



Assuring a System of Care for Iowa's Children and Youth with Special Health Care Needs

Social Determinants of Health Report Part C Recommendations

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PART C AND ADDRESSING SOCIAL DETERMINANTS OF HEALTH: OPPORTUNITIES FOR ACTION IN IOWA

Recommendations Related to Child Family Policy Center (CFPC) work with University of Iowa Child Health Specialty Clinics prepared by Charles Bruner, CFPC, June 30, 2011

The Notebook CFPC has developed regarding the social determinants of health shows that there is a very substantial number of young children (0 to third birthday) who, while not currently diagnosed with developmental delays or other disabilities, are at risk of starting school significantly behind their peers, to the extent that extensive remediation will be needed for them to progress reasonably well through school and be able to benefit from regular classroom and course instruction. The proportion of young children who fall within the category is at least 15% to 25% of all Iowa 0-3 year olds. Currently, Iowa's Part C program serves about 3% of Iowa's 0-3 year-olds at any one time. While Part C may not be the appropriate vehicle for serving all young children who fall within this category and some may be receiving services through other programs (home visiting, parenting education, family counseling, and behavioral health services), there is the potential for Part C, with sufficient resources and staffing to do so, to serve additional children within this group. The federal government offers states broad discretion in determining eligibility for Part C to enable Part C to serve preventive and very early intervention purposes, as well as to serve children with clearly diagnosable developmental delays and disabilities. Ideally, Iowa would expand its definition to include "environmental risk" and provide a broader range of services to children and families to prevent developmental delays from arising. Simply changing the definition, however, would not necessarily result in expanding services or providing needed and appropriate services to this population. There are a number of actions that Part C could undertake that could help take needed steps to assess how, where, and if expansion of Iowa's definition of eligibility and provision of Part C services makes sense.

- Conduct additional analyses of the children served under Part C by geography and family demographics, to determine if there are areas and subpopulations that are likely to be "underserved" by Part C services.

Analyzing the number of children served under Part C by county and sub county/census tract areas could identify areas of relatively high and low service penetration, based upon the young child population in those areas. Some of this can be done by geo-mapping Part C participants and connecting Part C information with census information. Some of this can be done by using the statewide longitudinal data base and demographic information on children in kindergarten to trace back the extent of use of Part C by different subpopulations (FRM, race, ELL, etc.), as well as by geography.

- Work to maximize the use of the infant and toddler provision within EPSDT to provide services to young children and their families.

Iowa has an infant and toddler provision within Medicaid that can be a substantial funding source for Part C services, but it currently constitutes a billing source for a very small share of the actual services provided under Part C. Given that Medicaid serves 40%

of all children 0-3 years in Iowa (and more than 60% of those with special health care needs), this funding source may well be underused by Part C programs and, if more extensively used, could help Part C expand its reach.

- Recommend a similar provision to the Medicaid provision within hawk-i and private health insurance and incorporate this within the implementation of “evidenced-informed” primary care (Bright Futures) within the Affordable Care Act (ACA).

The ACA requires that all health insurers provide primary and preventive health services under their coverage for children, essentially following the provisions of Bright Futures. While not defined in detail in the federal statute, this provision is one of those that could be most important to extending developmental health services to young children. This may involve work with the Insurance Commissioner and the Insurance Department and it also may involve work with the Magellan in its child mental health coverage service system under “remediation services.”

- Design and test strategies to engage in outreach for Part C services within areas and subgroups where data would suggest there is an under-identification of children eligible for Part C.

This could be done within Project LAUNCH and within other initiatives where there is an emphasis upon more comprehensive responses to young children’s healthy development. Some of this could involve use of the quality improvement model for developing practice change strategies (Plan, Do, Study, Act ((PDSA). Such work can be very useful in identifying and responding to barriers that can be related to language, culture, and living in poverty.

- Analyze the impact of using prematurity as an eligibility definition for Part C and whether there are other factors at birth that also might be used to identify candidates for Part C services.

Part C’s use of pre-maturity as an eligibility criteria for Part C is likely responsible for the relatively high rate of involvement of 0-1 year-olds in Part C in Iowa in comparison with other states, although this rate is still well below that for 1-3 year olds. Part C can use its experiences in employing pre-maturity to determine how it has benefited families and where other factors around the birth of a child also might be employed to identify families who would benefit from such services.

- Expand the definition of Part C to include “environmental risk” and develop protocols for working with families at environmental risk to support their child’s development.

Ideally, Iowa would use the broadest possible definition for eligibility for Part C services (and incorporate most services provided under Part C within Medicaid, hawk-i, and private health insurance funding). Implementing the previous recommendations would help to establish the knowledge base and the professional capacity to do this most effectively. It also could enable some calculations of the overall value of such preventive services to reducing the need for future remediation services and costs.