Young children’s health care critically impacts their healthy growth, educational, and social success. Children need a health care system that ensures they receive regular, preventive, and comprehensive evidence-based health services.

Over the last five years, Iowa has become a leader in developing a comprehensive child health system. To continue to lead, the Off to a Good Start Coalition offers specific policy recommendations to improve Iowa’s child health services across six goal areas. The policies outlined in this document are research and evidence-based and demonstrate successful health outcomes for children if implemented. These policies are needed to ensure young children’s health, reduce health disparities, and achieve long-term cost savings and health benefits.
Goal One: Increase access to and use of quality social, emotional and mental health services.

1. Assure that all primary health care providers have the knowledge and skills to incorporate developmental and behavioral screening into their practices by identifying a source of state match for the Healthy Child Development Provider Training Initiative.

2. Build community systems of care to identify and link young, at-risk children and families to appropriate services by expanding Iowa’s 1st Five Healthy Mental Development Initiative.

3. Develop a statewide network of behavioral health providers skilled in treating young children with challenging behaviors and families with multiple risks by identifying training strategies and securing funding to give providers the necessary skills.

4. Require all insurers to cover developmental and behavioral services for children.

Goal Two: Increase access to and use of preventive health services.

1. Secure additional funding to build upon the 1st Five Healthy Mental Development Initiative.

2. Develop and adopt child health quality measures to ensure that children receive appropriate preventive health services.

3. Incorporate nutrition and physical activity counseling as part of primary care coverage for young children under Medicaid and hawk-i (healthy and wells kids in Iowa, Iowa’s State Children’s Health Insurance Program, now CHIP program).

4. Allow Medicaid primary health care providers to be reimbursed for providing preventive (well-child) care on the same day as a “sick child” visit.

Goal Three: Increase the number of children with a medical home.

1. Continue to develop and sustain the Iowa Medical Home System Advisory Council to promote the medical home concept as a standard of care for all Iowa children.

2. Engage health care providers (including but not limited to: physicians, dentists, pharmacists, nurse practitioners, physician assistants, nurses, dental hygienists, chiropractors, dietitians, and physical therapists), their professional organizations, and public and private insurers to support the development of medical homes across Iowa.

3. Build and support a patient-centered medical home system that integrates and connects clinical practices, (including primary and specialty care), other community-based services, and families so as to deliver the highest quality of care in the most efficient manner.

Goal Four: Increase the number of children with a dental home.

1. Maintain funding for I-Smile to improve local public health infrastructure through use of dental hygienists within Title V to create systems for treatment referrals, preventive dental services, health care provider trainings, and education for underserved children and their families.

2. Promote state health care reform policy to include a stand alone hawk-i dental plan that prevents children with medical insurance from becoming eligible for hawk-i dental benefits.

3. Seek a legislative commission to review national examples of alternative dental workforce models with the potential to expand oral health services within Iowa rural communities, and increase use of the dental hygiene workforce, including development of minimum standards to work as public health professionals with less restrictive supervision requirements.

Goal Five: Increase the number of children with health care coverage.

1. Expand coverage under Medicaid and hawk-i to income-qualifying immigrant children.

2. Develop streamlined and presumptive eligibility and simplified re-enrollment programs under Medicaid and hawk-i.

3. Create a “wrap around” premium assistance program for hawk-i to complement employer-sponsored coverage for hawk-i eligible families.

4. Ensure affordable child health coverage for all families that offers comprehensive benefits.

5. Create a dental coverage-only option under hawk-i.

Goal Six: Increase access to and use of preventive health services and prenatal care services for women and men of reproductive age.

1. Extend Medicaid coverage to low-income non-pregnant women through family planning or other waivers and/or through hawk-i.

2. Include a Medicaid waiver for women with post partum depression or other behavioral health problems in Iowa.

3. Secure coverage for tobacco-use screening and cessation counseling for all women of reproductive age.

4. Improve access to nurse midwives and doulas for low risk pregnant women.
Social-emotional development in the young child provides a crucial foundation for later growth and achievement. Children who do not attain social-emotional milestones are at far greater risk for school failure, juvenile delinquency, and welfare dependency. In Iowa, there has been a significant increase in the number of children needing special education or remedial services due to behavioral problems.

Over the last decade, new tools have been developed to identify young children who are at-risk for social-emotional or behavioral problems, and evidence-based interventions have been developed to help children in need. Iowa has made a good start in addressing the need to identify and intervene with young children and families at-risk for long-term emotional or behavioral problems. We need to continue to build upon those efforts.
**Goal 1:** Increase access to and use of quality social, emotional and mental health services.

### 2009 Policy Recommendations:

1. **Assure that all primary health care providers have the knowledge and skills to incorporate developmental and behavioral screening into their practices by identifying a source of state match for the Healthy Child Development Provider Training Initiative.**

   **Rationale:** Building upon the success of Iowa’s ABCD II Healthy Mental Development demonstration project, this initiative has relied on grant funding to draw down matching federal Medicaid dollars. The project has proven successful but needs a continuing source of state matching funds for the next three years to achieve its goal.

2. **Build community systems of care to identify and link young, at-risk children and families to appropriate services by expanding Iowa’s *1st Five* Healthy Mental Development Initiative.**

   **Rationale:** This successful Iowa Department of Public Health community-based initiative now operates in four of Iowa’s Title V Maternal and Child Health regions. Level funding is required to maintain the program; increased funding is needed to implement the program statewide.

3. **Develop a statewide network of behavioral health providers skilled in treating young children with challenging behaviors and families with multiple risks by identifying training strategies and securing funding to give providers the necessary skills.**

   **Rationale:** While current parent education programs offered through Community Empowerment meet the needs of many families, more individualized intervention is required to help children and families with more intensive needs. Iowa currently has very few providers who have the skills required to work with the more challenging young child and family.

4. **Require all insurers to cover developmental and behavioral services for children.**

   **Rationale:** Currently, few insurers outside of Medicaid’s EPSDT program cover developmental/behavioral services. Health care plans should be required to provide coverage for developmental surveillance and screening for all children, as well as coverage for evidence-based behavioral and medical interventions for mental health conditions and neurodevelopmental disabilities, including intellectual disabilities and autism spectrum disorders.
Research shows the importance of children’s early years in promoting health, learning, and school readiness and demonstrates the crucial need to identify and mediate risks that can compromise later functioning. Regular, preventive (well-child) care monitors a child's health status and provides age-appropriate immunizations. Such care allows screening for lead exposure and dental problems, as well as for developmental, behavioral and family risks. It also provides families with preventive counseling on appropriate topics such as feeding, development and safety issues.

Evidence suggests not all Iowa children receive the preventive health services they need. In the 2005 Iowa Child and Family Household Health Survey, only 46 percent of the parents of young children remembered receiving preventive health counseling in the past year from a health care provider. Only 41 percent reported that their child had received a developmental assessment in the previous year.
Goal 2: Increase access to and use of preventive health services.

2009 Policy Recommendations:

1. Secure additional funding to build upon the 1st Five Healthy Mental Development Initiative.

   Rationale: Prevention strategies that focus on the social emotional needs of young children represent a substantial return on investment. Innovative partnerships between primary health care providers and four (4) child health agencies (Polk, Dubuque, Lee, and Marion counties) are demonstrating significant improvements in the quality of developmental screening including social-emotional development. These partnerships dramatically improved preventive health care to over 50,000 children (ages birth to five) and linked families at risk for poor health outcomes with local services. Additional communities are ready to implement the model; however, without additional funding, 1st Five is unable to expand to new communities.

2. Develop and adopt child health quality measures to ensure that children receive appropriate preventive health services.

   Rationale: “The U.S. health care delivery system does not provide consistent, high-quality medical care to all people. Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge - yet there is strong evidence that this frequently is not the case” (Crossing the Quality Chasm: A New Health System for the 21st Century; Institute of Medicine, March 2001). Use of quality measures will encourage enhanced standards of pediatric preventive care, which, in turn, will increase the likelihood of improved health outcomes and reduced costs.

3. Incorporate nutrition and physical activity counseling as part of primary care coverage for young children under Medicaid and hawk-i.

   Rationale: The prevalence of overweight among children is a serious policy concern. The CDC reports a 45 percent increase between 1988 and 1999. Adding nutrition and physical activity counseling to the primary care coverage under Medicaid and hawk-i would help to reduce insurance premiums in the long run. Research also shows that 80 percent of the adult disease could be dramatically reduced if addressed during the early years of a child’s life.

4. Allow Medicaid primary health care providers to be reimbursed for providing preventive (well-child) care on the same day as a “sick child” visit.

   Rationale: Most families can and will return for separate health care visits, but some, usually those at greatest risk, only overcome barriers to see the practitioner when their child is sick. Providers want the opportunity to address preventive health needs when the child makes it to the office. Currently, Iowa Medicaid policy does not allow practitioners to bill for preventive care when it is provided on the same day as a “sick child” visit. Iowa’s ABCD II project recommendations to Medicaid advocated a change in this policy.
The Medical Home System Advisory Council was established by the 2008 Iowa Health Care Reform legislation (HF 2539). The purpose of the Council is to assist the Iowa Department of Public Health to develop a medical home system consistent with both the 2007 Joint Principles of the Patient-Centered Medical Home and the 2002 American Academy of Pediatrics (AAP) policy statement that a medical home for infants, children, and adolescents should be accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Iowa’s medical home system will strive to:

- Reduce disparities in health care access, service delivery, and health status.
- Improve quality of health care and lower health care costs, thereby creating savings to allow more Iowans to have health care coverage within a sustainable health care system.
- Provide a pragmatic method to document that each Iowan has access to health care.

The first phase of this initiative is to implement medical homes for children enrolled in Medicaid. The goals and evidence-based quality measures for implementing a medical home for children include but are not limited to: childhood immunization rates, well-child care utilization rates, care management for children with chronic illnesses, emergency room utilization, and oral health services utilization.
**Goal 3:** Increase the percentage of children with a medical home.

2009 Policy Recommendations:

1. Continue to develop and sustain the Iowa Medical Home System Advisory Council to promote the medical home concept as a standard of care for all Iowa children.

   **Rationale:** The Council is the designated body to plan and implement the medical home-related provisions of Iowa’s health care reform legislation. In that capacity, the Council’s leadership would be highly influential in spreading and sustaining the concept.

2. Engage health care providers (including but not limited to: physicians, dentists, pharmacists, nurse practitioners, physician assistants, nurses, dental hygienists, chiropractors, dietitians, and physical therapists), their professional organizations, and public and private insurers to support the development of medical homes across Iowa.

   **Rationale:** Making the medical home a standard of care is a systemic change of such large magnitude that complete or near complete participation of the provider, payer, and professional association communities is needed to expedite and assure success.

3. Build and support a patient-centered medical home system that integrates and connects clinical practices, (including primary and specialty care), other community-based services, and families so as to deliver the highest quality of care in the most efficient manner.

   **Rationale:** Characteristics of the medical home model include connections among and between health and other community providers; and meaningful partnerships between providers and the families served. Without meeting these defining characteristics, a practice cannot be a true medical home.
The I-Smile dental home initiative is working to ensure oral health care for at-risk families. Since initial implementation in 2006, the number of Medicaid-enrolled children that received important preventive dental care through the local Title V child health agencies has more than doubled; and nearly 13 times as many fluoride varnish applications are being provided to children under three years of age by medical practitioners.

However, barriers still exist. Services for Medicaid-enrolled children provided by dentists has merely increased marginally, primarily due to a shortage of dentists in rural Iowa, low Medicaid reimbursement, and limited access to pediatric dentists for children younger than three years of age. In addition, 25 percent of Iowa children have no payment source for dental services.
Goal 4: Increase the number of children with a dental home.

2009 Policy Recommendations:

1. Maintain funding for I-Smile to improve local public health infrastructure through use of dental hygienists within Title V to create systems for treatment referrals, preventive dental services, health care provider trainings, and education for underserved children and their families.

   Rationale: The I-Smile initiative is increasing access to care, especially preventive dental care, for at-risk families. Twenty-four dental hygienists work as local I-Smile Coordinators around the state and are creating referral networks with dentists, providing training to medical practitioners about children’s oral health, and providing oversight of provision of preventive services for children at WIC clinics, child care facilities, preschools, and schools. As a result, in the past year 21 percent more Medicaid-enrolled children received a dental service than prior to I-Smile.

2. Promote state health care reform policy to include a stand-alone hawk-i dental plan that prevents children with medical insurance from becoming eligible for hawk-i dental benefits.

   Rationale: Several Iowa families are eligible for medical insurance through employers, but may not have the option of dental insurance. According to the Surgeon General, children without dental insurance are three times more likely to have unmet dental needs than children with public or private insurance.

3. Seek a legislative commission to review national examples of alternative dental workforce models with the potential to expand oral health services within Iowa rural communities, and increase use of the dental hygiene workforce, including development of minimum standards to work as public health professionals with less restrictive supervision requirements.

   Rationale: Dentists in Iowa are aging and retiring. In addition, many general dentists limit the number of Medicaid patients and approximately half always refer children younger than three years of age to pediatric dentists. There are a limited number of pediatric dentists in the state and most are located in urban areas. Reviewing alternative workforce models – which may include expanded functions of dental hygienists and assistants – would enhance available services to at-risk families, particularly in rural Iowa.
The first step for children to receive comprehensive, consistent, primary and preventive health services is for them to have good health care coverage. Currently, approximately 7 percent of Iowa’s children (35,000 to 45,000) do not have health care coverage. The majority of these children are eligible for Medicaid or hawk-i, both of which provide comprehensive coverage and already cover one-third of Iowa’s young children. There also are additional children who have very limited health care coverage. While Iowa has a strong Medicaid and hawk-i program, there are additional needed state actions to help assure that all children have access to affordable coverage.
Goal 5: Increase the number of children with health care coverage.

2009 Policy Recommendations:

1. Expand coverage under Medicaid and **hawk-i** to income-qualifying immigrant children.

   **Rationale:** Immigrant children are those most likely to be uninsured in Iowa, in large measure because Medicaid and **hawk-i** deny coverage until they have lived in the country at least five years. While immigrant children often receive health services for emergencies and illnesses through safety net providers, lack of health insurance means they are much less likely to receive primary and preventive health services or have a medical home. Iowa should take the lead from other states that have opted to cover immigrant children under their Medicaid and SCHIP programs, even if this means the state pays the full share of the costs.

2. Develop streamlined and presumptive eligibility and simplified re-enrollment programs under Medicaid and **hawk-i**.

   **Rationale:** Experience shows that simplified eligibility procedures and streamlined re-enrollment processes are important both to getting children enrolled in Medicaid and **hawk-i** and maintaining their enrollment. Last year, the General Assembly established continuous eligibility under Medicaid that has improved enrollment and retention. This year, the General Assembly should establish presumptive eligibility, further streamline processes, and simplify re-enrollment procedures, based upon best practices from other states.

3. Create a “wrap around” premium assistance program for **hawk-i** to complement employer-sponsored coverage for **hawk-i** eligible families.

   **Rationale:** Parents who have employer-based health coverage but whose children are eligible for **hawk-i** should not have to make hard choices on where their children are covered. The state should develop a premium assistance program for **hawk-i** that ensures children receive comprehensive coverage at affordable rates, building upon the employer's coverage where appropriate.

4. Ensure affordable child health coverage for all families that offers comprehensive benefits.

   **Rationale:** Even when families have incomes above 300 percent of poverty (the current limitation for eligibility for **hawk-i**), they do not necessarily have access to affordable child health coverage. Families can be expected to pay a fair share for child health coverage, but this should not exceed 6 percent of their overall income. The state needs to subsidize coverage to child health coverage in those instances.

5. Create a dental coverage-only option under **hawk-i**.

   **Rationale:** When families insure their children through employer-sponsored coverage, the coverage does not always include dental coverage. Allowing eligible families to purchase a dental only option under **hawk-i** would assure that children are not under-insured as well as keep them on employer-sponsored coverage.
Goal 6
Increase access to and use of preventive health services and prenatal care services for women and men of reproductive age.

Identifying maternal disease and risks for complications of pregnancy or birth during the prenatal period or early in pregnancy helps improve birth outcomes. Appropriate prenatal care management can also have a significant effect on the incidence of low birthweight (LBW), the risk factor most closely associated with neonatal mortality. Many risk factors for poor birth outcomes could be addressed with increased access to and with utilization of preventive health services and prenatal care service.
Goal 6: Increase access to and use of preventive health services and prenatal care services for women and men of reproductive age.

2009 Policy Recommendations:

1. Extend Medicaid coverage to low-income non-pregnant women through family planning or other waivers and/or through hawk-i.

   Rationale: This expanded coverage would allow for preconception care and adequate postpartum and interconceptional care for women otherwise unable to access health insurance. The first priority would be to cover women with a prior at-risk pregnancy. The health of a mother impacts the health of the fetus. Pre-conception counseling allows health care providers the opportunity to identify and modify biomedical, behavioral and social risk to the woman's health or pregnancy outcome through prevention and management.

2. Include a Medicaid waiver for women with postpartum depression or other behavioral health problems in Iowa.

   Rationale: The waiver would allow postpartum women to remain on Medicaid for one year following the birth of their infant. This waiver would provide women otherwise unable to access health insurance, coverage for mental health counseling, behavioral health medication and care coordination. Depression is one of the most prevalent and high-risk problem during pregnancy about 21 percent of new mothers have a major depressive episode during the first year postpartum. Untreated depression causes not only suffering for the women, but left untreated may affect the quality of the mother-child interaction. This adversely affects the subsequent emotional, behavioral and cognitive development of the child.

3. Secure coverage for tobacco-use screening and cessation counseling for all women of reproductive age.

   Rationale: Refer any willing clients to Quitline Iowa for ongoing telephone counseling. Support reimbursement to providers for tobacco cessation screening and counseling. There is considerable evidence that these anti-tobacco interventions are effective, can improve both maternal and child health and save health care dollars. Avoid induction or planned cesarean before the thirty-seventh completed week of pregnancy unless there is a strong medical reason. Prematurity causes increased risk and cost. Important development of the fetal lungs and brain occur in the last few weeks of gestation. Pregnancy induction increases risk of cesarean delivery and the maternity costs.

4. Improve access to nurse midwives and doulas for low risk pregnant women.

   Rationale: Evidence from the Cochrane review comparing midwife care to other models showed clients were less likely to experience labor induction, labor augmentation, electronic fetal monitoring, pain medications, cesarean section assisted vaginal birth and episiotomy leading to lower costs while maintaining quality of care and client satisfaction. This policy strategy would improve access to care in rural settings.