYSHCN program will continue to build on existing infrastructure for training and workforce development. Child and Community Health will continue efforts to build workforce capacity to support families through trainings for providers on family-centered care, culturally responsive care, and working with families of LGBTQ+ youth. Additionally, leaders in state government will receive information about supporting families of CYSHCN through policies that have a positive impact on families. This will occur through a state Legislative Day on the Hill in Des Moines where legislators will learn about how they can support their CYSHCN constituents. Participants will include the DCCH Family Advisory Council and graduates from the Iowa Family Leadership Training Institute.

Family Peer Support Specialist trainings were developed by Child and Community Health, the Iowa Department of Human Services, and the University of Iowa's National Resource Center for Family Centered Practice. Family Peer Support Specialists draw on their own experience as a parent or primary caregiver of a child with special health care needs and may be employed at social service agencies, clinics, residential programs, and other community-based organizations. They may also serve on a variety of advisory boards and committees at local, state, and national levels. This training is one of the requirements to become a certified Family Peer Support Specialist. Child and Community Health continues to provide trainers to facilitate and administer specific aspects of the program following an administrative transfer to the National Resource Center for Family Centered Practice at the University of Iowa School of Social Work.

Family Leadership
In FFY2025, Child and Community Health will continue efforts to strengthen the infrastructure for developing skills for family leaders. This will include formal trainings for families such as the Iowa Family Leadership Training Institute (IFLTI), Digital Storytelling, and Storytelling for Family Leaders.

Storytelling is a crucial skill for families to help focus their stories and strengthen advocacy and awareness efforts. A Digital Storytelling workshop will be offered during FFY2025. Digital Storytelling is a three-day workshop offered at no cost to families, designed to build and produce a 2–4 minute digital story. A link to examples of Digital Stories produced through this training can be found on the Storytelling for Families page of the CHSC website: https://chsciowa.org/programs/storytelling-families.

Child and Community Health will continue efforts to expand outreach to recruit families from underserved communities to participate in this training and provide added perspectives to the Digital Storytelling library.

Storytelling for Family Leaders training is designed to equip families of CYSHCN with the necessary skills to share their stories in a variety of settings and modes of delivery, in order to bring change and awareness about Systems of Care for CYSHCN. Participants work with a coach and a cohort of family storytellers to produce 10-minute stories to be used as part of their advocacy efforts. This training will be offered in FFY2025, with Child and Community Health continuing to expand its reach to underserved communities to include a variety of perspectives.

The Iowa Family Leadership Training Institute (IFLTI) aims to provide parents and caregivers of CYSHCN the opportunity to develop leadership and advocacy skills. Now in its 9th year, IFLTI leverages Title V Block Grant funding to train families to work with partners, build their own paths to leadership, advocate for other families, and prepare a

community service project. IFLTI has a history of including participants from underserved communities and has developed the necessary workflows and infrastructure to support non-English speaking participants. Historically, IFLTI has delivered this training at no cost to participants through five weekend-long sessions. In FFY2025, IFLTI will be offered to parents or primary caregivers of children ages 3 to 19 years with special health care needs living in Iowa; due to changes in funding, the program is examining new ways to lower costs and continue supporting this important family leadership training program. More information about IFLTI can be found on the CHSC website: https://chsciowa.org/programs/iowa-family-leadership-training-institute.

The Blueprint for Change crosswalk

Iowa's CYSHCN Title V program uses the Blueprint for Change national framework for program planning. The following tables crosswalk the Child and Community Health action plan activities and the Blueprint for Change Critical Areas and Principles, and are organized by priority need.

FFY2025 Action Plan Activities and Corresponding Blueprint for Change Critical Areas and Principles

Priority Need 1: Access to community-based services and supports, pediatric specialty providers, especially mental health providers and coordination of care

Iowa Title V CYSHCN program	Blueprint for Change	
Activity	**Critical Area**	**Principle**
Provide access to specialty care through DCCH Regional Centers	Access to Services	Principle 1: All services are easy to navigate.
Provide culturally responsive specialty care, including the use of interpretation services for in-person and telehealth visits	Health Equity	Principle 2: Sectors and supports are designed to reduce disparities
	Access to Services	Principle 1: All services are easy to navigate.
Provide family-centered care through a shared decision-making approach for all Regional Center visits	Well-Being & Quality of Life	Principle 1: Families can access services that support well-being.
		Principle 2: Systems value measurement of quality-of-life and health outcomes.
Provide opportunities for telehealth services through CHSC Regional Centers	Access to Services	Principle 1: All services and supports are easy to navigate.
Collaborate with pediatric specialty providers through telehealth activities	Access to Services	Principle 1: All services are easy to navigate.
Continue regularly evaluating, strengthening, and expanding telehealth infrastructure	Access to Services	Principle 3: Service sectors address processes that hinder access.
Provide workforce development opportunities to health care providers for treating CYSHCN in their communities	Access to Services	Principle 2: The workforce is trained to meet the needs of CYSHCN.
	Health Equity	Principle 2: Sectors and supports are designed to reduce disparities
Provide workforce development opportunities to provide appropriate services for mental health diagnoses in school-aged youth	Access to Services	Principle 2: The workforce is trained to meet the needs of CYSHCN.
	Health Equity	Principle 2: Sectors and supports are designed to reduce disparities

Priority Need 2: Transition to adulthood for CYSHCN

Iowa Title V CYSHCN program	Blueprint for Change	
Activity	**Critical Area**	**Principle**
Initiate and review transition plans with transition-aged youth and their families seen through CHSC Regional Centers	Well-Being & Quality of Life	Principle 1: Families can access services that support well-being.
	Access to Services	Principle 1: All services are easy to navigate.
Document transition to adult care progress for patients seen at Regional Centers	Well-Being and Quality of Life	Principle 2: Systems value measurement of quality-of-life and health outcomes.
Engage youth with special health care needs in an advisory capacity	Well-Being & Quality of Life	Principle 1: Families can access services that support well-being.
		Principle 2: Systems value measurement of quality-of-life and health outcomes.
Engage families of youth with special health care needs in transition planning	Well-Being and Quality of Life	Principle 1: Families can access services that support well-being.
Update and maintain transition to adult health care resource library, including translating resources	Well-Being & Quality of Life	Principle 1: Families can access services that support well-being.
	Access to Services	Principle 1: All services are easy to navigate.

Priority Need 3: Support for parenting CYSHCN

Iowa Title V CYSHCN program	Blueprint for Change	
Activity	**Critical Area**	**Principle**
Provide family-to-family support to families of CYSHCN through Family Navigators	Well-Being & Quality of Life	Principle 1: Families can access services that support well-being.
		Principle 2: Systems value measurement of quality-of-life and health outcomes.
	Access to Services	Principle 1: All services are easy to navigate.
Implement the Family Advisory Council to gather family feedback on future and current DCCH programs and services	Well-Being & Quality of Life	Principle 1: Families can access services that support well-being.
Provide monthly workforce development opportunities to Family Navigator Network	Health Equity	Principle 2: Sectors and supports are designed to reduce disparities
	Access to Services	Principle 2: The workforce is trained to meet the needs of CYSHCN.
Increase capacity of Family Navigator Network to provide family-to-family support to underserved communities	Health Equity	Principle 2: Sectors and supports are designed to reduce disparities
	Well-Being and Quality of Life	Principle 1: Families can access services that support well-being.
		Principle 2: Systems value measurement of quality-of-life and health outcomes.
Continue to certify Family Navigators as Family Peer Support Specialists	Access to Services	Principle 2: The workforce is trained to meet the needs of CYSHCN.
Strengthen infrastructure for developing family leadership skills through family training opportunities	Well-Being & Quality of Life	Principle 1: Families can access services that support well-being.
	Access to Services	Principle 2: The workforce is trained to meet the needs of CYSHCN.

Cross-Cutting/Systems Building

State Performance Measures

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			5	100	100
Annual Indicator			100	100	100
Numerator					
Denominator					
Data Source			Title V RFP/RFA	Title V RFP/RFA	Title V RFP/RFA
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

State Action Plan Table

State Action Plan Table (Iowa) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Infusing Health Equity with in the Title V System
SPM
SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve
Five-Year Objectives
By 2025, 99% of all Title V contractors will have developed a plan to identify and address health equity in the populations they serve
Strategies
Inclusion of health equity plan requirement language in BFH grant agreements
Increase the percent of contractors that demonstrate application of health equity strategies
Utilize Health Equity Advisory Committee (HEAC) to provide input into the health equity strategies for each NPM and SPM and local contractors
Inclusion of health equity activities in all Title V funded BFH Staff positions
Increase the percentage of Title V Contractors that engage diverse participant voices in program planning, decision making and implementation
Build internal capacity within the Bureau of Family Health/Title V Program Health Equity Team; completion of an organizational assessment of equity practices, and facilitation of staff professional development and technical assistance
Develop and implement a data analysis plan to assess distribution of Title V resources and services through a health equity lens
Conduct an environmental scan of current contractors engagement in health equity and presence of health equity plans

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

All local Title V Contractors have embedded a health equity focus into their developed plans. State Title V staff are working closely with contractors to monitor progress and provide technical assistance to ensure plans are achievable and evolving. State staff are looking at refining this measure to track deeper aspects of health equity throughout Iowa's entire Title V system.

Since 2021, as a requirement of the RFP, local Title V contractors have been taking steps to implement their plan to address the following:

- Assess effectiveness of health equity activities
- Effect policy change through culturally and linguistically appropriate strategies
- Recruit family engagement membership from priority populations
- Develop and enhance existing collaborative partnerships

The 2023 CAH RFP required contractors to continue to make progress through identified activities and to demonstrate application of health equity concepts. Contractors have engaged diverse participant voices in program planning, decision making and implementation. They have demonstrated inclusion of evidence-based/-informed community engagement and collective impact strategies. These strategies will continue during the current project period. Identified successes and barriers will be evaluated and utilized by state Title V staff to begin shaping the inclusion of enhanced health equity planning in the next RFP and subsequent project period.

To build upon the work of the previous project period, the FFY2023 RFP required local Title V contractors to submit a plan to identify and address health equity in the populations they serve. A requirement in the RFP was the development of a family engagement group with 10 required members representing the eight priority populations that were determined in the Title V Needs Assessment. Most local Title V contractors continually voiced they had difficulty recruiting members to serve on their family engagement group. This barrier was caused noticeable frustration and contributed to a lack of progress in some agencies. State staff evaluated the requirements of the family engagement section in the RFP and in subsequent RFAs have modified the requirements to encourage advancement. One modification will allow Contractors to continue to develop their own family engagement group or join an established community group within their CSA.

State Title V staff met with the contractors to evaluate the progress of health equity plans, engagement in health equity strategies, family engagement partnerships and provided needed support. Title V staff will have the opportunity to utilize the newly established Bureau of Health Equity to provide input, technical assistance and content expertise on the health equity strategies being developed at the state and contractor level.

All Title V Contractors who provide maternal health services ensured clients received culturally appropriate individualized education for each performance measure (NPM 4, NPM 6, NPM 14.1, and SPM 1). Agencies incorporated a health equity lens in order to meet the client where they were.

The FHB has incrementally increased internal understanding and capacity to address health equity in programs and services within Title V. The Bureau/Title V will continue to engage contractors to assure health equity in services and programs administered at the community level. Strategies to build capacity have included the development of all staff in concepts and strategies of health equity; identification and completion of ongoing assessments/analyses of health equity within Iowa's Title V program, development and implementation of a data analysis plan to assess distribution

of Title V resources and services through a health equity lens, and facilitation of staff professional development and technical assistance.

Cross-Cutting/Systems Building - Application Year

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

Iowa HHS is in the process of conducting a Department-wide Health Equity Assessment. This process started February 2024 with plans to have it completed by the end of July 2024. After the assessment is complete, strategies for next steps will be drafted and implemented in 2025 to address health equity across the Department.

Over the last few years the Family Health Bureau, including Title V staff, have been incrementally increasing internal understanding and capacity to address health equity in programs and services. Leadership is moving the Iowa Title V program from a working knowledge of Health Equity to the ability to embed equity within all the programs in the Bureau and Title V. This work will also overlap with CYSHCN Health Equity work, to ensure all Iowa Title V programming is moving toward addressing health inequities.

The 2025 CAH RFA requires that agencies outline strategies and activities that exhibit the use of health equity principles, involve diverse participant perspectives in program development, and incorporate evidence-based community engagement and collective impact tactics. This requirement underscores the importance of fostering inclusivity, equitable participation, and impactful community involvement in health-related initiatives.

Local Project Directors are required to host/provide an annual health equity professional development for staff. Training topics include improving cultural competence, impacts of implicit bias, use of interpretation services, improving outcomes for priority populations, CLAS standards, and how to report data in a culturally appropriate manner so as not to cause harm to priority populations.

During the previous Needs Assessment process, state level staff, including epidemiologists, utilized Census data to determine eight Priority Populations based on each CSA. For the 2025 CAH RFA each contractor must develop plans for the state-determined population in their respective area and will also have the option to identify a second priority population. Their plans will focus on partnership and engagement strategies to build connections and help continue to design programs to improve the health outcomes of these populations across the NPMs, SPMs and core Title V services. The 2023 RFP also required significant family engagement in tandem with health equity. Contractors were required to develop a Family Engagement group consisting of multiple members from each of the eight identified Priority Populations. This proved to be a challenging task for most agencies, with successful recruitment of members identified as the biggest barrier to success. Agencies have continued their efforts to build their Family Engagement groups, and most have found success by focusing on developing trust-based relationships within their communities, starting with small groups of willing participants, and taking advantage of in-person recruitment opportunities. Through discussions with local agencies and other programs it was determined that for the 2025 RFA agencies will also have the option to join existing groups that have participants from the priority populations, where those participants can provide feedback on the policies, procedures, and CAH services the agency provides. This will expand the agencies' ability to access feedback needed to improve programming.

The Title V program will continue to support the needs of local contractors as they encounter barriers and will continue to facilitate relationships between contractors, so they may learn from and support one another. Quarterly staffings, and more frequent reporting have been implemented, which allows the Title V program to provide timely technical assistance and ensure progression toward goals.

Iowa has been selected to host two interns from the MCH Workforce Development Center Title V Internship Program during the summer of 2024. One aspect of the internship plan includes an environmental scan of all health equity activities being conducted at local Title V agencies. Interns will also help connect agencies working on similar projects and encourage sharing of best practices. Local Title V CAH agencies are required to demonstrate efforts to

recruit a workforce that is diverse and reflective of the demographics of the CSA.

All Title V Maternal Health Agencies will ensure clients receive individualized education for each performance measure (Breastfeeding NPM, Safe Sleep NPM, Smoking During Pregnancy NPM and Maternal Mortality SPM) in culturally appropriate ways that incorporate a health equity lens and meet the client where they are. Maternal Health contractors will implement strategies to engage with clients and families to ensure that services are provided with a health equity lens, including client surveys and focus groups/key informant interviews. Maternal health contractors will also continue developing coalitions in their service areas that include organizations and partners who represent priority populations.

Implementing strategies to build capacity within the Family Health Bureau/Title V is crucial for promoting health equity. By educating all staff on the concepts and strategies of the Health Equity Team, regularly assessing the program's impact, analyzing data through a health equity lens, and providing ongoing professional development and technical assistance, the Iowa Title V program can enhance its ability to effectively address disparities and ensure equitable distribution of resources and services to the community. This holistic approach will not only strengthen the organization's capacity but also contribute to better health outcomes for all individuals.

III.F. Public Input

The Iowa MCH Advisory Council provided input into the proposed goals and activities as well as during the public comment period. The Council approved and endorsed the proposed priority needs, goals, and activities at the June 6, 2024 meeting.

Iowa continued to utilize the Family Health Bureau website to post the proposed plans for the NPMs and SPMs. HHS allowed a four-week period for interested MCH stakeholders and partners to provide feedback on Iowa's state priorities, proposed activities and performance measures through an online survey. The Title V Director sent the survey with an ask to many partners to forward it on to their distribution lists including Early Childhood Iowa, local Title V agencies as well as many other partner organizations and stakeholders.

During the public input period, 83 individuals completed the online feedback survey this was a large increase from the 70 in FY23 and 25 in FY22. Nearly all of those that completed the survey supported the proposed performance measure activities. Comments received mostly encouraged the expansion of performance measures to include larger populations and ideas that could help move the needle on many performance measures. All feedback was shared with program staff to include updates, as necessary, into the FFY25 plan.

III.G. Technical Assistance

Iowa HHS will be hosting a statewide women's health conference in 2025. Iowa's Title V program is interested in bringing in a national expert to provide expertise in building a comprehensive women's health plan in a combined health and human services agency.

Iowa is currently participating in the HHS Secretary's Postpartum Collaborative to reduce maternal mortality. A strategy that Iowa is interested in developing is a perinatal mental health consultation program for OB providers to improve screening for mental health and substance abuse. TA will be requested to learn from other states that have implemented these programs.

Iowa's Title V program will continue to focus on methods for effectively engaging community stakeholders and families in an advisory capacity. There is an opportunity to improve these efforts within health equity activities and exploring methods for utilizing community stakeholder and family input in a more effective capacity within all Title V programming.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MED-23-015 Omnibus contract - Executed.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Iowa Title V Map Locations.pdf

Supporting Document #02 - FFY23 Expenditure Report.pdf

Supporting Document #03 - FFY25 Budget.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - Iowa Org Charts June 2024.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Iowa

	FY 25 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,611,198	
A. Preventive and Primary Care for Children	$ 2,334,401	(35.3%)
B. Children with Special Health Care Needs	$ 2,201,529	(33.3%)
C. Title V Administrative Costs	$ 661,119	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,197,049	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,234,520	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 8,328,679	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 1,026,032	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 15,589,231	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,035,775		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 22,200,429	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 5,093,879	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 27,294,308	

OTHER FEDERAL FUNDS	FY 25 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 112,224
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 431,730
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 493,192
US Department of Education > Office of Special Education Programs > Grants to States for Education of Children with Disabilities (Part B of IDEA)	$ 144,931
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 215,686
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 115,706
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,555,410
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 850,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,000,000

	FY 23 Annual Report Budgeted		FY 23 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 6,549,016 (FY 23 Federal Award: $ 6,750,301)		$ 3,829,937	
A. Preventive and Primary Care for Children	$ 2,313,955	(35.3%)	$ 712,949	(18.6%)
B. Children with Special Health Care Needs	$ 2,180,822	(33.3%)	$ 2,198,201	(57.3%)
C. Title V Administrative Costs	$ 654,901	(10%)	$ 356,709	(9.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 5,149,678		$ 3,267,859	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 5,916,685		$ 6,754,112	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 8,925,468		$ 6,978,676	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 850,000		$ 1,206,326	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 15,692,153		$ 14,939,114	
A. Your State's FY 1989 Maintenance of Effort Amount $ 5,035,775				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 22,241,169		$ 18,769,051	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 16,824,943		$ 16,145,906	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 39,066,112		$ 34,914,957	

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 90,178
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 445,608	$ 406,588
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 487,155	$ 500,148
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000	$ 131,192
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 205,579
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 215,686	$ 178,210
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 5,489,953	$ 5,136,172
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 1,207,951	$ 1,207,951
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Innovation Grants	$ 3,980,262	$ 3,980,262
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) and Other Developmental Disabilities	$ 154,970	$ 372,000
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Early and Periodic Screening, Diagnosis & Treatment (EPSDT)	$ 115,706	$ 115,706
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,555,410	$ 1,240,734

OTHER FEDERAL FUNDS	FY 23 Annual Report Budgeted	FY 23 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020	$ 126,131
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000	$ 445,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 2,072,222	$ 2,010,055

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Current expenditures are based on the expenditures reported on 3/31/2024. All funds are obligated and are on target to be fully expended by the end of the budget period. For FFY23 funds, Iowa HSS continues to use considerable Title V funds to build in required functionality into the new Iowa Connected data system. Nearly $1M in Title V funding is obligated to this project. The Iowa Connected project was built on a deliverable-based budget and Iowa rolled out the new system's minimally viable product June 19, 2023. Iowa HHS continues to work with the vendor to build out additional functionality to meet the documentation and reporting needs of the Title V program. Expenses for continued development will be included in the close out for FFY23. Additionally, funding is obligated to local Title V MH and CAH agencies through the end of September 2024.	
2.	**Field Name:**	**Federal Allocation, A. Preventive and Primary Care for Children:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Current expenditures are based on the expenditures reported on 3/31/2024. All funds are obligated and are on target to be fully expended by the end of the budget period. For FFY23 funds, Iowa HSS continues to use considerable Title V funds to build in required functionality into the new Iowa Connected data system. Nearly $1M in Title V funding is obligated to this project. The Iowa Connected project was built on a deliverable-based budget and Iowa rolled out the new system's minimally viable product June 19, 2023. Iowa HHS continues to work with the vendor to build out additional functionality to meet the documentation and reporting needs of the Title V program. Expenses for continued development will be included in the close out for FFY23. Additionally, funding is obligated to local Title V MH and CAH agencies through the end of September 2024.	
3.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: At time of submission this amount reflects charges to administrative costs (MCH Director salary, travel, and other expenses) for the Title V Block Grant. The final indirect costs will be pulled prior to closeout based on actual expenses and will not exceed the 10% maximum.	
4.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**

	Field Note: For the 1st Five program, the Title V program was able to claim additional state funds as match than previously budgeted.	
5.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Lower expenditures in Other funds due to the ability to claim additional 1st Five funds as State Match.	
6.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: The FY23 Budget inadvertently included $850,000 in program income from a previous budget period.	
7.	**Field Name:**	**Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Improving Services for Children and Youth with Autism Spectrum Disorder (ASD) and Other Developmental Disabilities**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: The FY23 Budget was reported incorrectly in the FFY23 Application. The budget should have been $372,000.	

Data Alerts:

- The value in Line 1A, Preventive and Primary Care for Children, Annual Report Expended is less than 30% of the Federal Allocation, Annual Report Expended. A field-level note indicating the reason for the discrepancy was provided.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Iowa

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 1,364,098	$ 497,394
2. Infants < 1 year	$ 50,051	$ 64,684
3. Children 1 through 21 Years	$ 2,334,401	$ 712,949
4. CSHCN	$ 2,201,529	$ 2,198,201
5. All Others	$ 0	$ 0
Federal Total of Individuals Served	$ 5,950,079	$ 3,473,228

IB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Pregnant Women	$ 561,557	$ 508,944
2. Infants < 1 year	$ 5,693	$ 23,012
3. Children 1 through 21 Years	$ 11,086,533	$ 10,309,940
4. CSHCN	$ 3,935,448	$ 4,097,218
5. All Others	$ 0	$ 0
Non-Federal Total of Individuals Served	$ 15,589,231	$ 14,939,114
Federal State MCH Block Grant Partnership Total	$ 21,539,310	$ 18,412,342

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Iowa

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 966,929	$ 535,825
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 280,033	$ 95,043
B. Preventive and Primary Care Services for Children	$ 356,667	$ 111,052
C. Services for CSHCN	$ 330,229	$ 329,730
2. Enabling Services	$ 1,625,568	$ 829,710
3. Public Health Services and Systems	$ 4,018,701	$ 2,464,402
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 329,730
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 165,774
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 7,942
Other		
Gap Filling Services		$ 32,379
Direct Services Line 4 Expended Total		$ 535,825
Federal Total	$ 6,611,198	$ 3,829,937

IIB. Non-Federal MCH Block Grant	FY 25 Application Budgeted	FY 23 Annual Report Expended
1. Direct Services	$ 2,447,706	$ 2,171,537
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 56,593	$ 73,261
B. Preventive and Primary Care Services for Children	$ 1,407,067	$ 1,234,472
C. Services for CSHCN	$ 984,046	$ 863,804
2. Enabling Services	$ 3,125,553	$ 2,083,685
3. Public Health Services and Systems	$ 10,015,971	$ 2,575,689
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 863,804
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 1,051,887
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 50,394
Other		
Gap Filling Services		$ 205,452
Direct Services Line 4 Expended Total		$ 2,171,537
Non-Federal Total	$ 15,589,230	$ 6,830,911

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2025**
	Column Name:	**Application Budgeted**
	Field Note: Includes $92,557 in Admin Funds	
2.	**Field Name:**	**IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children**
	Fiscal Year:	**2023**
	Column Name:	**Annual Report Expended**
	Field Note: Includes $49,939 in Admin Funds	
3.	**Field Name:**	**IIA. - Other - Gap Filling Services**
	Fiscal Year:	**2025**
	Column Name:	**Annual Report Expended**
	Field Note: Gap Filling Services NOT provided in a physician office which include: Developmental testing Domestic violence screen Evaluation and Management (E&M) Health history Hearing Immunizations Mental health screenings Nursing assessments Nutrition assessments Preventive medicine counseling Social assessments Social Work assessments Substance abuse screenings Vision screenings	
4.	**Field Name:**	**IIB. - Other - Gap Filling Services**
	Fiscal Year:	**2025**
	Column Name:	**Annual Report Expended**

Field Note:
Gap Filling Services NOT provided in a physician office which include:
Developmental testing
Domestic violence screen
Evaluation and Management (E&M)
Health history
Hearing
Immunizations
Mental health screenings
Nursing assessments
Nutrition assessments
Preventive medicine counseling
Social assessments
Social Work assessments
Substance abuse screenings
Vision screenings

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Iowa

Total Births by Occurrence: 36,505 **Data Source Year: 2023**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	36,203 (99.2%)	2,534	124	124 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-Coa Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism	Propionic Acidemia
S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Iowa Newborn Screening is in the beginning stages of establishing a long-term follow-up program to include case management and surveillance activities for children through age 6.

Form Notes for Form 4:

Aggregate total number of out-of-range results includes borderline and indeterminate results for congenital adrenal hyperplasia and congenital hypothyroidism. Confirmed case count does not include newborns with late onset hearing loss.

Field Level Notes for Form 4:

None

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Iowa

Annual Report Year 2023

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	4,254	74.7	0.0	7.9	16.6	0.8
2. Infants < 1 Year of Age	2,130	79.3	0.1	4.1	15.8	0.7
3. Children 1 through 21 Years of Age	66,253	78.9	3.0	3.1	14.7	0.3
3a. Children with Special Health Care Needs 0 through 21 years of age^	8,415	44.1	6.1	31.8	18.0	0.0
4. Others	0					
Total	72,637					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	36,506	Yes	36,506	100.0	36,506	4,254
2. Infants < 1 Year of Age	36,731	Yes	36,731	100.0	36,731	2,130
3. Children 1 through 21 Years of Age	879,469	Yes	879,469	100.0	879,469	66,253
3a. Children with Special Health Care Needs 0 through 21 years of age^	175,921	Yes	175,921	100.0	175,921	8,415
4. Others	2,284,262	Yes	2,284,262	0.0	0	0

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2023**
	Field Note: Data was pulled from Iowa Connected, Iowa's Title V program data system. This count includes women served through the Maternal Health program. Services include: maternal health risk assessment, health education, psychosocial services, oral health services, care coordination, and presumptive eligibility.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2023**
	Field Note: Data was pulled from Iowa Connected, Iowa's Title V program data system. This count includes infants served through the Child Health program. Services include: Informing, care coordination, and gap filling direct care services.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Data was pulled from Iowa Connected, Iowa's Title V program data system. This count includes children served through the Child Health program. Services include: informing, care coordination, and gap filling direct care services.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2023**
	Field Note: Collected from electronic medical record data. Data is based on the last interaction with the individual. Iowa's Title V CYSHCN system is not currently able to distinguish between Title XIX and Title XXI, so these percentages are calculated based on statewide proportions of Title XIX (87.8%) and Title XXI (12.2%) numbers for children/youth ages 0-21 years. Title XIX/Title XXI:4226; Private/other (BC/BS (1906);Commercial (716); Medicare (1); Tricare (52)): 2675; None (Self-Pay) 1514; Unknown: 0	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2023**
	Field Note: All individuals served by Title V are accounted for in the previous categories.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2023**
	Field Note: The Statewide Perinatal Care Team, funded by Title V, visits all birthing hospitals to provide training and technical assistance.	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2023**
	Field Note: The Statewide Perinatal Care Team, funded by Title V, visits all birthing hospitals to provide training and technical assistance.	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: Iowa's Title V program has the potential reach of all children in Iowa because of activities that fall within the Public Health Services and Systems level of the MCH Pyramid. Activities included promotion of the AAP recommended screenings to primary care providers, statewide promotional campaigns, and statewide data collection and dissemination of ACEs data.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2023**
	Field Note: Iowa's Title V program has the potential to reach all children in Iowa which includes all CYSHCN. Additionally, CYSHCN specific activities include policy and infrastructure activities designed to impact all CYSHCN in Iowa.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2023**
	Field Note: All individuals served by Title V are accounted for in the previous categories.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Iowa

Annual Report Year 2023

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	33,583	24,585	2,466	4,005	134	904	399	757	333
Title V Served	5,910	3,146	531	1,346	11	122	120	403	231
Eligible for Title XIX	13,964	8,191	1,864	2,533	96	371	318	482	109
2. Total Infants in State	34,148	25,014	2,522	4,054	136	913	404	769	336
Title V Served	2,852	1,655	145	681	5	61	41	179	85
Eligible for Title XIX	14,067	8,256	1,881	2,547	97	372	319	486	109

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: lowa's data system collects Race and Ethnicity separately. Clients reported as Hispanic are duplicated in the Race categories based on self selection.	
2.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2023**
	Column Name:	**Total**
	Field Note: lowa's data system collects Race and Ethnicity separately. Clients reported as Hispanic are duplicated in the Race categories based on self selection.	

Form 7
Title V Program Workforce

State: Iowa

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	103.01
1a. Total Number of FTEs (State Level)	28.21
1b. Total Number of FTEs (Local Level)	74.80
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	1.90
3. Total Number of FTEs eliminated in the past 12 months	0.50
4. Total Number of Current Vacant FTEs	1
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	0.70

B. Training Needs (Optional)	
1	GROW (Goals, Reality, Options, Wrap-up) Model Coaching Training
2	Science of Hope
3	
4	

Form Notes for Form 7:

None

Field Level Notes for Form 7:

Form 7 Field Level Notes Table

1.	**Field Name:**	**Total Number of FTEs (Local Level)**
	Field Note: CHSC: 9.45 Maternal Health: 36.1 Child and Adolescent Health: 29.25	
2.	**Field Name:**	**Total Number of MCH Epidemiology FTEs**
	Field Note: FHB has 3 FTEs classified as Epidemiologists these positions are braided funding with other federal/state funding sources.	
3.	**Field Name:**	**Total Number of FTEs eliminated in the past 12 months**
	Field Note: CHSC has not had any layoffs in the past year that had been covered by the block grant funding. This 0.5 FTE was due to staff who left CHSC and their duties were shifted to staff with a different funding source. FHB did not have any eliminated FTEs in the past 12 months.	
4.	**Field Name:**	**Training Needs Line 1**
	Field Note: Currently working with Great Plains Leadership Institute	
5.	**Field Name:**	**Training Needs Line 2**
	Field Note: HHS is starting to embed the Science of Hope into programming	

Form 8
State MCH and CSHCN Directors Contact Information

State: Iowa

1. Title V Maternal and Child Health (MCH) Director	
Name	Marcus Johnson-Miller
Title	Title V Director/Family Health Administrator
Address 1	321 E 12th St
Address 2	
City/State/Zip	Des Moines / IA / 50319
Telephone	(515) 473-4540
Extension	
Email	marcus.johnson-miller@hhs.iowa.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Vanessa Curtis
Title	Director, Division of Child and Community Health
Address 1	University of Iowa Health Care
Address 2	100 Hawkins Drive
City/State/Zip	Iowa City / IA / 52242
Telephone	(319) 467-5009
Extension	
Email	vanessa-curtis@uiowa.edu

3. State Family Leader (Optional)	
Name	Rachel Charlot
Title	Program Coordinator and Family Navigator
Address 1	Child Health Specialty Clinics
Address 2	204 W. 7th St
City/State/Zip	Carroll / IA / 51401
Telephone	(712) 792-4825
Extension	
Email	rachel-charlot@uiowa.edu

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Jennifer Pham
Title	SSDI and PRAMS Project Director
Address 1	321 E 12th St
Address 2	
City/State/Zip	Des Moines / IA / 50319
Telephone	(515) 499-4600
Extension	
Email	jennifer.pham@idph.iowa.gov

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 369-2229

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Iowa

Application Year 2025

No.	Priority Need
1.	Infusing Health Equity with in the Title V System
2.	Access to care for the MCAH Population
3.	MCAH Systems Coordination
4.	Dental Delivery Structure of the MCAH Population
5.	Safe and Healthy Environments
6.	Access to community-based services and supports, pediatric specialty providers, and coordination of care
7.	Access to support for making necessary transitions to adulthood
8.	Support for parenting Children and Youth with Special Health Care Needs

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Infusing Health Equity with in the Title V System	New
2.	Access to care for the MCAH Population	Continued
3.	MCAH Systems Coordination	Continued
4.	Dental Delivery Structure of the MCAH Population	Continued
5.	Safe and Healthy Environments	New
6.	Access to community-based services and supports, pediatric specialty providers, and coordination of care	Continued
7.	Access to support for making necessary transitions to adulthood	Continued
8.	Support for parenting Children and Youth with Special Health Care Needs	Continued

Form 10
National Outcome Measures (NOMs)

State: Iowa

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Percent of pregnant women who receive prenatal care beginning in the first trimester (Early Prenatal Care, Formerly NOM 1) - PNC

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	82.5 %	0.2 %	30,013	36,398
2021	82.8 %	0.2 %	30,421	36,733
2020	81.9 %	0.2 %	29,474	35,979
2019	81.5 %	0.2 %	30,543	37,461
2018	81.5 %	0.2 %	30,619	37,568
2017	80.9 %	0.2 %	30,922	38,217
2016	81.1 %	0.2 %	31,801	39,213
2015	80.2 %	0.2 %	31,516	39,275
2014	80.2 %	0.2 %	31,680	39,516
2013	76.7 %	0.2 %	29,902	38,967
2012	76.6 %	0.2 %	29,528	38,556
2011	77.1 %	0.2 %	29,310	38,017
2010	76.4 %	0.2 %	29,210	38,212
2009	75.3 %	0.2 %	29,296	38,917

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PNC - Notes:

None

Data Alerts: None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	77.9	4.7	275	35,314
2020	69.1	4.5	240	34,746
2019	56.0	3.9	204	36,454
2018	54.3	3.9	198	36,451
2017	56.3	3.9	210	37,275
2016	53.4	3.8	202	37,807
2015	54.4	4.4	156	28,702
2014	45.9	3.5	175	38,096
2013	56.4	3.9	212	37,606
2012	48.9	3.6	182	37,228
2011	49.9	3.7	185	37,045
2010	47.4	3.6	178	37,531
2009	44.5	3.4	171	38,437
2008	44.0	3.4	169	38,397

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2022	19.5	3.3	36	184,889
2017_2021	18.7	3.2	35	186,813
2016_2020	12.1	2.5	23	189,381
2015_2019	10.4	2.3	20	192,749
2014_2018	13.9	2.7	27	194,787

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) (Low Birth Weight, Formerly NOM 4) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	7.2 %	0.1 %	2,621	36,494
2021	6.8 %	0.1 %	2,519	36,818
2020	6.9 %	0.1 %	2,503	36,102
2019	6.8 %	0.1 %	2,543	37,633
2018	6.9 %	0.1 %	2,608	37,768
2017	6.6 %	0.1 %	2,526	38,418
2016	6.8 %	0.1 %	2,661	39,385
2015	6.7 %	0.1 %	2,663	39,471
2014	6.7 %	0.1 %	2,675	39,667
2013	6.6 %	0.1 %	2,561	39,080
2012	6.7 %	0.1 %	2,579	38,689
2011	6.5 %	0.1 %	2,495	38,196
2010	7.0 %	0.1 %	2,700	38,695
2009	6.7 %	0.1 %	2,671	39,683

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks) (Preterm Birth, Formerly NOM 5) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	10.2 %	0.2 %	3,731	36,461
2021	10.0 %	0.2 %	3,692	36,813
2020	9.9 %	0.2 %	3,573	36,086
2019	9.5 %	0.2 %	3,569	37,633
2018	9.9 %	0.2 %	3,745	37,774
2017	9.2 %	0.2 %	3,524	38,421
2016	9.3 %	0.2 %	3,652	39,393
2015	9.0 %	0.1 %	3,565	39,470
2014	9.3 %	0.2 %	3,677	39,676
2013	9.0 %	0.1 %	3,512	39,070
2012	9.5 %	0.2 %	3,690	38,668
2011	9.2 %	0.2 %	3,505	38,166
2010	9.6 %	0.2 %	3,728	38,674
2009	9.4 %	0.2 %	3,720	39,662

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Percent of early term births (37, 38 weeks) (Early Term Birth, Formerly NOM 6) - ETB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	28.9 %	0.2 %	10,533	36,461
2021	28.1 %	0.2 %	10,358	36,813
2020	26.9 %	0.2 %	9,690	36,086
2019	26.0 %	0.2 %	9,770	37,633
2018	25.3 %	0.2 %	9,575	37,774
2017	24.3 %	0.2 %	9,344	38,421
2016	23.1 %	0.2 %	9,104	39,393
2015	22.5 %	0.2 %	8,878	39,470
2014	22.7 %	0.2 %	9,003	39,676
2013	22.3 %	0.2 %	8,708	39,070
2012	23.2 %	0.2 %	8,976	38,668
2011	23.1 %	0.2 %	8,835	38,166
2010	23.7 %	0.2 %	9,151	38,674
2009	23.7 %	0.2 %	9,403	39,662

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM ETB - Notes:

None

Data Alerts: None

NOM - Percent of non-medically indicated early elective deliveries (Early Elective Delivery, Formerly NOM 7) - EED

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022/Q1-2022/Q4	2.0 %			
2021/Q4-2022/Q3	2.0 %			
2021/Q3-2022/Q2	2.0 %			
2021/Q2-2022/Q1	2.0 %			
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	1.0 %			
2019/Q4-2020/Q3	1.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	1.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	2.0 %			

Legends:

NOM EED - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths (Perinatal Mortality, Formerly NOM 8) - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.4	0.4	164	36,925
2020	4.8	0.4	172	36,201
2019	4.9	0.4	185	37,751
2018	4.4	0.3	166	37,861
2017	4.9	0.4	188	38,527
2016	5.4	0.4	215	39,504
2015	3.9	0.3	154	39,564
2014	5.1	0.4	204	39,788
2013	4.7	0.4	185	39,190
2012	5.1	0.4	197	38,801
2011	4.9	0.4	189	38,312
2010	4.6	0.3	177	38,818
2009	4.8	0.4	191	39,805

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	4.0	0.3	147	36,835
2020	4.4	0.4	160	36,114
2019	5.0	0.4	189	37,649
2018	5.0	0.4	188	37,785
2017	5.3	0.4	204	38,430
2016	6.0	0.4	235	39,403
2015	4.2	0.3	167	39,482
2014	4.8	0.4	189	39,687
2013	4.2	0.3	166	39,094
2012	5.3	0.4	206	38,702
2011	4.7	0.4	181	38,214
2010	4.9	0.4	188	38,719
2009	4.6	0.3	183	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births (Neonatal Mortality, Formerly NOM 9.2) - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	2.6	0.3	94	36,835
2020	2.8	0.3	102	36,114
2019	3.0	0.3	112	37,649
2018	3.1	0.3	117	37,785
2017	3.3	0.3	126	38,430
2016	3.7	0.3	146	39,403
2015	2.5	0.3	99	39,482
2014	3.1	0.3	125	39,687
2013	2.7	0.3	105	39,094
2012	3.3	0.3	128	38,702
2011	2.9	0.3	110	38,214
2010	2.6	0.3	101	38,719
2009	2.6	0.3	105	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	1.4	0.2	53	36,835
2020	1.6	0.2	58	36,114
2019	2.0	0.2	77	37,649
2018	1.9	0.2	71	37,785
2017	2.0	0.2	78	38,430
2016	2.3	0.2	89	39,403
2015	1.7	0.2	68	39,482
2014	1.6	0.2	64	39,687
2013	1.6	0.2	61	39,094
2012	2.0	0.2	78	38,702
2011	1.9	0.2	71	38,214
2010	2.2	0.2	87	38,719
2009	2.0	0.2	78	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births (Preterm-Related Mortality, Formerly NOM 9.4) - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	124.9	18.4	46	36,835
2020	116.3	18.0	42	36,114
2019	122.2	18.0	46	37,649
2018	150.9	20.0	57	37,785
2017	130.1	18.4	50	38,430
2016	172.6	21.0	68	39,403
2015	103.8	16.2	41	39,482
2014	148.7	19.4	59	39,687
2013	120.2	17.6	47	39,094
2012	121.4	17.7	47	38,702
2011	149.2	19.8	57	38,214
2010	134.3	18.6	52	38,719
2009	115.9	17.1	46	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	65.2	13.3	24	36,835
2020	85.8	15.4	31	36,114
2019	93.0	15.7	35	37,649
2018	90.0	15.4	34	37,785
2017	98.9	16.1	38	38,430
2016	101.5	16.1	40	39,403
2015	88.6	15.0	35	39,482
2014	58.0	12.1	23	39,687
2013	89.5	15.1	35	39,094
2012	80.1	14.4	31	38,702
2011	83.7	14.8	32	38,214
2010	108.5	16.8	42	38,719
2009	80.6	14.3	32	39,701

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Percent of women who drink alcohol in the last 3 months of pregnancy (Drinking during Pregnancy, Formerly NOM 10) - DP

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.7 %	1.1 %	2,061	36,451
2014	4.6 %	1.0 %	1,686	36,813
2013	5.5 %	1.0 %	1,979	36,123

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM DP - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations (Neonatal Abstinence Syndrome, Formerly NOM 11) - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	2.5	0.3	88	35,631
2020	2.3	0.3	80	35,089
2019	3.2	0.3	117	36,560
2018	2.9	0.3	105	36,722
2017	2.7	0.3	101	37,481
2016	2.6	0.3	101	38,132
2015	2.9	0.3	84	28,917
2014	2.8	0.3	109	38,603
2013	2.2	0.2	84	38,016
2012	2.0	0.2	74	37,690
2011	1.4	0.2	52	37,533
2010	1.1	0.2	42	37,987
2009	0.8	0.1	30	38,906
2008	0.7	0.1	27	38,936

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL) (Newborn Screening Timely Follow-Up, Formerly NOM 12) - NBS

Federally available Data (FAD) for this measure is not available/reportable.

NOM NBS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL) (School Readiness, Formerly NOM 13) - SR

Federally available Data (FAD) for this measure is not available/reportable.

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	10.7 %	1.0 %	73,511	684,450
2020_2021	10.9 %	1.1 %	74,440	680,915
2019_2020	10.9 %	1.4 %	74,079	679,336
2018_2019	10.5 %	1.4 %	71,297	679,075
2017_2018	9.7 %	1.3 %	65,876	677,186
2016_2017	8.7 %	1.1 %	58,880	675,374

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 (Child Mortality, Formerly NOM 15) - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	20.6	2.4	72	349,735
2021	16.6	2.2	59	356,214
2020	18.8	2.3	67	356,026
2019	13.1	1.9	47	358,252
2018	16.9	2.2	61	361,042
2017	16.8	2.2	61	362,719
2016	17.6	2.2	64	363,753
2015	18.5	2.3	67	362,852
2014	18.2	2.3	66	361,818
2013	16.6	2.1	60	361,652
2012	17.4	2.2	63	361,686
2011	19.6	2.3	71	361,834
2010	13.5	1.9	49	363,614
2009	18.9	2.3	68	360,733

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	35.1	2.9	151	429,822
2021	31.0	2.7	135	435,060
2020	38.0	3.0	160	420,998
2019	33.1	2.8	139	420,543
2018	31.9	2.8	135	422,686
2017	35.8	2.9	151	421,448
2016	30.6	2.7	128	418,789
2015	31.6	2.8	132	417,513
2014	26.5	2.5	110	415,812
2013	26.8	2.5	111	414,779
2012	29.6	2.7	123	415,083
2011	35.5	2.9	148	417,468
2010	32.3	2.8	135	417,741
2009	28.8	2.6	121	419,835

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 (Adolescent Motor Vehicle Death, Formerly NOM 16.2) - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2022	13.1	1.4	86	654,900
2019_2021	12.2	1.4	79	645,033
2018_2020	12.4	1.4	79	638,740
2017_2019	13.7	1.5	88	641,170
2016_2018	13.7	1.5	88	644,088
2015_2017	13.0	1.4	84	644,325
2014_2016	11.7	1.4	75	642,181
2013_2015	10.9	1.3	70	639,567
2012_2014	11.1	1.3	71	638,549
2011_2013	14.0	1.5	90	641,683
2010_2012	16.3	1.6	105	646,012
2009_2011	16.3	1.6	106	651,930
2008_2010	14.6	1.5	96	657,062
2007_2009	18.0	1.7	119	661,090

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020_2022	8.0	0.8	103	1,285,880
2019_2021	8.1	0.8	104	1,276,601
2018_2020	7.9	0.8	100	1,264,227
2017_2019	8.5	0.8	108	1,264,677
2016_2018	7.8	0.8	98	1,262,923
2015_2017	8.3	0.8	105	1,257,750
2014_2016	7.0	0.8	88	1,252,114
2013_2015	7.1	0.8	89	1,248,104
2012_2014	6.6	0.7	82	1,245,674
2011_2013	7.2	0.8	90	1,247,330
2010_2012	7.3	0.8	91	1,250,292
2009_2011	6.6	0.7	83	1,255,044

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17 (CSHCN, Formerly NOM 17.1) - CSHCN

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	19.2 %	1.2 %	139,096	725,963
2020_2021	21.0 %	1.3 %	150,980	717,865
2019_2020	19.2 %	1.4 %	139,229	723,298
2018_2019	18.1 %	1.4 %	131,921	727,584
2017_2018	19.1 %	1.5 %	138,288	725,639
2016_2017	18.7 %	1.4 %	135,278	724,665

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CSHCN - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	16.6 %	2.6 %	23,158	139,096
2020_2021	17.3 %	2.7 %	26,192	150,980
2019_2020	22.8 %	3.3 %	31,709	139,229
2018_2019	25.9 %	3.7 %	34,166	131,921
2017_2018	22.8 %	3.6 %	31,507	138,288
2016_2017	23.6 %	3.3 %	31,982	135,278

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder (Autism, Formerly NOM 17.3) - ASD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	2.9 %	0.6 %	17,503	601,926
2020_2021	2.3 %	0.6 %	13,536	595,976
2019_2020	1.8 %	0.5 %	10,504	587,808
2018_2019	2.2 %	0.5 %	12,981	592,217
2017_2018	2.5 %	0.6 %	14,884	601,310
2016_2017	2.6 %	0.6 %	15,860	602,996

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ASD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD) (ADD or ADHD, Formerly NOM 17.4) - ADHD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	8.9 %	1.0 %	53,644	602,779
2020_2021	9.6 %	1.1 %	57,414	596,327
2019_2020	9.7 %	1.1 %	56,736	585,704
2018_2019	9.9 %	1.1 %	58,232	587,839
2017_2018	10.3 %	1.3 %	61,405	598,355
2016_2017	8.6 %	1.2 %	51,709	599,772

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADHD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling (Mental health treatment, Formerly NOM 18) - MHTX

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	58.9 %	4.2 %	54,101	91,825
2020_2021	62.6 %	4.5 %	55,222	88,174
2019_2020	63.0 %	4.9 %	53,619	85,078
2018_2019	64.2 %	4.7 %	56,500	88,012
2017_2018	61.4 %	5.7 %	59,058	96,123
2016_2017	60.9 %	5.8 %	54,375	89,292

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM MHTX - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	91.8 %	0.9 %	662,713	721,626
2020_2021	91.3 %	1.0 %	653,277	715,386
2019_2020	91.8 %	1.2 %	664,251	723,298
2018_2019	90.1 %	1.4 %	655,466	727,433
2017_2018	89.0 %	1.5 %	645,984	725,488
2016_2017	91.0 %	1.2 %	658,584	723,492

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile) (Obesity, Formerly NOM 20) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	15.8 %	0.3 %	2,284	14,447
2018	15.6 %	0.2 %	3,643	23,331
2016	15.2 %	0.2 %	3,724	24,427
2014	14.7 %	0.2 %	3,656	24,835
2012	15.1 %	0.2 %	4,033	26,722
2010	15.6 %	0.2 %	4,590	29,481
2008	15.7 %	0.2 %	4,089	26,103

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	15.8 %	1.8 %	21,039	132,855
2019	17.0 %	1.4 %	23,541	138,177
2017	15.3 %	1.7 %	21,043	137,135
2011	13.2 %	1.5 %	18,393	138,892
2007	11.1 %	1.4 %	15,756	141,858
2005	12.2 %	1.4 %	17,896	146,685

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	15.7 %	1.3 %	73,735	470,464
2020_2021	17.6 %	1.6 %	80,581	457,184
2019_2020	18.7 %	1.9 %	85,673	457,902
2018_2019	16.4 %	1.9 %	75,949	462,916
2017_2018	16.8 %	1.9 %	76,950	457,410
2016_2017	17.9 %	1.8 %	79,704	445,377

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, without health insurance (Uninsured, Formerly NOM 21) - UI

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	3.2 %	0.4 %	22,582	715,187
2021	3.3 %	0.4 %	24,311	733,658
2019	2.4 %	0.3 %	17,506	721,021
2018	3.1 %	0.5 %	22,513	731,105
2017	2.6 %	0.4 %	19,135	730,569
2016	2.2 %	0.3 %	15,817	723,558
2015	3.3 %	0.4 %	23,663	724,960
2014	3.2 %	0.4 %	22,951	724,668
2013	4.8 %	0.5 %	34,835	724,105
2012	4.3 %	0.5 %	31,251	721,858
2011	4.6 %	0.5 %	33,041	722,389
2010	4.3 %	0.4 %	31,080	722,835
2009	4.4 %	0.4 %	31,347	708,602

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM UI - Notes:

None

Data Alerts: None

NOM - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months (Childhood Vaccination, Formerly NOM 22.1) - VAX-Child

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	81.5 %	3.4 %	31,000	38,000
2017	69.5 %	3.9 %	27,000	39,000
2016	73.5 %	4.1 %	29,000	39,000
2015	75.0 %	3.5 %	30,000	40,000
2014	70.7 %	3.4 %	28,000	39,000
2013	70.2 %	3.6 %	27,000	39,000
2012	77.2 %	3.5 %	30,000	39,000
2011	71.4 %	4.2 %	27,000	38,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM VAX-Child - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza (Flu Vaccination, Formerly NOM 22.2) - VAX-Flu

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	59.0 %	2.0 %	408,377	692,165
2021_2022	61.9 %	2.0 %	418,820	676,654
2020_2021	63.7 %	2.3 %	433,352	680,301
2019_2020	66.3 %	1.7 %	488,181	736,322
2018_2019	65.8 %	1.9 %	452,825	688,184
2017_2018	58.9 %	2.1 %	404,858	687,676
2016_2017	58.7 %	2.1 %	401,512	683,774
2015_2016	59.1 %	1.7 %	401,179	679,043
2014_2015	57.5 %	2.0 %	391,098	680,763
2013_2014	54.4 %	2.2 %	373,587	687,152
2012_2013	52.6 %	2.2 %	361,225	686,646
2011_2012	50.1 %	2.2 %	336,614	672,137
2010_2011	50.6 %	2.6 %	342,515	676,908
2009_2010	46.6 %	2.2 %	306,473	657,668

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM VAX-Flu - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine (HPV Vaccination, Formerly NOM 22.3) - VAX-HPV

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	87.9 %	2.7 %	191,620	218,108
2021	79.2 %	3.8 %	164,878	208,160
2020	74.2 %	3.0 %	153,522	206,951
2019	75.1 %	2.9 %	154,299	205,386
2018	73.4 %	3.1 %	149,228	203,329
2017	71.4 %	2.8 %	144,996	203,089
2016	60.7 %	3.0 %	123,186	202,834
2015	57.2 %	3.1 %	116,137	203,164

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-HPV - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine (Tdap Vaccination, Formerly NOM 22.4) - VAX-TDAP

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	97.3 %	1.7 %	212,140	218,108
2021	92.3 %	2.4 %	192,235	208,160
2020	91.4 %	1.8 %	189,211	206,951
2019	94.1 %	1.4 %	193,216	205,386
2018	94.0 %	1.5 %	191,105	203,329
2017	93.4 %	1.5 %	189,740	203,089
2016	89.2 %	1.8 %	180,848	202,834
2015	85.5 %	2.4 %	173,608	203,164
2014	76.7 %	3.3 %	156,645	204,263
2013	79.6 %	2.6 %	161,155	202,457
2012	77.8 %	3.0 %	157,505	202,458
2011	74.8 %	3.0 %	152,366	203,835
2010	64.2 %	3.3 %	131,182	204,220
2009	61.2 %	3.1 %	124,745	203,850

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-TDAP - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine (Meningitis Vaccination, Formerly NOM 22.5) - VAX-MEN

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	97.9 %	1.1 %	213,623	218,108
2021	95.0 %	2.2 %	197,683	208,160
2020	90.7 %	1.9 %	187,696	206,951
2019	93.6 %	1.6 %	192,241	205,386
2018	89.2 %	2.3 %	181,356	203,329
2017	83.6 %	2.4 %	169,737	203,089
2016	74.9 %	2.6 %	151,976	202,834
2015	75.0 %	2.7 %	152,339	203,164
2014	64.4 %	3.5 %	131,631	204,263
2013	63.7 %	3.0 %	128,863	202,457
2012	64.4 %	3.4 %	130,376	202,458
2011	60.5 %	3.4 %	123,342	203,835
2010	53.7 %	3.4 %	109,756	204,220
2009	46.4 %	3.1 %	94,649	203,850

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM VAX-MEN - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females (Teen Births, Formerly NOM 23) - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2022	12.4	0.3	1,338	107,611
2021	12.7	0.3	1,363	107,213
2020	13.3	0.4	1,381	103,569
2019	14.1	0.4	1,460	103,383
2018	15.3	0.4	1,603	104,650
2017	16.0	0.4	1,678	104,979
2016	17.2	0.4	1,804	105,029
2015	18.6	0.4	1,943	104,477
2014	19.7	0.4	2,048	104,065
2013	22.1	0.5	2,289	103,809
2012	24.1	0.5	2,498	103,716
2011	25.3	0.5	2,665	105,140
2010	28.6	0.5	3,017	105,526
2009	32.1	0.6	3,421	106,721

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms following a recent live birth (Postpartum Depression, Formerly NOM 24) - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	7.9 %	1.3 %	2,597	32,868
2019	10.2 %	1.6 %	3,491	34,337
2018	9.5 %	1.7 %	3,266	34,454
2017	7.4 %	1.2 %	2,615	35,459
2016	12.1 %	1.5 %	4,376	36,319
2015	8.8 %	1.4 %	3,205	36,438
2014	10.1 %	1.4 %	3,709	36,666
2013	9.3 %	1.3 %	3,287	35,512

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year (Forgone Health Care, Formerly NOM 25) - FHC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	2.8 %	0.6 %	20,500	721,198
2020_2021	2.5 %	0.5 %	17,924	714,072
2019_2020	1.3 %	0.3 %	9,108	722,337
2018_2019	1.2 %	0.4 %	8,621	725,901
2017_2018	1.4 %	0.5 %	10,127	724,917
2016_2017	1.9 %	0.5 %	13,777	723,528

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FHC - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Iowa

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	84.5	85	85.5	86	86.5
Annual Indicator	84.5	80.2	84.7	82.4	82.7
Numerator	27,589	28,001	29,640	27,149	25,443
Denominator	32,646	34,927	34,980	32,950	30,761
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2023
Annual Objective	86.5
Annual Indicator	85.8
Numerator	30,706
Denominator	35,768
Data Source	NVSS
Data Source Year	2022

Annual Objectives		
	2024	**2025**
Annual Objective	87.0	87.5

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	30	30.5	31	31.5	32
Annual Indicator	30.5	24.8	27.3	27.0	25.0
Numerator	9,785	8,458	9,169	8,547	7,539
Denominator	32,069	34,057	33,621	31,621	30,105
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2023
Annual Objective	32
Annual Indicator	29.3
Numerator	29,078
Denominator	99,115
Data Source	NSCH
Data Source Year	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	32.5	33.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			87	87.5	88
Annual Indicator	86.7	84.8	85.7	85.7	85.7
Numerator	30,649	29,197	28,106	28,106	28,106
Denominator	35,356	34,418	32,785	32,785	32,785
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	88.5	89.0

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			48	48.5	49
Annual Indicator	44.2	47.5	46.5	46.5	46.5
Numerator	15,044	15,850	14,684	14,684	14,684
Denominator	34,022	33,343	31,570	31,570	31,570
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	49.5	50.0

Field Level Notes for Form 10 NPMs:

None

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			57.5	58	58.5
Annual Indicator	57.0	56.1	60.8	60.8	60.8
Numerator	19,594	18,702	19,376	19,376	19,376
Denominator	34,396	33,309	31,865	31,865	31,865
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	59.0	59.5

Field Level Notes for Form 10 NPMs:

None

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Field Level Notes for Form 10 NPMs:

None

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

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	28.6	34.5	44	44.5	45
Annual Indicator	34.2	43.2	34.0	35.0	35.6
Numerator	32,539	43,907	35,273	31,234	31,113
Denominator	95,266	101,539	103,777	89,276	87,348
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	45.5	46.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	83	84	86	87	88
Annual Indicator	81.1	88.5	83.2	77.7	76.1
Numerator	191,475	195,697	191,890	185,686	188,931
Denominator	236,185	221,185	230,603	239,022	248,333
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	89.0	90.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	51.6	51.7	51.8	54	54.2
Annual Indicator	51.0	52.3	53.8	52.5	47.1
Numerator	74,037	75,172	79,550	78,926	65,535
Denominator	145,140	143,725	147,830	150,375	139,096
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	54.4	54.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	53.7
Numerator	389,805
Denominator	725,963
Data Source	NSCH-All Children
Data Source Year	2021_2022

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	23	24	45	45.5	46
Annual Indicator	27.2	44.5	40.8	32.3	40.1
Numerator	20,601	30,962	29,858	24,358	27,274
Denominator	75,605	69,559	73,204	75,316	67,971
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	46.5	47.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	64.1	64.3	64.5	52	54
Annual Indicator	55.3	52.4	50.3	50.3	50.3
Numerator	19,796	18,294	16,828	16,828	16,828
Denominator	35,811	34,942	33,461	33,461	33,461
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2019	2020	2020	2020

Annual Objectives		
	2024	**2025**
Annual Objective	56.0	58.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	85	87	88	88.5	89
Annual Indicator	86.7	86.1	82.0	79.5	81.6
Numerator	585,814	583,397	553,776	538,939	559,852
Denominator	675,638	677,662	675,147	677,742	685,800
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	89.5	90.0

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy

Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			11.4	10	9.7
Annual Indicator	11.6	11.0	10.3	8.7	6.7
Numerator	4,388	4,120	3,713	3,214	2,456
Denominator	37,751	37,613	36,085	36,805	36,477
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	**2025**
Annual Objective	9.4	9.0

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally available Data (FAD) for this measure is not available/reportable.

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally available Data (FAD) for this measure is not available/reportable.

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Iowa

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			9	8.9	8.8
Annual Indicator		9.4	9.4	9.4	9.4
Numerator					
Denominator					
Data Source		Iowa's Maternal Mortality Review Committee (IMMRC)	Iowa's Maternal Mortality Review Committee (IMMRC)	Iowa's Maternal Mortality Review Committee (IMMRC)	Iowa's Maternal Mortality Review Committee (IMMRC)
Data Source Year		2019	2020	2019-2021	2019-2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	8.7	8.6

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The rate for non-Hispanic White women was 6.0, for non-Hispanic Black women 36.9, for Asian/Pacific Islander 23.5 and for Hispanic women 9.7. The Black/White ratio is 6.1, Asian/Pacific Islander/White ratio is 3.9 and the Hispanic/White ratio is 1.6.	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Iowa - National Vital Statistics System 10.4/100,000 (2015-2019)	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The rate for White women was 17.5, for Black or bi-racial women 37.4. The Rate for Non-Hispanic women was 17.2, the rate for Hispanic women, 26.5 These rates result from three years of data (2019-2021). Although tragic, the actual count of maternal deaths per year is small. Because of this, some of the findings presented above include collapsed variables to provide confidentiality of the cases. Rates and ratios based on events of less than 20 need to be interpreted with caution. A small population size may create an increased likelihood of skewed results; meaning some effects may be exaggerated, while others may remain underestimated. Working with small population sizes also prevents some statistical analysis that would provide additional insights on causes.	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The rate for White women was 17.5, for Black or bi-racial women 37.4. The Rate for Non-Hispanic women was 17.2, the rate for Hispanic women, 26.5 These rates result from three years of data (2019-2021). Although tragic, the actual count of maternal deaths per year is small. Because of this, some of the findings presented above include collapsed variables to provide confidentiality of the cases. Rates and ratios based on events of less than 20 need to be interpreted with caution. A small population size may create an increased likelihood of skewed results; meaning some effects may be exaggerated, while others may remain underestimated. Working with small population sizes also prevents some statistical analysis that would provide additional insights on causes.	

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			70	72	74
Annual Indicator		68	70	71.4	75.4
Numerator					
Denominator					
Data Source		IDPH Lead Report Card	IDPH Lead Program Data System (HHLPSS)	IDPH Lead Program Data System (HHLPSS)	Lead Program Data System (HHLPSS)
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	76.0	78.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: 68% 1 year olds; 38% 2 year olds (2019)	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 70% 1 year olds and 36% 2 year olds (Data year 2020)	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 71.36% of children 1 year of age received a blood lead test in 2021 38.82% of children 2 years of age received a blood lead test in 2021 (CLPPP Data; 2021)	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 75.37% of children 1 year of age received a blood lead test in 2022 39.8% of children 2 years of age received a blood lead test in 2022 (CLPPP Data; 2022)	

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

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	36	38	43	55	57
Annual Indicator	37.2	42.1	53.8	56.3	55.7
Numerator	1,563	1,759	2,153	2,117	2,023
Denominator	4,201	4,183	3,999	3,763	3,632
Data Source	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa	Healthy Child Care Iowa and Early Childhood Iowa
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	59.0	60.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			25	25	24.5
Annual Indicator		25	30	30	30
Numerator					
Denominator					
Data Source		Iowa Youth Survey	Iowa Youth Survey	Iowa Youth Survey	Iowa Youth Survey
Data Source Year		2018	2020	2021	2021
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	29.0	28.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The Iowa Youth Survey is conducted every two years. The most recent data is from 2018. Due to Covid-19 the 2020 survey was not completed. The Iowa Youth Survey (IYS) and Youth Risk Behavior Survey (YRBS) will be jointly administered in Iowa from September 27 to November 12, 2021. These surveys collect valuable youth health behavior data that drives funding, program and policy decisions in communities across the state	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 30% Total 11th grade 36% 8th grade 29% 6th grade 27%	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: 30% Total 11th grade 36% 8th grade 29% 6th grade 27%	
4.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: 30% Total 11th grade 36% 8th grade 29% 6th grade 27%	

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			1,100	1,800	2,700
Annual Indicator	873	1,080	1,710	2,634	2,488
Numerator					
Denominator					
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	2,550.0	2,612.0

Field Level Notes for Form 10 SPMs:

None

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			5	100	100
Annual Indicator			100	100	100
Numerator					
Denominator					
Data Source			Title V RFP/RFA	Title V RFP/RFA	Title V RFP/RFA
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	100.0	100.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
This was a new measure in 2021. Starting in 2021 Local Contractors had to begin to create steps for a plan to address including:
Assess effectiveness of health equity activities
Policy change through Cultural and Linguistically Appropriate Goals
Recruit membership from priority populations:
Collaborative Partnerships

2022 RFA was a continuation application due to COVID 19. Contractors continued to operate under their pervious work plans submitted and approved for FFY2021 with a few exceptions where plans were updated to reflect changes needed due to COVID 19 or to update with progress made and next steps.

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

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

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			88	88.5	89
Annual Indicator	87.4		83.2	86.5	87.6
Numerator	97		5,399	3,598	3,887
Denominator	111		6,486	4,160	4,437
Data Source	Youth Services Survey for Families		Youth Services Survey for Families	Youth Services Survey for Families	Youth Services Survey for Families
Data Source Year	2016		2021	2022	2023
Provisional or Final ?	Final		Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	89.5	90.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The numerator and denominator data are weighted (design weight and population weight). Before weighting, the denominator was 334 and the numerator was 279. This is the Satisfaction domain from the YSS-F which includes the items
• Overall, I am satisfied with the services I received:
• The people helping my child stuck with us no matter what
• I felt my child has someone to talk to when he or she was troubled
• The services my child and family received were right for us
• My family got the help we wanted for my child
• My family got as much help as we needed for my child

2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**

Field Note:
The YSS-F includes 26 questions with a 5-level Likert-type response scale ranging from 'Strongly Agree' to 'Strongly Disagree.' The items in the questionnaire are grouped into 6 domains: Access, Participation in Treatment, Cultural Sensitivity, Satisfaction, Outcomes, and Social Connectedness. The Satisfaction domain includes 6 items:

Overall, I am satisfied with the services I received
The people helping my child stuck with us no matter what
I felt my child has someone to talk to when he or she was troubled
The services my child and family received were right for us
My family got the help we wanted for my child
My family got as much help as we needed for my child

The state performance measure looks at the percent of families for whom the mean score for these items was over 3.5 on the 5-point scale.

Data were weighted to reflect the population of CHSC patients receiving direct services through ARNP visits, telehealth visits, Family Navigators, dietitians, or other contacts.

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Iowa

ESM BF.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age

Measure Status:	Inactive - Replaced				
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			23	46	25
Annual Indicator			17	19	28
Numerator					
Denominator					
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected and Year End Report
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM BF.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			30	65	85
Annual Indicator			64.7	81.5	69
Numerator			1,591	3,522	2,221
Denominator			2,460	4,324	3,219
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	73.0	75.0

Field Level Notes for Form 10 ESMs:

None

ESM SS.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			12	14	
Annual Indicator			6	34	60
Numerator					
Denominator					
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	65.0	70.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Numbers are low because Title V agencies were not required to document "Community Events" in SignifyCommunity this year.	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: Annual objective disappeared when updating ESM Detail Sheet.	

ESM DS.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	2	2.5	2.2	2.3	6
Annual Indicator	1.9	2	4.5	5.6	5.5
Numerator	1,076	2,537	5,240	6,606	6,554
Denominator	56,307	125,164	116,112	117,017	118,759
Data Source	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims	Medicaid Paid Claims
Data Source Year	2018	2020	2021	2022	2023
Provisional or Final ?	Provisional	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	5.7	5.9

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Will work with data system staff to get the updated numbers form 2019.

ESM AWV.2 - Percent of children 10 through 20 years of age enrolled in Medicaid with a well visit in the past year

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator	35	29
Numerator		
Denominator		
Data Source	Iowa Medicaid CMS 416	Iowa Medicaid CMS 416
Data Source Year	2022	2023
Provisional or Final ?	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	30.0	31.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.1 - Number of telehealth visits through Child Health Specialty Clinics

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			3,150	4,000	3,400
Annual Indicator	3,115	4,464	4,397	3,377	3,431
Numerator					
Denominator					
Data Source	Program Data	Program Data (EHR)	Program Data (EHR)	Program Data (EHR)	Program Data (EHR)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	3,450.0	3,500.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
The 2021 telehealth visits were higher than expected, but this is in part due to increased use of telehealth due to pandemic considerations. We expect this number to be lower in upcoming years.

ESM TR.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			64	66	98
Annual Indicator	62.1		92.2	97.8	94.7
Numerator	218		200	220	230
Denominator	351		217	225	243
Data Source	Program Data (EHR)		Program Data (EHR)	Program Data (EHR)	Program Data (EHR)
Data Source Year	2019		2021	2022	2023
Provisional or Final ?	Final		Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	98.0	98.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Youth ages 12-21 who were seen by CHSC ARNPs during FY2021/ Youth ages 12-21 who were seen by CHSC ARNPs during FY2021	
2.	**Field Name:**	**2023**
	Column Name:	**State Provided Data**
	Field Note: The Transition ESM number decreased from 2022 to 2023 because of changes for telehealth psychiatry providers. CHSC is in the process of evaluating the best way to include telehealth specialty providers from outside of CHSC in our transition to adulthood planning program.	

ESM PDV-Pregnancy.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	355	400	400	400	400
Annual Indicator	397	397	365	370	343
Numerator					
Denominator					
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	400.0	400.0

Field Level Notes for Form 10 ESMs:

None

ESM PDV-Child.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	385	400	400	400	400
Annual Indicator	397	397	365	370	343
Numerator					
Denominator					
Data Source	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report	Local Title V MCAH Year End Report
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	400.0	400.0

Field Level Notes for Form 10 ESMs:

None

ESM SMK-Pregnancy.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			50	75	76
Annual Indicator			73.6	52.9	69.3
Numerator			53	2,287	219
Denominator			72	4,324	316
Data Source			SignifyCommunity	SignifyCommunity	Iowa Connected
Data Source Year			2021	2022	2023
Provisional or Final ?			Provisional	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	77.0	78.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Title V did not start collecting this until July 2021, so only 3 months of data was available at this time.

Data system no longer active unable to pull final report for 2021 data.

Form 10
State Performance Measure (SPM) Detail Sheets

State: Iowa

SPM 1 - Number of pregnancy-related deaths for every 100,000 live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active
Goal:	To reduce preventable maternal mortality through modifiable actions based on recommendations from the Maternal Mortality Review Committee
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of maternal deaths **Denominator:** 100,000 live births
Data Sources and Data Issues:	Iowa Maternal Mortality Review Committee report and Viral Records. In the current Maternal Mortality Review Committee report there is 3 years worth of data. Vital Records data is based on 1 calendar year. Occasionally, this causes an incongruity between reported data.
Significance:	Maternal mortality rates are continuing to rise in the United States and Iowa, while all other Countries reporting data are seeing a decline in maternal mortality rates. The Maternal Mortality Review Committee has seen an increase in the rate of women dying due to pregnancy-related complications.

SPM 2 - Percent of children ages 1 and 2, with a blood lead test in the past year
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percent of Iowa children ages 1 and 2 with a blood lead test.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of children ages 1 and 2 (12-35 months) with a blood lead test **Denominator:** Number of children ages 1 and 2 (12-35 months)
Data Sources and Data Issues:	Healthy Homes & Lead Poisoning Surveillance System (HHLPSS) database and Annual Estimated Census Data by County
Significance:	Statewide in 2017, 88% of one year olds were tested for blood lead, compared to 43% of two year olds and 14% of three year olds. The typical development of toddlers increases their risk to environmental lead exposure during their second and third year of life through hand to mouth behavior and increased mobility. There is a significant need to test increase testing of 2 year olds, while maintaining the high rate of one year olds being tested.

SPM 3 - Percent of early care and education programs that receive Child Care Nurse Consultant services.
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the percentage of early care and education programs receiving Child Care Nurse Consultant services.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of early care and education programs receiving Child Care Nurse Consultant services. **Denominator:** Total number of early care and education programs.
Data Sources and Data Issues:	Healthy Child Care Iowa and Early Childhood Iowa
Significance:	Improving the quality of child care allows Iowa to address cross-cutting MCH needs such as nutrition and physical activity, breastfeeding support, developmental screenings, and safe sleep environments. Families of CYSHCN also reported difficulties finding childcare providers that are qualified and comfortable caring for their children. Iowa has a history in working with registered day care providers, both centers and in-home, through the Healthy Child Care Iowa program. The role of child care nurse consultants (CCNCs) is based on the Blueprint for Action from the Healthy Child Care America campaign. The CCNC program has the ability to reach a wide range of settings and provide support to day care providers in establishing practices that are medically sound and meet the objectives of Title V programs.

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

Measure Status:	Active
Goal:	Decrease the percent of adolescents who report that during the past 12 months they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number reporting during the past 12 months that they have felt so sad or hopeless almost every day for 2 weeks or more in a row that they stopped doing some usual activities **Denominator:** Total number of 6th, 8th and 11th graders completing Question B62 of the Iowa Youth Survey.
Data Sources and Data Issues:	Iowa Youth Survey
Significance:	This measure is significant as it is a direct result of the qualitative and quantitative data gathered during the needs assessment, in addition to emerging legislation creating a children's regional mental health system structure statewide in response to what has been a child/adolescent mental health crisis in the state. Title V in Iowa has not played a significant role in adolescent mental health previously, therefore an exploratory phase is required to better understand the gap filling role for Title V.

SPM 5 - Number of children 0-35 Months who have had fluoride varnish during a well visit with Physician/health care provider
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	Increase the number of children 0-35 months who have had fluoride varnish during a well visit with physician/health care provider
Definition:	**Unit Type:** Count **Unit Number:** 20,000 **Numerator:** Children 0-35 months enrolled in Iowa Medicaid who received a fluoride varnish application from a medical provider **Denominator:**
Data Sources and Data Issues:	Medicaid paid claims – requested by the Bureau of Oral and Health Delivery Systems annually
Significance:	Medicaid-enrolled children are more likely to receive routine care from a primary care or pediatric physician than a dentist, particularly for those younger than 3 years of age. Since low income children are more likely to suffer from dental decease, receiving fluoride varnish from physicians addresses this disparity.

SPM 6 - Percent of Title V contractors with a plan to identify and address health equity in the populations they serve
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Ensure the local Title V contractors have a plan to identify and address health equity in the populations they serve
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of local Title V contractors with a plan to identify and address health equity **Denominator:** Total local Title V contractors
Data Sources and Data Issues:	Local Title V RFA/RFP action plans
Significance:	To make progress in health equity, our local contractors delivering Title V services need to be planful and intentional about addressing health equity. Contractors need partnerships and knowledge of their community and to be engaged with priority populations in their community, to develop and implement a plan.

SPM 7 - Percent of caregivers of CYSHCN who report overall satisfaction with support services received through Title V
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active
Goal:	Increase the satisfaction with support services received through Title V
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of families who report overall satisfaction with services received **Denominator:** Total Families receiving CYSHCN services through DCCH
Data Sources and Data Issues:	Youth Services Survey for Families. DCCH will administer this survey annually
Significance:	CYSHCN whose parents receive needed support have better health outcomes

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Iowa

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Iowa

ESM BF.1 - Number of businesses or organizations who were provided education by Title V agencies in the past year about the importance of strong policies to support breastfeeding through or beyond 6 months of age
NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

Measure Status:	Inactive - Replaced
Goal:	Increase the education of businesses and organizations on the importance of strong policies to support employees to continue to breastfeed through or beyond 6 months of age.
Definition:	**Unit Type:** Count **Unit Number:** 150 **Numerator:** Number of businesses or organizations who were provided education by Title V agencies **Denominator:**
Data Sources and Data Issues:	RFA/RFP documentation from Local Title V Agencies
Significance:	Educating businesses and/or organizations on best practices and policies to implement within their practices will help ensure employees are able to continue to breastfeed when returning to work.

ESM BF.2 - Percent of women who receive education about breastfeeding through 6 months and pumping at work NPM – A) Percent of infants who are ever breastfed B) Percent of children, ages 6 months through 2 years, who were breastfed exclusively for 6 months (Breastfeeding, Formerly NPM 4) - BF

Measure Status:	Active
Goal:	Increase the number of Maternal Health clients who receive education about breastfeeding through 6 months and information on pumping at work
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Maternal Health clients who receive education **Denominator:** Total number of Maternal Health clients served
Data Sources and Data Issues:	Title V data system report. Ensuring agencies are aware of how to document the this activity in the data system
Significance:	Educating women on the benefits of breastfeeding through 6 months and their rights and best methods on pumping at work will help increase the rate on initiation and breastfeeding through 6 months.

ESM SS.1 - Number of community education opportunities Title V agencies provide education about safe sleep environments each year
NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep (Safe Sleep, Formerly NPM 5) - SS

Measure Status:	Active
Goal:	Provide evidence based training opportunities for state and local partners/contractors on the importance and best practices on the topic of safe sleep.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** Number of training opportunities provided on the topic of safe sleep **Denominator:**
Data Sources and Data Issues:	Title V state and local reporting
Significance:	Increasing the knowledge of staff on the importance and best practices of safe sleep will ensure the education being provided to maternal health clients is up to date and evidence based.

ESM DS.1 - Percentage of Medicaid enrolled children ages 0-6 receiving a brief emotional behavioral assessment using a standardized tool according to Early Periodic Screening Diagnosis and Treatment (EPSDT) guidelines. NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (Developmental Screening, Formerly NPM 6) - DS

Measure Status:	Active
Goal:	Increase the percentage of children with Medicaid coverage receiving a brief emotional behavioral assessment using a standardized tool.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Medicaid claims data for children ages 9 through 71 months for whom CPT code 96127 was billed. **Denominator:** All children ages 9 through 71 months with Medicaid coverage.
Data Sources and Data Issues:	Medicaid claims data.
Significance:	Emotional/behavioral assessments are important to detect delays early and link the families to services needed.

ESM AWV.2 - Percent of children 10 through 20 years of age enrolled in Medicaid with a well visit in the past year NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (Adolescent Well-Visit, Formerly NPM 10) - AWV

Measure Status:	Active
Goal:	Track the percent of adolescents enrolled in Medicaid with a well visit in the past year. By tracking this number through CMS 416 data we can see if the interventions we are implementing primarily with the Title V and Medicaid populations are impacti
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Adolescents 10 through 20 years of age enrolled in Medicaid with a CPT code for a well visit paid for by Medicaid in the previous 12 months. **Denominator:** Adolescents 10 through 20 years of age enrolled in Medicaid in the calendar year
Data Sources and Data Issues:	Iowa Medicaid paid claims/CMS 416. This provides a measure of behavior versus parent report and is a population Iowa HHS has paid claims data for with the ability to make policy change through Medicaid and Title V contracts.
Evidence-based/informed strategy:	This ESM monitors the extent to which adolescents receive well visits, to inform ongoing efforts around provider training and creation of more adolescent-friendly medical homes. References: American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf. Updated March 2021.
Significance:	Adolescents face a variety of health risks and health problems including unintended pregnancies, sexually transmitted diseases, substance-use disorders, and depression, among others. Getting an annual well-visit provides an opportunity for adolescents to discuss any physical, emotional, and behavioral health issues they may have. Medicaid provides comprehensive benefits for children, known as Early Periodic Screening Diagnosis and Treatment (EPSDT) services. Medicaid also provides health and long-term care for millions of America's poorest and most vulnerable people. By working towards improving the number of Medicaid-eligible adolescents receiving their annual EPSDT visit, progress will be made with the sector of the adolescent population that needs it the most.

ESM MH.1 - Number of telehealth visits through Child Health Specialty Clinics
NPM – Percent of adolescents, ages 12 through 17, who receive needed mental health treatment or counseling (Medical Home, Formerly NPM 11) - MH

Measure Status:	Active
Goal:	Increase the number of telehealth visits conducted for CYSCHN in the state
Definition:	**Unit Type:** Count **Unit Number:** 5,000 **Numerator:** Number of telehealth visits conducted **Denominator:**
Data Sources and Data Issues:	University of Iowa Health Care Electronic Medical Record
Evidence-based/informed strategy:	Strategy: Strengthen infrastructure and increase opportunities for specialty care through telehealth. The Standards for Systems of Care for CYSHCN 2.0 addresses telehealth as a strategy for increased access to care in this way: "Satellite programs, electronic communications, and telemedicine are used to enhance access to specialty care and regional pediatric centers of excellence, where available, and other multidisciplinary teams of pediatric specialty providers."
Significance:	This ESM Process Measure is an indicator of access to pediatric specialty care that is less dependent on geographical considerations. Access to pediatric specialty care through telehealth visits is especially helpful in rural areas of the state.

ESM TR.1 - Percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
NPM – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transitions to adult health care (Transition, Formerly NPM 12) - TR

Measure Status:	Active
Goal:	Increase the percent of youth ages 12--21 served by Child Health Specialty Clinics who have completed a transition checklist
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of DCCH ARNP patients ages 12--21 who have a transition checklist documented **Denominator:** Total number DCCH ARNP patients ages 12--21
Data Sources and Data Issues:	University of Iowa Health Care Electronic Medical Record
Evidence-based/informed strategy:	Strategy: Continue to provide direct services to youth with special health care needs and their families. The Standards for Systems of Care for CYSHCN includes transition to adult care as a key element of high performing pediatric care coordination. Initiation of the DCCH transition checklist is the first step in the implementation of assessments of transition readiness.
Significance:	The "percent of youth who have completed a transition checklist" is a process measure indicating the extent to which DCCH ARNPs initiate the transition to adulthood policy with youth. Measuring this is important to show progress because initiation of the process is necessary in order for appropriate policy implementation.

ESM PDV-Pregnancy.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator NPM – Percent of women who had a preventive dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

Measure Status:	Active
Goal:	Increase the number of medical practices receiving an outreach visit from an I-Smile Coordinator
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of medical practices received an outreach visit from an I-Smile Coordinator **Denominator:**
Data Sources and Data Issues:	Year end reports from local Title V agencies
Significance:	Partnering with local medical providers to do continued education for pregnant women on the importance of a dental visit will ensure the information is coming from a trusted source and will increase the number of patients with a dental visit in the past year.

ESM PDV-Child.1 - Number of medical practices receiving an outreach visit from an I-Smile Coordinator.
NPM – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child

Measure Status:	Active
Goal:	Increase the number of medical practices receiving an outreach visit from an I-Smile Coordinator.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** Number of medical practices who received an outreach visit from an I-Smile Coordinator **Denominator:**
Data Sources and Data Issues:	Year End Reports from local Title V agencies.
Significance:	Partnering with local medical providers to do continued education for pregnant women and children (1-17) on the importance of a dental visit will ensure information is coming from a trusted source and will increase the number of patients with a dental visit in the past year.

ESM SMK-Pregnancy.1 - Percent of pregnant women served by MH agencies who are screened for tobacco use with Ask, Advise, Refer
NPM – Percent of women who smoke during pregnancy (Smoking - Pregnancy, Formerly NPM 14.1) - SMK-Pregnancy

Measure Status:	Active
Goal:	Increase the percent of Maternal Health clients who are screened for tobacco use with Ask, Advise, Refer
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of maternal health clients who have been screened for tobacco use using the Ask, Advise, Refer **Denominator:** Total number of maternal health clients served
Data Sources and Data Issues:	Title V data system. Ensure agencies are documenting the screening and education appropriately.
Significance:	Ask, Advise, Refer is an evidence based product to screen for tobacco use with women. This will ensure Title V staff are appropriately screening and referring clients who need tobacco cessation services.

Form 11
Other State Data

State: Iowa

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
Part 1 – MCH Data Access and Linkages

State: Iowa

Annual Report Year 2023

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Annually	2		
2) Vital Records Death	Yes	Yes	Annually	3	Yes	
3) Medicaid	Yes	Yes	Daily	0	Yes	
4) WIC	Yes	Yes	More often than monthly	1	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	1	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	1	Yes	
7) Hospital Discharge	Yes	Yes	Annually	4	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Daily	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Iowa

Annual Report Year 2023

Products and Publications information has not been provided by the State.