1st Five components

Health providers, coordinators and families

1st Five is a public-private partnership operating in 49 Iowa counties. Participating health providers can refer children birth to age 5 with identified social, emotional or developmental concerns to 1st Five. Care coordinators work with families to identify risk factors and connect them to appropriate services. 1st Five continues to work with the family and update the provider on the outcome of the referral.

Evaluation by the Child and Family Policy Center for

1st Five
Healthy mental development in the first five years

IDPH
Iowa Department of Public Health

1st Five Healthy Mental Development Initiative

Summary of Evaluation Findings

More than one in five Iowa children ages four months to 5 years are at moderate or high risk of developmental, behavioral or social delays.[1] Among children at risk for developmental delays, only 50 percent are detected prior to school entry, when early intervention has the greatest impact.[2] Health providers play a key role in identifying the factors that hinder healthy development. In fact, more than nine of 10 young Iowa children visit a health provider for preventive health care[3]—far more than use any other formal support system. This makes 1st Five a critical strategy for reaching children in need.

In 2014, Iowa lawmakers, understanding the value of the initiative, expanded the appropriation for 1st Five. This boost increased the capacity of the seven implementation sites and allowed the four community planning sites to transition to full implementation. Now, all 11 sites support providers in implementing developmental surveillance and screening and offering care coordination and community coalition building.

KEY FINDINGS AND RECOMMENDATIONS

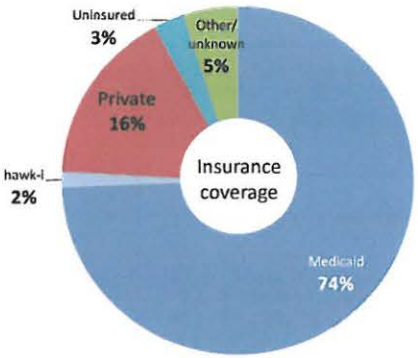
- **1st Five is helping more children.** In 2014, 1st Five supported the healthy mental development of over 1,000 young children. Nearly 8,000 children and families have been referred to 1st Five since 2007. The top reasons for referral are hearing/speech concerns (2,165), followed closely by parent/family stress (2,164).

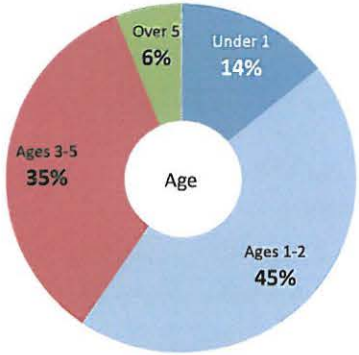
"I used to worry I was not meeting the needs of the families I worked with due to time constraints. Since our clinic began working with 1st Five a few months ago, **I feel the collaboration provides individualized, family-centered care that makes an immediate and tangible difference.** As a result, homeless children now have housing. Patients with developmental delays are attending therapy sessions, even if transportation is a barrier. I am so grateful we have this wonderful program to help us care for our youngest patients and their families."

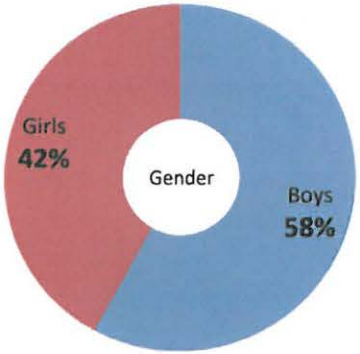
Sarah Kersevich, ARNP
Unity Point Pediatric Clinic, Muscatine

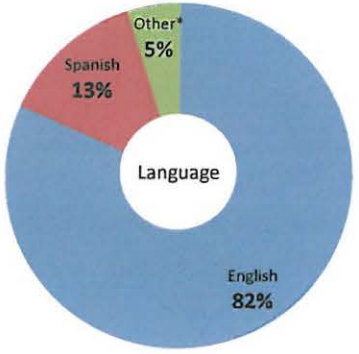
- **Increased staffing—allowing sites to focus on provider outreach and engagement—is expanding the number of practices engaged in 1st Five** (the state funding increase has allowed each site to be staffed by a full-time site coordinator). For example, Lee County Health Department was able to increase the number of engaged practices from 1 in 2013 (prior to the hiring of a full-time coordinator) to 11 in 2014 (after the hire). The site experienced a corresponding increase in referrals of 250 percent in the same period. Statewide, the number of 1st Five practices increased by over 150 percent from 2013 to 2014.

About children served by 1st Five







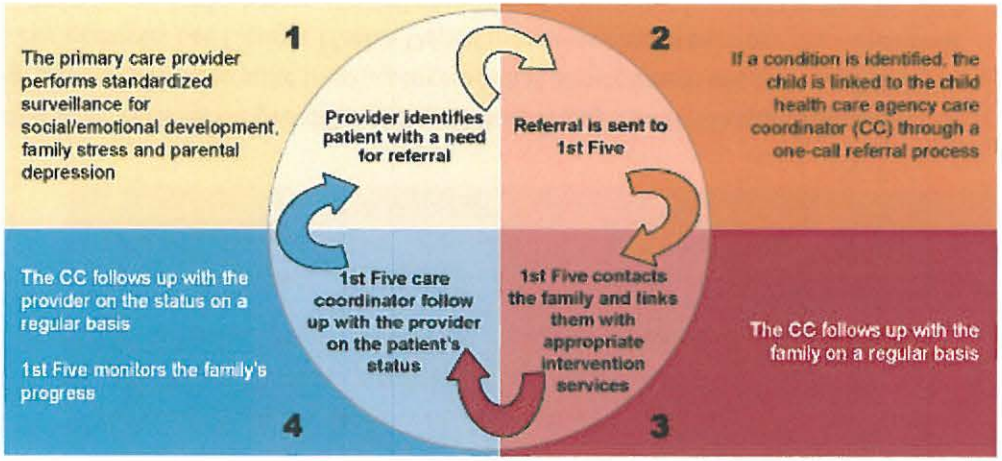


- **1st Five is connecting more families** to community resources to address family stress, caregiver depression and other environmental factors that can create toxic stress. Since 2007, over 19,000 connections to local resources have been made for families across 1st Five sites, up from 16,654 in 2013.

- **1st Five meets families where they are, regardless of their level of need, income or insurance status.** Providers value 1st Five's capacity to help all families. 1st Five works both with families that have very complex cases and require numerous referrals and on-going support *and* with families who only need minimal support. These families may not meet requirements to be eligible for other care coordination services but are able to access 1st Five because the initiative does not require children to have a specific diagnosis to participate. Similarly, 1st Five works with families at all income levels. While most children served by 1st Five are covered by Medicaid, almost 20 percent have private insurance or hawk-*i*.

- **Services gaps and community resource shortages exist.** Coordinators are often challenged by a lack of timely access to resources like mental health services and affordable housing. Even when resources are available in a community (in both rural and urban Iowa), many families struggle to access services due to transportation and language barriers. Still, 1st Five works to connect families to some professional or community-based service that helps them or their children.

1st Five care coordinators are the link between health providers and a broad range of community services



Source: 1st Five Healthy Mental Development Initiative

Among participating families who took a 1st Five satisfaction survey:

- Nearly **80 percent** were "completely" or "mostly" satisfied
- **16 percent** were "somewhat" satisfied
- Only **3 percent** were "slightly" or "not at all" satisfied

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For more information on this evaluation, contact Michelle Stover Wright (michellesw@cfpciowa.org) or Mary Nelle Trefz (mnt@cfpciowa.org).

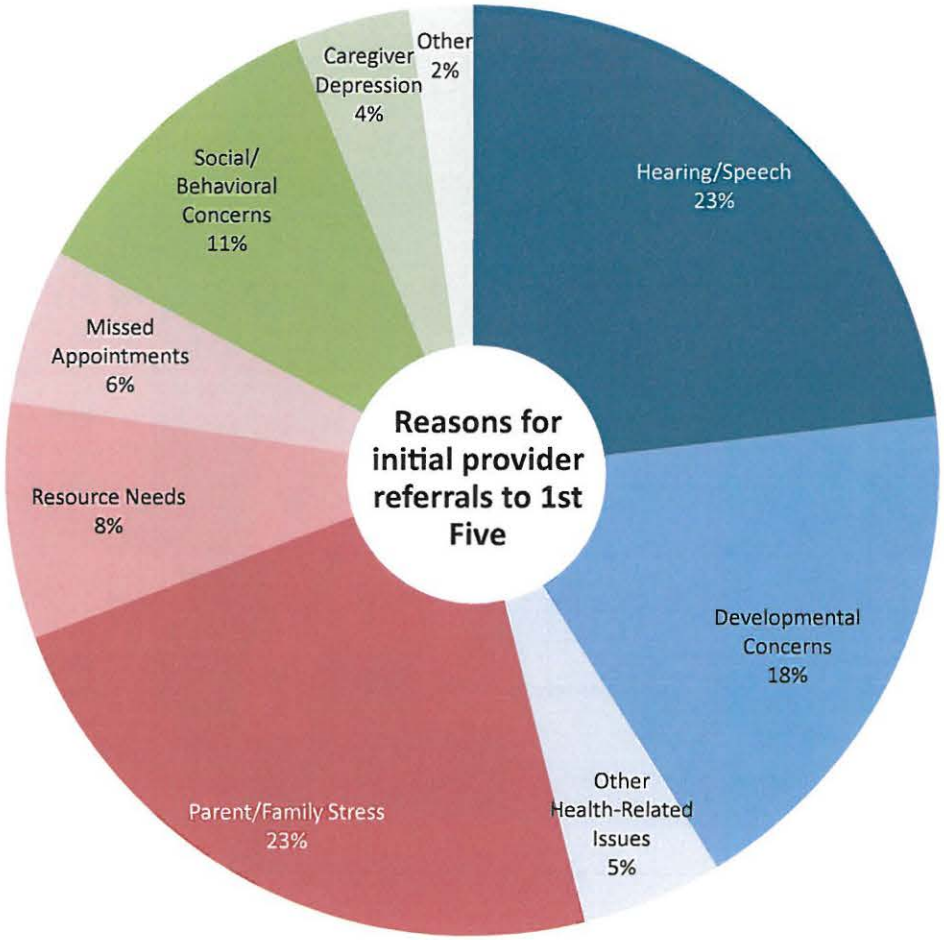
For general information on 1st Five, contact Michelle Holst (Michelle.Holst@idph.iowa.gov) or Rebecca Goldsmith (Rebecca.Goldsmith@idph.iowa.gov).

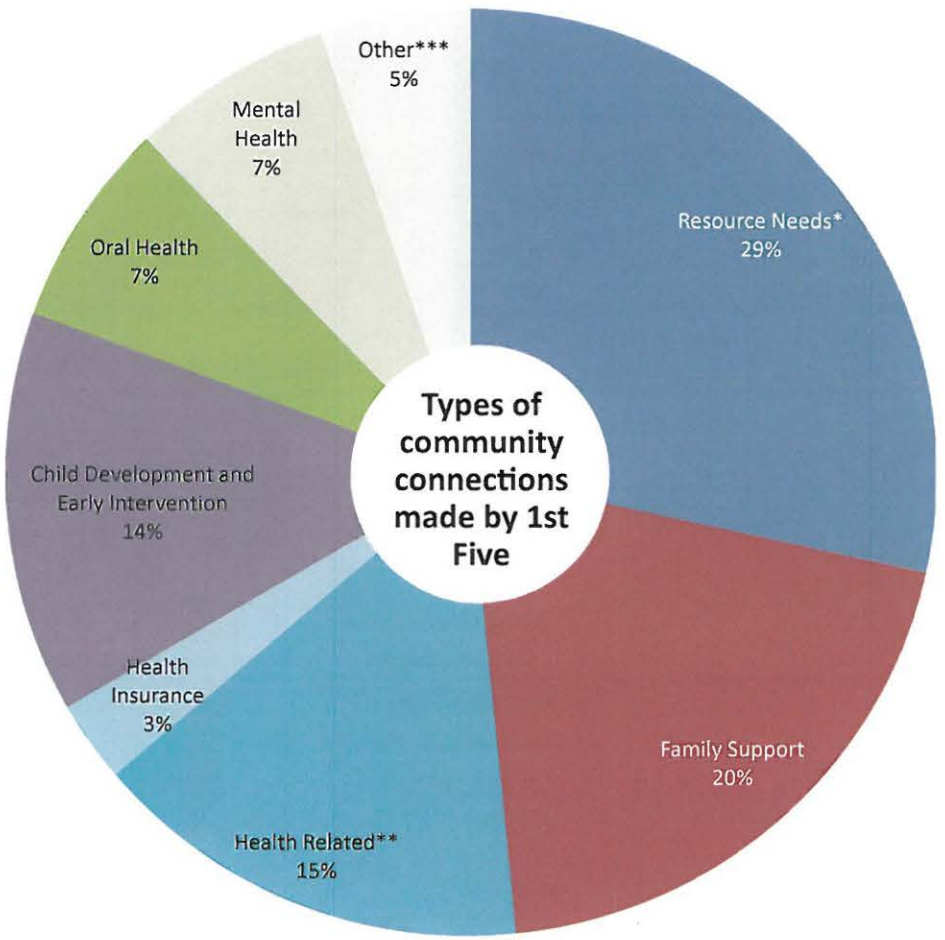
* Chinese, Burmese, Chin, Karenni, Vietanamese, Bosnian, Arabic, and Marshallese.

Sources:

[1] Child and Adolescent Health Measurement Initiative (CAHMI), National Survey of Children's Health, 2011.
[2] Centers for Disease Control and Prevention.
[3] CAHMI, 2011.
[4] Harvard Center for the Developing Child.

1st Five bridges health-provider referrals and community resources





When a health provider identifies a family need through surveillance or screening, she makes a referral to 1st Five.

Of 9,359 needs identified among 7,588 families, 46 percent were for health or developmental concerns, including speech and hearing (blue). Another 37 percent of referrals were connected to family stress and day-to-day resource needs (red). The final 17 percent ranged from caregiver depression and social and behavioral worries to language barriers and parent education needs (green).

After a referral, 1st Five coordinators work with the family to identify resources addressing the family's needs.

Of 19,223 connections, 29 percent were for resource needs (blue), 20 percent for family-support services (red), 18 percent for health-related needs (aqua) and 14 percent for early-intervention services (purple). The remaining 20 percent were for oral- and mental-health care and other family needs (green).

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* **Resource-need referrals** are for supports such as food, transportation, housing, child care/preschool, energy and baby supplies.

** **Health-related referrals** are for services such as lead screening, vision, immunizations, hearing assessments, nutrition and care at the Child Health Specialty Clinics.

*** **Other referrals** are for services like domestic violence support, legal and translation services and resource guides.

1st Five coordinators help families with wide variety of needs

Here's a real-life example of how the 1st Five referral and care coordination process works:

A 3-year-old boy was referred to the 1st Five initiative for speech concerns. Through enhanced care coordination, his speech needs were assessed, and he began speech therapy via the local AEA.

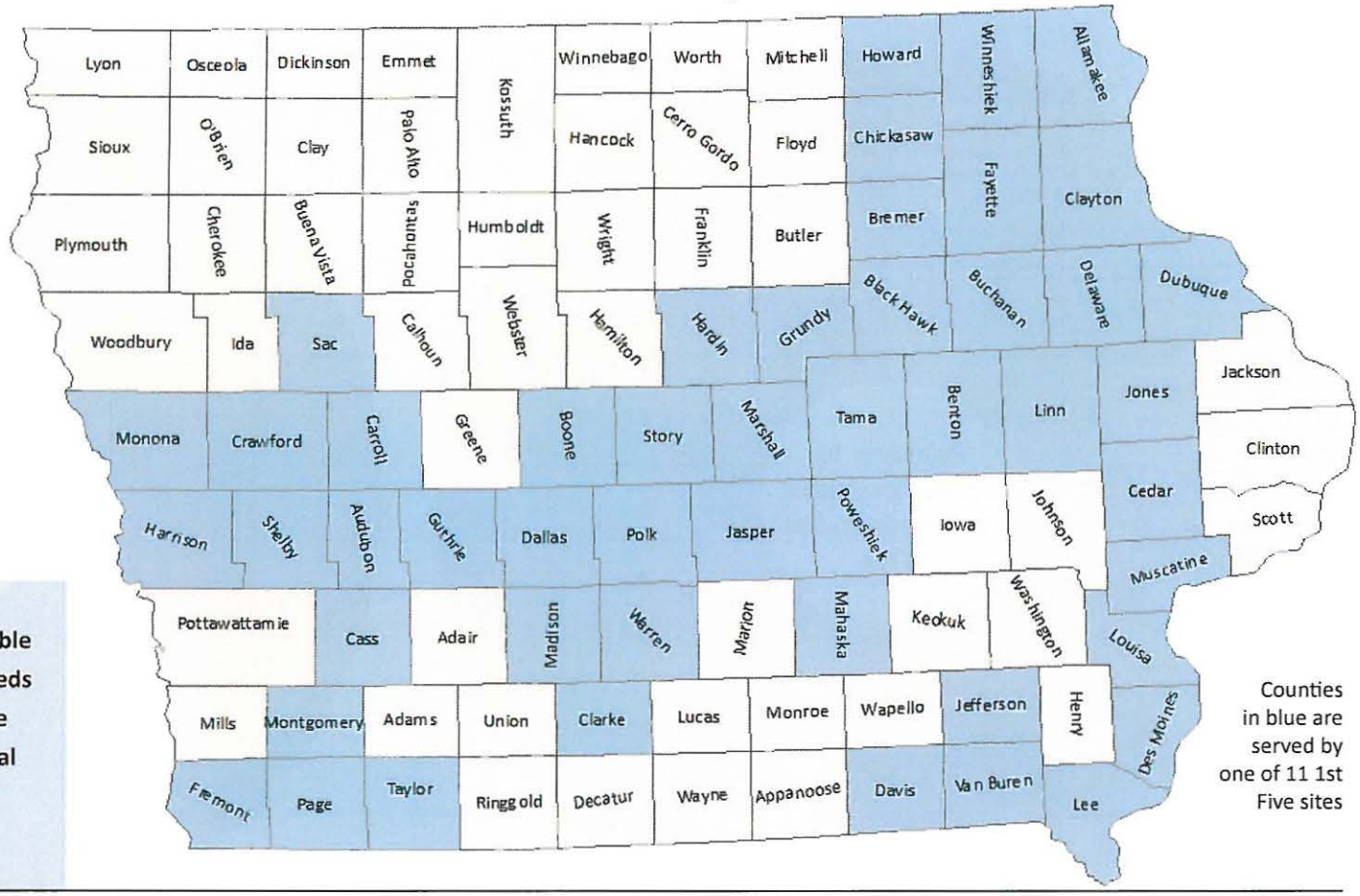
In the care coordination process, broader issues— high levels of family stress based on financial conacerns— also emerged. In response, the family was referred to local programs providing winter clothing and food assistance. They were referred to LIHEAP for heat assistance, and the father accessed employment support. The family continues to work with a Family Development Specialist.

1st Five was able to address needs that go far beyond the original referral for a speech delay.

Mom and Dad report less anxiety, improving their interactions and relationship with their children.

1st Five was able to address needs far beyond the original referral for a speech delay.

Iowa counties with a 1st Five presence



Counties in blue are served by one of 11 1st Five sites

Intervening early pays off in the future

Experts agree that early detection of developmental delays increases the effectiveness of interventions. There is also growing evidence of how chronic stress in the form of family stress, caregiver depression and other environmental factors is detrimental to developing brains and can lead to poor health outcomes and risky behaviors in adulthood.[4] Missed opportunities to intervene early affect not only the lives of individual children and families, but Iowa's health, education, child welfare and juvenile justice systems.

By identifying at-risk children early and connecting them to effective supports, 1st Five can help establish a healthy trajectory for children, setting them on the path to be healthy, productive adults.

Child & Family POLICY CENTER

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DIMENSIONS OF DIVERSITY AND THE YOUNG CHILD POPULATION

Iowa Data Snapshot

June 2014

Like the rest of the nation, Iowa is growing more diverse, and children are leading the way. From birth, young children are growing, learning, developing and exploring the world. Their vision of themselves and the world is being shaped in how they respond to others and how others respond to them. Gender, appearance, language, culture and socio-economic status all play into how they perceive themselves and others perceive them.

Information about young children is collected at various points in time and various places, but there is no single data source. Understanding how all young children are doing in a comprehensive manner—with data broken down by subgroup where possible—is imperative to identify their needs and implement policies to address them.

This data snapshot accumulates indicators from various sources to create a holistic picture of Iowa's young children, their families and the communities where they live.

In past decades, the Iowa population has become much more diverse. Children of color now comprise 17 percent of all young children (0 to 5), compared with 10 percent of working-age adults and fewer than 3 percent of seniors (top chart).

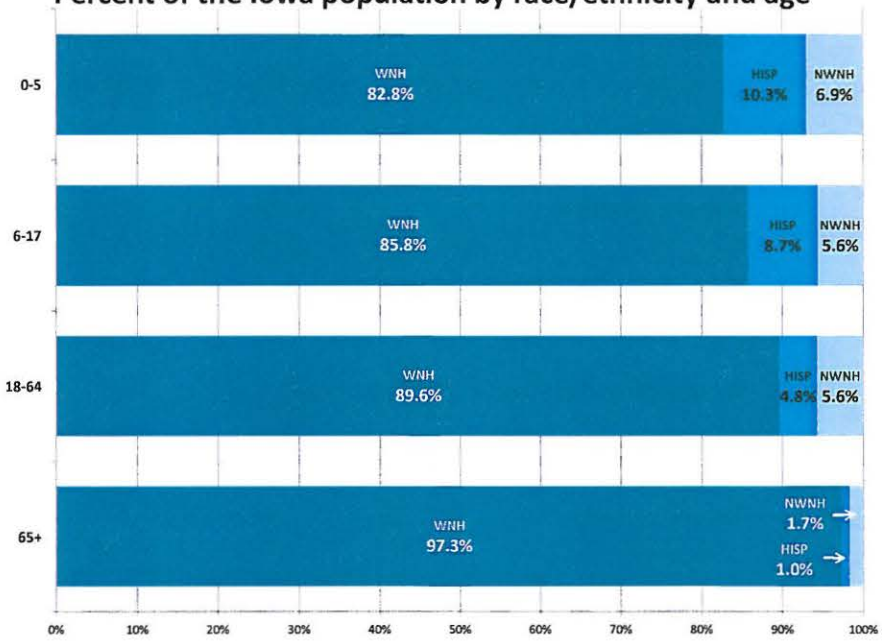
Young children are also most likely to be poor. In Iowa, 37 percent of young children live in low-income households (below 200 percent of poverty), compared with 28 percent of working-age adults and 31 percent of seniors (bottom chart).

Race and poverty are intertwined. Poverty often reflects other forms of marginalization that jeopardize healthy development.

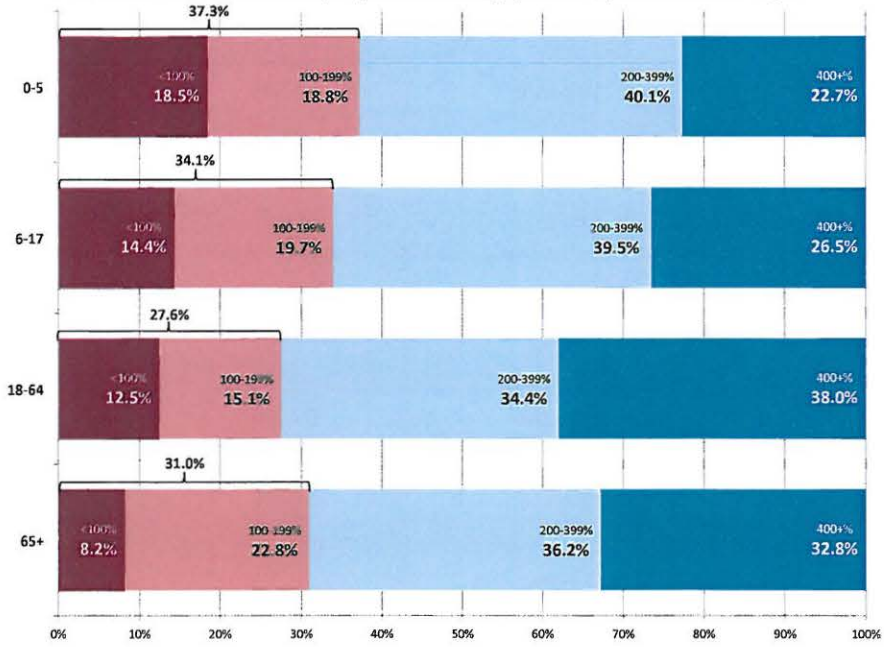
Poverty's effects on development are well documented. Many poor families provide their children with strong nurturing environments, but the simple fact is that poverty remains a risk factor and is often indicative of other forms of deprivation or marginalization that jeopardize healthy development.

How well Iowa does in assuring the healthy development of all its children—and eliminating inequities by race, language, culture or ethnicity—will determine how well the state is positioned over the next generation to lead and compete in the world economy.

Percent of the Iowa population by race/ethnicity and age*



Percent of the Iowa population by poverty level and age

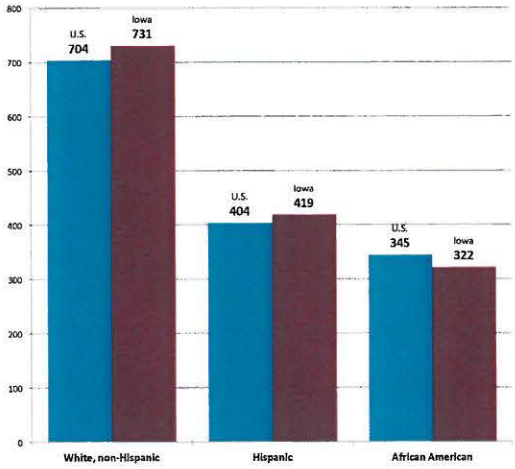


Source: U.S Census Bureau, Public Use Microdata Sample, 2012

*** WNH: White, non-Hispanic. HISP: Hispanic. NWNH: Non-white, non-Hispanic.**

How does Iowa rank among states on child well-being by race and ethnicity?

'Race for Results' composite scores
Iowa and U.S.

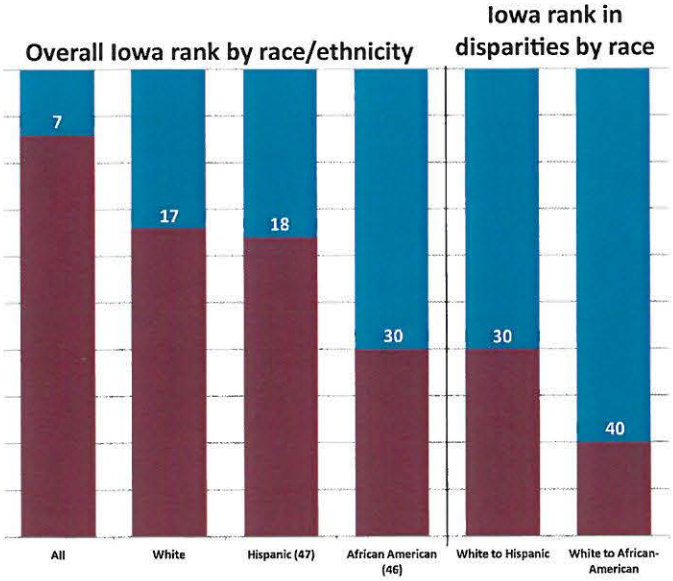


The Annie E. Casey Foundation's 2014 "Race for Results" report compares how children are progressing on key milestones across racial and ethnic groups at national and state levels. The index is based on 12 indicators that measure a child's success from birth to adulthood. In both Iowa and the U.S., there are profound differences in well-being by race and ethnicity.

On national Kids Count reports, which do not break out data by race, Iowa ranks well among states. Race to Results, however, provides a very different picture.

Iowa's high overall rankings reflect the homogeneity of the population more than particularly high levels of child well-being.

Iowa ranks 7th overall in terms of child well-being, but its rank for white, non-Hispanic children is 17th, its rank for Hispanic children 18th and for African Americans children 30th. Iowa is also home to some of the largest gaps in well-being among white, non-Hispanic children and African-American and Hispanic children.



Race and poverty in the U.S. are intertwined. Hispanic and non-white children are much more likely to live in poor households than are white, non-Hispanic children. In part this is due to housing, education and employment policies that have led to a lack of wealth, resources and opportunities for minority communities and intergenerational poverty that disproportionally harms families of color.

The indicators below highlight how a young child's race/ethnicity and income play a role in their life.

Indicators by race/ethnicity for young children*

Births at low birthweight

	U.S.	Iowa
White, non-Hispanic	7.0%	6.4%
Hispanic	7.0%	5.7%
African American	13.2%	11.0%
All	**8.0%**	6.7%

Centers for Disease Control and Prevention (CDC), National Vital Statistics Reports, Final Report Internet Tablets, 2012

Infant mortality rate (per 1,000 live births)

	U.S.	Iowa
White, non-Hispanic	5.3	4.7
Hispanic	5.4	6.3
African American	12.2	12.1
All	6.4	5.1

CDC, National Center for Health Statistics, 2008-2010

Births to mothers with late or no prenatal care

	U.S.	Iowa
White, non-Hispanic	4.5%	3.2%
Hispanic	8.8%	7.8%
African American	10.6%	10.1%
All	6.6%	4.0%

National Council of La Raza, Latino Kids Data Explorer, 2009

Children ages 19-35 months fully vaccinated**

	U.S.	Iowa
White, non-Hispanic	69.3%	77.5%
Hispanic	67.8%	*
African American	64.8%	*
All	68.4%	74.8%

CDC, 2012 **estimates

Children 10 months to 5 years screened for developmental, behavioral and social delays in past 12 months

	U.S.	Iowa
White, non-Hispanic	29.9%	32.5%
Hispanic	32.4%	48.9%
African American	31.7%	53.6%
All	**30.8%**	**34.3%**

CAHMI, National Survey of Children's Health, 2011-2012

Children 0-2 receiving intervention services under Part C of the Individuals with Disabilities Education Act (IDEA)

	U.S.	Iowa
White, non-Hispanic	3.0%	2.9%
Hispanic	2.6%	3.3%
African American	2.8%	3.6%
All	**2.8%**	**3.0%**

U.S. Census Bureau, Census and Early Childhood Technical Assistance Center Data Tables, 2010

Foster care placement rate (per 1,000) among children 0-4

	U.S.	Iowa
White, non-Hispanic	5.5	7.5
Hispanic	4.5	8.5
African American	10.7	25.0
All	**5.2**	**9.0**

U.S. Department of Health and Human Services, Adoption and Foster Care Analysis and Reporting System, 2012

Other indicators by race/ethnicity

Children 0-17 who are uninsured

	U.S.	Iowa
White, non-Hispanic	3.9%	1.7%
Hispanic	9.7%	13.9%
African American	4.9%	0.1%
All	**5.5%**	**2.7%**

Child and Adolescent Health Measurement Initiative (CAHMI), National Survey of Children's Health, 2011-2012

Children 0-17 reported as having coordinated, ongoing comprehensive care within a medical home

	U.S.	Iowa
White, non-Hispanic	65.7%	70.9%
Hispanic	37.2%	48.1%
African American	44.7%	51.8%
All	54.4%	66.8%

CAHMI, National Survey of Children's Health, 2011-2012

Children 0-17 who have seen a medical provider for preventive medical (well-child) care in past 12 months

	U.S.	Iowa
White, non-Hispanic	86.4%	85.9%
Hispanic	80.7%	71.9%
African American	84.2%	93.1%
All	**84.4%**	**84.5%**

CAHMI, National Survey of Children's Health, 2011-2012

Children 0-17 whose mother's mental/emotional health status is fair or poor

	U.S.	Iowa
White, non-Hispanic	5.7%	5.3%
Hispanic	10.0%	14.6%
African American	11.4%	2.6%
All	**7.7%**	**6.1%**

CAHMI, National Survey of Children's Health, 2011-2012

Children 0-17 whose parents report their neighborhood or community is never or sometimes safe for children

	U.S.	Iowa
White, non-Hispanic	6.8%	3.6%
Hispanic	22.8%	23.0%
African American	23.0%	9.9%
All	**11.5%**	**5.9%**

CAHMI, National Survey of Children's Health, 2011-2012

4th graders at or above proficient in reading

	U.S.	Iowa
White, non-Hispanic	45%	41%
Hispanic	19%	23%
African American	17%	15%
All	**34%**	**38%**

U.S. Department of Education, National Center for Education Statistics, 2013

Adults age 18-64 with associate degree or higher

	U.S.	Iowa
White, non-Hispanic	40.0%	38.8%
Hispanic	17.1%	13.1%
African American	23.8%	25.2%
All	**34.8%**	**37.2%**

Population Reference Bureau, Analysis of American Community Survey, 2011

* Data sources referenced in this report use different terms for racial and ethnic groups. For consistency, this brief uses the terms Hispanic, African American and white, non-Hispanic.

Indicators by poverty

Children (10 months to 5 years) screened for developmental, behavioral and social delays during the past 12 months

	U.S.	Iowa
Under 100% of poverty	31.8%	29.8%
100%-199% of poverty	31.3%	31.9%
200%-399% of poverty	29.7%	34.8%
400% of poverty+	30.5%	40.5%

CAHMI, National Survey of Children's Health, 2011-2012

Children 0-17 who are uninsured

	U.S.	Iowa
Under 100% of poverty	8.2%	4.2%
100%-199% of poverty	9.2%	5.9%
200%-399% of poverty	4.3%	1.7%
400% of poverty+	1.7%	0.4%

Child and Adolescent Health Measurement Initiative (CAHMI), National Survey of Children's Health, 2011-2012

Children 0-17 years reported as having coordinated, ongoing comprehensive care within a medical home

	U.S.	Iowa
Under 100% of poverty	36.4%	55.2%
100%-199% of poverty	48.0%	58.9%
200%-399% of poverty	60.3%	70.3%
400% of poverty+	67.7%	76.7%

CAHMI, National Survey of Children's Health, 2011-2012

Percent of children who have seen a medical provider for preventive medical (well-child) care during past 12 months

	U.S.	Iowa
Under 100% of poverty	78.5%	79.0%
100%-199% of poverty	81.0%	80.4%
200%-399% of poverty	85.9%	84.5%
400% of poverty+	90.3%	91.9%

CAHMI, National Survey of Children's Health, 2011-2012

Children whose mother's mental/emotional health status is fair or poor

	U.S.	Iowa
Under 100% of poverty	15.5%	7.7%
100%-199% of poverty	9.8%	11.6%
200%-399% of poverty	4.9%	4.1%
400% of poverty+	2.8%	2.9%

CAHMI, National Survey of Children's Health, 2011-2012

Children whose parents report their neighborhood or community is never or sometimes safe for children

	U.S.	Iowa
Under 100% of poverty	25.7%	12.5%
100%-199% of poverty	16.5%	9.3%
200%-399% of poverty	9.7%	3.1%
400% of poverty+	4.9%	2.5%

CAHMI, National Survey of Children's Health, 2011-2012

4th graders at or above proficient in reading

	U.S.	Iowa
Eligible for Free or Reduced Lunch	20%	23%
Not Eligible for Free or Reduced	51%	48%
All	**34%**	38%

U.S. Department of Education, National Center for Education Statistics, 2013

Children living in high-poverty census tracts by poverty rate

	U.S.	Iowa
40.0%+ in poverty in tract	4.1%	0.7%
30.0-39.9% in poverty in tract	6.5%	3.1%
20.0-29.9% in poverty in tract	14.2%	9.0%
0-19.9% in poverty in tract	75.2%	87.2%

U.S. Census Bureau, 2006-2010 American Community Survey

Child & Family POLICY CENTER

Build INITIATIVE
Strong Foundations For Our Youngest Children

This data snapshot is a companion piece to the Fifty-State Chartbook produced by the Child and Family Policy Center and BUILD Initiative for use by states to identify disparities in outcomes and access to services by race/ethnicity and socio-economic status.

CFPC and BUILD are partnering to develop a Center on Health Equity and Young Children, whose purpose is to support and strengthen efforts at the state-policy and community-practice levels to ensure that every child has full opportunities for healthy growth and development during the critical birth-to-five years.

This piece (and others from the Center on Health Equity and Young Children) was made possible by generous funding from the Kresge Foundation, The Colorado Trust and the Alliance for Early Success.

To learn more, visit www.cfpciowa.org or call (515) 280-9027.

THE P.A.R.E.N.T.S SCIENCE

Protective Factors. *Drawing from the risk and protective factors research, the Center for the Study of Social Policy has identified five key protective factors to prevent child abuse and neglect and support healthy development in young children: (1) concrete services in times of need, (2) knowledge of child development, (3) resiliency, (4) social ties, and (5) supportive child environments and activities.*

Adverse Childhood Experiences (ACEs). *Drawing on adult reports of adverse experiences in childhood, the Centers for Disease Control and Prevention has shown a strong relationship between those adverse experiences in childhood and health morbidity among adults across both physical and mental health.*

Resiliency.*The research on resiliency—at the individual, family, school and community level—has shown the importance of fostering resiliency to ensuring healthy development. The American Academy of Pediatrics has established a working group to further promote resiliency in health practice.*

Epigenetics. *Recent findings from the science of genetics show that early childhood experiences can even affect genetic make-up and therefore transmission to the next generation.*

Neurobiology. *While there is a great deal of plasticity in the brain, neurobiology has shown the critical importance of the first years of life to not only set the foundation for cognitive development, but to establish the basis for healthy social and emotional development.*

Toxic Stress. *The Harvard Center for the Developing Child has identified persistent, unrelieved and unmitigated stress as "toxic" to the development of the infant and toddler brain at the its most critical period of development – and the need for early interventions to ensure that stresses in early childhood do not produce toxicity.*

Social Determinants of Health. *The World Health Organization and Healthy People 2020 both describe the primary contribution that social determinants—as opposed to bio-medical determinants—have on child development and adult morbidity and mortality. For young children, addressing these social determinants require addressing stress, discrimination, and social and economic disadvantage.*

The P.A.R.E.N.T.S. Science points to the centrality of the home health, safety, and learning environment for young children to their healthy physical, cognitive, social, and emotional development. It also identifies where preventive and early intervention services need to focus in providing for that safe, secure, consistent, and nurturing home environment.

When children are young, the health practitioner is frequently the only professional who sees the child and family and is in a position to identify and begin to respond to stresses in the family as well as health conditions in the child. Iowa's 1st Five Initiative provides an avenue to practitioners to serve in this preventive and developmental, first responder role. While over ninety percent of very young children in Iowa receive at least one well-child visit, fewer than one in six are in a formal child care setting and one in twenty, at most, is receiving home visiting or family support services.