

**FFY2017
Title V State Plan
State Performance Measures (SPMs)**

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What are State Performance Measures (SPMs)?

Iowa’s application for Title V funding reflects national efforts toward a transformed national performance measurement system that is intended to show more clearly the contributions of Title V programs in impacting health outcomes. SPMs are developed by the states to address the priorities identified based on the findings of the Five-year Needs Assessment and to the extent that a priority need has not been fully address through the selected National Performance Measures (NPMs). SPMs will utilize state-level data to track prevalence rates and work towards demonstrated impact. Collectively, the SPMs represent six MCH population health domains: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) CSHCN; 5) Adolescent Health; and 6) Cross-cutting or Life Course.

SPM 1: Percent of CYSHCN who meet criteria for Quality of Care

**Plan for the
Coming Year
(FFY2017)**

1. Shared Plan of Care

The Division of Child and Community Health (DCCH), as part of the HRSA Systems Integration Grant, is developing a Shared Plan of Care (SPoC) template and protocol recommendations to be used in coordinating care across systems for children and youth with special health care needs (CYSHCN). A SPoC will include information necessary to assure that issues affecting a child's health and health care are identified and accessible across systems. The SPoC will also document activities and accountability for addressing the child's health issues.

DCCH has identified a pilot population with whom to test the template and protocol recommendations. The pilot will run from April 2016 to June 2016 and will include a subset of children being served in the Pediatric Integrated Health (PIH) Program of Johnson County. Pilot partners include PIH staff, a local school district, and the targeted children's primary care providers.

In FFY 2017, DCCH will use the information learned from the pilot to scale up use of the SPoC. Using evaluation data provided by the National Resource Center for Family Centered Practice, DCCH will refine the SPoC template and protocols. DCCH will work with partners to identify the next targeted population and build buy-in with those stakeholders. DCCH will then implement the SPoC template and protocols with the new larger population.

2. Web-based Portal

DCCH's work with the HRSA Systems Integration Grant includes developing a web-based resource for CYSHCN, their families, and the providers that care for them. The website is called Iowa Child Health Connections, and it provides information on diagnoses, an interactive statewide map of resources, and a searchable database of thousands of services available to CYSHCN in Iowa. Content and design was developed in consultation with families, providers, care coordinators, and service providers from across the state.

During FFY 2017, DCCH will partner with the Iowa Chapter of the American Academy of Pediatrics and a local marketing firm to increase traffic to the website through a variety of marketing mediums. Also, DCCH will explore marketing the site through an application for mobile phones. DCCH will use Google Analytics and survey responses to improve the website's content and usability. Using a pop-up survey that asks users to fill out a longer survey, DCCH will gather data on a variety of site performance indicators. DCCH will work with other information and referral sites to explore coordination of databases.

3. Telehealth

DCCH has an established telehealth infrastructure for providing children, youth and their families access to specialists in the fields of psychiatry, genetics, neurology and nutrition. The infrastructure reaches a majority of Iowa counties that are medically under-served. DCCH recognizes the importance of providing designated telehealth hubs throughout Iowa to ensure that families can have a reliable connection to their healthcare specialist within a short distance from their homes. DCCH began using telehealth in 2004 and has built a network of 14 regional centers plus satellite locations to provide gap-filling clinical services to parts of Iowa with poor access to specialty healthcare.

For state performance measure (SPM) one, DCCH used the 2013 Rural-Urban Continuum Codes to identify low-access areas of Iowa. Counties designated as non-metropolitan areas (codes 4-9) are those that will be targeted in SPM one. Seventy-eight of the 99 counties in Iowa are coded in the range of 4-9.

In FFY 2017, DCCH plans to expand the telehealth network available to CYSHCN beyond the existing 14 regional centers by coordinating with the University of Iowa Health Care (UIHC) eHealth and eNovation Center ©. First steps include determining which eNovation sites currently connect CYSHCN with specialty UIHC care. DCCH will then collaborate with the remaining sites to ensure they can also be used to provide specialty services needed by CYSHCN in Iowa. DCCH also plans to identify telehealth hubs that exist through nationally accredited healthcare systems outside UIHC to prevent duplication of services and identify Iowa counties that have access to telehealth.

**Comments for
SPM 1**

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

**Plan for the
Coming Year
(FFY2017)**

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

Through Iowa's Title V Needs Assessment, the importance of establishing medical homes for all children and adolescents remains a high priority. A medical home is a partnership between the client, family, and primary provider in cooperation with specialists and supports from the community. Based upon data from the 2010 Iowa Household Health Survey, children in lower income groups were less likely to meet the definition of having a medical home than those at higher income levels. CYSHCN were less likely to have a medical home than children without special health care needs. Medical homes promote regular preventive medical and dental care and have been shown to reduce morbidity and mortality, hospitalizations, readmissions, and emergency room visits.

Bureau of Family Health (BFH) staff will continue to monitor data for the percent of children and adolescents served with a medical home. This is accomplished through reports from the Child and Adolescent Reporting System (CAREs). Local Child and Adolescent Health (CAH) contract agencies will continue to assess a child's medical home status with each contact (when providing presumptive eligibility, informing for new Medicaid eligibles, and gap-filling direct care services). Each local contractor enters this client information in CAREs, monitors medical home percentages for their service area, and reports at fiscal year-end. Statewide data is tracked and available on the Child Health Program Profile. During FFY 2017, the BFH will begin work on development of an integrated data

system that will incorporate data and services from seven of its programs, beginning with CAH.

As children and adolescents are assessed for medical home status, local CAH contractors will work to assure children have a medical home. Effective April 1, 2016, Iowa's EPSDT population will be assigned to one of three newly established Medicaid Managed Care Organizations (MCOs) with an assigned primary care practitioner (PCP). This practitioner may be their regular family doctor. In other instances, they may be assigned a new PCP. In this era of great change for Iowa families with children and adolescents on Medicaid, local CAH agency staff will promote health literacy by working to assure that families understand their health insurance coverage, know how to use it to access care, and assist with any needed transitions to new providers or new types of coverage.

Local CAH agencies will strive to advance public-private partnerships with local medical providers of preventive health care services, including educating practitioners on the CAH agency's role in serving children in the EPSDT program and the importance of establishing medical homes. This work is especially strong among CAH agencies that hold a contract for Iowa's 1st Five Healthy Mental Development Initiative. 1st Five builds partnerships between primary care practices and public service providers to promote high quality well child health care. It incorporates the use of developmental surveillance and screening tools that support healthy mental development for children ages 0-5 years. The tools address social-emotional development and family risk factors. Providers are able to identify children at risk for developmental concerns. Referrals from providers are made to CAH agencies to facilitate linkage to needed services. Although not yet statewide, 1st Five works in local CAH agencies operating in 65 of Iowa's 99 counties.

Local contract agencies will be working with primary care practitioners in the area of adolescent health, with a goal to increase the number of adolescents served and enhance the quality of the well visit. Agencies will partner with school districts and other adolescent serving organizations to promote adolescent well visits in an established medical home.

At the state level, BFH staff will work with the Iowa Medicaid Enterprise (IME) and MCOs to help facilitate a smooth transition for the EPSDT population. Of particular interest are establishing medical homes for EPSDT clients and population health strategies. Medical care coordination becomes a responsibility of the MCO and will no longer be reimbursed to local CAH agencies for a majority of the EPSDT population. CAH agencies want to work effectively with MCO coordinators of care to assure clients' needs are met. Other access to care issues may include transportation and interpreter services.

BFH staff will explore partnerships with health care provider workforce incentive

programs such as PRIMECARRE, J-1 Visa Waiver, and the National Health Services Corps. The goal will be to determine if there are opportunities to work together to increase access to care through medical homes.

BFH staff will work with Child Health Specialty Clinics regarding efforts to promote medical homes for children with special health care needs and assure appropriate resources for referral from CAH agencies.

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

Title V staff will assess the pregnant women's medical home status at each visit or contact and assure the client has a medical home. Assist families with health insurance literacy- helping them understand their coverage and how to use it to access providers and services.

Staff will work with pregnant women who may need transition from Medicaid to private insurance after delivery. This will be conducted through face to face contact through a home visit or clinic visit, when possible. If the client will not allow a home visit or clinic visit, phone care coordination will be provided.

Local Title V agencies will work with local medical practitioners and providers of preventive health care services, including face to face meetings on the role of Title V Maternal Health programs, working to help women get into a Medical Home for their pregnancy and finding a Medical home for their infant as well.

Staff will educate women after delivery on the Family Planning Waiver to make sure women understand that if Medicaid paid for their delivery they can receive birth control at no cost to them for a year after their birth.

**Comments for
SPM 2**

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

**Plan for the
Coming Year
(FFY2017)**

Staff within the Bureau of Oral and Health Delivery Systems will partner with Iowa Medicaid Enterprise and *hawk-i* dental carriers to monitor enrollment data, identify strategies to increase enrollment, and collaborate on outreach and health promotion ideas. OHDS staff will also maintain communication with Medicaid's managed care organizations to exchange information about barriers and available payment options for dental care.

Through regular meetings, correspondence, and site visits, OHDS staff will assist I-Smile coordinators to identify ways to reach uninsured families. I-Smile

coordinators will assure that parents of children receiving preventive services (at WIC, child care, schools, and other locations) that do not have a payment source for dental care receive care coordination and are informed of payment options. Coordinators will be required to conduct outreach to dental offices about payment options for uninsured families and to also ensure that other MCH staff members have basic understanding about insurance options for families served. Expansion of the school-based sealant program provides more opportunities for outreach to school nurses regarding dentally uninsured children. Information about payment resources will be shared with sealant program coordinators at their annual meeting. In addition, I-Smile coordinators will be asked to encourage medical and dental offices to do presumptive eligibility.

**Comments for
SPM 3**

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

**Plan for the
Coming Year
(FFY2017)**

The federal Child Care Development Block Grant Health and Safety training and Emergency Preparedness Plan requirement for all child care providers will be a focus for CCNCs in FY17. CCNCs will have the opportunity to provide services to child care providers who may have not requested services in the past. The Health and Safety training modules include information that are health focused (Medication Administration, Food Allergies, Infectious Disease Prevention including Immunizations, etc.) and resources available on the IDPH and HCCI websites. CCNCs are a vital resource for health and safety information for child care providers. State and regional support of local CCNCs will continue in FY17 with 2 state and 2 regional meetings. Connecting local CCNCs with their regional technical assistance consultant and other CCNCs in their area will improve collaboration, consistent data collection/reporting, and encourage sharing of ideas for outreaching to early care and education providers.

**Comments for
SPM 4**

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

**Plan for the
Coming Year**

Adolescent Health Coordinators will work with the Iowa Department of Education to identify existing programs or initiatives to collaborate on and expand upon. This

(FFY2017)

information will be shared with MCAH agencies.

Adolescent Health Coordinators will discuss SPM #5 with the Adolescent Health Collaborative and Iowa State University Extension to identify gaps in educational delivery and gather additional community resources.

MCAH agencies will continue screening for physical activity within MCAH programs.

BFH will continue to promote IAMincontrol that has information about physical activity and nutrition for the adolescent population.

**Comments for
SPM 5**

General Comments

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