



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Indiana**

**Application for 2013
Annual Report for 2011**



Document Generation Date: Monday, September 24, 2012

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	7
C. Needs Assessment Summary	7
III. State Overview	8
A. Overview.....	8
B. Agency Capacity.....	17
C. Organizational Structure.....	25
D. Other MCH Capacity	28
E. State Agency Coordination.....	32
F. Health Systems Capacity Indicators	36
IV. Priorities, Performance and Program Activities	40
A. Background and Overview	40
B. State Priorities	41
C. National Performance Measures.....	43
Performance Measure 01:.....	43
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated	45
Performance Measure 02:.....	46
Performance Measure 03:.....	50
Performance Measure 04:.....	53
Performance Measure 05:.....	57
Performance Measure 06:.....	60
Performance Measure 07:.....	64
Performance Measure 08:.....	66
Performance Measure 09:.....	68
Performance Measure 10:.....	71
Performance Measure 11:.....	74
Performance Measure 12:.....	76
Performance Measure 13:.....	79
Performance Measure 14:.....	81
Performance Measure 15:.....	84
Performance Measure 16:.....	86
Performance Measure 17:.....	88
Performance Measure 18:.....	90
D. State Performance Measures.....	93
State Performance Measure 1:	93
State Performance Measure 2:	95
State Performance Measure 3:	97
State Performance Measure 4:	100
State Performance Measure 5:	102
State Performance Measure 6:	104
State Performance Measure 7:	107
State Performance Measure 8:	109
State Performance Measure 9:	111
State Performance Measure 10:	113
E. Health Status Indicators	115
F. Other Program Activities	118
G. Technical Assistance	119

V. Budget Narrative	121
Form 3, State MCH Funding Profile	121
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds.....	121
Form 5, State Title V Program Budget and Expenditures by Types of Services (II)	122
A. Expenditures.....	122
B. Budget	123
VI. Reporting Forms-General Information	124
VII. Performance and Outcome Measure Detail Sheets	124
VIII. Glossary	124
IX. Technical Note	124
X. Appendices and State Supporting documents.....	124
A. Needs Assessment.....	124
B. All Reporting Forms.....	124
C. Organizational Charts and All Other State Supporting Documents	124
D. Annual Report Data.....	124

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are kept on file at the Indiana State Department of Health in the Office of Grants Management. They are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The State Title V program solicited public comments for this application using several methods. The first method was to place a request for public comments on the Maternal and Child Health (MCH) web page for ongoing public input. The web page encourages the public to comment on the previous, and the current years Title V Block Grant. This includes the Narrative, Forms, and a 2010 Executive Summary which is updated yearly.

A second method for soliciting public comments involved the use of surveys for identifying priority needs for the Five Year Needs Assessment from providers, partners, collaborators, disparity families and families of children with special healthcare needs. The surveys were either used for collecting comments of individuals in group settings, mailed by request to individuals, or electronically e-mailed to professionals. Professionals who were surveyed in small group settings included but were not limited to: Prenatal Substance Abuse (PSUPP) statewide directors, the Indiana Coalition to Improve Adolescent Health (ICIAH) steering committee, the Healthy Families of Indiana Think Tank, Indiana State Department of Health's Chronic Disease Division, State Perinatal Advisory Board, Indiana State Nutrition Council, an Indiana University-Purdue University-Indianapolis nursing class, a Butler University health class, Sunny Start core partners group, Sunny Start Family Advisory Subcommittee, Sunny Start Evaluation Subcommittee, WIC Breastfeeding Committee, the Breast Feeding Center at Clarian, WIC Steering Committee, Indiana Dietitian Associations Meeting, Indiana Nutrition Council, Infant Health & Survival Council, and Indiana's FIMRs.

Needs assessment surveys were sent by e-mail to the 139 member Virtual Advisory Committee, 92 Local Health Departments (LHD) and listed on the LHD Sharepoint, all community health centers, and to all MCH clinics. Surveys were mailed to any professional upon their request. A copy of the Completed Title V Block Grant will be e-mailed to the states public library system for access in their government document sections.

In surveying these small groups and individuals MCH was able to obtain input from a cross section of disciplines. It included but was not limited to the following professions: health service directors, physicians, registered nurses, public health professionals, students, educators, social workers, lactation specialists, Healthy Family Workers, clinic staff, early childhood service providers, outreach workers, WIC staff, registered dietitians, and fundraisers. These individuals reside in over two-thirds of Indiana's 92 counties, but their service delivery systems represent all of Indiana.

A third method for soliciting public comments before the submission of the Title V Block Grant involved the use of a twenty-page MCH Title V Block Grant Executive Summary. The summary was sent out the first week of June 2010 to the expanded 250 Virtual Advisory Committee members, all LHDs, MCH clinics, 131 Indiana libraries, community health centers, MCH Network/Community Partners, and the Minority Health Coalitions. All groups were advised that the Title V Five Year Needs Assessment and Grant Application had to be submitted no later than July 15, 2010. Therefore their deadline for submitting comments could be no later than Friday, June 25th. As of July 6, over 15 reviewers submitted comments. Title V staff have reviewed all comments and have incorporated as many comments as possible into the needs assessment. All public comments received after submission of the current Title V Block Grant will be used during the preparation of the application for the following year.

Loren Robertson, Deputy Commissioner at Indiana State Department of Health (ISDH) commented that smoking during pregnancy is an extremely important issue. A sampling of other public comments include:

"I have read and agree with the goals outlined to meet the state's priority health issues and needs. I found the ten goals that have been identified as needed areas for improvement in Indiana to be appropriate and necessary. I believe the work plan outlined with each of these goals will allow Indiana to attain the projected outcomes."

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"The goal over the next five years is to reduce the proportion of births that occur within 18 months of a previous birth, to the same mother, to the level of 10% from (INCLUDE CURRENT LEVEL) I WOULD SUGGEST WORKING WITH FATHERHOOD INITIATIVE ON THIS ONE TOO! THEY NEED EDUCATION ABOUT THIS ISSUE MORE THAN MOMS!"

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"As the CEO of Learning Well school-based clinics in Marion County, I would like to offer the mention of our relationship with the State in order to add the power of our large, 9 year collaboration with healthcare providers; school partners; and advisory partners (including local foundations, the United Way of Central Indiana, Health & Hospital Corporation, Clarian....and many others) to an already strong proposal. I have attached a list of the working partnerships and collaborations that are presently in place. I noted there are many areas where Learning Well could be utilized as a prime example of how the State of Indiana has been successful in creating programs that are based upon partnerships and collaborations."

Donna A. Stephens, MBA

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/2012/Title V staff continue to reach out to providers, parents, families, partners, and collaborators for continued input into Title V programs and policies. As an example of the importance of public input, Title V staff have strengthened statewide partnerships with specialty physicians, hospitals, and other relevant entities and created a Perinatal Quality Improvement Collaborative. Also this year, we are working on an interactive web-based presentation of the Title V Five Year Needs Assessment. We also encourage collaboration by making it a requirement of grant sub-awards. Subsequent to the Title V Five Year Needs Assessment, we have conducted two additional needs assessments -- one focused on home visiting and the other focused on pregnant and parenting teens. In both instances, we sought public input through surveys and meetings to make our needs assessments the strongest they could be. We are continuing to seek out public input, especially from pregnant and parenting teens and their families. To this end, IU is convening a three-day community conversation with pregnant and parenting teens and the community that is scheduled for summer 2011. The conversation will be facilitated by research sociologists from Indiana University. "Families served by MCH and CSHCS programs routinely encounter opportunities both informal and formal to share their input. These opportunities via surveys, public forums and advisory work are a key piece of the family partnership that enhances MCH and CSHCS." -- Rylin Rodgers, Family Voices Indiana//2012//

/2013/ MCH has continued in its efforts to work with community and public partners. As an example, Sunny Start recently completed a statewide Community Survey. The distribution of the survey resulted in 508 individual responses from 152 families and 356 community providers. Forty-eight of the 92 counties in Indiana were represented. As an example, one respondent said, in response to an open-ended question about actions needed to ensure services are coordinated, cost effective and community based, that "We really need a one-stop shopping - one place families can go to get information and access resources." The information from this survey will guide Sunny Start's activities in the next few years.//2013//

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2013/Population Strengths and Needs

As mentioned in FY 2011 and 2012 Needs Assessments, utilizing the data from the 2003 Version of the birth certificate has had an effect on the percent of mothers receiving prenatal care. Between 2008 and 2009, the percent of infants born to women receiving prenatal care in the first trimester showed a slight decrease from 66.6% to 66.1%. In prior years, the percentage of Black women ages 15-44 with a live birth whose prenatal visits are at least adequate on the Kotelchuck Index has not only been very low, but also decreasing. However, from 2008 to 2009, the measure increased from 54.1% to 57.0%. At the same time, the overall percentage of women ages 15-44 for this measure increased slightly from 69.3% to 70.0%.

Indiana's infant mortality rate increased from 6.9 to 7.8 between 2008 and 2009. Unlike the year prior, Indiana saw a decrease in the percentage of births occurring within 18 months of a previous birth from 2008 to 2009 -- 36.0% to 35.4%. While a decrease in premature births took place between 2008 and 2009 (12.4% to 11.8%), Indiana's low birth weight remained stable (8.3%). Disparities are also a great concern in Indiana, and in 2008 the black infant mortality rate increased to 16.1% (was 15% in 2008). Very low birth weight increased slightly from 2008 to 2009 (1.4% to 1.5%). The rate of suffocation deaths in Indiana also increased (from 15.7 to 16.4) between 2008 and 2009.

Changes in MCH Programs Capacity

MCH program formed a new division known as MCH Epidemiology, Surveillance and Data Analysis Division under the direction of Joseph Haddix. The team comprises of Aigul Amankeldi (WIC Epidemiologist), Lisa Eastcott (Perinatal Epidemiologist), Kelsey Gurganus (State Systems Development Initiative Epidemiologist, SSDI), Helmneh Sineshaw (Genomic and Newborn Screening Epidemiologist), and Tiffany Young (Women of Childbearing Age Epidemiologist).

Ongoing Activities and Needs

Under the State Systems Development Initiative Grant (SSDI) the MCH program is collaborating with the Information Technology team in effort to implement the Business Intelligent tool (BI). It is expected to focus resources on establishing or improving the data linkages between birth records and 1) infant death certificates, 2) Medicaid eligibility or paid claims files, 3) WIC eligibility files, and 4) newborn screening files. In addition to, life course performance metrics that will assist in measuring the State's progress towards incorporating life course principles into policy development, strategic and operational planning and program evaluation. //2013//

III. State Overview

A. Overview

Indiana is a state rich with the history of an industrial and agricultural past and the promise of an agricultural and high tech future. Like the rest of the country, this past year has forced the State to deal with serious changes and hardships due to the United States' economic downturn. However, Indiana has fared far better than most of its neighbors and most of the country. Under Governor Mitch Daniels' administration, innovative programs have emerged to combat high unemployment and the lack of health insurance that accompanies such changes.

State Introduction

The Indiana State Department of Health (ISDH), one of the largest state agencies, serves the population in a wide variety of ways including providing environmental public health, food protection services, health facility licensing, public health preparedness, health promotion programs, statistical information, direct health services, and many other infrastructure building programs.

The Mission of the ISDH supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities. To achieve this mission, ISDH has adopted principles that guide policy development and programs. These principles mandate that ISDH and its Commissions:

- Focus on data-driven policy to determine appropriate evidence-based programs and initiatives.
- Evaluate activities to ensure measurable results.
- Engage partners and include appropriate intra-agency programs in policy-making and programming.
- View essential partners to include local health departments, physicians, hospitals and other health care providers, other state agencies and officials as well as local and federal agencies and officials, community leaders, businesses, health insurance companies, Medicaid, health and economic interest groups, and other groups outside the traditional public health model.
- Actively facilitate the integration of public health and health care activities to improve Hoosiers' health.

/2013/ ISDH adopted a new Mission, Vision, and Strategic Priorities in 2012. They are as follows.

Mission:

"Promoting and providing essential public health services to protect Indiana communities"

Vision:

A healthier and safer Indiana

Agency Strategic Priorities:

The Indiana State Department of Health believes that the following agency priorities will have the most impact on the way it operates and on its ability to deliver on its Mission and Vision:

- ***Decrease disease incidence and burden***
- ***Improve response and preparedness networks and capabilities***
- ***Reduce administrative costs through improving operational efficiencies***
- ***Recruitment, evaluation, and retention of top talent in public health***
- ***Better use of information and data from electronic sources to develop and sponsor outcomes-driven programs***
- ***Improve relationships and partnerships with key stakeholders, coalitions and networks throughout the State of Indiana//2013//***

In its desire to make Indiana the healthiest state in the country, ISDH also recognizes that key

factors such as prevention of disease, ensuring access to health care, and promoting personal responsibility of individual Hoosiers for their own health must also be an integral part of the state's initiatives. ISDH works hard to collaborate effectively with its many partners in policy-making and programming. ISDH also works hard to develop an environment of respect -- for those who serve Hoosiers in the public health field and the public it serves -- by honoring diversity, equality of opportunity, cultural differences, and ethical behavior.

As of January 2010, the State's Priority Health Initiatives included activities that support data driven efforts for both health conditions and health system initiatives; INShape Indiana; and integration of medical policy that values public health principles; and preparedness. The state is emphasizing the integration of health care policies with evidence-based and results oriented programming. It also continues to highlight preparedness and effective responses to threats that cannot be prevented.

In particular, InShape Indiana is a statewide initiative designed to help Hoosiers make healthier choices about food, physical activity and tobacco. Governor Daniels began this program and remains heavily involved in support of this program. The website link (<http://www.in.gov/inshape/>) provides access to valuable information and resources that can help Hoosiers live a more healthful life. As a result of the initiative, thousands of Hoosiers have decided to start living a healthier lifestyle by choosing to eat better, move more and avoid tobacco.

Health Status and Health Needs of Hoosiers

In comparison to other states, the health status of Hoosiers is below average. However, Indiana does have certain strengths including a low rate of uninsured population at 11.9%, increasing immunization coverage of children, and decreasing cardiovascular deaths. In the past ten years, immunization coverage increased from 41.8% to 78.4% of children ages 19 to 35 months who received complete immunizations. Since 1990, the rate of deaths from cardiovascular disease decreased from 425.0 to 310.0 deaths per 100,000 population.

In terms of state challenges, Indiana ranks poorly on the prevalence of smoking at 26.0% (the same rate as in 1999); high levels of pollution at 13.2 micrograms of fine particulate per cubic meter; 49th in public health funding at \$36 per person; and a high percentage (23.3%) of children in poverty. In the past five years, the percentage of children in poverty increased from 13.7 % to 23.3 % of persons under age 18. Additionally, Indiana ranks 37th in cardiovascular deaths; 37th in cancer deaths; and 39th in overall infant mortality. Compared to 43 other states that have sufficient data, Indiana ranks 40th in terms of black infant mortality. (Infant mortality rates by state 2004-2006, Statehealthfacts.org)/2012/The percentage of adults smoking decreased to 23.1% in 2009 according to the BRFSS.//2012// **/2013/Most recently, the Indiana Smoke Free Air Law began on July 1, 2012, which will make nearly all public places, including restaurants and workplaces, smoke free.//2013//**

Health disparities are also a very large issue in Indiana. Obesity is more prevalent among non-Hispanic blacks than non-Hispanic whites at 36.7% vs. 27.2 % respectively. The prevalence of diabetes also varies by race and ethnicity in the state; 12.9 % of non-Hispanic blacks have diabetes compared to 7.7 % of Hispanics and 8.4 % of non-Hispanic whites.

In 2007, the total infant mortality rate in Indiana was 7.5 per 1,000. The white non-Hispanic rate was 6.5 per 1,000, the black non-Hispanic rate was 15.7 per 1,000 and the Hispanic rate was 6.8 per 1,000. The low birth weight for infants in Indiana in 2007 was 8.5 % of births. The percentages were 7.8% for white non-Hispanic, 14.1% for black non-Hispanic and 7.2% for Hispanic for low birth weight infants in Indiana in 2008. **/2013/In 2009, the infant mortality rate increased to 7.8 while the percent of low birth weight infants decreased to 8.3%.//2013//**

Demographics

The State of Indiana is located in the Great Lakes Region of the United States. Indiana is ranked 38th in land area, and is the smallest state in the continental U.S. west of the Appalachian

Mountains. Its capital and largest city is Indianapolis, the largest of any state capital east of the Mississippi River. As of 2008, Indiana is the 38th most populated state in the United States with 6,376,792 people living in 2,795,024 households. Indiana has several metropolitan areas with populations greater than 100,000 as well as a number of smaller industrial cities and small towns. Residents of Indiana are known as Hoosiers./2012/Based on the 2010 census, Indiana's population is now 6,483,802. Since 2000, Indiana's population has increased by 6.6% which is below the national average of 9.7%./2012//

Indianapolis ranks as the 13th largest city and 11th largest metropolitan area in the United States, and also the 3rd largest city in the Midwest. The Indianapolis Metropolitan Area, defined as Marion County and the counties immediately surrounding it, is among the fastest-growing metropolitan areas in the US, with the largest growth centering in the counties surrounding Marion County. (FY2008, US Census Bureau.)

In the state, 26.9% of the population are under the age of 18, 6.9% are under the age of five and 12.8% are 65 years of age or older. The median age is 36.4 years. In 2005, 77.7% of Indiana residents lived in metropolitan counties. In Indiana, the population is 51% female and 49% male.

Indiana has limited cultural diversity outside of its metropolitan areas with over two-thirds of its counties reporting white, non-Hispanic populations of more than 95%. Indiana's overall Hispanic population is 5.2%, its white, non-Hispanic population is 83.2%, and its black non-Hispanic population just over 9%. This contrasts highly with Indiana's largest county, Marion County, which has an African-American population of 25.9%, a Hispanic population of 7.4%, and a white, non-Hispanic population of 63.8%. Asians and people reporting two or more races account for almost all of the remaining 2.9%.

Indiana's economy is considered to be one of the most business-friendly in the United States. This is due in part to its conservative business climate, low business taxes, relatively low union membership, and labor laws. The doctrine of at will employment, whereby an employer can terminate an employee for any or no reason, is in force.

Despite its reliance on manufacturing, Indiana has been much less affected by declines in traditional rust belt manufactures than many of its neighbors. According to the Bureau of Labor Statistics, Indiana is one of very few states where the unemployment rate declined from March 2009 to March 2010 (10.1 vs. 9.9%). The explanation appears to be certain factors in the labor market. First, much of the heavy manufacturing, such as industrial machinery and steel, requires highly skilled labor, and firms are often willing to locate where hard-to-train skills already exist. Second, Indiana's labor force is located primarily in medium-sized and smaller cities rather than in very large and expensive metropolises. This makes it possible for firms to offer somewhat lower wages for these skills than would normally be paid. Firms often see in Indiana a chance to obtain higher than average skills at lower than average wages.

Indiana is home to the international headquarters of pharmaceutical company Eli Lilly in Indianapolis, the state's largest corporation, as well as the world headquarters of Mead Johnson Nutritionals in Evansville. Overall, Indiana ranks fifth among all the states in total sales and shipments of pharmaceutical products and second highest in the number of biopharmaceutical related jobs.

Indiana is located within the U.S. corn and grain belts. The state has a feedlot-style system raising corn to fatten hogs and cattle. Along with corn, soybeans are also a major cash crop. Indiana's proximity to large urban centers, like Chicago and Indianapolis, supports dairying, egg production, and specialty horticulture. Other crops include melons, tomatoes, grapes, mint, popping corn, and tobacco in the southern counties.

Poverty

For all age groups, Indiana has less people living in poverty than the nation as a whole. However, Indiana has slightly more children than the nation as a whole who live in households

lower than 100% of the Federal Poverty Level. Additionally, Indiana's median income, \$50,303 is below the national average. (www.statehealthfacts.org)

In terms of poverty rate by race/ethnicity, Indiana's black population is significantly more affected by poverty than the rest of the black population in the United States. The black population living in Indiana is almost three times more likely to suffer from poverty. According to a 2007 GAO report titled, *POVERTY IN AMERICA: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions As Well As the Economic Growth Rate*, economic research suggests that individuals living in poverty face an increased risk of adverse outcomes, such as poor health and criminal activity, both of which may lead to reduced participation in the labor market. While the mechanisms by which poverty affects health are complex, some research suggests that adverse health outcomes can be due, in part, to limited access to health care as well as greater exposure to environmental hazards and engaging in risky behaviors.

Additionally, exposure to higher levels of air pollution from living in urban areas close to highways can lead to acute health conditions. Data suggest that engaging in risky behaviors, such as tobacco and alcohol use, a sedentary life-style, and a low consumption of nutritional foods, can account for some health disparities between lower and upper income groups.

The relationship between poverty and adverse outcomes for individuals is complex, in part because most variables, like health status, can be both a cause and a result of poverty. These adverse outcomes affect individuals in many ways, including limiting the development of skills, abilities, knowledge, and habits necessary to fully participate in the labor force.

Low-income children are less likely to be covered by healthcare and thus are more likely to lack primary care and other necessary medical services. Because of these disparities, providing services to children from low-income households is of paramount concern for our nation and has led to national coverage programs for children. Healthcare financing sources for low-income and disabled children include Medicaid and SCHIP funding, administered in Indiana through Hoosier Healthwise which includes a risk-based managed care (RBMC) program, Care Select for aged, blind, disabled, and other special populations, and fee-for service Medicaid programs.

According to information compiled by Covering Kids and Families (CKF) in Indiana, there are 1,680,000 children under the age of 19 in Indiana. Of these children, about one in 10 (or 161,000) has no health insurance. ***/2013/The number of uninsured children in Indiana has decreased to 9.1% (or 148,000) in 2009./2013//***

- Indiana ranked 35th in the nation in 2006 for the number of children living in poverty.
- 95.3% of Indiana's uninsured children are members of working families. (Families USA)
- In 2007, 7% of Indiana's children under the age of 6 were uninsured.
- In 2007, 8% of Indiana's children between the ages of 6 and 12 were uninsured; 14% of children between the ages of 13 and 18 were uninsured.
- 48.2% of Indiana's uninsured children live in families with annual incomes at or below twice the federal poverty level (Families USA 2008)
- Indiana had the highest per capita rate of individual medical bankruptcies in the nation in 2006.
- From 1999 to 2005, Indiana had the nation's highest percentage drop in workers who receive employer-sponsored health insurance.

At the Governor's direction, Indiana is working diligently to improve the economic status of Hoosier children and their families.

Racial/Ethnic Disparity

Like the rest of the United States, Indiana is growing more diverse culturally, racially, and ethnically. This change will continue to increase over the coming years and will enrich Indiana as a state and help to expand its global perspective. However, while there are many positive outcomes due to this growth, there are also problems, such as inadequate health delivery.

The National Institutes of Health states that "Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the US." It is racial and ethnic minorities that are facing a disproportionately greater burden of disease, injury, premature death, and disability. Indiana's MCH and CSHCS programs are aware of racial and ethnic health disparities in Indiana and are working to impact the many contributing factors that influence an individual's health. These factors include but are not limited to the environment, lifestyle choices, cultural beliefs, poverty, past experiences, insurance status, and employment. Additionally, racial and ethnic minorities also experience barriers to health including access to care; limited English proficiency; no continual source of health care; limited health education; racial and ethnic assumptions; and lack of diverse employment skills.

Reducing health disparities among racial and ethnic groups in Indiana requires the cooperation of legislators, governments (both local and state), providers of health care, and the community. Improved data collection, better access to care, essential preventative care, and community involvement are also necessary to improve current health status and conditions of all racial and ethnic minority groups.

Minority, racial, and ethnic populations in Indiana make up more than 15% of the current population. Overall, blacks have the highest age-adjusted death rates, followed by whites and Hispanics.

In Indiana, the black non-Hispanic population consistently has more severe health outcomes than the white non-Hispanic population. The infant mortality rate for black non-Hispanic is about two and a half times that of the white non-Hispanic population. The percentage of low birth weight infants for black non-Hispanics is nearly double that of the white non-Hispanic infants. The percentage of black non-Hispanic and Hispanic mothers who received adequate prenatal care or who received prenatal care in the first trimester is much lower than the white non-Hispanic mothers. The percentage of mothers receiving late or no prenatal care is much higher for black non-Hispanic and Hispanic mothers compared to white non-Hispanic mothers. The percent of black non-Hispanic mothers who initiated breastfeeding is well below that of the white non-Hispanic mothers.

This information has helped to guide the development of the newly revised State Performance Measures and will be used to determine the judicious allocation of scarce Title V resources.

Geography

In Indiana, 70% of the population lives in a metropolitan area while 30% lives in a rural area. According to the Indiana Rural Health Association, rural communities have higher rates of chronic illness and disability and poorer overall health status than urban communities. Rural residents tend to be older and poorer than urban residents. Eighteen percent of rural residents are over 65 compared to 15% of urban residents and more rural residents live below the poverty level compared to urban residents.

Chronic conditions such as heart disease and diabetes are more prevalent in rural areas. Injury-related deaths are 40% higher in rural communities than in urban communities. Cancer rates are higher in rural areas. People living in rural areas are less likely to use preventive screening services, exercise regularly, or wear safety belts. These disparities among rural and urban Hoosiers may be caused by a number of reasons including:

Transportation--Many individuals lack access to treatment because appropriate transportation is too expensive, limited by weather factors, or because the patient is too sick to use the options that are available.

Lack of Providers --Residents of rural areas have less contact and fewer visits with physicians. Although 20% of Americans live in rural areas, only 9% of the nation's physicians practice in rural

areas and only 10% of specialists practice in rural areas. In addition, 81% of urban counties and 98% of rural counties in Indiana fail to meet the national benchmark for an adequate ratio of primary care specialists per 100,000 population that affects services to children with special healthcare needs. There are 6,000 unfilled nurse positions in our hospitals. Both urban counties (65%) and rural counties (87%) fail to meet the U.S. benchmark for an adequate ratio of RNs per 100,000 population. Indiana has a shortage of 1,000 primary care physicians. If current trends continue, we will need almost 2,000 additional primary care physicians and 20,000 registered nurses (RNs) in Indiana by 2020.

Lack of Services-- Nationally, many rural hospitals have negative operating margins and, from 1984 to 1997, over 500 rural hospitals closed. Several counties in Indiana, such as Pike and Crawford counties in southwest Indiana, do not have a hospital and a number of areas in Indiana have limited or no trauma services at all. In west central Indiana (this geographic area includes Indiana to the Illinois state line on the west, Lebanon on the north, Sullivan on the south, and Bloomington/Indianapolis is on the east), Hoosiers have to travel more than 50 miles to a trauma center.

Limited Services--Rural residents are more likely to report that their provider does not have office hours at night or on weekends.

Insurance--One national study found that almost 20% of rural residents were uninsured compared with 16% of urban residents. Rural residents under 65 are disproportionately uninsured. According to the National Association of Community Health Centers, Indiana had 18 Federally Qualified Health Centers (FQHC) and 86 delivery sites in 2008. These FQHCs saw a total number of 218,738 patients seen in 2008. Of those patients, 4,526 were migrant/seasonal workers and 8,810 were homeless. On average, 42% of clients were uninsured, 40% had Medicaid and 5% were Medicare clients. Twenty-nine percent resided in a rural area.

Urbanization

Since the 2000 Census, the population has increased 7.2% in the U.S. and 4.4% in Indiana. Within Indiana, metropolitan areas experienced population gains, while other areas experienced population declines. The fastest growth during both time periods was in the Indianapolis metropolitan area. (Urban Institute and Kaiser Commission on Medicaid and the Uninsured)

Urbanization can have a serious impact on health and many of the negative impacts are suffered by the poor and minorities in greater disproportion. Urbanization is associated with changes in diet and exercise that increase the prevalence of obesity with increased risks of Type II diabetes and cardiovascular disease; vulnerability to sexual abuse and exploitation; and separation from social support networks. Many of these conditions affect the most vulnerable segment of the population - women, children and the elderly.

Environmental contaminants, although not restricted to urban settings, can alter the reproductive process and increase the risk of abortion, birth defects, fetal growth and perinatal death. Particularly in cities, motor vehicles are an important source of air pollution and studies in Indiana are associating pesticides in water with poor birth outcomes. Children are especially susceptible to disease in an urban environment. Not only can they suffer from overcrowding, poor hygiene, excessive noise, and a lack of space for recreation and study, they also suffer from stress and violence that such environments create.

Many of the ill effects of urban life affect people from all incomes. Although most people living in the city take basic public services such as drinking water supply, housing, waste disposal, transportation, and health care for granted, these services are often either deficient or nonexistent for the poor.

Private Sector Title V Service Delivery Challenges

The three private sector challenges in providing Title V services are (1) lack of providers who

accept Medicaid reimbursement, (2) lack of cultural competency, and (3) location of services.

Medicaid Providers -- Indiana has a risk based managed care system for all MCH populations on Medicaid. Providers in some counties have refused to participate in Medicaid reimbursement for pregnancy and infant care until the infants are on CHIP. These counties tend to have poorer pregnancy outcomes.

A serious challenge in Indiana over the past few years is not only the number of physicians who do not accept Medicaid reimbursement but also a flawed Medicaid enrollment system that has left many eligible women and infants without insurance coverage throughout the pregnancy and critical first few months of age. In an effort to overcome enrollment challenges for pregnant women, Indiana Medicaid began Presumptive Eligibility (PE) on July 1, 2009. Even so, there are areas of the state where providers are less likely to accept Medicaid reimbursement. Of 92 counties, five have no providers participating in Presumptive Eligibility. Due to the small numbers of prenatal care providers participating in presumptive eligibility, twenty-two (22) counties have lower numbers of pregnant women enrolling in prenatal care.

Lack of Cultural Competency -- Lack of cultural competency has played a role in driving black-to-white perinatal disparities higher. In 2006, three counties had a black infant mortality rate greater than 30 per 1,000, approaching third-world statistics. MCH is targeting 5 counties in Indiana that have 80% of the black population and the highest disparity issues. MCH has worked with these counties to increase the cultural competency knowledge of providers and funded programs to address disparate issues.

To address these disparities, MCH is utilizing a life course perspective to impact change. For Indiana to make a difference in black disparities, MCH must work at the neighborhood level to educate and empower high risk populations that encounter cultural barriers to equitable health care services. MCH has been collaborating with the ISDH Office of Minority Health, the Indiana Minority Health Coalition (IMHC), and local minority health coalitions in the five disparity counties. The Indiana Perinatal Network (IPN) and the IMHC both provide agency cultural competency training.

Immigrant populations are also facing barriers to healthcare. An increasing Hispanic population is facing barriers to care from lack of insurance, interpreters, and educational materials and forms that are translated into Spanish. Hispanic centers around the state do not have the capacity to assist all Hispanic families in need.

Indiana also has the largest Burmese population outside of Burma than anywhere else in world. While there are services in place to help this population, they may not be adequate to ensure the Burmese have access to culturally appropriate healthcare services.

Location of Services -- Indiana's counties are all autonomous. Efforts in the past to regionalize health systems were not accepted. This has led to lack of accessible services for all Title V populations. The majority of Indiana's primary care physicians are located within 5 counties. Seventeen counties are without a hospital. The only two specialty children's hospitals are both located in Marion County (Indianapolis). Families in some parts of the state must travel long distances to receive specialty care during pregnancy and for children. A large population of pregnant women and children seek health care services in four neighboring states -- Illinois, Ohio, Kentucky and Michigan. Service in the State of Indiana may improve because three large healthcare systems in Indianapolis are buying hospitals around state and providing an increase in services in some counties. MCH will address regionalization of hospitals providing perinatal services over the next five years. ***/2013/As of 2012, 29 of the 92 Indiana counties do not have a delivery hospital./2013/***

Current and Emerging Issues

In terms of MCH, an overriding issue is the effectiveness of our interventions and programs.

Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this phenomenon, it is an issue that we are in the process of addressing. First, we have renewed our commitment to improve the health and well being of mothers, children, and women of childbearing ages. Second, we have rethought our strategies and are focusing on evidence-based interventions. Third, we are defining and implementing a life course health perspective and intend to partner with many more providers and communities to make a difference. With a fresh eye and renewed energy, we are moving in a new and exciting direction.

From our five year needs assessment, we have identified 10 top State priority issues -- two are continuing, three have been modified, and five are new. The following paragraphs provide a brief overview of these issues. More discussion on these issues can be found in the State Performance Measures and the Five Year Needs Assessment.

Pregnancies occurring at short interval are an important issue because they increase the risk for adverse outcomes such as low/very low birth weight babies, premature births, and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to increase opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns.

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions, initiation of a recognition program acknowledging Baby Friendly Hospitals, and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers. /2012/ Indiana's breastfeeding rate increased to 67.1%.//2012// **/2013/ Indiana's breastfeeding rate increased to 69.9% in 2009.//2013//**

Two problems concerning infants require a special focus: (1) prematurity rates, and (2) accidental suffocation under one year of age. Although premature birth rates are approximately at the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Steering Committee, which is driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will also include communication of safe sleep practices, updates to nurse managers/nursing staff, and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network (IPN), and local community organizations in the four largest counties to conduct training and educational sessions. **/2013/ Indiana's infant mortality rate increased to 7.8 per 1000 live births in 2009.//2013//**

Concerns involving children and adolescents involve lead poisoning, sexually transmitted infections (STIs), obesity, and social-emotional health of very young children. Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and work with Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated. Reduction in the number of STIs is another state objective. Strategies to reduce the STI numbers include providing education and materials to providers treating adolescents, conducting a needs

assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Family Health Council to increase screening for STIs.

Obesity in high school age children is also a state concern. Recent data indicates that 13.8% of youth have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks, and increased physical activity. ***/2013/ In 2011, the number of youth in Indiana with a BMI greater than the 95th percentile for their age and sex increased to 14.7%.//2013//***

Addressing issues pertaining to the social-emotional health of children under the age of 5 is also an initiative. Foremost among these issues is the lack of qualified service providers to treat children in this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refugees/immigrants, and children of deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area.

The CSHCS division will be focusing its efforts with families and other partners in two main areas. First, the mission of the Integrated Community Services (ICS) Program started in 2008 within the division of Children's Special Health Care Services (CSHCS) is to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. This is a new initiative for the Indiana CSHCN program that has traditionally concentrated on reimbursing medical services for children with specific chronic conditions. Indiana was one of six states to be awarded federal funding from HRSA/MCHB to support system improvement for CYSHCN and their families and began working on systems improvement on June 1, 2009. Indiana is addressing objectives that fill gaps for CYSHCN in Indiana in each of the six core outcomes of successful systems of care for CYSHCN while synthesizing the goals into "umbrella" or overarching goals focused on 1) Medical Home Implementation, 2) Transition to Adult Care, and 3) The Indiana Community Integrated Systems of Services (IN CISS) Advisory Committee development in order to sustain the project. */2012/Indiana is working to address IN CISS sustainability through the formation of the Indiana Child Health Improvement Partnership, to be called "CHIP IN for Quality", a model that is self-sustaining through grants and partnerships.//2012//*

/2013/The CSHCN Division will continue focusing its efforts with families and other partners to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. The CSHCN Division continues to provide reimbursement for gap filling direct care medical services for children with specific chronic conditions. Over the past 3 years the CSHCN Division has made significant improvements in the area of QI efforts in Medical Homes; Transition to adult healthcare, work and independence and the establishment of a Child Health Improvement Partnership (CHIP-IN) to continue the work of the IN CISS Project to support and promote QI in Medical Homes and the many systems of care CYSHCN and their families encounter. The CSHCN Division has recently begun working with its partners in an Action Learning Collaborative model to create a statewide strategic plan to address Ease of Use of Services for Latino families with CYSHCN in Indiana. CSHCN will also continue to use the CDC's Act Early, Learn the Signs materials to not only educate families and providers regarding early screening and diagnosis of Autism, but to coordinate community-based service systems for CYSHCN and their families in the state.//2013//

The second emerging area of focus involves Indiana's CSHCS program reimbursement of providers for direct service expenses related to the CSHCS participants' medical condition. With the present economic climate the program faces continuing challenges to provide the past level of

benefits within the current budget constraints.

B. Agency Capacity

In terms of services during the fiscal year 2010, MCH was able to use Title V grant money to fund 12 family planning projects; five genetics centers (providing information, education and services to families of children with genetic disorders or birth defects); 11 infant health projects (providing primary, direct care services to children from birth to less than one year of age); nine prenatal care clinics (providing direct pre-natal medical care by an OB provider), 11 child health clinics (providing direct medical health services to children); six sites provide adolescent health services (three of them are school based providing direct health care services, education and referrals to high school students); one high risk infant follow-up program (providing follow-up care to newborns who were diagnosed with neurological or developmental problems); 15 prenatal care coordination (providing in-home visiting program to high risk pregnant women); six prenatal substance use prevention programs (providing high risk, chemically dependent pregnant women with education, referrals for treatment, and follow-up); six family care coordination programs (providing assessments, education, referrals, and advocating for families); and four dental projects. The narrative that follows provides some insight into the extensive partnership system that helps to ensure services, at all pyramid levels, to the Title V populations. (Please refer to Section B.2 of the Five Year Needs Assessment for a full listing of all partnerships.)

State Program Collaboration with Other State Agencies and Private Organizations

Collaboration with other state agencies and private organizations is key to continued capacity building to meet the needs of the Title V populations. At the State level, at least two agency partnerships have been pivotal in meeting the needs of the Title V population. These include the Family & Social Services Administration (FSSA) and Department of Education (DOE). Under FSSA, the Office of Medicaid Planning & Policy (OMPP) assists not only with payment issues but also with protocol and policy issues that help to establish uniformity and quality of care for women of childbearing age, pregnant women, children, and children with special needs. Collaboration with the DOE ensures that the needs of children/children with special needs are met in the educational venue. The partnership with DOE also provides an entryway for educational curricula on public health issues such as HIV/AIDS, STIs, and fetal alcohol spectrum disorders.

Partnerships with private organizations provide a mechanism for growing capacity beyond the reaches of government. Especially important are the partnerships with professional organizations in the healthcare industry. Examples include the American Academy of Pediatrics (Indiana Chapter) and the Indiana Academy of Family Physicians, which have been key partners in the Community Integrated Systems of Services project. The Indiana chapter of the American College of Obstetricians and Gynecologists and Indiana Certified Nurse Midwives assist in creation and implementation of prenatal standards of care as well as participating on initiatives such as decreasing prematurity. Organizations, such as the Indiana Perinatal Network and the Indiana Chapter of March of Dimes, are also instrumental in bringing issues on health/healthcare for the Title V populations to the legislative forefront, and disseminating perinatal health information throughout the state.

/2012/ New Partners - MCH is particularly excited about its new partnership with Goodwill Industries of Central Indiana. Specifically, through the Maternal, Infant, and Early Childhood Home Visiting Program, ISDH is funding Goodwill Industries to implement Nurse Family Partnership (NFP) in high risk communities in Indiana. This innovative public / private partnership will be the state's first implementation of NFP. Goodwill will wrap its innovative program, Goodwill Guides (Guides), around NFP. Guides is Goodwill's early childhood initiative. Guides works with the entire family, which in this case would be the family members of the NFP participants to:

1. Provide holistic services such as education, financial literacy, workforce development,

and health;

2. Early childhood development by navigating quality childcare options; and
3. Continue a relationship with the family and NFP clients after the NFP program ends after the child's second birthday.

Goodwill is well-positioned in central Indiana and has the capacity to implement such a new and broad-reaching program in Marion County, the most heavily populated county in the state. Goodwill can easily position itself in the high-risk areas identified in Marion County and is able to assist with leveraging MIECHV funds. Once families are through the NFP portion of the program, its program, Goodwill Guides will accept its participants to ensure continuity of support services until the child reaches age 5. //2012//

State Support for Communities

Limited staff at the State level means that resources must be used in a judicious manner to support the local communities. Dedicated State staff serve as a focal point or clearing house, providing local communities with information and research on evidence-based protocols and best practices. Since staff at the State level are aware of a wide range of programs across the state, Title V staff members also provide a means of connectivity between projects. This connectivity allows the sharing of information concerning successes and challenges in the implementation of a variety of local programs.

One example of an interface with local programs is the prenatal care coordination (PNCC) program. This program develops and coordinates access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. The PNCC project provides outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients.

One further example of state and local collaboration is the Early Hearing Detection and Intervention (EHDI) project. EHDI screens newborns for possible hearing impairment. Any infants testing positive for hearing impairment receive early intervention services. EHDI coordinates with Indiana First Steps, hospitals, providers, and other local agencies to provide intervention and follow-up services.

MCH also funds the Indiana Family Help Line (IFHL) which provides a means of connecting families with community level services. For example, during calendar year 2009, the top five needs were dental, transportation, food & clothing, health/medical, and financial assistance, respectively. A strong relationship between MCH staff and MCH clinic directors also allows for a sharing of information concerning local participation in community programs such as school wellness projects.

/2012/ During calendar year 2010, the top five information needs were transportation, dental, health/medical, Spanish Services, and Medicaid Services, respectively.//2012//

Coordination with Health Components of Community-Based Systems

Key health components in community systems include access to care, insurance coverage, prevention initiatives, and a medical home for children with special needs. At the state level, MCH and CSHCS collaborate with the OMPP, in the Indiana FSSA, to ensure a woman's access to prenatal care via the "presumptive eligibility" program. Children's Special Health Care Services (CSHCS) also collaborates with OMPP to provide supplemental medical coverage to families of children with chronic medical conditions. Community-based staff provide feedback to MCH staff concerning strengths and issues associated with these processes. Prevention programs are a key component in addressing issues, especially those associated with pregnancy. Examples of such initiatives include smoking cessation during pregnancy and prematurity prevention. IPN and

the Coalition to Prevent Smoking in Pregnancy (CPSP) are two examples of organizations that provide a conduit between state and local advocates in support of these initiatives.

The medical home is an especially important component for children/children with special needs. Currently, the pediatric staff at Indiana University School of Medicine is working with the Community Integrated System of Services on the medical home learning collaborative. This collaborative involves 9 pediatric and family practice members and is charged with establishing medical homes in these practices and others.

/2012/ The Medical Home Learning Collaborative has now expanded to 18 pediatric and family practices statewide. //2012//

Coordination of Health Services with Other Services at the Community Level

Indiana has at least two major mechanisms to coordinate health services with other community services. The IFHL is a centralized clearing house which connects families with services located in their respective counties/communities on a statewide basis. IFHL participates in the Indiana 211 Partnership, a regionalized information and referral service. IFHL is also involved with Connect2Help which provides a forum for discussion/implementation of standards, resources and policies concerning information and referral systems. The second mechanism of coordination of services concerns the contractual agreement with each of the MCH clinics providing services. Inclusion of Memorandums of Understanding (MOUs) with community organizations providing support services is strongly encouraged and reviewed with each clinic grant application.

/2012/ IFHL is also a member of Alliance for Information and Referral Systems (AIRS) which provides guidelines for implementation of standards, resources and policies concerning information and referral systems.//2012//

State Statutes Related to Title V Authority

In terms of state statutes, the following summaries present the most recent legislation that affects the Title V populations.

Newborn Screening Law (IC 16-41-17) -- Requires screening for 44 genetic and metabolic conditions.

Universal Newborn Hearing Screening (IC 16-41-17-2) -- Requires newborn hearing screening prior to infants leaving the hospital. This statute also requires appropriate referrals for confirmed positive test results.

Birth Defect Information (IC 16-38-4 and rule 410 IAC 21-3) -- Requires the collection and maintenance of birth defect information. This provides for the creation and support of the Indiana Birth Defects and Problems Registry.

Funding for Children with Special Health Care Needs (IC 16-35-2 and IC 16-35-4) -- Requires provision for and distribution of funds for children with special health care needs.

Workplace Lactation Support (SEA 219; P.L.13-2008) -- Requires government and private employers to provide a private space and access to cold storage for women to express breast milk while at work.

Tobacco Warning During Pregnancy (HEA 1118; P.L. 94-2008) -- Requires all retail outlets that sell tobacco products to post a warning of the dangers of smoking during pregnancy and post the toll-free Indiana Quitline number.

Family Planning Waiver (SEA 572; P.L. 20-2005) -- Requires the OMPP to submit a waiver to the

federal government extending Medicaid coverage for up to two years postpartum for family planning services.

Prenatal Substance Use Report (HEA 1314; P.L. 86-2006)--Requires the ISDH to assess the incidence and factors associate with substance abuse use during pregnancy in the State of Indiana.

Prenatal Substance Use Commission (HEA 1457; P.L. 193-2007) -- Establishes a statewide, multi-agency, bi-partisan commission to make recommendations on how to reduce substance use during pregnancy in the State of Indiana.

Cigarette Tax Increase (HEA 1678; P.L. 218-2007) -- Increases the tax on cigarettes and designate funds to support smoking-cessation activities, covering uninsured individuals and immunizations.

Other legislative activities include efforts to implement a smoking ban in public places; however, this effort failed. One highlight in tobacco-related legislation involved the failed attempt to abolish the Indiana Tobacco Prevention and Cessation Agency's Executive Board, dissolve the agency, and transfer the assets of the ITPC to the ISDH a part of SB 298.

As reported in the Indianapolis Star (3/23/10), Governor Daniels suspended future enrollments for childless adults in the Healthy Indiana Plan, blaming the healthcare reform package passed by Congress. Daniels said the state should continue to enroll families for the immediate future so it would not be forced to forfeit federal stimulus dollars.

Based on Senate Act 226, the health finance commission is studying the topic of teen suicide, including the root causes and prevention, during the 2010 legislative session. Finally, House enrolled Act 1320, which controls the selling and purchase of ephedrine and pseudoephedrine, also requires the legislative council to assign study topics on this issue. It was signed into law by Governor Daniels on 3/18/10.

/2012/

SEA 04, suicide prevention

Effective July 1, 2011, SEA 04 allows a school's governing body to adjourn its schools to allow teachers to participate in a basic or in-service course of education and training on suicide prevention and recognition of signs that a student may be considering suicide. The Division of Mental Health and Addiction (DMHA) is required to provide information and guidance to local school corporations on evidence-based programs for teacher training on the prevention of child suicide and recognition of signs that a child may be considering suicide. After June 30, 2013, an individual may not receive an initial teaching license unless he/she has completed training on suicide prevention and the recognition of signs that a student may be considering suicide.

Family Planning Services

Language regarding Indiana's long-standing attempts to implement a family planning waiver was incorporated into SB 461, Health Care Reform Matters, which also stipulates that a state agency may not implement or prepare to implement the federal Patient Protection and Affordable Care Act. Before January 1, 2012, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human Services for approval of a state plan amendment (SPA) to expand the population eligible for family planning services. The SPA must include women and men, set income eligibility at 133% of the federal income poverty level, and incorporate presumptive eligibility for services to this population. In addition, the law requires OMPP to report on the progress of the SPA to the Medicaid oversight committee during its 2011 interim meetings.

Perinatal HIV

SB 581, HIV Testing of Pregnant Women was passed with widespread support. The law now

permits consent by a pregnant woman to have HIV testing to be documented in the pregnant woman's medical chart instead of requiring a written statement of consent. It also requires the issue of general HIV consent to be addressed by a summer study committee.

Abortion and Reproductive Health Care Services

National attention has focused on HB 1210, which ends the use of public funds for Planned Parenthood of Indiana (PPIN), prohibits Medicaid payment for PPIN services, sets a 20 week cutoff for abortions, and requires physicians to notify patients of a link between abortion and infertility, fetal pain and numerous other provisions.

On June 1, the US Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) rejected the Indiana Office of Medicaid Policy and Planning (OMPP) request to block Medicaid recipients from receiving care at PPIN, saying that such a provision is in violation of federal law. Indiana has 60 days to appeal the decision if it chooses. In response, state officials have said they will continue to follow and enforce the law, and are seeking guidance from the Indiana Attorney General's office. PPIN and the American Civil Liberties Union have filed suit against the law. Their request for an immediate injunction to cease its enforcement was initially denied, then granted by US District Judge Tanya Walton Pratt while she considers the case.

Tobacco and Other Drugs

Efforts to pass comprehensive smokefree air legislation failed once again when a heavily-amended HB 1018, Smoking Ban in Public Places, was voted down by Senate committee. The Indiana Campaign for Smokefree Air will continue meeting over the summer to assess strategies for the 2012 session. HB 1233, State Boards and Commissions, moved the Indiana Tobacco Prevention and Cessation Agency into the Indiana State Department of Health. Tobacco-prevention funds were cut by over \$2 million. The subject of substance use by pregnant women will be examined by a summer study committee, as required by HB 1502.

Newborn Screening

In 2011, the Indiana legislature added pulse oximetry to Indiana's newborn screen. Per 16-41-17-2, effective January 1, 2012, all birthing facilities in Indiana will be required to perform pulse oximetry screening on all newborns to detect critical congenital heart defects. The ISDH Newborn Screening Program is working with neonatologists, nurses, pediatric cardiologists, and high-risk obstetricians to finalize the screening protocols; identify any guidelines or recommendations related to purchasing, upgrading, or standardizing pediatric pulse oximetry equipments; and identify the type of data that will be required for reporting to ISDH. //2012//

State Title V Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants

MCH and CSHCS are committed to providing quality, comprehensive, holistic health care to low-income pregnant women, mothers and infants in community settings and decreasing infant mortality and low birth weight babies. In FY 2010-2011, Indiana Title V funded 36 direct care services in 24 counties. These direct care services provided care to 26,016 pregnant women, 89,607 infants, 73,030 children 1 to 22 years of age, and 6,551 children with special health care needs.

MCH provides the "Free Pregnancy Test Program", a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The program also helps pregnant women obtain early prenatal care through Hoosier Healthwise, WIC, and prenatal care coordination. Furthermore, it assists the entrance of non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Currently, Free Pregnancy Test program is in 58

counties and served 14,382 clients in FY 2009.

/2012/From October 1, 2009 to September 30, 2010, clinics funded to provide free pregnancy tests offered a total of 9,438 tests. Of these tests offered, 60.5% were offered to patients who were White; 21.5% to patients who were Black; 10.4% to patients with an Unknown Race; 2.4% were offered to patients who were Asian/Pacific Islander or American Indian; and 19.5% were offered to patients who were Hispanic / Latino. In addition, nearly 2 in 3 patients (61.4%) were at or below 150% of the poverty level. Over 1 in 3 (34.2%) were not high school graduates and nearly 1 in 10 (9.4%) were currently attending high school. Over 8% of all patients were under the age of 17, while 45.2% were between the ages of 18 to 24 and another 25% were between the ages of 25 and 30. Of all tests, 40.1% were Positive while 57.7% of the tests were Negative. Of all patients, two out of three (66.3%) had no insurance. One in three patients (33.9%) was a smoker. Over 8,200 referrals were made as a result of the pregnancy tests. The FPTP is one of the most cost effective ISDH Title V programs considering the volume of data generated by each test that is not available elsewhere. FPT's provide the "proof of pregnancy" required by Medicaid for enrollment in PNC much earlier in their pregnancy than they would have without it. With only \$8,677 available for this program during the project period, an incredible number of women were served and invaluable data was gathered regarding low-income women of childbearing age who engage in sexual activity.//2012//

MCH provides enabling services for pregnant women, mothers and infants through grants to five prenatal care coordination programs. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women. The program targets pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCH staff also oversees the training and certification of community health workers to assist prenatal care coordinators.

MCH supports pyramid level enabling services for smoking, alcohol and drug use cessation in the Prenatal Substance Use Prevention Program (PSUPP). MCH receives money from the State's Division of Mental Health and Addiction (DMHA) to fund all or part of eight of the grantees, Tobacco Settlement funds three grantees and Title V funds all or part of five grantees, including one site that receives partial funding from both Title V and DMHA.

/2012/ MCH now operates three new federally-funded programs that serve women of childbearing age and their families: (1) Social Immersive Media for Lifecourse Education [SIMPLE]; (2) Pregnant and Parenting Adolescent Support Services [PPASS]; and (3) Maternal and Infant and Early Childhood Home Visiting Program [MIECHV].

SIMPLE is an innovative social marketing approach to increase public awareness of the importance of integrating the life-course perspective into preconception planning and care. To improve health and pregnancy outcomes, new and expectant parents must first be aware of protective and risk factors that may affect birth outcomes. The purpose of this program is to (1) increase knowledge of life-course perspective for pregnant and parenting women and their families; (2) increase knowledge of life-course perspective for the local community; (3) decrease poor birth outcomes utilizing a social immersive interactive media tool to teach healthy habits; and (4) expand public health professional's ideas of teaching tools to include new technology.

At the foundation of the SIMPLE project is SNIBBEInteractive's InfoTiles (<http://www.snibbeinteractive.com/platforms/socialscreen/products/infotiles>). With InfoTiles, people can browse large amounts of information in a playful social game. People move a game tile over a series of boxes. When they rest the selection box, the tile turns over and reveals video, images, and text. By making information browsing a game, people are engaged and excited to explore all the information. SIMPLE targets populations on all levels of the Social Ecological Model - the individual new or expectant parent, those that provide social and medical support to the new or expectant parent, communities identified as high risk, and the general population.

SIMPLE brings public health initiatives to the communities of Indiana through the use of a social media website and an interactive media device. The evaluation piece of this unique and innovative project will provide MCH with necessary data to assist the state of Indiana in reducing adverse health outcomes among first time parents and their children by increasing the knowledge that the public holds on conception and the course of pregnancy. The SIMPLE tool will be used at local community health fairs, baby expos and exhibits, health centers, and other nonprofit and for profit resources used by expecting parents, their family members, and their friends. SIMPLE truly acts as a public health program which enters into the community instead of asking the community to come to us-- "mobile" information in this sense. This program reaches mothers, fathers, family members and friends of those expecting a new baby across the state of Indiana. The SIMPLE tool is being taken into 5 Indiana counties which represent the urban, rural, and suburban populations during the course of its three year federally funded research stage. Specific counties were chosen to help us better understand how social media outlets and interactive devices impact the knowledge that one can gain on public health through such formats.

The purpose of PPASS is to work with community partners to implement evidence-based programs at high schools and community organizations to provide assistance and support for pregnant and parenting teens. MCH developed a survey to assess perceptions of stakeholders to identify community perceptions, partnerships, resources and challenges related to the population of pregnant and parenting adolescents. All 92 of Indiana's counties were represented in the responses. There were 197 respondents who began the survey and 137 who completed the survey. Results from the web-based survey supported that stakeholders felt many services available to pregnant and parenting teens were lacking or missing.

MCH works in collaboration with community partners to increase public awareness about Indiana's Early Childhood Comprehensive Systems (ECCS) project, Sunny Start, and enrollment by pregnant and parenting teens in Text4baby. MCH and its funded partners employ a life course approach to the services provided to pregnant and parenting teens through the PPASS grant opportunity, allowing for needs to be met in areas such as perinatal and child health care, child development, nutrition, adolescent development, case management, education, mental health, domestic violence, and strengthening families. Through this program, at least six sub-grantees will be awarded funding to provide direct services and programs and/or research and evaluation of pilot studies that better assist pregnant and parenting teens in completing school and achieving improved health outcomes. With the PPASS grant, ISDH's MCH division hopes to strengthen infrastructure in the state so comprehensive sets of services are available to pregnant and parenting teens. MCH has created a Life Course Model for the PPASS Program that demonstrates the need to create systems of services involving both traditional and non-traditional partners. Accordingly, MCH is not funding applicants that propose single agency/organization solutions. Rather, MCH is requiring grantees to partner with other service agencies to wrap comprehensive services around a pregnant and/or parenting adolescent and his/her family.

The last of the three grants is the Home Visiting Program (MIECHV) under the Affordable Care Act, to support evidence-based home visiting programs focused on improving the wellbeing of families with young children. Through the Maternal, Infant, and Early Childhood Home Visiting Program, nurses, social workers, or other professionals meet with at-risk families in their homes, evaluate the families' circumstances, and connect families to the kinds of help that can make a real difference in a child's health, development, and ability to learn, such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance. There is strong research evidence that these programs can improve outcomes for children and families and also yield Medicaid savings by reducing preterm births and the need for emergency room visits. In Indiana, the MIECHV program is co-let by MCH and the Department of Child Services (DCS) which is Indiana's Child Welfare Agency. A statewide needs assessment was conducted to find the areas of greatest need for home visiting services.//2012//

/2013/ MCH contracted with the IU Neonatology Division to develop the first "Circles"

national resource center. Circles is a program to assist individuals who want to get out of poverty.//2013//

Preventative and Primary Care Services for Children

MCH provides preventative and primary care for children through grants to 11 child health care clinics and 6 adolescent health care clinics. These clinics provide both direct medical and enabling services. Many of these grantees are community health centers or are a part of a larger health care facility. MCH provides additional enabling services through six family care coordination programs. Family care coordinators are trained professionals who make home visits to coordinate services for high risk families. In addition coordinators provide referrals, education, and support.

Children's Special Health Care Services (CSHCS)

Indiana's CSHCS provides supplemental medical coverage to help families of children who have serious, chronic medical conditions, age birth to 21 years of age. The program serves families with an income before taxes no greater than 250% of the federal poverty level. Statewide partnerships include family support organizations, Medicaid, hospitals and providers of medical services. CSHCS has gone from covering a few diagnoses to providing coverage for well over a thousand specific conditions. The caseload has grown from the original 12 to more than 8,500 participants.

/2012/ In 2011, CSHCS is expanding Care Coordination Services at the central state level. The number of enrolled children has fallen from 8,500 to 5,000 due to a number of factors including lack of a central application system, budget decreases and decreased marketing.//2012//

The Integrated Community Services (ICS) Program focuses on building collaborative relationships with agencies and organizations to integrate family-centered and culturally competent service systems for Children and Youth with Special Healthcare Needs (CYSHCN). The ICS Program was awarded a three year (6/1/2009-5/31/2012) HRSA grant to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families.

The Indiana Community Integrated Systems of Services (IN CISS) Project is focused on three primary objectives including (1) implementing Medical Homes within primary care practices throughout the State; (2) transitioning youth with special healthcare needs to adult healthcare, work and independence, and (3) building systems sustainability through the organization of a Statewide Advisory Committee representing CYSHCN, their families, and the organizations that serve them.

/2012/Indiana is working to address sustainability through the formation of the Indiana Child Health Improvement Partnership, to be called "CHIP IN for Quality", a model that is self-sustaining through grants and partnerships.//2012//

ICS partnerships include CYSHCN and their families, family support organizations, Indiana American Academy of Pediatrics (AAP), Indiana Academy of Family Physicians (AFP), governmental, State and local agencies, medical professionals/providers, medical institutions and local communities.

/2012/ The ICS program is working with the Vermont Child Health Improvement Partnership to adopt their model for Indiana.//2012//

Core partners include (1) the IU School of Medicine (IUSOM) that provides a project facilitator, parent consultants, and project evaluator, (2) the Center for Youth and Adults with Conditions of Childhood (CYACC) that provides a website and educational office visits to help youth with

specials healthcare needs transition to adult healthcare, and (3) About Special Kids (ASK) that provides meeting support and stipends for families and youth.

//2012/Indiana is working with CYACC on training for youth and young adults with chronic conditions who will be trained as leaders for the "Be Your Own Boss" Chronic Disease Self-Management workshop, that will be conducted throughout the state //2012//

To enhance the capacity of CSHCS to access family-centered, community based coordinated care, the IN CISS project has recruited nine healthcare practices to participate in a medical home learning collaborative. This project is aiding the nine practices in developing and implementing quality improvement efforts. Teams are participating in biweekly teleconferences and face-to-face site visits. A face-to-face kick-off meeting was held in October 2009 and a follow-up large group meeting was held in May 2010.

//2012/The Indiana CISS project held a second annual meeting in October 2010 and conducted a follow-up meeting with the practices in May 2011. //2012//

Cultural Competence

In an effort to address health disparities in Indiana, the General Assembly passed legislation creating the Indiana Council on Black and Minority Health (IC 16-46-6 1992) and directed ISDH to create an Interagency Council on Black and Minority Health. This council includes representation from both government and State agencies. According to the Interagency Council on Black and Minority Health's Report for 2008, some of the key issues in minority health include teen pregnancy and entrance into prenatal care in the first trimester. The teen pregnancy rate is significantly higher for minorities and the percentage of minorities who have early entry into prenatal care is much lower than whites.

MCH staff work with the Director of the Office of Minority Health and the Minority Health Epidemiologist on disparity issues such as prematurity, low birth weight, very low birth weight, and infant mortality. MCH also encourages all grantees, especially those in areas with large or growing minority populations, to work with local Minority Health Coalitions to develop culturally competent staff and materials.

MCH funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Training in cultural competency is provided by one of MCH's grantees, IPN, on an as requested basis.

The Indiana Minority Health Coalition (IMHC) director serves on the Steering Committee of Core Partners for Early Childhood Comprehensive Systems (ECCS) initiative. IMCH also participates in programs such as "Have a Healthy Baby", "Operation Fit Kids", and "Diabetes Self Management".

MCH also collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meet

C. Organizational Structure

The Honorable Mitchell (Mitch) E. Daniels, Jr. (R) was sworn in January 2005 as Indiana's 49th Governor. The Governor was re-elected for his second and final term in November 2008. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head ISDH. She led the Health Department until her resignation in March 2010 to take a position at the Centers for Disease Control as the Deputy Director and Director of the new Office of State, Tribal, Local and Territorial Support.

The new State Health Commissioner, Dr. Gregory N. Larkin, M.D., FAAFP, was appointed by Governor Daniels as the Indiana State Health Commissioner in March 2010. At that time, he was asked by the Governor to continue the State's progress in immunizing children, reporting and reducing medical errors, and improving the health culture of Indiana. Prior to his appointment, Dr. Larkin served as the Chief Medical Officer for the Indiana Health Information Exchange, which promotes health information technology for the advancement of quality patient and community care. He is a recognized leader in the promotion of health information and technology and will extend Indiana's recognized preeminence in that area. Before joining the Indiana Health Information Exchange as its Chief Medical Officer, Dr. Larkin was the Director of Corporate Health Services for Eli Lilly and Company. During his tenure at Eli Lilly, Dr. Larkin was the company's Global Medical Director managing five domestic health care clinics, the domestic employee and retiree health plan and was the global liaison for the company's world affiliates for occupational and corporate health care. He has been a member of the Healthy Indiana Plan task force, served as Chairman of the Board of the Indianapolis Medical Society and the Indiana Blood Center, and volunteered with many other medical and community organizations.

ISDH is one of several major agencies in State government. ISDH has five commissions overseen by the State Health Commissioner and Deputy Health Commissioner (Please refer to the attached organizational chart). Loren Robertson M.S., R.E.H.S. was appointed Deputy Commissioner in June 2009. Prior to his appointment, Loren served as the Assistant Commissioner for Public Health and Preparedness at ISDH. For more than 30 years, he was associated with the Ft. Wayne - Allen County Department of Health before he began his career with ISDH in May 2005./2012/Loren Robertson resigned in May, 2011. Dr. Larkin appointed Sean Keefer as Chief of Staff on April 14, 2011. Prior to his appointment, Mr. Keefer served as Deputy Secretary of State and Chief of Staff in the Indiana Secretary of State's office. Before joining the Secretary of State's office, he served as the Director of Global Health & Science Policy for the American College of Sports Medicine (ACSM). One of his key responsibilities was to spear-head legislative efforts at the state and federal level on various health-related initiatives with the NFL, NCAA, American Academy of Pediatrics and Centers for Disease Control and Prevention, among other organizations. He also served on many committees to promote physical activity and healthy lifestyles, including serving as one of the U.S. liaisons for Raza/PANA (Physical Activity Network of the Americas), and served as chair of the Media and Policy Committee for the "Exercise is Medicine" initiative which worked directly with the U.S. Surgeon General's office. He also worked with leadership from the Pan American Health Organization (PAHO) to execute a Memorandum of Understanding between ACSM and the World Health Organization to tackle health issues such as diabetes, obesity and built environment in urban settings in North and Central/South America.

Mr. Keefer also served as the Deputy Commissioner for the Indiana Department of Labor under the Daniels' administration. In his role as Director of the State OSHA Consultation program-INSafe Indiana, he managed a team that worked to educate and ensure workplace safety and health. In 2008, in his role as Director, Indiana was awarded for the first time the US Department of Labor's Excellence in OSHA Consultation Program Award. Additionally, he was co-chair of the state's largest Work Safety and Health conference from 2007-2010. He also served as the Legislative Director and Public Information Officer.//2012//

The five commissions at the ISDH include Laboratory Services, Public Health and Preparedness, Operational Services, Health Care Quality and Regulatory, and Health and Human Services, which is where the Title V Program resides. As of June 2010, Dawn Adams is the Interim Assistant Commissioner of the Health and Human Services (HHS) Commission. HHS includes the Office of Women's Health, Nutrition and Physical Activity, WIC, Chronic Disease, Children's Special Health Care Services (CSHCS) and Maternal and Child Health (MCH). MCH and CSHCS are responsible for administering and coordinating all parts of the Title V Block Grant for Indiana. //2013// ***The Operational Services Commission is no longer. The responsibilities of that Commission have been assumed by the Chief of Staff.***//

Dawn M. Adams, J.D., has been with ISDH since 2006 and currently serves as the Interim Assistant Commissioner of the Health and Human Services Commission. She was hired as a Staff Attorney in the Office of Legal Affairs and was recruited by the former Assistant Commissioner of the Public Health and Preparedness Commission, Loren Robertson, to serve as his Operations Manager in the fall of 2008. Her work with public health began in 1993 when she worked as an Environmental Health Specialist for the Grant County Health Department. As the Operations Manager, Ms. Adams took on special projects and served as a resource to the division directors for all things "operational" (finances, contracts, legal issues, human resources, IT, etc.). In addition to these duties, she serves as the Preventive Health and Health Services Block Grant Coordinator on behalf of the agency and frequently takes on other special assignments as requested by the Deputy State Health Commissioner. /2013/ Dawn Adams resigned from her position in December, 2011. Ellen Whitt was appointed Assistant Commissioner of the Health and Human Services Commission at the same time. Ms. Whitt previously served as deputy chief of staff and senior advisor for health promotion in the office of the governor, working as liaison to the Indiana State Department of Health (ISDH), Indiana Tobacco Prevention and Cessation (ITPC), and the statewide trails plan initiated by Governor Daniels and managed by the Indiana Department of Natural Resources (DNR). She also participated fully in the development of the statewide obesity prevention plan called the "Indiana Healthy Weight Initiative," serving for a time as the director of the Division of Nutrition and Physical Activity at ISDH.//2013//

Judith A. Ganser, M.D., M.P.H. is Medical Director for Maternal and Child Health, Children's Special Health Care Services and WIC at ISDH. In this position, she is responsible for providing public health leadership, policy development, and medical guidance to programs including prenatal, child and adolescent health, CSHCS, Genomics Program, PSUPP, Indiana RESPECT teen pregnancy prevention, WIC, Early Childhood Comprehensive System planning and Community Integrated Systems of Service for children with special health care needs (CSHCN). She works with a multidisciplinary professional team and administrative staff. Dr. Ganser received her medical degree from Temple University Medical School and her Masters in Public Health from the University of North Carolina at Chapel Hill. She is board certified in Pediatrics and did a Preventive Medicine residency. Prior to joining ISDH in 1991, she served five years as the Medical Director of the Adolescent Health Program for MCHD. She has also worked as a Pediatrician in a Community Health Center in Pueblo, Colorado and Physician-team leader in School-Based Pediatric/Adolescent Clinics in Dallas, Texas. ***/2013/ Dr. Ganser retired from ISDH in February, 2011. ISDH has not hired a replacement as of this writing. However, Dr. Joan Duwve, State Medical Director, and Dr. Meena Garg, Director of Chronic Disease, are available to answer questions and address any concerns.//2013//***

In the Health and Human Services Commission, Mary M. Weber, MSN, RN, NEA-BC, became the new Director of the Maternal & Child Health Division in October 2009. Kimberly Minniear became the new Director of CSHCS in February 2010, after serving as the Director of Integrated Community Services since May 2007. Also, in April 2010, James R. Miller, DDS was hired as the Director of Oral Health.

Mary Weber, MSN, RN, NEA-BC, joined ISDH as the Director of the Division of Maternal and Child Health in October of 2009. Prior to joining ISDH, Ms. Weber served in leadership roles related to maternal and child health for over twenty years in both for-profit and not-for-profit corporations. Most recently, she was the administrator for Women's Health for the Clarian Health System in Indiana, responsible for strategic planning, program development, labor management, and overall operational administration. Specific programs included perinatal outreach, childbirth education, Clarian Breastfeeding Center, perinatal bereavement, postpartum home visits, postpartum mood disorders, support groups for mothers of infants and toddlers, and an interpreter-doula program for Spanish speaking maternity patients.

Ms. Weber has been active on many volunteer boards, including IPN, the Indiana University National Center of Excellence for Women's Health, and the Indiana Mothers' Milk Bank, and CKF. She led the effort to establish the Indiana Mothers' Milk Bank, which pasteurizes human milk from screened donors and distributes it to newborn intensive care units throughout the Midwest. Ms. Weber received her Master's degree in Nursing Administration from Indiana University School of Nursing, and is board certified as a Nurse Executive Advanced.

Kimberly K. Minniear is the Director of the Children's Special Health Care Services (CSHCS) Division. With a BA from Indiana University in Social and Behavioral Sciences, she received the honor of the 2004 Marion County Social Worker of the Year. Ms. Minniear's professional experience includes serving for seven years as a Marion County Family Case Manager at the Department of Child Services, for two years as the Executive Director for the Kokomo Academy in Kokomo, IN., and for five years as the Executive Director of the Carroll County Department of Family & Social Services in Delphi, IN. Among her many accomplishments, Ms. Minniear developed treatment programming for a new juvenile male residential treatment; wrote grants, secured funding, and established Peer Counseling Program for children; developed programs to enhance parenting skills for at-risk families; served as a member of the Child Protective Team; and is a Certified Child Protective Social Worker.

Dr. Jim Miller joined the HHS Commission as the Oral Health Director in April 2010. He has over twenty-five years combined experience in teaching, practice, and dental public health research. He holds D.D.S. and M.S.D. degrees from the Indiana University School of Dentistry, and was a Senior Fellow for five years in the Department of Dental Public Health Sciences at the University Of Washington School Of Dentistry. He also holds a Ph.D. degree in Epidemiology from the University of Washington.

Although not housed in the same commission, MCH works closely with the Office of Primary Care, Lead and Healthy Homes, HIV/STI, Public Health and Preparedness, Immunization, and the Epidemiology Resource Center which are housed in the ISDH Public Health and Preparedness Commission. MCH programs and staff also work closely with the ISDH Operational Services Commission for Finance, Information Technology, (HIPAA) Compliance, Public Affairs, the Office of Minority Health, Legal (and Legislative) Affairs, and Vital Records.

Title V Program Administration

MCH distributes the Title V Federal-State Block Grant Partnership budget primarily through grants to community agencies that provide direct, enabling, population-based, and infrastructure building services that impact the federal and State performance measures.

MCH Business and Grants Management staff manages all contracts, grants, MOUs and MOAs, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures for the MCH Division and the CSHCS Division. This section makes Title V budget and planning recommendations and coordinates all applications for funding, including primary responsibility of preparing Title V Budget and Budget Narrative and Budget. The staffs coordinate all contracting, procurement and programmatic financial tracking and provide clerical support for the MCH Division. Since July 2007, Vanessa Daniels, MPA, MRC, CRC, has managed this Section.

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Title V funds enable 86 full-time employees and 34 contractors (16 part-time and 18 full-time for MCH and CSHCS). Title V funds also support one dentist and one secretary in the Oral Health Program, one Information Technology Service (ITS) professional, and two contractual positions in ITS. Outside the HHS Commission, Title V funds support the following staff: one Director, two

Environmental Scientists, one Administrative Assistant and one Data Processing Operator for Indiana Lead and Healthy Homes; one Chemist for LRC Chemistry Lab; and four fluoridation staff which include two General Sanitarians, and two Fluoridation Consultants.

Mary Ann Galloway joined the MCH Division on April 19th as the Director of Life Course Health Systems. Ms. Galloway has an MPH from the University of South Carolina and received a PMP certification in 2006. She established and directed the Project Management Office at MPlan, a large health care insurer in Indiana, for three years. Prior to that engagement, she founded and directed a national consulting firm for over 20 years that specialized in healthcare system delivery development, project management and managed healthcare. Her company worked with primary care and other providers in over 20 states who served mothers, infants and children. She manages a team of seven Life Course Health Systems staff. The team oversees the MCH grantees, collaborations and partnerships. They also implement evidence based strategies to improve MCH outcomes with recognition of all socio-economic factors that impact health at the community level.

/2012/ The Life Course Health Systems Team (LCHST) has grown substantially in the past year, primarily due to the award of three new grants. Currently, the LCHST has seven state staff positions and eight contracted positions. Recruitment is underway for two additional contracted positions to help with the Statewide Home Visiting Program. This increased capacity has enabled MCH to improve the reach and depth of programs and services. //2012// **/2013/ The LCHST has eight state positions and seven contracted staff.//2013//**

Bob Bowman has served five years as Director of Genomics and Newborn Screening Program at ISDH. As Director, he oversees the Newborn Screening Program, the Early Hearing Detection and Intervention (EHDI) program, and Genomics program, including the Indiana Birth Defects and Problems Registry. Previously, Mr. Bowman served as Genetic Specialist for ISDH, where he had direct oversight of the Birth Defects and Problems Registry. Prior to joining ISDH, Bob received a Master's degree in Genetic Counseling from Indiana University, as well as two prior Master's degrees in Secondary Education and Developmental Biology and Genetics from West Virginia University.

Andrea L. Wilkes joined ISDH as a Public Health Administrator in MCH in November 2000. She serves as the Project Manager for the Early Childhood Comprehensive Systems grant (Indiana's Sunny Start: Healthy Bodies, Healthy Minds initiative) and supervises two professional staff in the program area of child health. She earned two bachelor degrees (English and Psychology) from Miami University in Oxford, OH, Prior to her employment with MCH, Ms. Wilkes joined State service with the Disability Determination Bureau of FSSA. She served as a manager of a disability claims adjudication unit for many years, during which time she was assigned as a consultant to the Office of the Commissioner at Social Security Administration Headquarters in Baltimore, MD.

/2012/ Charrie Buskirk, MPH joined ISDH as a contractor to serve as the Women's Health Coordinator for women of childbearing ages in October 2010. She has since joined ISDH full-time at 1.0 FTE in April 2011 and now serves as the Public Health Administrator of Women's Health ages 14-44. In this capacity, Ms. Buskirk oversees staff operating the three new federally-funded programs that serve women of childbearing ages: (1) PPASS; (2) SIMPLE; (3) MIECHV. In addition, Ms. Buskirk directs the operations of the Free Pregnancy Test Program and is in the process of ensuring that data collection and reporting as well as ordering methods are streamlined for optimal efficiency. Ms. Buskirk is also responsible for working with statewide partners on the child-spacing state priority measure and to ensure that women of childbearing age in Indiana are receiving adequate and timely preconception and interconception care. Finally, Ms. Buskirk serves as a Title V consultant with ISDH-funded clinics throughout the southern parts of the state. With 10 years of nonprofit programming and fundraising experience, Ms. Buskirk, comes with expertise in procuring and managing federal, state, and private grants and foundation funding after serving as the Director of Grants for a county health and hospital system. After

graduating from Purdue University School of Science with a major in Psychology in 2005, Charrie earned her Master of Public Health degree with a concentration in Behavioral Health Science from Indiana University School of Medicine in 2009. ***/2013/Charrie Buskirk left her position in October 2011. Carolyn Runge was hired as her replacement and began work in June 2012./2013//***

Stephanie Woodcox, MPH, CHES, joined ISDH in 2006 and was promoted to Public Health Administrator in 2010. Ms. Woodcox serves as the State Adolescent Health Coordinator and oversees the Adolescent Health Services (AHS) Program. AHS focuses on serving young people ages 10-24. In this position Ms. Woodcox is the Program Manager for Indiana RESPECT, the state's teen pregnancy prevention initiative; is the state's administrator for the Indiana Family Planning Partnership; is a consultant to school-based adolescent health clinics; and provides leadership to the Indiana Coalition to Improve Adolescent Health (ICIAH) by serving as its facilitator. Ms. Woodcox also supervises the Youth Risk Behavior Survey (YRBS) Coordinator. ***/2013/ Stephanie Woodcox resigned her position in August 2011. Jeena Siela, her replacement, began work in January 2012./2013//***

Beth Johnson joined ISDH in 1993 and currently serves as the State Perinatal Health Coordinator. Ms. Johnson oversees the State Perinatal Quality Improvement that is developing hospital levels of care standards for obstetric and neonatal care, establishing a State Perinatal Database, and addressing a state transport program for mothers and infants. In addition, Ms. Johnson oversees the state Prenatal Care Coordination Program, the State Community Health Worker Program, the Infant Health and Survival Council, and maternal and infant mortality programs. ***//2012//***

Larry S. Nelson, Public Health Administrator, serves as a Team Leader and the Training Manager for MCH. Larry has a B.S. from Indiana State University with a concentration in Public Administration and Political Science. Larry has served in the position of Prenatal Substance Use Prevention Director for one year, CSHCS Team Leader for ten years and in his current position as MCH Team Leader for five years.

/2012/ Larry Nelson, Team Leader and the Training Manager for MCH, retired. His position will be used to add capacity to the Business and Grants Management section. //2012// /2013/Larry resigned in May 2011. Recruitment is underway for his position./2013//

Vanessa Daniels, MPA, MRC, CRC, became the Business and Grants Management section's manager and supervises the Assistant Grants Manager and the MCH Administrative Support Section. Vanessa has a Bachelors of Science in Business Management and Human Resource Management. She also has two Masters Degrees: one an MPA in Public Affairs and Nonprofit Management as well as a MRC in Counseling and is a licensed Rehabilitation Counselor with 12 years of grants management and grant writing experience. Additional staff that are a part of the Business Management Section includes an Assistant Grants Manager with over 15 years experience in State government, an Administrative Assistant, three support staff, and one contract support staff.

/2012/ December 2010, Ms. Daniels was promoted to serve as the Director of Grants and Business Management. This change ensures continuity of services provided to grantees of Title V and compliance with all federal and state requirements./2012//

The MCH Data Analysis Section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies such as all of the MCH projects and clinics in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section is headed by Joel Conner, a Public Health Administrator with a BS in

Education and over twenty years of data analysis experience. Joe Haddix, MPH, serves as epidemiologist for Title V programs.

/2012/ Joel Conner who headed the Data Analysis Section also retired. Plans are underway to expand the Data Analysis section to become an MCH Epidemiology, Data Analysis and Surveillance group.//2012//

/2013/ During 2012, MCH developed an Epidemiology Surveillance and Data Analysis team that resides in the same area as MCH program staff. Joe Haddix, MPH, heads a team of five epidemiologists.//2013//

Hope Munn is a social worker who began her career in 2000 after completing her undergraduate studies and earning a Bachelor of Social Work degree from Indiana University. In 2006, she earned a Master of Social Work degree also from Indiana University. Ms. Munn has served in numerous social service settings with various populations including families with low income; veterans with mental illness; persons who are homeless; individuals/families of domestic violence; and children with mental illness and/or behavioral challenges. Ms. Munn's experience as a social worker includes eligibility determination for public assistance programs, provision of in-home counseling to at-risk children/families, and facilitation of care coordination of mental health services. Ms. Munn was recently hired as supervisor of the IFHL and brings social work expertise to the MCH leadership team.

The CSHCS Division's management team includes the CSHCS Director, CSHCS Eligibility Manager, CSHCS Claims Manager, CSHCS Prior Authorization Manager, CSHCS Provider Relations Manager and the CSHCS System Manager. In 2007, the CSHCS division added the Integrated Community Services Program and a manager were hired to lead that program. In 2009, the Integrated Community Services Program was awarded a HRSA/MCHB grant to work on systems of care improvement for children and youth with special healthcare needs and their families. The project employs five contract staff to facilitate the work of the project. Two of the team members are parents with children having special health care needs.

Role of Parents of Special Needs Children

Parents of children with special health care needs are members of MCH and CSHCS as paid staff and serve in the important role of providing support and leadership to families navigating the complexities of determining diagnosis, treatment, and follow up necessary for their children. Staff support the EHDl Program Director and the Guide By Your Side program. The EHDl program has employed parents via contract agencies since June 2007. Currently, the EHDl program includes three parents as staff members, all of whom are contracted through Indiana Hands & Voices, a parent support organization. One parent works as the Parent Program Coordinator. They oversee the two EHDl parent consultants, is the primary contact for families of children diagnosed with hearing loss through EHDl, and is the coordinator of the Guide By Your Side (GBYS) Program. GBYS is a parent-to-parent mentor program that is offered jointly through EHDl and Indiana Hands & Voices. The primary role of the two EHDl Parent Consultant is to conduct follow-up activities (phone calls and letter generation) to families of the nearly 2,000 children who are referred to EHDl annually after receiving a did not pass newborn hearing screening result. One parent consultant is bilingual (Spanish). The other parent consultant has a child who has been diagnosed in the past year and so is highly familiar with negotiating the current process of hearing loss identification and early intervention.

Additionally two other parent consultants serve on the IN CISS project and provide parent perspective to the Project in developing/selecting educational materials and information and developing policies and procedures. They assist in IN CISS Advisory Committee and Learning Collaborative and training meeting preparation, staffing of the IN CISS Advisory Committees, reviewing Learning Collaborative/Quality Improvement Tool Kit materials, and providing parent perspective training and technical assistance to the quality improvement medical home team

practices participating in the Learning Collaborative. Parent consultants assist the project and the practices in the identification, recruitment, and training of parents for participation on practice teams and IN CISS Advisory committee representation. They assist with the development of the agendas for the conference calls and conferences, scheduling practice visits (currently nine pediatric/family practices), and helping collect data.

/2012/ The Medical Home Learning Collaborative has now expanded to 18 pediatric and family practices statewide. //2012//

The About Special Kids (ASK) contract supports parent involvement by using trained and experienced Parent Liaisons to provide peer support, information and referral, and education and training for families of CSHCN. Activities include sending a monthly e-newsletter, developing and sending out educational materials, operating an information "hotline" and a system of follow-up contact with families, conducting training sessions, and assessing the ongoing and changing needs of families with special health needs. ASK, utilizes family input to develop strategies to address issues such as childcare, community resources, early intervention, and health care financing.

E. State Agency Coordination

Organizational Relationships

Title V staff excel in the area of collaboration. In many cases MCH and CSHCS provide leadership in coordinating efforts among the many public and private organizations concerned with the Title V populations.

Public Health -- The local health departments operate independently in the State of Indiana. However, the ISDH Local Health Department's Outreach Office hosts a monthly conference call and webcast. Agenda topics are gathered from the various commissions at ISDH. The MCH Division uses this opportunity to broadcast updates to the 92 counties throughout the State. In addition, the Outreach Office has established an online communication tool which allows not only a sharing of information but also coordination of events.

Mental Health & Alcohol and Substance Abuse -- The Division of Mental Health and Addiction (DMHA) provides input to the Social, Emotional & Training Committee of the Early Childhood Comprehensive Systems (ECCS) initiative. For example, DMHA recently awarded \$50,000 to MCH to further the goal of developing a certification program for infant and toddler mental health professionals. DMHA also provides supplemental funding support for seven PSUPP sites and collaborate on the Access to Recovery (ATR) program for pregnant women with substance abuse problems. A representative from DMHA participates in the Indiana Coalition to Improve Adolescent Health (ICIAH). ***/2013// DMHA and MCH submitted a joint application for Project LAUNCH funds in July 2012. If awarded, the grant will begin in October 2012. //2013//***

Education -- DOE is a core partner in the Early Childhood Comprehensive Systems initiative and Indiana Community Integrated Systems of Service (IN CISS) Project Advisory Committee. DOE is also instrumental in the administration of the Youth Risk Behavior Survey (YRBS). DOE participates on the EHD Advisory Committee and is an integral partner with CSHCS on early and late transition committees. DOE also assists in training and curricula on HIV and sexuality issues for adolescents (This includes a recent MCH-DOE partnership on a recent federal grant application for a new statewide teen pregnancy prevention program).

Vocational Rehabilitation/Disability Determination/Rehabilitation Services -- MCH and CSHCS work closely with several divisions in FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps, which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps, Indiana's Early Intervention

Program, also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Medicaid, SCHIP/Social Security Administration -- OMPP, under FSSA, is a key collaborator in the establishment of payment policies and procedures for CSHCS and the development of the Family Information & Resource Directory, Sunny Start Financial Fact sheets, and the Sunny Start Developmental Calendar in both English and Spanish. OMPP has also been instrumental in several prenatal initiatives including PNCC and FCC education for Medicaid Managed Care Organizations; creation of the physician's Notification of Pregnancy forms for prenatal first visits; development of a new Prenatal Risking tool sensitive to psychosocial and nutrition issues; and participation in Quality Improvement Initiatives and setting of performance measures such as Neonatal Quality Outcomes and prenatal smoking cessation. OMPP is also assisting in the assessment and review of child health with the development of the 'State of the Hoosier Child' report. Working with MCH, IPN, Indiana March of Dimes (MOD), and Indiana Primary Health Care Association, OMPP restructured presumptive eligibility for pregnant women in July 2009.

/2012/ As of July 1, 2011 Medicaid will no longer reimburse targeted case management for Prenatal Care Coordination and HIV Case Management. However, MCH is working to see how this service can be provided through the state's home visiting program or partially funded through Title V.//2012//

Corrections -- MCH partners with the Department of Corrections (DOC) to provide to funding for "Wee Ones Nursery" (WON). WON is located at the Indiana Women's Prison and provides care for children from birth up to 18 months. The goal of the program is to reduce infant placement into foster care and allow an opportunity for bonding and attachment between mothers and their newborns. DOC also offers the Mother and Child Safe Care and Development program and works with Craine House, a step down program for early release of mothers.

Federally Qualified Health Centers -- In 2010, ISDH is funding 46 community health centers (CHCs) that have over 85 locations throughout Indiana. The Office of Primary Care (OPC) provides CHC support with funds from the Master Tobacco Settlement as authorized by the Indiana General Assembly in March 2009. Nineteen community health centers are designated FQHCs. The CHCs are located in 43 of 92 counties. Ten counties have more than one CHC. There are an additional 58 Rural Health Centers in Indiana.

The OPC and MCH share information on statewide needs and how funding is distributed. MCH funds four CHCs for prenatal care coordination. Many CHCs were originally funded as MCH clinics, but they have now developed into comprehensive primary care centers. MCH staff share health information and educational materials with Indiana CHCs through the OPC mailing lists. In addition to sharing of information via staff, activities are also coordinated between MCH, CHCs, and local health departments using a web-based tool.

Primary Care Associations -- The Indiana Primary Health Care Association (IPHCA), advocates for quality health care for all persons residing in Indiana and supports the development of community-oriented primary care initiatives. IPHCA partners regularly with MCH by providing staffing on many MCH committees and councils.

MCH Medical Director works with IPHCA to increase primary care physicians in Indiana through the J-1 Visa Waiver program. IPHCA participates in the development of the Oral Health Coalition.

Tertiary Care Facilities -- The CSHCS program funds an enrollment office at Riley Children's Hospital in Indianapolis, Indiana. CSHCS also trains other hospitals on how to enroll children needing services. Title V also funds five hospital-based genetics clinics throughout the State.

These clinics provide both local and outreach services, expanding the effective number of clinics to 13. Services provided at these clinics cover both prenatal genetic counseling as well as pediatric consultation. Prenatal counseling includes the management of high risk pregnancies and provides services such as ultrasound, amniocentesis, and first trimester screening. Several specialty clinics address issues including bone dysplasia, neurogenetics, fetal alcohol syndrome and Marfan syndrome.

Representatives from the Indiana Hospital Association and representatives from several hospitals have been particularly active on committees and coalitions to improve perinatal outcomes. Hospital medical staff serve on our Prematurity Prevention Initiative Committee. Several hospital staff have committed to assisting in the development of obstetric and newborn levels of care in FY 2011.

Technical Resources and Health Professional Educational Programs and Universities -- IUSOM provides research and evaluation, particularly on adolescent health and behavior, for committees and grantees. Indiana University also participates in the Leadership Education in Neurodevelopmental and Related Disorders (LEND) program. Purdue University provides technical assistance and maintains websites, especially those related to adolescent health. The National Association for Social Workers provides professional certification of prenatal care coordinators. IPN provides professional education pertaining to prenatal care. Organizations such as the Indiana Society for Public Health Education (InSOPHE) provide public health seminars and forums to allow sharing of information and relationship-building.

MCH Medical Director facilitates a month-long elective in Public Health/Preventative Medicine for eight to ten senior medical students per year. In addition, students pursuing a Master's degree in public health frequently perform their internship and project at MCH.

Coordination of Title V Programs with Other Federal Programs and Providers

MCH collaborates with numerous providers and many federal programs to ensure that services are available and accessible to members of the MCH population. In addition, MCH partners with other organizations in the sharing of data and the funding of services. Some examples of collaborative efforts follow.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) -- HealthWatch/EPSDT is the coordinated program established by OMPP to provide periodic screening for children under the age of 19. Information concerning Title V and Medicaid providers can be obtained using the toll-free number to the IFHL.

Womens, Infants and Childrens (WIC) -- WIC has numerous partnerships with Divisions within the HHS Commission as well as within ISDH. The IFHL, funded and administered by MCH, provides referrals not only to WIC but also other appropriate agencies. Twenty-one of the WIC clinics house the MCH Free pregnancy testing program. WIC also partners with the immunization program that promotes immunization across the State. The Indiana Lead Safe and Healthy Homes program (ILHHP) collaborate with WIC in the use of the I-LEAD web application to produce consistent and effective risk assessments and environmental information.

Disability -- Both MCH and CSHCS work closely with several divisions in the FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Family Planning Programs -- The Indiana Family Planning Partnership is a partnership among the

Indiana Family Health Council (IFHC), ISDH, the Indiana Department of Child Services (IDCS) and FSSA. These agencies have agreed that the coordinated funding of family planning services in Indiana will increase access to services ensure quality of services, and minimize administrative overhead. All funds have been granted to the IFHC, Indiana's Title X agency. IFHC contracts with local agencies in locations with the highest risk populations to provide comprehensive reproductive health and family planning services to the citizens of Indiana. The goal of the coordinated funding is to use the public family planning funds as efficiently and effectively as possible to target the women most in need, to provide complete services to all low income women, to maximize Indiana competitive position family planning funding regionally, and to minimize the amount of paperwork for the providers.

OMPP has had a Family Planning Waiver request at the federal level for at least two years. Under the Health Care Reform legislation, states now have the option to expand Medicaid eligibility for family planning services without obtaining a federal waiver. The IPN has shared this new information with representatives from the OMPP, ISDH, and others involved in efforts to secure the waiver's approval. Whether changes can be made under current fiscal constraints is unknown at this time.

//2012/ OMPP has chosen to not pursue the option to expand family planning services without a waiver. The Indiana state legislature addressed Indiana's long-standing attempts to implement a family planning waiver by incorporating language into SB 461, Health Care Reform Matters, which also stipulates that a state agency may not implement or prepare to implement the federal Patient Protection and Affordable Care Act. Before January 1, 2012, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human Services for approval of a state plan amendment (SPA) to expand the population eligible for family planning services. The SPA must include women and men, set income eligibility at 133% of the federal income poverty level, and incorporate presumptive eligibility for services to this population. In addition, the law requires OMPP to report on the progress of the SPA to the Medicaid oversight committee during its 2011 interim meetings. The bill passed and was signed by the Governor.
//2012//

Identification of Pregnant Women and Infants Eligible for Title XIX

In 2009, Indiana initiated a presumptive eligibility program for pregnant women who might qualify for Medicaid. The need for the program resulted from a flawed enrollment system that caused long delays in eligibility determination. To participate in the Presumptive Eligibility Program, Indiana requires that health care providers (clinics, OB/GYN, pediatricians, etc) enroll with Indiana Health Coverage Programs (IHCP). These providers must collect basis income information on clients and submit it to Medicaid. They may then provide services which will be reimbursed by Medicaid even if the woman does not turn out to be eligible for Medicaid. The pregnant woman has the responsibility to submit a full application to Medicaid within a certain time period so that she will be enrolled with a Hoosier Healthwise managed care program. MCH assists this mission with its Free Pregnancy Test program. The program focuses on outreach to sexually active women of child-bearing age to improve access to primary, prenatal, and family planning care to impact the State's high infant mortality rate.

//2012/ The presumptive eligibility (PE) process relies on Qualified Providers (QPs) that volunteer to assist pregnant women with the PE Application process. In the first 18 months of the PE program there were 270 Qualified Providers signed up in 66 counties. Over 15,000 pregnant women have been enrolled in PE, about 25% of all pregnant women on Medicaid. Roughly 78% enrolled in PE become Medicaid approved. MCH and IPN are assisting OMPP with promoting the program through newsletters, trainings, requirement for Title V grantees.

Department of Child Services - ISDH works closely with the Indiana Department of Child Services (IDCS) for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). IDCS operates the Healthy Families program throughout the state while ISDH contracts with Goodwill Industries of Central Indiana to implement Nurse Family Partnership program. This partnership

ensures that all federally-recognized home visiting programs in operation throughout the state are coordinated for optimal service provision, recruitment of highest-need families, and non-duplication of efforts.//2012//

State Disabilities Determination and Vocational Rehabilitation -- CSHCS works through DDRS in the Indiana FSSA to determine services and rehabilitation for children with special health care needs. First Steps, Indiana's early intervention program, coordinates services for/with CSHCS. Healthy Families Indiana, another early intervention program, identifies, at the time of birth, those families that are at risk of child abuse. CSHCS provides financial support for the training efforts involved in this statewide home visiting program. CSHCS coordinates with developmental disabilities programs primarily through interactions with the First Steps Program and with the UNHS/EHDI follow-up efforts. Coordination with vocational rehabilitation programs is conducted primarily through the database of providers maintained by the IFHL. IFHL provides appropriate referral contacts to statewide vocational rehabilitation offices and agencies.

/2012/ The Sunny Start initiative (MCHB- ECCS) is working collaboratively with other state agencies to increase capacity for social and emotional health of young Hoosier children. This year, the Department of Mental Health and Addiction, the State Head Start Collaboration Office and the Department of Child Services all contributed significant financial funding to the effort.

MCH's Sunny Start initiative has a very active Family Advisory Committee. Among other activities the Family Advisory group is working with the Riley Child Development Center to create a Family Leadership Institute. The Initiative has created a portfolio to track leadership development and a set of leadership competencies (tiered across three levels) that complement the Maternal and Child Health Leadership Competencies.

Indiana is very supportive of state agency coordination and collaboration. In this regard, MCH has initiated two large projects with a number of state agencies. The first project, the Prenatal Substance Abuse Cross Agency Committee, began in August, 2010. The Committee meets monthly to address the significant prenatal substance abuse problem in Indiana. Collaborative state agencies include Indiana State Department of Health (ISDH), Department of Education, Office of Medicaid Policy and Planning, Department of Child Services, and the Division of Mental Health and Addiction. The second project is the Statewide Home Visiting Program. The governor appointed ISDH and the Department of Child Services as co-lead agencies to implement the Indiana Maternal, Infant, and Early Childhood Home Visiting Program.

The Adolescent Health Services Program within MCH has benefited from some unique, new partnerships during FY11. Through the Indiana Coalition to Improve Adolescent Health, which is facilitated by the State Adolescent Health Coordinator (SAHC) in MCH, came the opportunity to partner with a design and marketing firm to help the Coalition produce an adolescent handbook-- a pocket-sized guide for young people about a variety of health issues (dating violence, STIs, binge drinking, stress and depression) and important facts and resource information. Also through the Coalition, the MCH has formed a partnership with a local medical magnet school for high school students. The magnet school is currently participating in a pilot study of the handbooks developed by the Coalition. The Adolescent Health Services Program and MCH also forged a new partnerships with individuals at the Indiana Division of Mental Health and Addiction. The SAHC and other injury-prevention staff at ISDH teamed up to write a large federal grant for SAMHSA funding for suicide prevention among young people. Grant announcements are anticipated in the fall of 2011//2012//

F. Health Systems Capacity Indicators

Health System Capacity Indicators

The Indiana State Department of Health- Maternal and Child Health Division (MCH) has been working on further developing and enhancing its Life Course Health Framework in efforts to reduce and eliminate health disparities and improve quality of life for children throughout Indiana. MCH is working to achieve the overarching goal of Healthy People 2020 of promoting quality of life, healthy development, and healthy behaviors across all life stages by addressing the Healthy People 2020 leading health indicators of infant deaths and preterm births. MCH is specifically focusing on addressing the preventable root causal factors associated with poor health outcomes, such as low birth weight, infant mortality, and first trimester prenatal care for mothers. MCH believes that improving these indicators will help to lead to improved health outcomes for all Hoosiers. Health System Capacity Indicators of interest for MCH relate to low birth weight (5A), infant mortality (5B), and the percent of mothers receiving prenatal care in the first trimester (5C). MCH is aware of the negative long term affects that these indicators have on children and adult throughout their lifetimes. MCH staff work to identify and report the significance and impact of these indicators on the lives of Hoosiers. Indiana is working diligently to address disparities amongst groups that are disproportionately affected by these health indicators, such as African American and Medicaid-insured infants. All of the data relating to birth weight, infant mortality, and prenatal care is collected from the birth and death certificate and is analyzed by the ISDH Epidemiology Resource Center.

5A: Percent of low birth weight (<2,500 grams)

The first Indicator, 05A, is related to low birth weight which is defined as an infant born weighing less than 2,500 grams. Low birth weight is calculated by dividing the number of infants born weighing less than 2,500 grams by the total number of infants born that year in Indiana. Low Birth weight infants are at significant risk of neurologic abnormalities, developmental delays, and functional delay at 18 to 22 months' corrected age" (Vohr et al, 2000). These infants are at an increased risk for serious health problems and sometimes death.

They can experience short term and long term problems including intellectual disabilities, learning problems, cerebral palsy and vision and hearing loss (March of Dimes). "Educational disadvantage associated with very low birth weight persists into early adulthood" (Hack et al, 2002). The percent of low birth weight births in Indiana increased between 2000 (7.3%) and 2008 (8.5%) before decreasing to 8.3% in 2009.

Similar to many other health outcomes, disparities exist between different sub-populations and race/ethnic groups. In 2008, 14.1% of black infants were low birth weight compared to only 7.6% of white infants. There was also a higher percentage of Medicaid-insured birth (9.1 %) with low birth rates compared to non- Medicaid births (7.1%).

The desired outcome is to decrease the overall percent of low birth weight babies born in Indiana. Reducing the disparity of low birth weight births between black and Medicaid-insured infants is also an important outcome this health indicator. MCH is working through collaborative efforts with stakeholders, including: Indiana Medicaid, Managed Care Entities, Indiana Hospital Association, March of Dimes, Indiana Perinatal Network, representatives from Indiana State Medical Association, Indiana American Congress of Obstetricians and Gynecologists, American Academy of Pediatrics Indiana Chapter, American Academy of Family Physicians Indiana Chapter, Association of Women's Health, Obstetric and Neonatal Nurses Indiana Chapter, American College of Nurse Midwives, Indiana University National Center of Excellence in Women's Health, hospital administrators, obstetric and neonatal unit medical and nursing directors to address this health indicator.

5B: Infant deaths per 1,000 live births

The second indicator, 05B, relates to infant mortality which is a major concern in Indiana. Infant mortality is defined as a death within the first year of life and is represented as a rate per 1,000 live births. The infant mortality rate is calculated by dividing the number of infant deaths by the

total number of live births and multiplying by 1,000. After seeing a relatively steady trend between 2000 and 2003, the infant mortality rate increased to 8.1 per 1,000 live births in 2004 but had decreased to 6.9 per 1,000 live births in 2008. In 2009 however, Indiana saw another increase in the infant mortality rate of 7.8 per 1,000 live births. This rate is unacceptable and is above the national average.

As with the other health indicators of interest, the disparities for African Americans and Medicaid-insured infants are also present in the infant mortality rate. In 2008, the infant mortality rate among black infants was 14.9 per 1,000 live births compared to a rate of 5.5 among white infants. Medicaid-insured infants had a rate of 7.5 per 1,000 live births compared to non-Medicaid infants who had an infant mortality rate of 6.5.

The desired outcome for infant mortality is to decrease the number of babies who die before their first birthday. Also decreasing the rates among black and Medicaid-insured is vital to reducing the disparities and also reducing the overall infant mortality rate in Indiana. A more specific outcome is to determine why the rate increased again in 2009 and to address the problem. MCH plans to look at the underlying and root casual factors associated with this increase in infant mortality rates.

5C: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

The final indicator, 05C, focuses on the percent of women who received prenatal care in the first trimester. Indicator 05C is represented as the percent of women who received prenatal care in the first trimester and is calculated by dividing the number of women who received prenatal care in the first trimester by the total number of live births. Receiving prenatal care is vital during a pregnancy, especially for women who are at a higher risk of things such as low birth weight and preterm births. Prenatal care often includes screening and treatment for medical conditions, and identification and interventions for behavioral risk factors associated with poor birth outcomes (March of Dimes). "A meta-analysis of case control studies reported from 1980 to November 2001 that examined cognitive and behavioral outcomes found that the mean IQ for school-aged children born very preterm was approximately two-thirds SD below that of healthy controls"(Anderson, 2003).

Due to birth certificate revisions, the 2007 and later prenatal care data are strictly not comparable with data from prior years. However, between 2007 and 2009, the percent of pregnant women receiving prenatal care in the first trimester decreased from 67.5% to 66.1%. Even so, disparities still exist among black and Medicaid-insured infants with fewer of these women receiving prenatal care in the first trimester compared to white and non-Medicaid births. In 2008, 52.6% of black mothers received prenatal care in the first trimester compared to 68.9% of white mothers. Additionally, 60.6% of Medicaid-insured others received prenatal care in the first trimester compared to 74.4% of non-Medicaid insured mothers.

The outcome for health systems capacity indicator 05C is to increase the number of women who are receiving prenatal care in the first trimester. Another goal is to focus on specifically increasing the percent of black and Medicaid-insured mothers who receive prenatal care in the first trimester to decrease the disparity and increase the overall percentage in Indiana. MCH is addressing the health indicator of first trimester prenatal care for mothers to lower the rates of preterm births. "Preterm birth is recognized as a major public health problem by both clinicians and researchers because it is the leading cause of infant mortality in industrialized countries and also contributes to substantial neuro-cognitive, pulmonary, and ophthalmologic morbidity" (Kramer et al, 2000). Early prenatal care is so vital to the health of the fetus and it is imperative that every pregnant woman sees a doctor to help decrease the number of adverse outcomes in births such as low birth weight and infant mortality. "Mild and moderate preterm birth infants are at high relative risk for death during infancy and are responsible for an important fraction of infant deaths" (Kramer et al, 2000).

MCH is has been making many innovative efforts to address this health indicator. "The extreme prematurity of most of the infants and their survival indicate that reducing infant mortality rates requires a comprehensive agenda to identify, to test, and to implement, effective strategies for the prevention of preterm birth" (Callaghan et al, 2006). MCH began distributing the "40 Weeks is Best" tool kits Medicaid and MCEs to OB physicians, providing them with resources for patient education. Also MCH's collaborative stakeholder, March of Dimes, has enrolled three pilot hospitals to implement the MOD <39 week protocols. Indiana Hospital Association has made unnecessary inductions and cesareans part of their patient safety and quality programs. They are presenting a webinar to all birthing hospitals 7-9-12. Partners will begin planning for an infant mortality, prematurity awareness campaign through the months of September, October, and November. A partner planning committee is developing the program for the third Indiana birthing hospital summit September 14, 2012, which prematurity reduction will be a focus.

References

- Anderson, P. & Doyle, L.W. (2003). Neurobehavioral outcomes of school-age children born extremely low birth weight or very preterm in the 1900s. *JAMA*, 289 (24).
- Callaghan, W.M., MacDorman, M.F., Rasmussen, S.A., Qin, C., & Lackritz, E.M. (2006). *Pediatrics*, 118 (4).
- Declercq, E.R., Sakala, C., Corry, M.P., & Applebaum, S. (2007). Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences. *The Journal of Perinatal Education*, 16 (4).
- Hack, M., Flannery, D.J., Schluchter, M., Cartar, L., Borawski, E., & Klein, N. (2002). Outcomes in young adulthood for very low- birth weight infants. *The New England Journal of Medicine*, 346 (3).
- Hauck, F.R., Herman, S.M., Donovan, M., Iyasu, S., Moore, C.M., Donoghue, E., Kirschner, R.H., & Willinger, M. (2003). Sleep environment and the risk of sudden infant death syndrome in an urban population: The Chicago Infant Mortality Study. *Pediatrics*, 111 (1): 1207-1214.
- Kogan, A.D., Kotelchuck, M., Alexander, G.R., & Johnson, W.E. (1994). Racial Disparities in Reported Prenatal Care Advice from Health Care Providers. *American Journal of Public Health*, 84 (1).
- Kramer, M.S., Demissie, K., Yang, H., Platt, R.W., Suave, R., Liston, R. (2000). *JAMA*, 284 (7).
- Lemons, J.A., Bauer, C.R., Sheldon, W.O., Korones, S.B., Papile, L., Stoll, B.J., Verter, J., Temprosa, M., Wright, L.L., Ehrenkranz, R.A., Fanaroff, A.A., Stark, A., Carlo, W., Tyson, J.E., Donovan, E.F., Shankaran, S. & Stevenson, D.K. (2001). Very low birth weight outcomes of the National Institute of Child Health and Human Development Neonatal Research Network, January 1995 through December 1996. *Pediatrics*, 107 (1).
- Singh, G.K. & Yu, S.M. (1995). Infant Mortality in the United States: Trends, Differentials, and Projections, 1950-2010. *American Journal of Public Health*, 85 (7).
- Singer, L.T., Salvatoe, A., Cua, S., Collin, M., Lilien, L., Baley, J. (1999). Maternal psychological distress and parenting stress after the birth of a very low- birth- weight infant. *JAMA*, 281 (9).
- Vohr, B.R., Wright, L.L., Dusick, A.M., Mele, L., Verter, J., Steichen, J.J., Simon, N.P., Wilson, D.C., Broyles, S., Bauer, C.R., Delaney- Black, V., Yolton, K.A., Fleisher, B.E., Papile, L. & Kaplan, M.D. (2000). Neurodevelopment and functional outcomes of extremely low birth weight infants in the National institute of Child Health and Human Development Neonatal Research Network, 1993-1994. *Pediatrics*, 105 (6): 1216-1226.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to promote integration of public health and health care policy, strengthen partnerships with local health departments, and collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities. ISDH will also support locally-based responsibility for the health of the community. ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, MCH and CSHCS continue to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as State initiatives, based on the latest needs assessment. The needs assessment results focused on health system capacity indicators and health status indicators, including asthma hospital discharges, Medicaid/SCHIP screening, prenatal care adequacy, low/very low birth weight, fatal/non-fatal injuries, chlamydia rates, dental screening, and adolescent tobacco use.

The needs assessment results have dictated the focus of the State priorities listed in the following section, B. State Priorities. Program and resource allocation issues are determined using the State priorities for guidance. Utilizing the MCH pyramid, program and resource funding has been carefully allocated to cover not only the State priorities but also to cover all four of the pyramid levels.

Outcome measure data for infant mortality, black/white infant mortality disparity, neonatal mortality, post-neonatal mortality, perinatal mortality, and the child death rate are also monitored and reported annually.

Specifically, within the pyramid level of direct medical services, Title V funds programs to provide genetics services, immunizations, dental sealants, sickle cell prophylactic medicine, lead poisoning prevention, direct medical care for pregnant women, infants, children, adolescents, family planning, STD screens, free pregnancy screens, as well as specialty medical services and primary care for CSHCN. Funded Enabling Services programs provide genetics services education, prenatal and family care coordination, newborn screening and referral, sickle cell management, prenatal substance use prevention program (PSUPP), and coordination with Medicaid and WIC in addition to many other programs.

Population-based services that are provided or funded by Title V include the Indiana Family Helpline (IFHL), the Early Childhood Comprehensive Systems (ECCS) program, the Indiana Joint Asthma Coalition (InJAC), the adolescent pregnancy prevention initiative, sudden infant death prevention, dental fluoridation efforts, and fetal infant mortality review. ISDH Infrastructure Building Services include efforts such as the Indiana Perinatal Network; the MCH, NBS and PSUPP data systems; the integration of data systems to facilitate the Indiana Birth Defects and Problems Registry (IBDPR), the Genomics in Public Health and Newborn Screening education efforts and other data analysis efforts for planning and reporting; policy and standards development; planning, evaluation, and monitoring; and quality assurance to MCH and CSHCS grantees.

Progress toward the achievement of our national and State performance goals is reported in Sections C and D following. MCH and CSHCS continue to build on previous years successes.

This year's annual report reflects that for 2009, MCH and CSHCS continue to make progress on eight of the thirteen national performance measures that are not reported through the CSHCN survey. Progress was made on the five performance measures that are reported through the CSHCN survey.

MCH and CSHCS are proposing a new set of State negotiated performance measures (SPM) based on the results of the needs assessment. Two of the new SPM's are identical to the previous SPM's and one has been modified. There are seven entirely new proposed SPM's and some of the previous SPM's are being discontinued. These are enumerated in Sections B and D.

B. State Priorities

Indiana comprehensively evaluated quantitative and qualitative information to develop the State's priority healthcare needs. Indiana allocated \$4,982,945 for FY 2009 in grants to community-based organizations. In the coming year, Title V staff will re-evaluate the distribution of money based on the new state priorities.

For pregnant women, priority healthcare needs include decreasing smoking during pregnancy, with emphasis on the Medicaid population; increasing the number of black women having adequate prenatal care; decreasing the proportion of births occurring within 18 months of a previous pregnancy to the same mother; and increasing the number of women who initiate exclusive breastfeeding. These priorities are related to State Performance Measures (SPM) 2, 3, 4, 6, and 7, along with National Performance Measures (NPM) 11, 15 and 18. Indiana's capacity to work on these priorities include collaboration with partners at Medicaid, Indiana Tobacco Prevention and Cessation, new initiative development for minorities, educational programs for breastfeeding mothers, and further program expansion within the State Department of Health.

Smoking during pregnancy increases the risk for both a preterm delivery as well as a low birth weight baby. Although the smoking during pregnancy rate has declined in general in Indiana, the rate is still very high for certain populations or locales. Activities to address this issue include providing training and materials to prenatal Medicaid providers; assessing/comparing counties with highest and lowest smoking rates to determine successful anti-smoking strategies; and working with Indiana Tobacco Prevention and Cessation (ITPC)/Indiana Preventing Smoking in Pregnancy Initiative to explore successful cultural and literacy appropriate educational messages targeted to low income women.

During the period from 2002 to 2006, the percentage of women, overall, receiving prenatal care within the first trimester declined from 80.5% to 77.6%. The black percentage decreased from 68.6% to 65.6% over this time period. To address the low level of entry into prenatal care for black women the new focus will target counties having a lower percentage of black women entering prenatal care in the first trimester. Initiatives will include free pregnancy tests, development of a Premature Birth Initiative especially for African American women, and collaboration with the National Fatherhood Initiative on train the trainer workshops.

Short interval pregnancies are an important issue because such pregnancies increase the risk for adverse outcomes, such as low/very low birth weight babies; premature births and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to reduce opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average

but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions; initiation of a recognition program acknowledging Baby Friendly Hospitals; and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers,

Two problems concerning infants require a special focus: prematurity rates and accidental suffocation under one year of age. Although prematurity birth rates are at about the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Executive Group driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal. These priorities are related to State Performance Measures (SPM) 1 and 7. Indiana's capacity to work on these priorities include collaboration with the First Candle Project and Indiana Perinatal Network. Indiana has started a premature birth coalition with public and private agencies that increases the State's capacity for these priorities.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will center around communication of safe sleep practices/updates to nurse managers/nursing staff and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network, and local community organizations in the four largest counties to conduct training and educational sessions.

Concerns involving children and adolescents center around lead poisoning, STDs, obesity, and social-emotional health of very young children. These priorities are related to State Performance Measures (SPM) 5, 8, 9, and 10, along with National Performance Measures (NPM) 7, 14 and 16. Indiana is increasing the capacity to improve these priorities. Indiana will continue to work with Medicaid, and the Lead and Immunization Programs to improve children's health. The State is also increasing capacity by funding new positions that focus on youth risks, which include STD's, physical activity, and weight and nutrition. Indiana will increase capacity over the next 5 years to improve social-emotional health for children.

Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and to work with the Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated.

Reduction in the number of sexually transmitted diseases (STDs) is another state objective. Strategies to reduce the STD numbers include providing education and materials to providers treating adolescents, conducting a needs assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Indiana Family Health Council to increase screening for sexually transmitted infections.

Obesity in high school age children is also a state concern. Recent data indicate that 13.8% of youth to have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks and increased physical activity.

Addressing issues pertaining to the social-emotional health of children under the age of 5 is the final initiative. Foremost among these issues is the lack of qualified service providers to treat children in this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refugees/immigrants, and children of

deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	98	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	132	160	184	190	207
Denominator	132	160	184	190	207
Data Source		ISDH - NBS	ISDH - NBS	ISDH- NBS	ISDH- NBS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Data is final.

Notes - 2010

Data is final.

Notes - 2009

Based on 4 year Average.

a. Last Year's Accomplishments

100% of newborns whose screens were abnormal or presumptive positive received appropriate & timely follow-up services.

All infants with confirmed positive results were referred to the Biochemical & Medical Genetics clinic at Riley Hospital for Children at Indiana University Health, the Pediatric Endocrinology clinic at Riley Hospital for Children at Indiana University Health; the Indiana Hemophilia and Thrombosis Center (IHTC); Cystic Fibrosis (CF) Foundation-accredited CF clinics; First Steps; and/or the CSHCS programs, as appropriate.

NBS trained additional birthing facilities & health care providers to utilize the Indiana NBS Tracking and Education Program (INSTEP) web-based application within the ISDH Repository in order to provide more efficient and effective tracking and follow-up of children with a positive newborn screen. The INSTEP Director continued to provide in-house training sessions to birthing facilities, with 98% (98/100) birthing facilities to date using INSTEP to submit Heelstick Monthly Summary Reports. The remaining 2% (2/100) of birthing facilities do not have internet access & therefore must submit paper MSRs. In addition, the state-contracted Metabolic Genetics and

Pediatric Endocrinology clinics and IHTC are using INSTEP to submit long-term follow-up information on children with metabolic conditions, endocrine conditions, or hemoglobinopathies, respectively.

NBS staff members co-presented on health IT at an AMCHP webinar in September 2011. They also did a presentation on adding CCHD screening to the Secretary's Advisory Committee on Heritable Disorders and Children in January 2012 and a presentation on the implementation of long-term follow-up to an NBSTRN Workgroup in February 2012.

The NBS Director, INSTEP Director, EHDI Program Director, Sickle Cell Program Director, and Genomics/CF Programs Director participated in the Region IV Genetics Collaborative and on the Indiana Genetics Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NBS is continuing to follow-up on all abnormal and presumptive positive test results until they are complete and all babies with abnormal NBS results are receiving appropriate treatment.			X	
2. NBS is continuing to develop the INSTEP application. This is a web-based application that will allow all NBS partners to quickly and accurately enter information directly into the ISDH Repository and will provide access to integrated, real-time, popu			X	
3. NBS is continuing to refer infants with confirmed positive results to the Biochemical & Medical Genetics clinic at Riley Hospital for Children at Indiana University Health, the Pediatric Endocrinology clinic at Riley Hospital for Children at Indiana		X		
4. NBS has updated the in-service training for Public Health Nurses and birthing facilities. Updated presentations have been completed and are available on the Genomics/NBS Program website.				X
5. Children identified by newborn screen with sickle cell disease or another hemoglobinopathy are immediately referred to a hematologist to ensure that the child receives appropriate care.		X		
6. NBS staff members co-presented on health IT at an AMCHP webinar in September 2011. They also did a presentation on adding CCHD screening to the Secretary's Advisory Committee on Heritable Disorders and Children in January 2012 and a presentation on				X
7.				
8.				
9.				
10.				

b. Current Activities

Continue to follow-up on abnormal or presumptive positive NBS results until results are complete and all babies with abnormal NBS results are receiving appropriate treatment.

Refer infants with confirmed positive results to the Biochemical & Medical Genetics clinic at Riley Hospital for Children at Indiana University Health, the Pediatric Endocrinology clinic at Riley Hospital for Children at Indiana University Health; the Indiana Hemophilia and Thrombosis Center (IHTC); Cystic Fibrosis (CF) Foundation-accredited CF clinics; First Steps; and/or the CSHCS programs.

Train remaining birthing facility personnel and state-contracted NBS follow-up care providers to utilize INSTEP to submit monthly statistics and long-term follow-up information for children with

confirmed newborn screening conditions, as needed.

Collaborate with CF Foundation-accredited CF clinics in Indiana to collect long-term follow-up information on children confirmed to have cystic fibrosis.

Develop the INSTEP application to include a Reporting Center to allow NBS program staff to create data reports as requested and to provide access for primary care providers and Public Health Nurses.

Continue to collaborate with the Region 4 Genetics Collaborative and its contracted third-party software vendor in order to implement electronic transmission of data from INSTEP to the Region 4 Genetics Collaborative (for children whose parents have signed a release form authorizing NBS to transmit data to Region 4).

c. Plan for the Coming Year

Continue to follow-up on all invalid, abnormal, and positive test results until the results are complete and negative or the babies are receiving treatment.

Continue to refer infants with confirmed positive results to state-contracted Genetics, Endocrinology, and/or Metabolic Clinics; Indiana Hemophilia and Thrombosis Center (IHTC); Cystic Fibrosis clinics; First Steps; and the Children's Special Health Care Services (CSHCS) programs.

Continue to provide trainings to Public Health Nurses, hospitals, midwives, and birthing centers. Public Health Nurses and hospital staff will have the option of completing these trainings in person or online.

Work with the Indiana Hemophilia and Thrombosis Center (IHTC) and the state Cystic Fibrosis clinics to collect long-term follow-up information, via INSTEP, on children confirmed to have sickle cell anemia or cystic fibrosis.

Collaborate with state-contracted NBS follow-up care providers, the Indiana Genetics Advisory Committee, and the Indiana chapters of the American Academy of Pediatrics (AAP) and the American Academy of Family Practice (AAFP) to develop & implement INSTEP Physician Toolkits and Family Toolkits (to include information on Indiana's Community Integrated Systems of Services, educational information, financial resources, and support resources), which will be provided to primary care providers and families of children with confirmed newborn screening conditions.

The NBS Director will continue to participate in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee. The Director of Genomics and Newborn Screening, Bob Bowman, is a member of the Follow-up and Treatment subcommittee of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC) Subcommittee. As a subcommittee member, Bob is expected to help the subcommittee identify and make recommendations to SACHDNC on issues relevant to the follow-up and treatment of newborns and children identified as screen positive through newborn screening.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	86126			
Reporting Year:	2009			
Type of Screening	(A) Receiving at	(B) No. of Presumptive	(C) No. Confirmed	(D) Needing

Tests:	least one Screen (1)		Positive Screens	Cases (2)	Treatment that Received Treatment (3)	
	No.	%			No.	No.
Phenylketonuria (Classical)	87429	101.5	8	8	8	100.0
Congenital Hypothyroidism (Classical)	87429	101.5	67	44	44	100.0
Galactosemia (Classical)	87429	101.5	2	2	2	100.0
Sickle Cell Disease	87429	101.5	26	26	26	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	64	60	60	59.3	60
Annual Indicator	59.3	59.3	59.3	59.3	72.6
Numerator					
Denominator					
Data Source		SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	73	73	74	74	75

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

a. Last Year's Accomplishments

Indiana's Children's Special Health Care (CSHC) Division's Community Integrated Systems of Service (IN CISS) Project worked to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families through continued quality improvement (QI) activities in primary care practices throughout the state. We were successful in maintaining 18 family/parent partners in the 18 Medical Home Learning Collaborative (MHLC) practices. Practices began incorporating both English and Spanish speaking family/parent partners and others from diverse cultural backgrounds to ensure culturally linguistic needs were being met for all families. Stipends continued to be available to family/parent partners for their participation in QI activities. Site visits continued to focus on linking community resources to the practices. Our partners began attending the visits, staff from the Center for Youth and Adults with Conditions of Childhood (CYACC) attended to share adult transition information and resources, representatives from the parent organizations About Special Kids (ASK), INSOURCE, The Arc, and Family Voices Indiana attended to share information and resources and also introduce the practices to family leaders who serve in their community.

The IN CISS Project continued monthly advisory group meetings; sponsored a statewide medical home conference; ongoing bi-weekly teleconferences to educate and support families; and provided ongoing trainings and conference presentations to support the partnerships. The Indiana Family Delegate and a representative from the parent organization, Family Voices Indiana, sit on the IN CISS Advisory Board.

The IN CISS Project participated in a QI exercise with the National Initiative for Children's Healthcare Quality (NICHQ) staff to promote and strengthen parent/professional partnerships in Medical Homes.

IN CISS and CSHCN submitted four newsletter articles promoting parent/professional partnerships and development of family leaders within Medical Home on the agency, community, and national level.

The IN CISS Project was invited to participate in two conference poster sessions on the IN MHLC and Family/Professional Partnership: the AAP Futures Conference in Chicago, IL and IU School of Medicine's Children's Health Services Research Symposium Conference in Indianapolis, IN.

The IN CISS Project parent consultants assisted the CSHCN Division by bringing the parent perspective to the table in work on policy, procedures, and care coordination processes.

CSHCN Division continued its grant funding to About Special Kids (ASK), a parent-to-parent organization that supports CSHCN and their families by providing trainings, information, peer support, education and partnerships building with professionals and communities. FY 2011 activities included: Parent-to-parent contact through the telephone was available to families for questions related to health care coverage, education, early intervention, community resources, parent leadership training, and other issues. During FY 2011, a total of 3,726 new families and a total of 615 new professionals were served by ASK staff; 1,554 families and professionals received education, mentoring and/or support on partner/decision making between families and professionals. The ASK website had a total of 108,000 hits, with 12,194 visitors to their online Resource Directory containing 2,200 resources; and publishing an e-newsletter reaching approximately 54,000 CYSHCN, families, and the professionals that serve them.

ASK participated with the Indiana State Department of Health (ISDH) on advisory committees and other statewide disability-related committees.

CSHCN continued to keep the CSHCN Division website updated to include informational materials, program guidelines, and copies available for downloading of the program's updated brochures, manuals, application, and links to other resources for families. CSHCN continued to provide developmental calendars, transition resources (including the CSHCN Transition Manual), and health care financing options to all its participants. CSHCN participated in statewide trainings, conferences, and exhibitions to promote the CSHCN program and offered the new web portal feature to enrolled providers. This web portal allows providers to check participant enrollment and claim status/history and will also enable providers to print an EOP/Remittance Advice.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Indiana Community Integrated Systems of Service IN CISS Advisory Committee continues to work on improving access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs.				X
2. The IN CISS Project continued its participation in the Quality Improvement exercise with the National Initiative for Children's Healthcare Quality (NICHQ) staff to promote and strengthen parent/professional partnerships in Medical Homes.				X
3. CSHCN Division produced and submitted four newsletter articles on the agency, community, and national level and developed magnets for the Care Coordination Section to distribute to all CSHCN providers, parent support agencies, and other community-bas		X		
4. CSHCS continues to keep the CSHCS Program website updated to include up-to-date informational materials, program guidelines, and copies of the program's updated brochures, manuals, application, and links to other resources for families.		X		
5. The IN CISS Project updated the English and Spanish brochures on Medical Home for families, created English and Spanish brochures on Medical Home for youth and young adults, and the program Transition manual to be distributed to all CSHCN providers,			X	
6. CSHCS continued to provide Developmental Calendars, Transition Resources-including the CSHCS Transition Manual and Health Care financing options to all its participants.		X		
7. ASK continued to receive grant funding from CSHCS at a reduced amount due to budget restraints. ASK will continue its work with families and professionals served through its staff and programs		X		
8. CSHCS participated in statewide trainings, conferences and exhibitions to promote the CSHCS program.				X
9. . The Children's Special Health Care Services program continued enhancing and offering the new web portal feature to enrolled providers that will allow access to certain program information via the internet.				X
10. The CSHCS Program collaborated with families of CYSHCN to bring the family perspective to the table in work on policy, procedures and care coordination processes. IN's Title V Family Delegate actively attends CSHCS Team Leader meetings.				X

b. Current Activities

The IN CISS Project parent consultants continued to develop and support parent/professional partnerships within the project's 18 MHLC practices.

IN's Title V Family Delegate participated in CSHCN Team Leader meetings to bring the parent perspective to the table in work on policy, procedures, and care coordination processes.

The IN CISS Project sponsored one face-to-face statewide meeting, one statewide retreat for project sustainability, ongoing bi-weekly teleconferences, and provided ongoing trainings to support parent/professional partnerships.

The IN CISS Project updated the English and Spanish Medical Home brochures for families and created brochures for young adults to be distributed to all CSHCS providers, families, parent support agencies, other community-based systems that care/support CYSHCN, and made available electronically on the CSHCS website.

The CSHCN Division's Care Coordination Section expanded its reach to provide care coordination services to all Indiana families with CYSHCN. Staff was increased to include nurses and social workers, including a parent of a CSHCN.

CSHCS will participate in statewide conferences and exhibitions to promote the CSHCN Division and continue enhancing and offering the new web portal feature to enrolled providers. We were successful in enrolling 85% of CSHCS providers in the portal.

The CSHCN Division funded a new project for Family Voices Indiana that will build new family leaders through web-based training modules.

c. Plan for the Coming Year

The IN CISS Project parent consultants will continue to develop and support parent/professional partnerships within the project's 18 Medical Home Learning Collaborative practices and continue to assist the CSHCN Division by bringing the parent perspective to the table throughout the no cost extension period.

The IN CISS Project Pre and Post data that was collected will be analyzed from practices using the Medical Home Index to assess the level of improvement in each of the 18 MHLC practices by establishing a parent/professional partnership within the practices. The outcomes will be published through the Children's Health Research Service Department at the IU School of Medicine.

The IN CISS Project will sustain its efforts in improving access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families through the adoption of a child health improvement model, CHIP IN for Quality. The top priority identified at the CHIP IN for Quality retreat was medical home which will allow the parent consultants to continue to promote and enhance parent/professional partnerships.

The CSHCN Care Coordination Section will continue to support all Indiana families of CYSHCN by having in-depth discussions with IN families to help guide them through the systems of care and work with the child's family and doctors to identify needs and the resources available to meet their health care needs. The CSHCN Medical Eligibility Section will assist families in their linkages to Medical Homes and will work with the CSHCN Care Coordination staff to address areas of opportunity to promote and enhance parent/professional partnerships.

CSHCS will continue to use a portion of its Title V funds to support programs and projects that utilize care coordination, provide family support, and build new family leaders through web-based training modules. Once Family Voices Indiana completes all modules, they will be shared with program providers throughout the state to help educate their families and share with parent and other community-based systems that support CYSHCN and parent partnerships.

CSHCS will continue to participate on disability and CYSHCN specific boards and councils that incorporate the family leader perspective at the state level.

CSHCS will continue to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN through focused grant opportunities on Ease of Use of Services for Latino Families Who Have CYSHCN and the Center for Disease Prevention and Control's

(CDC) Act Early, Learn the Signs campaign for early diagnosis and screening of Autism.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	56	55	55	54.6	55
Annual Indicator	54.6	54.6	54.6	54.6	48.5
Numerator					
Denominator					
Data Source		SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	50	52	54	56	58

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2009

The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

a. Last Year's Accomplishments

CSHCN continued to promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based and culturally

competent and provided through a Medical Home. The 2009-2010 National Survey for Children with Special Health Care Needs (NS-CSHCN) showed that Indiana was above the national average for CSHCN who receive coordinated, ongoing, comprehensive care within a medical home.

The IN CISS Project continued its monthly Advisory Board meetings to seek group input and recommendations to further coordinate the development, implementation, and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana. IN CISS Project continued to work with About Special Kids (ASK) to collect information from families about their understanding of a medical home and identifying steps to take toward furthering the medical home concept in Indiana.

About Special Kids (ASK) continued to interact with pediatric residents on a monthly basis who are being trained at Indiana University on information about community resources and the Medical Home Concept and the importance of sharing this information with families who they will be seeing in practice.

The IN CISS Project was successful in redirecting the focus of the quality improvement activities for the 18 Medical Home Learning Collaborative (MHLC) practices into two evenly distributed groups of interest within Medical Home: chronic care management, specifically asthma, and relational team-based care. Additionally, the scheduled bi-weekly calls to support the MHLC practices were redirect to focus on relational team based care and chronic care management. The IN CISS Project continued to educate the 18 MHLC practices on the Medical Home Concept using the American Academy of Pediatrics (AAP) MHLC toolkit. Information regarding the toolkit was provided electronically and hard-copies were given to each practice to include in their MHLC binders.

IN CISS and CSHCN submitted four newsletter articles promoting parent/professional partnerships and development of family leaders within Medical Home on the agency, community, and national level.

The IN CISS Project Sustainability Committee introduced an Improvement Partnerships (IP) model to the IN CISS Advisory Board for adoption to sustain the work begun through IN CISS. Indiana's IP model, CHIP IN for Quality Child Health Improvement Partnership was introduced through a statewide meeting and a stakeholder retreat. Priorities identified by participants included medical home, mental health, and well child EPSDT. The initial priority project will be selected from among these three areas based on commitment of adequate core partner participation and resources.

The CSHCN Division continued to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a PCP in the clinical and parent-to-parent settings.

The CSHCN Division continued to develop and expand the In-house Care Coordination services. The Care Coordinators linked the participants to a PCP, provided the families with "Tools" to help them prepare for medical visits, and educated CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential. In FY 2011, CSHCS linked over 1,400 participants to a PCP.

The CSHCN Division continued to keep the CSHCN website updated to include information on the Medical Home Concept and how the concept is being implemented in Indiana through the MHLC.

CSHCS continued to distribute a Medical Home educational "Fact Sheet" for parents regarding Medical Homes in mailings to consumers from the CSHCS, MCH, Newborn Screening (NBS), and Indiana Family Helpline (IFHL) programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The IN CISS Project Advisory Board continues its monthly meetings with partners to work on a statewide plan to improve				X

access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families through primary care				
2. The IN CISS Project maintains a sub-committee titled “Medical Home”, whose focus is to evaluate current systems of care for CYSHCN that promote quality, comprehensive, coordinated community based systems of services for CYSHCN and their families.				X
3. The IN CISS Project continues to provide TA to the 18 Medical Home Learning Collaborative (MHLC) practices participating in Quality Improvement activities that will assist the practices transformation to family-centered, community-based, and cultural				X
4. CSHCS continues to distribute a Medical Home educational “Fact Sheet” for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS, and Indiana Family Helpline (IFHL) programs.		X		
5. ASK continues to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources, the Medical Home Concept, and the importance of sharing this information with families w				X
6. ASK continues to participate on the IN CISS Project Medical Home sub-committee of this project to further the plan for spreading the medical home concept more broadly in Indiana.				X
7. The IN CISS Project continues working with ASK to collect information from families about their understanding of a medical home and identifying steps to take toward furthering the medical home concept in Indiana.				X
8. The IN CISS Project and CSHCN submitted four newsletter articles promoting parent/professional partnerships and development of family leaders within Medical Home on the agency, community, and national level.			X	
9. CSHCS continues to develop and expand the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits, an		X		
10. The CSHCN Division continues to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a PCP in the clinical and parent-to-parent settings.			X	

b. Current Activities

CSHCN continues to promote quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based and culturally competent and provided through a Medical Home.

The IN CISS Project educated MHLC practices on the Medical Home Concept using the AAP MHLC toolkit.

The IN CISS Project updated the English and Spanish Medical Home brochures for families and created brochures for young adults to be distributed to all CSHCS providers, families, parent support agencies, other community-based systems that care/support CYSHCN, and made available electronically on the CSHCS website.

CSHCN continues to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a PCP in the clinical and parent-to-parent settings.

CSHCN Care Coordinators link CSHCS participants and all CYSHCN statewide to a PCP,

provided the families with "Tools" to help them prepare for medical visits, and educate them on the Medical Home Concept.

CSHCS distributes a Medical Home educational "Fact Sheet" for parents regarding Medical Homes in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs.

ASK continues to interact with Indiana University pediatric residents on a monthly basis that are trained on information about community resources and the Medical Home Concept and the importance of sharing this information with families who they will be seeing in practice.

c. Plan for the Coming Year

The IN CISS Project Pre and Post data that was collected will be analyzed from practices using the Medical Home Index to assess the level of improvement in each of the 18 MHLC practices who completed QI work establishing them as a Medical Home. The outcomes will be published through the Children's Health Research Service Department at the IU School of Medicine.

CHIP IN for Quality will meet with partners to work on statewide plan to improve access to quality, comprehensive, coordinated community-based systems of services through primary care medical homes for CYSHCN and their families that are family-centered, community-based and culturally competent. The IN CISS Advisory Board will become a part of the CHIP IN for Quality committee structure.

ASK will continue connecting with pediatric residents on a monthly basis who are being trained at Indiana University on information about community resources and the Medical Home Concept and the importance of sharing this information with families who they will be seeing in practice.

The CSHCN Care Coordinators will continue to link CSHCS participants and all CYSHCN statewide to a PCP, provided the families with "Tools" to help them prepare for medical visits, and educate them on the Medical Home Concept.

The CSHCN Division will continue to provide Title V funding to projects that promote the Medical Home Concept and link CYSHCN and their families to a PCP in the clinical and parent-to-parent settings.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	67	62	62	61.8	62
Annual Indicator	61.8	61.8	61.8	61.8	58.6
Numerator					
Denominator					
Data Source		SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	62	63	63	64	64

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2009

The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

a. Last Year's Accomplishments

Actual figures, based upon information in the Agency Claims and Administrative Processing System (ACAPS), of participants in Indiana's CSHCS program who have either private or public health insurance 85% of participants have some kind of private or public health insurance.

CSHCS continued to update the ACAPS system to utilize insurance information for processing electronic pharmacy claims. Electronic Coordination of Benefits (COB) processing of pharmacy, dental, and medical claims has been accomplished.

CSHCS continued to review and followed-up on system reports that were created to identify coordination and benefit issues for electronic pharmacy claims.

CSHCS tracked insurance and Medicaid utilization in ACAPS. This activity allowed for denial of claims for which other insurance or Medicaid coverage is available.

CSHCS continued to monitor the activities and progress of the Health Insurance for Indiana Families Committee, a group of state leaders charged with developing no-or low-cost options to provider services for the uninsured.

CSHCS continued to monitor the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of children and adults who benefit from federal and state health care coverage programs.

CSHCS program provided financial support for a satellite CSHCS office at Riley Children's Hospital. During FY 2011, the satellite CSHCS office at Riley Hospital performed the following services for CSHCN and their families:

- Completed 750 CSHCS applications and re-evaluations.

- Generated 4,336 Prior Authorizations.

- Completed 1,222 Travel vouchers.

- Obtained 9,003 additional requests for medical information for the CSHCS program.

- Conducted 1,221 outreach efforts within Riley Hospital.

- Provided 6,968 CSHCS Program informational responses to families and providers of Riley Hospital.

- Referred 965 families to support organizations/agencies to facilitate needed services for CSHCN and their families.

The CSHCN Division granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. ASK staff members spoke with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and helped families navigate through the

complex systems.

ASK continued to offer trainings to families and professionals that outline the various public health insurance programs. Follow-up with an ASK Parent Liaison helped families determine which of these programs will serve their children the best. ASK staff spoke with approximately 4,500 families in Indiana about health insurance options.

ASK provided training to approximately 1,500 families and professionals on financial need services.

CSHCS program sent all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.

Family Voices Indiana began serving as Indiana's Family-to-Family Health Information and Education Center (F2FHIC). Through their use of social media, Family Voices Indiana posted 132 posts on their blog site on a number of topics (including health care financing) and received 13,088 views.

CSHCS continued to oversee and improve the electronic COB process for medical and dental claims; continued to review and follow-up on system reports relating to electronic pharmacy claims; continued to update the Provider and Participant Manuals; tracking insurance and Medicaid utilization in ACAPS; monitoring the activities and progress of the Health Insurance for Indiana Families Committee; monitoring the activities and progress of Covering Kids & Families (CKF).

CSHCS continued as a "Registered Agency" with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.

The IN CISS Project staff provides TA and distributed Sunny Start Financial Fact Sheets to the 18 Medical Home Learning Collaborative (MHLC) practices to assist both the provider and patient's insurance needs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS will oversee and update the electronic COB process for medical claims which will allow medical claims to be processed more efficiently. CSHCS continues to review and follow-up on system reports created to identify coordination and benefit issue				X
2. CSHCS program provides financial support for a satellite CSHCS office at Riley Children's Hospital. During FY 2012, the Riley CSHCS office will continue to support CYSHCN and their families.		X		
3. CSHCS granted funds to About Special Kids (ASK), a parent-to-parent organization, that supports CYSHCN and their families. As a part of this grant, ASK staff members speak with families about a variety of health insurance options.		X		
4. ASK continued to offer trainings to families and professionals that outline the various public health insurance programs.		X		
5. Family Voices Indiana began serving as Indiana's Family-to-Family Health Information and Education Center (F2FHIC).		X		
6. CSHCS program continued to send all participants age 17 years and up information on insurance options to apply for as they age off Hoosier Healthwise and their parents' healthcare policies.		X		
7. CSHCS continued to monitor the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of				X

children and adults who benefit from federal and state health care				
8. The CSHCS program continues to be a “Registered Agency” with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.				X
9. The IN CISS Project staff provides TA and distributed Sunny Start Financial Fact Sheets to the 18 Medical Home Learning Collaborative (MHLC) practices to assist both the provider and patient’s insurance needs.		X		
10. CSHCS continued to monitor the activities and progress of the Health Insurance for Indiana Families Committee, a group of state leaders charged with developing no-or low-cost options to provider services for the uninsured.				X

b. Current Activities

The IN CISS Project staff provided Sunny Start Financial Fact Sheets to MHLC practices at site visits.

CSHCS provides updates to Provider and Participants; overseeing and improving the electronic COB process for medical and dental claims; enhancing the ACAPS system; reviewing and following-up on system reports created to identify coordination of benefit issues for electronic pharmacy claims; sending bulletins to providers to clarify the programs reimbursement method; tracking insurance and Medicaid utilization in ACAPS.

CSHCS is monitoring the activities and progress of the Health Insurance for Indiana Families Committee and the activities and progress of CKF.

CSHCN is providing funding for a satellite CSHCS office at Riley Children's Hospital.

CSHCN is providing funding to ASK and its other Title V projects for the purpose of having them speak with families about a variety of health insurance options and help families navigate through these complex systems.

CSHCN Care Coordinators discuss with CYSHCN and their families health care financing options through CSHCS and other state programs. CSHCS program continues sending all participants aged 17 years information on their insurance options as they age off Hoosier Healthwise and parent healthcare policies.

The CSHCS program assisted in the enrollment and paid the monthly premiums for the CSHCS Program participants who had no health insurance coverage into the Federal Pre-Existing Condition Insurance Program (PCIP).

c. Plan for the Coming Year

CSHCS will continue providing updates to Provider and Participants; overseeing and improving the electronic COB process for medical and dental claims; enhancing the ACAPS system; reviewing and following-up on system reports that were created to identify coordination of benefit issues for electronic pharmacy claims; sending bulletins to providers which clarifies the programs reimbursement methodology; tracking insurance and Medicaid utilization in ACAPS; will also coordinate with pharmacies to ensure that proper methods for billing insurance information are being utilized.

CSHCS will continue monitoring the activities and progress of the Health Insurance for Indiana Families Committee and the activities and progress of CKF.

CSHCN will continue to provide funding for a satellite CSHCS office at Riley Children's Hospital.

CSHCN will continue to fund ASK and its other Title V projects for the purpose of having them speak with families about a variety of health insurance options and help families navigate through these complex systems.

CSHCN Care Coordinators will continue to discuss with CYSHCN and their families available options for health care financing through CSHCS and other state programs. CSHCS program will continue sending all participants aged 17 years information on their insurance options as they age off Hoosier Healthwise and parent healthcare policies.

CSHCS will continue to assisted in the enrollment and pay the monthly premiums for the CSHCS Program participants who have no health insurance coverage into the Federal Pre-Existing Condition Insurance Program (PCIP).

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	80	95	95	94.3	95
Annual Indicator	94.3	94.3	94.3	94.3	65.9
Numerator					
Denominator					
Data Source		SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	66	68	70	72	74

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2009

The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

a. Last Year's Accomplishments

The CSHCN Division continued to improve the organization and delivery of services to children and youth with special health care needs (CYSHCN); reimburse families for in-state and out-of-state transportation of CSHCS participants to medical facilities for services; maintain and provide lists of primary care PCPs participating in the CSHCS program; use a customer service representative on an "as needed" basis to take applications in specialty care centers such as hospitals and other care facilities; communicate with the programs participants, providers and community partners via e-mail, the new web portal, and the CSHCS website to provide real-time information sharing on an ongoing basis.

The CSHCN Division maintained a satellite CSHCS Program office at Riley Children's Hospital to complete applications and re-evaluations, generate prior authorizations for services, complete travel vouchers, conduct CSHCS Program informational sessions to families and providers of Riley Hospital, and make referrals to support organization and agencies that serve/support CYSHCN.

The CSHCN Division Care Coordination Section continued providing in-house care coordination to the CSHCS participants. The Care Coordinators assessed the participants and their families' needs and made appropriate referrals to community, medical, and other identified areas. The section maintained a focus linking the participants to a Primary Care Physician (PCP), provided the families with "Tools" to help them prepare for medical visits, and educated the participants and their families on the Medical Home Concept where families and physicians work together to identify and access the medical and non-medical services needed to help children and their families reach their maximum potential.

The CSHCN Division Care Coordination Section continued to participate in community trainings and conferences through parent support organizations in order to expand their awareness of up-to-date community resources while also sharing their knowledge at community health and transition fairs that support CYSHCN.

The IN CISS Project's sub-committee, "Organization of Community Services for Easy Use By families", continued to focus on enhancing systems of care for CYSHCN around the issues of community based service systems that are organized so families can use them easily.

The IN CISS Project developed and provided resources to the 18 Medical Home Learning Collaborative (MHLC) Practices professional staff and parents. Site visits continued to focus on linking community resources to the practices. Our parent partner organizations began attending MHLC site visits, staff from the Center for Youth and Adults with Conditions of Childhood (CYACC) attended to share adult transition information and resources; representatives from the parent organizations About Special Kids (ASK), INSOURCE, The Arc, and Family Voices Indiana attended to share information and community-based resources.

The IN CISS Project continued to employ two parent consultants who provide the parent perspective on improvement efforts in the area of organized community-based service systems that are easy for CYSHCN and their families to access.

The CSHCN Division continued its funding and collaborative partnership with About Special Kids (ASK) and its statewide network of family-to-family peer support. ASK continued to update and add new resources to its online resource directory. ASK continued to update its county-specific community resource pads that have been distributed to health care settings, community health centers, and through various information fairs throughout the state. Key community resources were selected for listing on these materials and they were made "user-friendly" so they could be easily utilized.

The CSHCN Division used Title V funding to support projects that provide care coordination services that link the CYSHCN and their families to appropriate community-based resources and services.

Title V maintained an 800 Family Help Line with V/TDD capabilities and bilingual support that refers families to community-based services and maintains a database of over 10,000 resources. IN FY 2011, the Family Help Line received a total of 37,173 calls.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. CSHCN continued to develop the in-house Care Coordination System. The Care Coordinators assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families wit		X		
2. CSHCN continued to fund and collaborate with About Special Kids (ASK) and its statewide network of family-to-family peer support.		X		
3. ASK continued to update existing resources in its online directory and add new resources as they become available.			X	
4. ASK continues to serve families on a one on one basis and will continue to provide follow-up to these families to insure that they are accessing the appropriate resources.		X		
5. The CSHCN Division continued to fund Title V projects that provide care coordination services that link the CYSHCN and their families to appropriate community-based resources and services.		X		
6. The Indiana Community Integrated Systems of Service Advisory Committee (IN CISS) continues working with the statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs.				X
7. The IN CISS sub-committee titled "Organization of Community Services for Easy Use By families" is focused on enhancing systems of care for CYSHCN around the issues of community based service systems that are organized so families can use them easily.				X
8. The IN CISS Project works with providers, parents, and family members of CYSHCN to provided TA and resource information to assist all parties.				X
9. The IN CISS Project employs two parent consultants who provide the parent perspective on improvement efforts in the area of organized community-based service systems that are easy for CYSHCN and their families to access.				X
10. MCH maintains an 800 Family Help Line with V/TDD capabilities and bilingual support and refers families to community-based services.		X		

b. Current Activities

The IN CISS Project continued to work on system improvement for CYSHCN and their families that are family-centered, community-based and culturally competent. The IN CISS Project sub-committee, "Organization of Community Services for Easy Use by Families", will continue to work with providers, parents and family members of CYSHCN to provide TA and resource information to improve the organization of community-based service systems during the no cost extension. Title V continues to maintain an 800 Family Help Line with V/TDD capabilities and bilingual support that refers families to community-based services.

CSHCN Division expanded its Care Coordination Section to increase its ability to reach all CYSHCN and their families statewide and provide them with community-based resources that meet their needs.

CSHCN will continue to collaborate with ASK and Family Voices Indiana. ASK continues to update existing resources in its online directory, serve families on a one-on-one basis, and provide follow-up. Family Voices Indiana serves as IN's Family to Family Health Information Education Center (F2FHIC).

CSHCN continues to serve on boards and councils focused on improving community-based

service systems that are coordinated and easily accessible for CYSHCN and their families. CSHCN continues its involvement in national initiatives for Ease of Use of Services for Latino families with CYSHCN and the Act Early, Learn the Signs Campaign.

c. Plan for the Coming Year

The CSHCN Division will continue its ongoing efforts to provide and streamline services and resources for all CYSHCN and their families that are coordinated, easily accessible, community-based, family-centered, and culturally-competent.

The CSHCN Division will continue to collaborate with its partners in an Action Learning Collaborative model to create a statewide strategic plan to address Ease of Use of Services for Latino families with CYSHCN in Indiana. CSHCN will also continue to use the CDC's Act Early, Learn the Signs materials to not only educate families and providers regarding early screening and diagnosis of Autism, but to coordinate community-based service systems for CYSHCN and their families in the state.

Title V will continue to maintain an 800 Family Help Line with V/TDD capabilities and bilingual support that refers families to community-based services and also will continue to manage its resource database to ensure resources are up-to-date.

The CSHCN Division will continue to collaborate with ASK and Family Voices Indiana and share their trainings and services with families with CYSHCN throughout the state.

The CSHCN Division Care Coordination Section will continue expanding its reach throughout the state to make appropriate community-based referrals to CSHCS participants, CYSHCN statewide, and their families that are coordinated, easily accessible, community-based. The section will also continue to participate as an exhibitor at community health and transition fairs and in trainings to expand their knowledge of community-based resources.

The CSHCN Division will continue to support its Title V projects that provide care coordination services to ensure all CYSHCN and their families are linked to community-based resources that are coordinated and easily accessible.

CSHCN Division will continue to serve on boards and councils focused on improving community-based service systems that are coordinated and easily accessible for CYSHCN and their families. CSHCS will continue to reimburse families for in-state and out-of-state transportation to medical facilities for services for CSHCS participants and continue to communicate with the programs participants, providers and community partners via e-mail and the CSHCS website to provide real-time information sharing on an ongoing basis.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6	41.5	41.5	41.1	42
Annual Indicator	41.1	41.1	41.1	41.1	43.7
Numerator					
Denominator					
Data Source		SLAITS	SLAITS	SLAITS	SLAITS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year					

moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	44	45	46	47	48

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2009

The SLAITS/Survey of Child Health Needs is done every other year; thus the results remain the same for any two year period. Some questions changed significantly from 2005 to 2007, but the pre-populated fields remain the same from 2007 to 2008.

Source of data: Pre-populated SLAITS federal survey.

a. Last Year's Accomplishments

The CSHCN Division provided financial support to The Center for Youth and Adults with Conditions of Childhood (CYACC) to provide leadership in facilitating the transition to adulthood for Indiana youth and young adults with special health care needs. CYACC and The IN CISS Project partners worked together to coordinate and share information and develop resources that support transition to adulthood, concentrating on targeting CYSHCN and their families as well as primary and specialty care practices. Resources were developed through collaborations between CYACC, IU School of Medicine, and Indiana Institute on Disability and Community (IIDC). CYACC receives input through multiple community agencies via a community advisory board. Learners and current professionals are trained on concepts of transition, supporting community resources, and methods to implement into practice to assist Indiana's CYSHCN become more prepared for adult life. During the past year, CYACC has addressed transition and providing primary care for adults with disabilities with over 150 providers. The team has developed a website targeting healthcare professionals and individuals with special health care needs. CYACC has spent this past year focusing on methods of communicating information with primary care providers and strengthening supplemental transitional support to their clinical services through self-management education.

The CYACC team mailed 121 Individual Health Assessment Plans (IHAPs) to the primary care providers of new patients seen during the past year. In addition, CYACC has evaluated 141 new patients, bringing the total number of youth and young adults initially assessed for transition to adult health care by the CYACC team to 656 patients.

The CYACC team made progress in piloting two chronic condition self-management programs. The team piloted 6 modules on Health Habits, Physical Activity, Decision-Making, Living Independently, Education, and Healthy Relationships to the Down Syndrome Indiana Self Advocates in "Welcome to Adult Life" program. The "Be Your Own Boss" program, a research project in collaboration with Stanford Chronic Disease Self-Management Programs and Alberta Health Services, trained 15 individuals with chronic conditions from four different geographical areas in the state to be Lay Leaders for the BYOB program in March 2011.

The CSHCN Division distributes the Transition Manual to 100% of the CSHCS participants aged 11-21 years and continues to receive ongoing training and updates regarding transitioning CSYHCN to adult health care, work, and independence.

The CSHCN Division distributed the Transition Manual to CYSHCN aged 11-21 years when exhibiting at health and transitional fairs throughout the state.

The CSHCN Division provided financial support to the CYACC Bridging Team through Title V and the IN CISS Project funds.

The IN CISS Transition Project continued including parents of CYSHCN on the CYACC Advisory Board to provide their perspective on transition issues.

CSHCN and the CYACC Transition Clinic continued to develop transition resource materials for clients and training for providers.

CYACC provided clinic observations for pediatric, med/peds, and internal medicine residents during ambulatory pediatric and development pediatric rotations. Residents and students are instructed about the transition issues common to CYSHCN and learn about community resources which assist these patients and families. CYACC also includes medical students in clinic observations. Last year, CYACC trained 53 medical residents and 9 medical students.

CSHCN Division continued to work with interagency initiatives (Department of Education 290 Group and CYACC Advisory Board) regarding transition for individuals with disabilities from school to work or youth to adult health services.

The IN CISS Transition Project is working with health care providers statewide on transitioning youth with special health care needs to adult care. Members from the CYACC team attended the IN CISS MHLIC site visits to share transition resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN continues to distribute the Transition Manual to 100% of the CSHCN participants aged 11-21 years.		X		
2. CSHCN continues to participate in transitional fairs as an exhibitor.			X	
3. CSHCS staff continues to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult health care, work, and independence through TA trainings and informational materials.				X
4. CSHCN continues to provide financial support to the Center for Youth and Adults with Conditions of Childhood (CYACC) Bridging Team. The centers focus is on transitional health care for youth with special health care needs.		X		
5. The Indiana Community Integrated Systems of Service Project continues to financially support work to identify system improvement initiatives for CYSHCN relating to Transition to adult healthcare, work, and independence.				X
6. The IN CISS sub-committee titled "Transitions to Adult Health Care, Work and Independence" continues its focus to enhance systems of care for CYSHCN around the issues of transition.				X
7. The IN CISS Project has recruited youth with special				X

healthcare needs and their families to form an Advisory Committee to provide their perspective on transition issues. The members are provided a stipend for their participation on the committee.				
8. CSHCN continues to provide transition materials and resources to IN CYSHCN and their families to meet their transitional needs in all aspects of life.		X		
9. CSHCN and the CYACC Transition Clinic continued to develop transition resource materials for clients and training for providers.			X	
10. CSHCN continues to work with interagency initiatives (Department of Education 290 Group and CYACC Advisory Board) regarding transition for individuals with disabilities from school to work or youth to adult health services.				X

b. Current Activities

The CYACC Transition Project continues to work with health care providers statewide on transitioning CYSHCN to adult health care. Materials and tools developed at the CYACC transition clinic as well as additional tools, resources, and Educational Office Visits (EOV) are used by the CYACC team to build partnerships with community physicians and/or their healthcare teams to assist in meeting the transition needs of CYSHCN in their practices.

CSHCN continues to meet with the IN CISS Advisory Committee to address transition in the state and work on improving access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families that are family-centered, community-based and culturally competent.

CYACC convenes their Youth Advisory Board, comprised of youth and young adults with a number of chronic conditions and diverse backgrounds, quarterly to provide consumer perspective on transition issues.

CSHCN Division is updating and redesigning the state Transition Manual with CYACC to distribute to all CSHCS participants aged 11-21 years. The manual will be available on the CSHCS website and linked to partner websites supporting CYSHCN. CSHCN Division will distribute manuals at health and transitional fairs attended as an exhibitor.

CYACC trained 14 young adults with chronic conditions as leaders for the "Be Your Own Boss" self-management workshop. The workshops were led by 5 youth Lay Leaders who previously completed the workshop.

c. Plan for the Coming Year

CSHCN will continue to provide financial support to the CYACC Transition Clinic through Indiana University School of Medicine, Department of Pediatrics to continue providing transitions services, support and materials to CYSHCN, families, and providers throughout the state.

The CSHCN Care Coordination Section will continue to have in-depth discussions with IN families regarding transition to adult health care and providing resources that meet their transition needs. CSHCN will continue to participate in transitional fairs as an exhibitor.

CSHCN staff will continue to receive ongoing training and updates regarding transitioning CYSHCN to adult health care, work, and independence through TA trainings and informational materials provided by the Got Transition National Center and CSHCN partnerships with CYACC and parent organizations.

CSHCN will continue to work with the CYACC Advisory Board to address transition related issues.

CYACC will continue to execute the "Be Your Own Boss" workshops over the next year and continue work with Down Syndrome Indiana self-advocates on the "Welcome to Adult Life" curriculum in order to education youth and young adults on transition and self-management.

CSHCN will continue to work with CYACC to create transition fact sheets that can be distributed to CSHCN participants aged 11-21 years, discussed and shared with families through the Care

Coordination Section, and posted on the CSHCN website.

CYACC will continue identifying various methods of mental health screening for patients with varying cognitive and developmental abilities, allowing them to better document mental health status.

CYACC will continue to expand its resident learner training and curriculum to medical students and residents and also continue to educate interns from multiple academic disciplines (social work, public health, and nursing).

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	84	84	85	89.5	90.5
Annual Indicator	76.8	89.1	89.1	90.5	90.5
Numerator					
Denominator					
Data Source		ISDH - Imm. Pgm	ISDH - Imm. Pgm	ISDH - Imm Pgm	ISDH - Imm Pgm
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	90.5	91	91.5	92	92

Notes - 2011

Data based on trend analysis.

Notes - 2010

Figure provided without numerator or denominator.

Source of data: ISDH Immunization program.

Notes - 2009

Figure provided without numerator or denominator.

Source of data: ISDH Immunization program.

a. Last Year's Accomplishments

The Immunization Program conducted VFC and AFIX visits at VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH worked with the Immunization Program to increase the number of sites using the Children Hoosiers Immunization Registry Program (CHIRP) reminder/recall feature.

MCH coordinated with the Immunization Program to provide educational opportunities for WIC

program staff.

MCH staff attended the Indiana Immunization Coalition and participated in its activities.

MCH worked with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

The ISDH Immunization Division Director implemented a policy allowing Federally Qualified Community Health Centers (FQCHCs) to delegate authority to local health departments for immunization of underinsured children under the VFC program.

MCH assisted the Immunization Program in implementing new vaccine eligibility changes in public and provider offices.

MCH ECCS initiative, Sunny Start, consulted with the Immunization Director when updating its Children's Wellness Passport to include up-to-date immunization information and support for its CHIRP Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Immunization Program will conduct Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled Maternal and Child Health (MCH) sites to assess implementation of VFC policies.				X
2. MCH will work with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.				X
3. MCH will coordinate with the Immunization Program to provide educational opportunities for WIC program staff.			X	
4. MCH staff will attend the Indiana Immunization Coalition and participate in its activities.				X
5. MCH will work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Immunization Program conducts VFC and AFIX visits at all VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH works with the Immunization Program to increase the number of sites entering data into CHIRP, whether manually or electronically through interfaces.

MCH works with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

MCH coordinates with the Immunization Program to provide educational opportunities for WIC program staff.

MCH staff attends the Indiana Immunization Coalition and participates in its activities.

The ISDH Immunization Division Director continues to implement a policy allowing Federally Qualified Community Health Centers (FQCHCs) to delegate authority to local health departments for immunization of underinsured children under the VFC program.

MCH and the Immunization Program work with the Family and Social Services Administration to ensure the immunization status of child care attendees complies with state requirements.

MCH and the Immunization Division work with providers to increase compliance with the ACIP recommendations by conducting reminder recalls at the state and local level.

c. Plan for the Coming Year

The Immunization Program will conduct VFC and AFIX visits at all VFC-enrolled MCH sites to assess implementation of VFC policies.

MCH will work with the Immunization Program to increase the number of sites using the Children Hoosiers Immunization Registry Program (CHIRP) reminder/recall feature.

MCH will coordinate with the Immunization Program to provide educational opportunities for WIC program staff.

MCH staff will attend the Indiana Immunization Coalition and participated in its activities.

MCH will work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

MCH will work with the Immunization Program and the Indiana Immunization Coalition to increase awareness of the HPV vaccine in an effort to reduce cervical cancer in women.

The ISDH Immunization Division Director will affirm and/or renew the policy as needed allowing Federally Qualified Community Health Centers (FQCHCs) to delegate authority to local health departments for immunization of underinsured children under the VFC program.

MCH will assist the Immunization Program in implementing new vaccine eligibility changes in public and provider offices.

MCH will work with the Immunization Program to promote the use of MyVaxIndiana, a web-based tool that enables parents to view and print their child's immunization record.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	19	20.1	20	19.8	19.6
Annual Indicator	22.1	20.5	20.8	20.5	20
Numerator	2955	2728	2730		
Denominator	133975	132756	131357		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	19.8	19.6	19.4	19.2	19

Notes - 2011

Figure projected from past data.

Source of past data: ISDH ERC

Notes - 2010

Figure projected from past data.

Source of past data: ISDH ERC

Notes - 2009

2009 is final data.

Source of past data: ISDH ERC

a. Last Year's Accomplishments

SAHC worked with and supervised the Youth Risk Behavior Survey Coordinator (YRBS) to disseminate data findings from the 2009 survey as well as assist with the administration of the 2011 YRBS survey.

SAHC continued to facilitate the Indiana Coalition to Improve Adolescent Health (ICIAH) which has addressing risky sexual behaviors among adolescents as one of its priorities.

SAHC served as a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy.

SAHC promoted the National Day to Prevent Teen Pregnancy, sponsored by the National Campaign to Prevent Teen and Unplanned Pregnancy.

MCH funded three school-based adolescent health clinics to provide services to students, including free pregnancy tests and counseling about sex and abstinence.

SAHC served as the adolescent family planning consultant for the state and administrator of the Indiana Family Planning Partnership.

SAHC promoted the ISDH Free Pregnancy Test program to school-based clinics and community organizations.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SAHC will continue supervising the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assist with the administration of the 2013 YRBS survey.		X		X
2. SAHC will continue supervising the Pregnant and Parenting Adolescent Support Services (PPASS) Program, which has a priority area of reducing subsequent pregnancies among Indiana teens.	X			X
3. MCH will contract with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free pregnancy tests and counseling about sex and abstinence.	X			X
4. After state approval, MCH will conduct a media marketing campaign to ensure that teens have access to relevant, reliable, and accurate information regarding pregnancy prevention.	X			X
5. MCH will contract with Health Care Education and Training (HCET) to develop a texting method for parents to talk to their kids about sex and abstinence.		X		
6. MCH will continue to fund three school-based adolescent health clinics to provide services to students, including free pregnancy tests and counseling about sex and abstinence.	X			X
7. SAHC will continue to serve as the adolescent family planning consultant for the state and administrator of the Indiana Family Planning Partnership.				X
8.				
9.				

10.				
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b. Current Activities

SAHC is supervising the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assist with the administration of the 2013 YRBS survey.

SAHC is participating on the ICIAH which has addressing risky sexual behaviors among adolescents as one of its priorities.

ICIAH created and published a handbook for teens that provides health information on a variety of topics including STIs, pregnancy and abstinence. ICIAH is working with its statewide partners to distribute the handbooks to young people, specifically high school students. ICIAH also hosts a website for teens. Teens can submit health questions that are answered by a medical professional. It is anticipated that most questions will be related to sex and reproductive health issues.

SAHC is promoting the National Day to Prevent Teen Pregnancy, sponsored by the National Campaign to Prevent Teen and Unplanned Pregnancy to its grantees, community organizations, and other funded partners.

SAHC is finalizing the Indiana RESPECT grant application process for SFY 2012-2013 and overseeing the application and review process, including the identification of funded projects and provision of technical assistance to funded projects.

SAHC is serving as the family planning consultant for the state and administrator of the Indiana Family Planning Partnership.

SAHC is promoting the ISDH Free Pregnancy Test program to school-based clinics and community organizations.

c. Plan for the Coming Year

SAHC will continue supervising the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assist with the administration of the 2013 YRBS survey.

SAHC will continue supervising the Pregnant and Parenting Adolescent Support Services (PPASS) Program, which has a priority area of reducing subsequent pregnancies among Indiana teens.

SAHC will continue to serve as the adolescent family planning consultant for the state and administrator of the Indiana Family Planning Partnership.

MCH will continue to fund three school-based adolescent health clinics to provide services to students, including free pregnancy tests and counseling about sex and abstinence.

SAHC will continue to participate in the ICIAH in addressing risky sexual behaviors among adolescents as well as other issues that affect teen health.

With state approval, SAHC will oversee a media marketing campaign to ensure that teens have access to relevant, reliable, and accurate information regarding sex and abstinence.

MCH will contract with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free pregnancy tests and counseling about sex and abstinence.

MCH will contract with Health Care Education and Training (HCET) to develop a texting method for parents to talk to their kids about sex and abstinence.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	48	49	50	50	24
Annual Indicator	48.7	49	50	24	24

Numerator					
Denominator					
Data Source		ISDH - Oral Hlth	ISDH - Oral Hlth	ISDH - Oral Hlth	ISDH- Oral Hlth
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	24.5	25	25.5	26	26.5

Notes - 2011

Data is final.

Notes - 2010

For the years 2005-2010 the Annual Performance Objective was based on the CDC Healthy People 2010 goal of increasing to 50% by year 2010 the proportion of children aged 8 years who had received dental sealants on their molar teeth.

For the years 2011-2020 the Annual Performance Objective will be based on the CDC Healthy People 2020 Target (OH-12.2) of increasing to 28.1% by the year 2020 the proportion of children aged 6-9 years who have received dental sealants on one or more permanent first molars.

Notes – 2008-2010

The Annual Indicators for years 2008-2010 were projected values based on questionnaire survey data obtained by the ISDH in years 2000-2005. Based on these projections, the ISDH has met its goals for each of these years.

However, for years 2011-2020 the ISDH has decided to use Indiana Medicaid data to determine what proportion of children aged 6-9 years have received dental sealants on one or more permanent first molars.

Notes - 2009

Projected based on last year's information from ISDH Oral Health program.

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This means that, based on our revised projection, we met our goal for 2008.

a. Last Year's Accomplishments

Accomplishments of special note for FY 2011:

Adoption of new Annual Performance Objective and Annual Indicator:

The Oral Health Program (OHP) at the Indiana State Department of Health (ISDH) decided to use the CDC Healthy People 2020 Target for dental sealants for children aged 6-9 years old (OH-12.2) as its Annual Performance Objective.

The OHP decided to use data from Indiana Medicaid to measure the Annual Indicator for Performance Measure 09, if these data are available; otherwise, Seal Indiana data will be utilized.

Accomplishments for FY 2011:

The OHP utilized grant dollars to enhance and support dental sealant projects already in existence in Title I schools by the dental mobile provider Seal Indiana at the Indiana University School of Dentistry.

The OHP promoted community-based dental sealant programs among existing programs and will continue to collaborate to develop community-based dental sealant programs.

The OHP collaborated with partners such as the IU School of Dentistry, Indiana Dental Association and other partners in the state.

The OHP collaborated with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

The OHP consulted with the ISDH Primary Care Director to help communities gain designation as Dental Health Professional Shortage Areas (DHPSA).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The OHP is utilizing grant dollars to enhance and support dental sealant projects already in existence in Title I schools by the dental mobile provider Seal Indiana.	X			
2. The OHP is promoting community-based dental sealant programs among existing programs and will continue to collaborate to develop community-based dental sealant programs.				X
3. The OHP is collaborating with partners such as the IU School of Dentistry, Indiana Dental Association and other partners in the state.				X
4. 1. The OHP is collaborating with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future CHC.				X
5. The OHP is consulting with the ISDH Primary Care Director, as needed, to help communities gain designation as DHPSA.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Grant activities for FY 2012:

The OHP submitted an application to the Delta Dental Foundation for a Community Mini-Grant to conduct a pilot project to abstract surveillance data on the oral health status (including dental sealants) of children.

Activities of special note for FY 2012:

The OHP collaborated with the IU School of Dentistry to submit a grant application to the federal government for funding to study the possibility of dental hygienists placing dental sealants on children's teeth in schools using prescriptive supervision.

The OHP worked with the ISDH's Division of Nutrition and Physical Activity to submit a proposal

to conduct a joint survey on the oral health and BMI status of children.

Activities for FY 2012:

The OHP utilized grant dollars to enhance and support dental sealant projects already in existence in Title I schools by the dental mobile provider Seal Indiana at the Indiana University School of Dentistry.

The OHP promoted community-based dental sealant programs among existing programs and has continued to collaborate to develop community-based dental sealant programs.

The OHP collaborated with partners such as the IU School of Dentistry, Indiana Dental Association and other partners in the state.

The OHP collaborated with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical

c. Plan for the Coming Year

Plans of special note for FY 2013:

The OHP plans to submit an Indiana Oral Health Plan for state approval by the end of calendar year 2012 including plans for using dental sealants for the primary prevention of dental caries.

The OHP plans to use the funds from the Delta Dental Foundation Community Mini Grant to conduct a pilot project to abstract surveillance data on the oral health status (including dental sealants) of 8-9 year old children in two or more local communities in collaboration with private practice pediatric dental practices.

The OHP plans to collaborate with the IU School of Dentistry to study the possibility of Federally Qualified Health Centers and schools working together to allow dental hygienists to place dental sealants on children's teeth, in schools, using prescriptive supervision, if funds become available.

The OHP plans to work with ISDH's Division of Nutrition and Physical Activity to conduct a joint survey to obtain data on dental caries, dental sealants, weight and height of children aged 8-9 years old, if funds become available.

The OHP plans to collaborate with Indiana University in Bloomington and a local after school program to submit a grant application to the federal government for funding, to study the behavior and motivation behind tooth brushing and to promote proper tooth brushing technique in children 8-9 years old.

Plans for FY 2013:

The OHP plans to use grant dollars to enhance and support dental sealant projects already in existence in Title I schools by the dental mobile provider Seal Indiana at the Indiana University School of Dentistry.

The OHP plans to promote community-based dental sealant programs among existing programs and has continued to collaborate to develop community-based dental sealant programs.

The OHP plans to collaborate with partners such as the IU School of Dentistry, Indiana Dental Association and other partners in the state.

The OHP plans to collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers.

The OHP plans to consult with the ISDH Primary Care Director, as needed, to help communities gain designation as Dental HPSA.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	3.2	3	2.8	3.3	3.2
Annual Indicator	3.4	3.6	2.0	2	1.9
Numerator	44	47	27		
Denominator	1310331	1311912	1318933		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1.9	1.8	1.8	1.7	1.7

Notes - 2011

Projected based on data provided in previous years.

Source of data: ISDH - ERC

Notes - 2010

Projected based on data provided in previous years.

Source of data: ISDH - ERC

Notes - 2009

2009 data is final.

Source of data: ISDH - ERC

a. Last Year's Accomplishments

ISDH, through the Public Health Block Grant, funded a part-time epidemiologist for the ISDH Injury Prevention Program until her resignation in May, 2011. ISDH provided meeting space for periodic meetings of the Injury Prevention Advisory Council (IPAC) which is coordinated by the IPAC Chair.

The ISDH Epidemiologist updated the "Injuries in Indiana" data report that has an entire section which focuses on motor vehicle crashes but not specific to adolescent driving.

ISDH continued to work with the Injury Prevention Advisory Council to share information with partners concerning programs and activities; and to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the Indiana Adolescent Health Plan.

In June 2010, ISDH completed a State and Territorial Injury Prevention Director's Association site visit to conduct a needs assessment to establish appropriate focus areas for the Injury Prevention Program.

Indiana Criminal Justice Institute (ICJI) provided grants to the Automotive Safety Program (ASP), which funded 121 permanent fitting stations for infant and child car seats and booster seats through 5 local health departments

Additional Injury Prevention training were incorporated into Healthy Families training.

ICJI supported a new E-code project where additional data was collected from ER visits and hospitalization records on the impact of MVA. The ISDH Injury Prevention Epidemiologist

attended the meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Indiana State Department of Health (ISDH), with Preventative Block Grant funds a full-time Director of Trauma and Injury Prevention and a full-time Injury Prevention Epidemiologist, prioritizing trauma as a division within the agency.				X
2. ISDH Chief Medical Officer attends monthly state Child Fatality Review meetings.				X
3. ISDH hosts and the Health Commissioner leads the quarterly meetings of the Injury Prevention Advisory Council, which MCH staff attends.				X
4. ISDH completed a May 2012 Trauma White Paper which includes data on MV Death Rates and proposes the trauma system concept.				X
5. ISDH continues to work with the Injury Prevention Advisory Council to ensure information is shared with internal and external partners concerning programs and activities involving injury prevention.				X
6. ISDH continues to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the Indiana Adolescent Health Plan (pages 46-48).				X
7. The Injury Prevention Advisory Council is focusing on Motor Vehicle crashes with a recent review of the ICD-10 codes, hospitalization/ED rates, and death rates by age and sex from 2007-2009.				X
8. The Indiana Criminal Justice Institute provides grant funding to ISDH Injury Prevention for an e-code validation project, including chart review of hospitalizations due to motor vehicle crash injury		X		
9. . ISDH is named as the lead agency responsible for development of a state trauma system				X
10.				

b. Current Activities

ISDH, through the Preventive Health Block Grant, funds a Director of Trauma and Injury Prevention and an Injury Prevention Epidemiologist.
 ISDH, through the ICJI, funds a full-time Trauma Registry Manager and a full-time Trauma Registry Data Analyst.
 ISDH works with the Injury Prevention Advisory Council to ensure information is shared with internal and external partners concerning programs and activities involving injury prevention.
 ISDH coordinates information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the IN Adolescent Health Plan.
 ISDH promotes automobile safety through participation in relevant local/state programs.
 ICJI in partnership with IU Center for Criminal Justice Research gathers data and publishes the IN Traffic Safety Fact Sheets and IN Crash Fact book. ICJI continues to provide grants to fund 122 permanent fitting stations for infant and child car seats and booster seats through 5 local health departments.
 ISDH participates in establishing priorities for the Injury Prevention Program based on the State and Territorial Injury Prevention Association's 2010 needs assessment.
 ICJI supports an E-code project where data are collected on e-code completeness of hospitalization records. A focus of this project is on improving the linkage of motor vehicle related

records with hospital records by increasing the percentage of records with e-codes.

c. Plan for the Coming Year

ISDH, through the Preventive Health Block Grant, will continue to fund a full-time Director of Trauma and Injury Prevention and a full-time Injury Prevention Epidemiologist.

ISDH, through the Indiana Criminal Justice Institute, will continue to fund a full-time Trauma Registry Manager and a full-time Trauma Registry Data Analyst.

The ISDH Injury Prevention Epidemiologist will update the "Injuries in Indiana" data report that will have an entire section focused on motor vehicle crash fatalities and hospitalizations.

ISDH will work with the Injury Prevention Advisory Council to share injury data and identify areas where prevention efforts should be focused. Examples of prevention efforts include compiling proven policies and best practices.

The E-code project, through the Preventive Health Block Grant, will continue and data will be collected on e-code completeness of hospitalization records. A focus of this project is on improving the linkage of motor vehicle related records with hospital records by increasing the percentage of records with e-codes.

ISDH will promote automobile safety through participation in relevant local/state programs.

The Indiana Criminal Justice Institute in partnership with Indiana University Center for Criminal Justice Research Center gathers data and publishes the Indiana Traffic Safety Fact Sheets and Indiana Crash Fact book. Indiana Criminal Justice Institute continues to provide grants to ASP, which funds 122 permanent fitting stations for infant and child car seats and booster seats through 5 local health departments: Boone County Health Department, Lebanon -Elkhart County HD, Elkhart -Henry County HD, New Castle -Marion County HD, Indianapolis -Spencer County HD, Rockport.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	31	35	36	37	38
Annual Indicator	34.6	35.4	31.4	35	37
Numerator					
Denominator					
Data Source		US CDC Report	US CDC Report	US CDC Report	US CDC Report
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	39	40	41	42	43

Notes - 2011

Based on trend analysis.

Notes - 2010

Projection based on trend analysis.

Notes - 2009

US CDC Report will be updated prior to end of 2010. Projection used until then based on trend analysis.

a. Last Year's Accomplishments

There are 39 local breastfeeding coalitions covering 62 of Indiana's 92 counties. The State Breastfeeding Coordinator (SBC) published a monthly e-newsletter. Eighteen new community drop-in centers opened to provide community based breastfeeding support.

Indiana Perinatal Network (IPN) funded 24 applicants to take the lactation certifying exam; for reduced or no cost.

ISDH, IPN, and ISBC hosted a second invitation-only Summit for administrators of all birthing hospitals. Hospital mpinc scores and Baby Friendly designations were discussed.

A survey of hospitals in Aug/Sept 2011 showed: 52% initiated a new breastfeeding policy or practice; 75% now employ at least 1 IBCLC; 23% have started the baby friendly process.

SBC continues to serve on the ISDH breastfeeding steering committee of the Indiana Healthy Weight Initiative State Obesity Plan.

On April 27, 2011, ISDH, Indiana FSSA Bureau of Child Care, Indiana Association for Child Care Resource and Referral, and IPN provided a Train the Trainer course to childcare regional educators.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance to increase the number of Baby Friendly Hospitals in Indiana.		X		
2. Provide ongoing technical support and consultation to sustain and increase the capabilities of all 40 local breastfeed coalitions.		X		X
3. Increase the number of hospitals that develop and implement evidence based breastfeeding policies by 10%.			X	
4. Increase the number of drop-in breastfeeding centers in local communities.				X
5. Increase the number of businesses that implement The Business Case for Breastfeeding for lactation support in the workplace.			X	
6. Create additional workgroups of the ISBC to address barriers and solutions in the following areas: clinical, community outreach, minority health, childcare, and educating the provider.				X
7.				
8.				
9.				
10.				

b. Current Activities

The SBC is continuing to work with state birthing hospitals to increase the number of Baby Friendly Hospital designations. IU Health Bloomington Hospital has become Indiana's 5th Baby Friendly Hospital on 12-12-2011.

Provide ongoing technical support and consultation to sustain and increase the capabilities of all 40 local breastfeeding coalitions.

SBC will work with hospitals to develop and implement evidence based breastfeeding policies.

Increase the number of drop-in breastfeeding centers in local communities with low breastfeeding rates.

Increase the number of businesses that implement lactation support in the workplace. Two new lactation rooms were created at ISDH. Lactation stations were created at Black Expo, and the Super Bowl Village.

Create additional workgroups of the IN State Breastfeeding Coalition to address barriers and solutions in the following areas: clinical, community outreach, minority health, childcare, and educating the provider

c. Plan for the Coming Year

ISBC will continue to pursue insurance coverage for lactation consultation and supplies, and will create a registry of International Board Certified Lactation Consultants in the state.

SBC will continue to provide expert advice to businesses and employees on the implementation of lactation support in the workplace. ISBC will form an action group to explore broader ways to increase workplace support of lactating employees.

Additional workgroups will be formed to address barriers and solutions in the following areas: clinical, community outreach, minority health, childcare, and educating the provider. WIC will have their own action group and will interface with the other groups on WIC-related issues. The meetings previously held monthly will be held quarterly and action groups will meet during the off-months.

The ISBC plans to develop a coalition website and have IPN's and DNPA's breastfeeding pages link to it.

Future goals of the ISBC are to recruit someone to search for and write grants for breastfeeding and to update the state's Call to Action, launched five years ago.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	99.6	99.7	98.5	99.6	99.7
Annual Indicator	98.1	99.5	99.5	99.6	99.7
Numerator	88005	87076	85695		
Denominator	89719	87520	86126		
Data Source		ISDH - UNHS	ISDH - UNHS	ISDH - UNHS	ISDH - UNHS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	99.7	99.8	99.8	99.8	99.8

Notes - 2011

Based on trend analysis.

Notes - 2010

Based on trend analysis.

Source of data: ISDH UNHS

Notes - 2009

Data is final.

a. Last Year's Accomplishments

To date all of Indiana's birth hospitals continue active use of the EHDI (Early Hearing Detection and Intervention) Alerts Response System (EARS) web-based application that enables timely, accurate follow-up for children not receiving Universal Newborn Hearing Screening (UNHS), not passing UNHS and those passing but at risk for developing hearing loss after birth. In addition, three midwife birthing facilities have now been granted hearing screening equipment through the EHDI program and are reporting newborn hearing screening results.

In February 2012, EHDI submitted summary data to the Center for Disease Control and Prevention for children born in 2010. The data indicated that 97.4% of all babies born in Indiana were screened for hearing loss and 2.6% (2,170) of these babies did not pass UNHS. Follow-up for babies who did not pass indicated that 68.5% of the babies were found to have normal hearing, 6.2% of the babies were ultimately diagnosed with permanent hearing loss, 13.2% of families were unresponsive to our follow-up efforts and 3.9% of the babies were lost to follow-up. Not only does the lost to follow-up rate continue to be quite a bit lower than the national average but also the timeliness with which children are receiving their diagnostic follow-up continues to improve. Median age of diagnosis was 48 days (national goal is 90 days). Overall, EHDI was able to report 253 children who were diagnosed with permanent hearing loss (134 did not pass UNHS, 8 passed UNHS, did not receive UNHS or were born in other state, and 111 were born in previous years).

Since the inception of the Guide By Your Side (GBYS) program in September 2009, 238 families have enrolled in GBYS with 107 of those families enrolling in 2011. In order to serve families most appropriately families are matched with Parent Guides based on geographic location within the state, by language spoken in the home (English or Spanish), or by type of hearing loss (unilateral or bilateral).

As the number of families who speak Spanish increase, the Family Resource Guide -- now called the Ready Guide was translated into Spanish.

In 2011 EHDI staff provided numerous presentations to physicians, audiologists, families, early interventionists and others at a variety of educational meetings and conferences including the Annual EHDI Conference, the EHDI Family Conference, two First Steps provider forums, and more than 35 hospital visits/meetings.

Indiana EHDI continued its participation in a project with the CDC called iEHDI evaluating the possibility of state providing de-identified, child-centric data to the CDC from multiple states. The project has enabled the EHDI program to identify opportunities for improving care to families, improving data quality, and for evaluating progress of the overall progress of the EHDI program. In July 2011, EHDI staff assisted the staff of the Early Childhood Hearing Outreach (ECHO) program to train 3 Early Head Start (EHS) Programs to offer periodic hearing screening to children birth to 3 years of age. The EHDI Regional Audiology Consultants provided ongoing technical support to the EHS Program as needed throughout the year.

Also in July 2011, the Genomics and Newborn Screening Programs implemented the use of the Data Audit Tool that identifies children with either no heel stick card or a heel stick card with missing data. Three hospitals were identified with the largest proportion of data missing. These facilities participated as the pilots for this new tool and the remainder of the hospitals was added in by the end of the year. The tool has enabled the EHDI program to confirm UNHS results for any child born in Indiana if screening was completed. It has also assisted in identifying children who did not pass UNHS but were not reported to EHDI appropriately.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to work with individual hospitals to train new staff members and to encourage timely reporting of children in need of follow-up into the EARS web-based data system.			X	
2. Continue efforts to educate physicians regarding follow-up recommendations for children not passing UNHS and children at risk for delayed onset hearing loss.				X
3. Continue to refine EARS reports and the Integrated Data Store (IDS) to enable more timely analysis of program progress.			X	
4. Continue partnership with Indiana Hands & Voices to provide family education and support services.		X		
5. Provide two large trainings to audiologists on audiology procedures and related content areas to increase the skills, knowledge base and number of providers who serve very young babies and children.				X
6. Continue to work with Level 1 and Level 2 centers to maximize audiologic services for infants and young children.			X	
7. Continue to support the Office of Management and Budget in the development of the new Center for Deaf and Hard of Hearing services (House Enrolled Act 1367).				X
8. Continue development of a comprehensive program evaluation with assistance from CDC EHDI team members.			X	
9.				
10.				

b. Current Activities

During the Current year EHDI has continued...

Monitoring of submission of reports by hospitals and have provided ongoing technical assistance of hospitals not following recommended reporting practices.

Disseminating of loaner hearing screening equipment to hospitals or birthing facilities and diagnostic hearing equipment to at least two audiology practices in areas of the state where comprehensive diagnostic evaluations are not currently being provided.

Partnering with the Indiana Hands & Voices to provide family-to-family support for parents as they proceed through EHDI process through the Parent Consultants and the GBYS Program including support to specific groups of families (i.e., Spanish speaking, parents with children with unilateral hearing loss, bilateral hearing loss or auditory neuropathy.)

Working with the State Head Start Collaboration Office to spread ECHO to other interested EHS programs.

Providing ongoing feedback and support to the Office of Management and Budget for the development and implementation of the Center for Deaf and Hard of Hearing Education.

Participating in the CDC iEHDI project which shares de-identified, child-centric data for the purpose of EHDI program improvement. In addition, participating in the CDC Sentinel Data project to determine the feasibility of sharing timely summary data on a select number of CDC data items.

Using of the Data Audit Tool to improve reporting of UNHS results on the heel stick card

c. Plan for the Coming Year

During the upcoming year, the EHDI program will continue to participate in the development and implementation of the Center for Deaf and Hard of Hearing Education as requested by the Office of Management and Budget. As part of the Center's development EHDI will conduct a comprehensive survey assessment with parents, hospitals, early intervention providers, and

physicians.

Ongoing training of hospitals, birthing facilities, audiologists, physicians, early intervention providers and other stakeholders regarding the importance of newborn hearing screening, timely follow-up, and enrollment in early intervention services will continue. New methods of training including web-casts, prerecorded training curriculum, and teleconferences will be highlighted to provide training in more cost effective, time efficient manner. In addition, Public Health Nurses (PHN) will be targeted to increase PHN awareness of newborn hearing screening, follow-up recommendations and services for children with diagnosed hearing loss.

Genomics and Newborn Screening staff will continue to support the EHDI program my continued use of the Data Audit Tool in order to increase the number of children with documents UNHS results as well as implementation of the Data Management Tool that will enable the identification and merging of files with potential duplicates.

EHDI Program with work with IT staff to conduct a data sharing pilot project with a small number of birthing facilities that will allow data to be imported into the EARS data management system directly from screening equipment.

EHDI staff will continue to strive to meet the national EHDI goals of 1) screening all babies by one month of age, 2) ensuring confirmation of hearing status before three months of age, 3) enrollment of children with diagnosed hearing loss into appropriate intervention services by six months of age, and 4) assisting families in connecting with a medical home for provision of coordinated medical care.

Ongoing development of EARS will continue to include improved reporting capabilities, addition of a hearing aid reporting form, and methods of capturing results and dates of screening data not provided by a hospital or birthing facility.

In partnership with Indiana Hands & Voices, EHDI staff will develop and implement a minimum of two hearing screening days in northeastern Indiana to determine the feasibility of offering UNHS to children not previously screened.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	9.5	8.5	7.5	7.3	7
Annual Indicator	7.0	6.7	7.0	7.0	6.8
Numerator	111000	106000	111256	126000	
Denominator	1584441	1584681	1589365	1800000	
Data Source		Kids Count Bk	Kids Count Bk	Kids Count Bk	Kids Count Bk
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	6.7	6.5	6.1	6	6

Notes - 2011

Based on trend analysis.

Notes - 2010

Data is final.

Notes - 2009

Program would not allow saving without indicator for 2009.

a. Last Year's Accomplishments

The MCH ECCS initiative (Sunny Start: Healthy Bodies, Healthy Minds) provided service information to families via the redesigned and expanded Early Childhood Meeting Place website. The Financial Fact sheets were updated and new topics were added. MCH grantees served as enrollment sites for Hoosier Healthwise or referred clients to local Hoosier Healthwise enrollment sites. MCH required grantees providing primary care to children to be Medicaid providers. The Indiana Family Helpline provided referrals and screened clients for Hoosier Healthwise eligibility. MCH staff worked with Covering Kids & Families (CKF) to advocate for health coverage for IN families and participated on the Health Policy and Early Childhood Subcommittees. The Director of CKF served as Chair of the ECCS Evaluation Committee and provided regular updates to the Committee and the ECCS Core Partners regarding insurance enrollment trend data of Hoosier children. The IN Community Integrated Systems of Services Project (IN CISS) developed a Medical Home Collaborative which involved 18 Pediatric and Family Medicine practices. The Sunny Start Financial Fact Sheets served as a resource to these practices. Information on the fact sheets was also distributed to Pediatric and Family Medicine Newsletters. The MCH Director served on the IN Commission on Childhood Poverty. The Commission evaluated the costs and effects of childhood poverty and provided a plan to reduce childhood poverty by 50% by the year 2020.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The MCH Sunny Start: Healthy Bodies, Healthy Minds initiative provides service information to families via a website. The website will be expanded to include more information.				X
2. MCH grantees serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.		X		
3. The Indiana Family Helpline provides referrals and screens clients for Hoosier Healthwise eligibility.		X		
4. MCH requires all grantees providing primary care to children to be Medicaid providers.		X		
5. The MCH Director serves on the Board of Covering Kids & Families, which advocates for health coverage for Indiana families and MCH staff participate on the Health Policy and Early Childhood subcommittees.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MCH ECCS Initiative Financial Fact sheets have been updated and new topics will be added, as appropriate.

MCH grantees serve as enrollment sites for Hoosier Healthwise or refer clients to local Hoosier Healthwise enrollment sites.

The IFHL provides referrals and screen clients for Hoosier Healthwise eligibility.

MCH requires all grantees providing primary care to children to be Medicaid providers.

MCH staff works with CKF and continues to participate on the Health Policy and Early Childhood Subcommittees. The Executive Director of CKF serves as the Chairman of the Sunny Start Evaluation Committee and provides regular updates to the Committee as well as at the quarterly Sunny Start Core Partners meetings regarding the latest insurance enrollment trend data of Hoosier children.

IN CISS continues to provide training within the 18 Medical Home Learning Collaborative practices to families, practice staff and physicians on healthcare financing options for Children and Youth with Special Health Care Needs (CYSHCN).

Sunny Start and the IN CISS grant project staff continues collaborating to increase financial resource information to all families.

The new IN Home Visiting Program for Mothers and Infants facilitates families enrolling children into the Hoosier Healthwise program.

The IN Adolescent Health Plan, which addresses the health needs of children age 10 to 24, includes a priority on access to health care and health care capacity.

c. Plan for the Coming Year

The IN Home Visiting Program for Mothers and Infants will continue to facilitate families enrolling children into the Hoosier Healthwise program. For the Home Visiting program, one of the benchmark requirements is to increase the number of children with health insurance.

The MCH ECCS Initiative's Financial Fact sheets will be updated and new topics will be added, as appropriate.

MCH grantees will continue to serve as enrollment sites for Hoosier Healthwise or refer clients to local Hoosier Healthwise enrollment sites.

The IFHL will continue to provide referrals and screen clients for Hoosier Healthwise eligibility.

MCH will continue to require all grantees providing primary care to children to be Medicaid providers.

MCH staff will continue to work with CKF and to participate on the Health Policy and Early Childhood Subcommittees. The Executive Director of CKF will continue to serve as the Chairman of the Sunny Start Evaluation Committee and provide regular updates to the Committee as well as at the quarterly Sunny Start Core Partners meetings regarding the latest insurance enrollment trend data of Hoosier children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	49	17	30	36.5	36.5
Annual Indicator	29.8	30.8	36.5	31.3	31.4
Numerator	20391	24218	21292	26776	26371
Denominator	68500	78700	58260	85683	84091
Data Source		ISDH - WIC pgm			
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	31	31	30	30	30

Notes - 2011

Data is final.

Notes - 2010

Data is final.

Notes - 2009

Note: Denominator calculated depending on the rate and numerator.

a. Last Year's Accomplishments

WIC health professionals screened all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCH health care professionals also screened all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI 85% to < 95%) status using height for weight BMI.

WIC health professionals and MCH clinics assessed WIC eligible children's diets for nutrition, feeding practices and eating habits that would affect growth patterns.

When appropriate, WIC staff provided counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCH clinics provided guidelines on healthy eating habits and physical activity to families and children.

WIC and MCH clinics displayed posters/bulletin boards communicating information on physical activity, nutrition and healthy eating.

WIC and MCH clinics provided educational materials (books, handouts, videos, handouts/fliers) on healthy eating and physical activity.

MCH supported Division of Nutrition and Physical Activity (DNPA) initiatives, objectives and strategies in the reduction of percentage of children, ages 2 to 5 years, with a Body Mass Index at or above the 85th percentile.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCH health care professionals are also screening all participants for "Overweight"	X			
2. WIC health professionals are assessing WIC eligible children's diets for nutrition and feeding practices that would affect growth patterns. MCH clinics assess children's diets for nutrition and eating habits that would impact growth patterns.	X			
3. When appropriate, WIC provides counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCH clinics provide guidelines on healthy eating habits and physical activity.		X		

4. WIC is displaying posters/bulletin boards on physical activity, nutrition and healthy eating. MCH clinics is displaying posters and creating bulletin boards communicating information on physical activity, nutrition and healthy eating habits.		X		
5. WIC provides educational materials (books, handouts, videos) on healthy eating and physical activity. MCH clinics are providing educational information (handouts/fliers) on healthy eating and physical activity.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WIC health professionals screen all applicants for Overweight/BMI equal or > 95% and At Risk for Overweight/BMI 85% to < 95%. MCH health care professionals also screen all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI 85% to < 95%) status. WIC professionals and MCH clinic staff assess WIC eligible children's diets for nutrition and feeding practices that affect growth patterns.

When appropriate, WIC provides counseling to families of WIC eligible children that include physical activity ideas and healthy eating information. MCH clinics provide information on healthy eating habits, physical activity, and on family activities that support healthy eating/physical activity habits.

WIC provides educational materials (books, handouts, videos) on healthy eating and physical activity. MCH clinics provide educational and referral information on healthy eating habits, physical activity and family- and community-centered activities that support healthy nutrition and physical activity.

MCH supports Division of Nutrition and Physical Activity (DNPA) initiatives, objectives and strategies in the reduction of percentage of children, ages 2 to 5 years, with a Body Mass Index at or above the 85th percentile.

MCH explores pilot projects in collaboration with WIC to increase physical activity in children, ages 2 to 5 years, and track effectiveness of intervention.

c. Plan for the Coming Year

WIC health professionals will screen all applicants for Risk Factor 113 (Obese/BMI equal or > 95%) and Risk Factor 114 (Overweight/BMI 85% to < 95%). Risk Factor 113 is designated as high risk and requires individual nutrition education counseling by a qualified nutritionist. In addition, a new Risk Factor 115 (High Weight for Length/> 97.7 percentile weight for length on the Birth to 24 months WHO growth charts) will be used to screen infants and children < 24 months of age beginning July 1, 2012. This risk factor will also be designated as high risk. WIC health professionals will assess WIC eligible children's diets for nutrition and feeding practices that would affect growth patterns. They will also receive training in the Fall of 2012 concerning participant centered services and how to effectively approach the topic of a child's weight.

The statewide WIC Nutrition Education Plan includes action plans for successful activities or programs to increase physical activity for children, including WIC Fit and the local YMCA. Methods used to incorporate fresh and frozen fruits and vegetables into the WIC participants' lifestyles and food intake along with how to increase the redemption of cash value vouchers are also a part of the plan.

WIC will provide educational materials (books, handouts, videos) on healthy eating and physical activity. This year all WIC local agencies will receive "Reggie and the Veggies" DVDs and two "Nutrition Matters" cards with suggestions for physical activity. WIC families will be encouraged to use these items at home. The accompanying Individual Learning Activity will provide

information for discussion at their next WIC nutrition education visit.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	15.8	15.6	15.6	17.5	17
Annual Indicator	17.3	18.5	15.3	15.3	15.2
Numerator	17005	16437	13157		
Denominator	98408	88679	86126		
Data Source		ISDH - VR	ISDH - VR	ISDH - VR	ISDH-VR
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	15.2	15.1	15.1	15	15

Notes - 2011

The numbers represent the number of women who smoke during pregnancy -- not just the last three months. Data is not currently available. 2010 and 2011 are based on a trend analysis.

Notes - 2010

The numbers represent the number of women who smoke during pregnancy -- not just the last three months. Data is not currently available. 2010 and 2011 are based on a trend analysis.

Notes - 2009

2009 data is final.

Source of data: ISDH Vital Records (Birth Certificate Information)

a. Last Year's Accomplishments

In 2011 an in-depth review of perinatal outcomes by hospital revealed that a total of 19.1% of IN residents delivering in Indiana smoked during pregnancy in 2007. Of the 16,426 women who smoked, 2,584 (15.7%) quit smoking by delivery; 13,842 (84.3%) continued to smoke throughout the pregnancy; 2.1% quit smoking in the 1st trimester; 10.9% quit in the 2nd trimester, and 2.7% quit in the 3rd trimester.

Five counties with the highest smoking rates among the Medicaid population were targeted for outreach and training initiatives: Daviess, Dekalb, Delaware, Porter and Putnam Counties.

MCH led the Prenatal Substance Abuse Cross Agency Task Force in an assessment of state capacity to provide adequate prenatal substance abuse (including smoking), screening, counseling, treatment, and outcome data. Indiana was found to have many gaps in treatment services for pregnant women. Services such as the Indiana Quitline were greatly underused. To increase capacity of the task force it was decided to include ATOD under the umbrella of the Indiana Perinatal Quality Improvement Collaborative.

MCH consultant attends all meetings of the Medicaid Neonatal Quality Outcomes committee to

address quality improvement issues, including prenatal smoking cessation. Statistics from the Notification of Pregnancy assessment tool show that 68% of current smokers want to quit but only 59% were referred to the Quitline or PSUPP for cessation counseling, with no follow-up of referrals. The managed care entities were charged with decreasing smoking in pregnancy since 2009. Prenatal smoking rate among the Medicaid population has increased yearly. A review of 2011 NOP submissions shows that 32.8% of pregnant women on Medicaid with a completed NOP, currently used tobacco, from a baseline of 27% in 2009. Due to poor results in 2010 OMPP added a new metric to the MCEs 2011 contract that incentivized the MCEs to encourage providers to counsel members about smoking cessation. OMPP and MCH decide that just referring women to the Quitline was not enough and that the MCE providers needed to follow-up on the referrals to identify barriers to completing the referral. Each MCE has developed their own smoking cessation program but at this time have few members enrolled. Monitoring use of reimbursable tobacco screening and cessation counseling procedure codes by prenatal care providers reveals that despite training and incentivization to MCEs, providers are not utilizing the codes. This makes the referrals to smoking cessation noted on the NOP suspect. Providers state they really do not have time to screen and counsel their pregnant women for smoking cessation. Training of the whole office staff was discussed as a next step.

All MCH Title V funded projects are mandated to ask all pregnant women if they smoke, assess and assist smokers to quit. Ongoing trainings with trainings with Title V funded projects and Prenatal Substance Use Prevention Programs (PSUPP) continued. 2011 annual project reports reveal that some projects are more successful than others in assisting women to quit smoking in the last three months of pregnancy. Quit rates range from 5% to 41%. Cultural factors and local resources also played a part in quit rates.

The Prenatal Substance Use Prevention Program (PSUPP) funded by MCH and Mental Health and Addictions was reviewed for effectiveness. PSUPP projects were given mandated performance measures to track progress and outcomes.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct a series of key informant interviews with a diverse group of health care providers to assess current provider practices; existing provider and patient barriers to cessation treatment.			X	
2. Continue to participate as a member of Promoting Smokefree Pregnancies in Indiana Coalition.		X		
3. Monitor Title V funded prenatal projects quarterly reports for effectiveness of project efforts to implement the 5As and 5Rs.		X		
4. MCH in collaboration with DMHA will fund PSUPP projects in targeted counties.				X
5. Target counties with the highest prenatal smoking rates for outreach and training initiatives.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

IPN in conjunction with the IU School of Medicine, Department of Public Health will conduct a series of key informant interviews with a diverse group of health care providers to assess current provider practices; existing provider and patient barriers to cessation treatment. After analysis of findings, develop strategies for additional interventions to improve smoking cessation efforts with

pregnant women in Indiana.

Continue to participate as a member of Promoting Smokefree Pregnancies in Indiana Coalition. Monitor Title V funded prenatal projects quarterly reports for effectiveness of project efforts to implement the 5As and 5Rs.

MCH in collaboration with DMHA will fund PSUPP projects in targeted counties.

Target counties with the highest prenatal smoking rates for outreach and training initiatives.

c. Plan for the Coming Year

A prenatal smoking sub-committee will be included under the prematurity committee of the Indiana Perinatal Quality Improvement Collaborative. The sub-committee will use data briefs and Quitline materials to educate health care providers, local health department staff, community policy leaders, and consumers about the prevalence of smoking during pregnancy, including the consequences of smoking before, during and after pregnancy, best practice models for awareness activities to target low income women, and proposed best practice models to decrease smoking among women of childbearing age across the lifespan with special emphasis on the Indiana Tobacco Quitline.

MCH Consultant will attend all meetings of Medicaid Neonatal Quality Outcomes committee to work on prenatal smoking cessation among the Medicaid population.

Baby First Packets that include information on smoking cessation and second hand smoke will be sent to Prenatal Indiana Family Help Line callers.

Analyze prenatal smoking cessation in by the 3rd trimester yearly. Notify counties that are not meeting expectations. Reward counties that are meeting expectations during the County Health Officer annual meeting.

Continue to include prenatal smoking issues in at least one Perinatal Focus magazine yearly.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6.9	7.1	6.9	9	9
Annual Indicator	8.0	9.7	8.7	8.7	8.6
Numerator	36	44	40		
Denominator	452551	451711	460787		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	8.6	8.5	8.5	8.4	8.5

Notes - 2011

2011 data is provisional based on a trend analysis.

Notes - 2010

2010 data is provisional based on a trend analysis.

Notes - 2009

2009 data is final.

Source of data: ISDH - ERC

a. Last Year's Accomplishments

State Adolescent Health Coordinator (SAHC) and other Indiana State Department of Health (ISDH) injury-prevention staff partnered with the Division of Mental Health and Addiction (DMHA) to write a Substance Abuse and Mental Health Services Administration (SAMHSA) grant for suicide prevention among adolescents and young people to implement evidence-based and promising practices to educate school administrators and staff. Funding was not awarded to Indiana.

SAHC partnered with organizations through the Indiana Coalition to Improve Adolescent Health (ICIAH) to implement recommendations regarding the prevention of suicide as noted in the state adolescent health plan.

SAHC supervised the YRBS Coordinator. Surveying students for year 2011 was completed in June 2011. ISDH obtained weighted data, so survey findings are generalized to all students in grades 9-12 throughout the state.

SAHC served as a consultant to the school-based clinic implementing Natural Helpers (a peer-led suicide prevention program).

Indiana Cares (SAMHSA-funded partner) provided technical assistance to individuals and organizations regarding suicide prevention, intervention and postvention until the end of their grant funding cycle (September 30, 2011).

Indiana Cares strengthened and grew regional/local suicide prevention councils. Indiana Cares offered prevention, intervention, means restriction training (QPR, safeTALK, ASIST, CALM, Connect) to individuals from youth serving organizations. Indiana Cares distributed educational materials about suicide prevention and related resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SAHC will partner with organizations through the ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.		X		X
2. SAHC will work with other internal staff at ISDH to collaborate on injury-prevention activities related to the prevention of suicide among adolescents.		X		X
3. SAHC will continue supervising the YRBS Coordinator to disseminate data findings from the 2011 survey, highlighting findings related to various health risk behaviors, including thoughts of suicide, attempted suicides, and feelings of sadness and depr		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SAHC is ensuring continued partnership and collaboration with the Division of Mental Health and Addiction (DMHA) after the submission of the federal grant for suicide prevention funding, regardless of its future funding status.

SAHC is partnering with organizations through the ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.

SAHC is working with other internal staff at ISDH to collaborate on injury-prevention activities related to the prevention of suicide among adolescents.

YRBS Coordinator is disseminating data from the 2011 YRBS, highlighting findings related to various health risk behaviors, including thoughts of suicide, attempted suicides, and feelings of sadness and depression.

c. Plan for the Coming Year

SAHC will partner with organizations through the ICIAH to implement recommendations regarding the prevention of suicidality as noted in the state adolescent health plan.

SAHC will work with other internal staff at ISDH to collaborate on injury-prevention activities related to the prevention of suicide among adolescents.

SAHC will continue supervising the YRBS Coordinator to disseminate data findings from the 2011 survey, highlighting findings related to various health risk behaviors, including thoughts of suicide, attempted suicides, and feelings of sadness and depression. SAHC will also assist with the administration of the 2013 YRBS Survey.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	81	78	80	70	82
Annual Indicator	56.3	80.7	85.3	86	86
Numerator	738		1015		
Denominator	1310		1190		
Data Source		MCH Cons Pgm	MCH Cons Pgm	MCH Cons Pgm	MCH Cons Pgm
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	87	87	88	88	89

Notes - 2011

Data is final.
 All data are for the calendar year and not the fiscal year.
 Source of data: ISDH MCH Consultant Program.

Notes - 2010

Estimates provided based on trend analysis.
 Source of data: ISDH MCH Consultant Program.

Notes - 2009

All data are for the calendar year and not the fiscal year.

Data is final.

a. Last Year's Accomplishments

MCH established a Perinatal Level of Hospital Care Task Force. MCH invited professionals representing all types of perinatal providers, from Level I, II, III hospitals as well as Indiana Hospital Association IN March of Dimes, Indiana Women's Center of Excellence, and the Indiana Perinatal Network. The first meeting was held 10/7/10. Two sub-committees were formed. The Definitions and Standards by Hospital Levels of OB and Neonatal Care sub-committee and the Data Subcommittee to assist MCH in the assessment of the perinatal system in Indiana. The Perinatal Hospital Standards sub-committee completed a final draft of OB and neonatal standards in August 30, 2011. The standards were sent to all birthing hospitals for review and the standards were discussed at the second annual birthing hospital summit September 24th. In October, 2011 comments received were discussed and some changes were made. The sub-committee learned that AAP was changing their hospital their levels of care guidelines to combine levels IIIABC into one level III. It was decided by the sub-committee that the standards would be put on hold until further word from AAP. The Data Subcommittee was charged with reviewing hospital outcome data by level and county to identify problem areas to address and to make recommendations to the Standards Subcommittee based on data findings. The report "Hospital Levels of Care Review", completed with detailed hospital outcomes data, was presented at the 5/14/11 task force meeting. A need for improved vital record data in a timely manner was identified as a barrier to accurate reports. An MOU with Level III St. Vincent's Women's Hospital, completed to develop an updated training curriculum using AAP Perinatal Continuing Education Program (PCEP) new educational tools and curriculum, and host coordinator workshops with staff from 2 Level II or I hospitals; Dunn Memorial-Bedford and New Castle Hospitals. Train prenatal care providers on universal screening for alcohol, tobacco and other drugs and brief interventions will be completed in two counties by the fourth quarter. Trainings held in St. Joseph County and Allen County. Attended all meetings of the Office of Medicaid Policy and Planning (OMPP) Neonatal Quality Committee. Shared data on birthweight, gestation, method of delivery, transport of mother and/or newborn, NICU admission, number of NICU days, neonatal death, hospital level of Care, county. Indiana Chair of the Data sub-committee started the Indiana neonatal quality Improvement collaborative made up of all but three Indiana NICUs to address prevention of NEC in VLBW infants with use of exclusive Breastmilk.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop a state perinatal database.				X
2. Finalize and implement the Perinatal Hospital Levels of Care Standard.				X
3. Develop a new hospital level of care survey to be verified and signed by the hospital CEO.		X		

4. Begin development of a perinatal hospital system of care with three perinatal Centers linking Levels I, II, III hospitals for outreach, education, consultation, technical assistance.				X
5. Continue training of prenatal care providers on universal screening for alcohol tobacco, and other drugs and brief interventions.		X		X
6. Enroll more physicians as certified providers for high risk care of pregnant women on opioids, etc.				
7.				
8.				
9.				
10.				

b. Current Activities

Provide support for the Neonatal Quality Improvement Collaborative made up of all but three Indiana NICUs is addressing prevention of NEC with use of exclusive Breastmilk. NeoData and Vermont Oxford data are being used for this initiative.
 Develop a state perinatal database.
 Implement the Hospital Level of Care standards.
 Develop a new hospital level of care survey to be verified and signed by the hospital CEO as part of licensure.
 Explore developing waivers, and an auditing method: self-report vs. validation.
 Indiana currently has 29 counties without a delivering hospital. MCH will begin an in depth analysis of the impact of this recent loss of birthing hospitals on the perinatal system and Indiana's families. Begin development of a perinatal hospital system of care with perinatal Centers linking Levels I, II, III hospitals for outreach, education, consultation, technical assistance.
 Develop standards for transporting pregnant women and neonates, to prevent injury and provide quality neonatal services.
 Continue training of prenatal care providers on universal screening for alcohol tobacco, and other drugs and brief interventions.
 Enroll more physicians as certified providers for high risk care of pregnant women on opioids, etc.

c. Plan for the Coming Year

Enroll more physicians as certified providers for high risk care of pregnant women on opioids.
 Develop standards for caring for newborns with Newborn Abstinence Syndrome.
 Distribute and review a new hospital level of care survey. IPN will facilitate technical assistance to hospitals requesting help with completing the survey.
 MCH will host the kick-off meeting of the Indiana Perinatal Quality Improvement Collaborative in the first quarter.
 Update the perinatal data report by county, hospital, and hospital levels and publish on the MCH website.
 Collaborate with March of Dimes, the Indiana Hospital Association, OMPP, the Office of Primary Care, and IPN to address loss of perinatal providers, and hospitals in Indiana. How can surrounding states provide quality high risk perinatal care if needed.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2007	2008	2009	2010	2011
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Data					
Annual Performance Objective	78.5	76.6	77.5	66	68
Annual Indicator	67.5	66.6	66.1	66.5	68
Numerator	60535	59063	56966		
Denominator	89719	88679	86126		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	70	72	74	75	76

Notes - 2011

Data is based on a trend analysis and takes into account the use of the revised birth certificate that went into effect 2007.

Notes - 2010

Data is based on a trend analysis and takes into account the use of the revised birth certificate that went into effect 2007.

Notes - 2009

2009 Data is final.

Source of data: ISDH ERC

a. Last Year's Accomplishments

Identify counties with the highest and lowest first trimester entrance into prenatal care and identify systems, provider, individual barriers to accessing care, as well as local capacity to provide quality care. Thirty-five (35) counties had a lower percent of women entering prenatal care in the first trimester than the state. Of those 35 counties 10 were significantly lower than the state rate. Five of the counties had birth outcomes at or better than the state rate for LBW, VLBW, and preterm birth despite their low entry into prenatal care in the first trimester. Five of the counties with low entry into prenatal care in the first trimester also had worse birth outcomes than the state. Three of the ten worse counties were part of the "big five" counties in the state; Marion, Lake, and St. Joseph. All three of these counties had zero to less than expected providers participating in presumptive eligibility. MCH funded the Indiana Perinatal Network to make site visits to these counties to identify access barriers and educate providers on presumptive eligibility. Enrolled providers increased in Marion and Lake counties but not St. Joseph County. Monitor birth certificate data and disseminate a yearly report to the State Perinatal Advisory Board, providers and county health officers on Natality outcomes by race and county. MCH will use GIS techniques to target areas in the state where access to prenatal care occurs late or not at all and areas where poor birth outcomes exist. Data was shared with the State Perinatal Advisory Board and with the Levels of Care data sub-committee.

Implement the IPN consensus ER protocol in one ER in one Priority County with an existing MCH program in 2011 to improve access to prenatal care in the first trimester. The Lake County Perinatal Network worked with Gary Methodist to implement the ER protocol and provided ER staff with a list of resources and referrals for all pregnant women seen in the ER.

Increase the percent of women enrolling in presumptive eligibility (PE) at MCH funded prenatal care clinics, prenatal care coordination programs, hospitals, community health centers and local

health departments. Collaborated with Medicaid to provide regional trainings on enrolling as a qualified provider for presumptive eligibility
 A collaborative effort between MCH, OMPP, Managed Care Organizations and Indiana Perinatal Network (IPN) resulted in a restructured, comprehensive, system of providing case management services to all high risk mothers on Medicaid. However, on May 13, 2011 OMPP told MCH that due to budget cuts they would have to discontinue reimbursement for Prenatal Care Coordination effective July 1, 2011. After the July rule change many prenatal care coordination programs reduced staff and home visiting services. The 14 Title V funded projects lost their match money and some also decreased services. The Prenatal Care Coordination program will be reevaluated. Plans to contest the rule change are in the works.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increase the percent of women enrolling in presumptive eligibility.			X	
2. Implement media messages targeted to high risk black women of childbearing age in the five disparity counties.			X	
3. Provide free pregnancy tests to all counties to promote early entrance into prenatal care.				X
4. Explore the use of Patient Navigators at CHCs for pregnant women with psychosocial needs to assist them with referrals, education, and facilitation of prenatal care appointments.				X
5. Continue to fund prenatal care coordination projects from 2011.				X
6. Provide technical assistance to prenatal care coordination projects to increase collaborative partners to assure sustainability.				X
7. Continue to assess entrance into prenatal care at the county level and publish best practices to improve this indicator.			X	
8.				
9.				
10.				

b. Current Activities

MCH will work on increasing the percent of women enrolling in presumptive eligibility (PE) at MCH funded prenatal care clinics, prenatal care coordination programs, community health centers and local health departments. MCH will collaborate with IPN and Medicaid to identify counties with low entrance into prenatal care and poor birth outcomes to target providers with education to increase the number of women enrolled in presumptive eligibility early in the pregnancy.

MCH will partner with the Indiana Minority Health Coalition (IMHC) and the local minority coalitions to develop and implement media messages targeted to high risk black women of childbearing age in the five disparity counties (Allen, Lake, Marion, St. Joseph, and Vanderburgh). MCH awarded IMHC funding to promote Text4baby in counties with local minority health coalitions and statewide.

MCH continues to provide free pregnancy tests to all counties requesting the program to promote outreach and facilitated entrance into prenatal care early.

MCH will explore the use of Patient Navigators at CHCs for pregnant women with psychosocial needs to assist them with referrals, education, and facilitation of prenatal care appointments.

MCH will continue to fund prenatal care coordination projects from 2011. Technical assistance will be given to projects on sustainability.

MCH will continue to assess entrance into prenatal care at the county level and publish best

practices to improve this indicator.

c. Plan for the Coming Year

Update previous reports on county capacity to provide early, adequate, and equitable prenatal care. Publish on website. Share with State Perinatal Advisory Board. Present at INACOG and INAAFP yearly conferences. Publish results in Perinatal Focus Magazine.
 Market the MCH Free Pregnancy Test Program to more counties and programs.
 Explore ways to increase the percent of pregnant women who receive at least one prenatal assessment care visit in the first trimester.
 Promote preconception and healthy women across the life course.
 Encourage the use of neighborhood based community health workers to promote preconception health messages within their neighborhood.
 Focus on systems for patient outreach.
 Create an infrastructure to support quality improvement efforts that will increase early entrance into prenatal care.
 Build on the efforts of others states by using changes that worked.

D. State Performance Measures

State Performance Measure 1: *Rate of suffocation deaths of infants.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					15.3
Annual Indicator		15.7	16.4	15.3	15.3
Numerator		97	111		
Denominator		619	675		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	15.2	15.1	15	14.9	14.8

Notes - 2011

Data is based on a trend analysis.

Notes - 2010

Data is based on a trend analysis.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

MCH Partnered with First Candle and IPN to provide two regional NIH Model Nurse train-the-trainer trainings for hospital nursery/NICU managers/educators.
 A regional safe sleep workshop completed on 6/8/2011 in Kosciusko County. Three first responder trainings conducted at the IN Law Enforcement Academy on 3/29/2011, 6/21/2011, and 7/5/2011. A webinar was produced for the Academy to provide training updates.
 A local Safe Sleep Summit was held in Howard County after 3 infants died of suffocation in bed

within 2 weeks. A local task force was developed and the Infant Health and Survival Coordinator continued to provide leadership and technical assistance to the task force in addressing their suffocation deaths. The task force is working on population based interventions and education programs about safe sleep practices for infants that take into account the influence of social determinates and cultural differences.

Two statewide CDC death scene investigation training for coroners, medical examiners, law enforcement, EMS, deputy coroners and other possible first responders, was provided by the state training team.

Technical assistance was provided to all delivering hospitals in the five largest counties to develop and implement a best practice model safe sleep hospital policy that includes guidelines for physician and nursing care practices and parent education. Most hospitals have completed a policy or policy revision.

MCH met with members of the State Child Fatality Review Committee to combine a State Fetal Infant Mortality Review (FIMR) with the State Child Fatality Review (The CFR). The INCFR only looks at cases where child abuse was involved. They are not set up to review extra cases. MCH will continue to pursue this avenue to combine CFR and FIMR.

The Infant Health and Survival community Council began planning for the bi-annual Safe Sleep conference in 2012.

MCH collaborated with Indiana AHEC and Vital Records to improve the accuracy of birth and death certificate data through collaborative trainings of coroners, medical residents, on accurate diagnosis and completion of death certificate fields. The State Registrar presented at the yearly coroner's conference in June.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Redevelop a state FIMR task force to set up a system for a statewide review of infant deaths caused by suffocation and asphyxia in bed.				X
2. Survey communities of color with high SUID rates for input into development of a culturally correct safe sleep media campaign.			X	
3. Design and implement the bi-annual safe sleep conference.			X	
4. Support the Gates First Candle Crib Program.		X		
5. Develop and disseminate a hospital tool kit to assess use of safe sleep policies in the newborn nursery and NICU.		X		
6. Address infant mortality among minority populations.			X	
7. Plan safe sleep activities for infant mortality month.			X	
8.				
9.				
10.				

b. Current Activities

Redevelop a state FIMR Task Force to set up a system to review electronic birth and death certificates for all infant deaths caused by suffocation or asphyxia in bed. The State Child Fatality Review Committee continues to only review child deaths related to abuse or neglect.

The bi-annual safe sleep conference; Protecting Indiana's Babies: Safe Sleep & Breastfeeding, is scheduled for October 24, 2012. Dr. Moon and Dr. Haywood Brown, from Duke University are scheduled to present.

MCH will continue to support the Gates First Candle Crib Program. The crib program was discontinued May 1, 2012. Indiana provided 12,529 cribs to families in need compared to 2,383 in D.C., and 2,022 in Washington State. Other options for cribs will be explored.

MCH will continue to support the Indiana Infant Health and Survival Council activities to develop

and disseminate a hospital tool kit to assess use of safe sleep policy in the newborn nursery and NICU.

MCH will work with internal and external partners to plan safe sleep activities during Infant Mortality Month in September, 2012.

Two more counties experienced three suffocation deaths within a short period of time. MCH assisted Delaware County in development of a summit on SUIDS. The number of SIDS deaths in 2008 was 44 compared to 62 deaths in 2009. The number of suffocation deaths dropped from 44 in 2008 to 39 in 2009. MCH will continue to work with internal and external partners to reach all families with safe sleep messages

c. Plan for the Coming Year

Offer safe sleep education and prevention activities to people where their daily activities take place, such as prenatal Care/Family Planning clinics, well-child clinics, and school prevention programs, Early Head Start, Head Start, and Title V funded projects.

Complete an in-depth analysis of infant mortality, including SIUDS. Publish results. Develop plans based on findings.

Incorporate more safe sleep messages into Text4baby initiatives.

Evaluate the process of information dissemination, behavioral change, and health outcomes at the local level among minority populations.

Incorporate infant mortality task force into the Indiana Perinatal Quality Improvement Collaborative.

Finalize a state infant death data system using linked birth and death records. Work with coroners, police, and other first responders to link their data with vital records linked files. Work with the Indiana Hospital Association and hospital medical records systems to provide pertinent medical records of infant birth and death.

Work with the Indiana preparedness group committee to complete training of all county first responders the CDC death scene investigation.

State Performance Measure 2: *The percentage of mothers who initiate exclusive breastfeeding.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					68.5
Annual Indicator		68.5	69.9	68.5	68.5
Numerator		60765	60189		
Denominator		88679	86126		
Data Source		ISDH/ERC	ISDH/ERC	ISDH/ERC	ISDH/ERC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	69	69	70	70	71

Notes - 2011

Based on trend analysis.

Notes - 2010

Based on trend analysis.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

Local coalitions worked on local projects with support and guidance from State Breastfeeding Coordinator (SBC) as needed.

Indiana Perinatal Network (IPN) funded 24 applicants to take the lactation certifying exam.

On April 27, 2011, a partnership between ISDH, Indiana FSSA Bureau of Child Care, Indiana Association for Child Care Resource and Referral, and the Indiana Perinatal Network rolled out a new training module called "We Care for Breastfed Babies" and provided a Train the Trainer course to childcare regional educators.

ISDH, IPN, and Indiana State Breastfeeding Coalition (ISBC) hosted a second invitation-only Summit for administrators of all birthing hospitals in the state 9/23. The morning sessions focused on mpinc and baby friendly hospitals.

Indiana WIC continued to build their Peer Counselor (PC) Program. There is now a PC in every WIC Clinic. Lactation Management education was offered to WIC staff and community partners, with plans to provide programs again next year.

ISBC took on the role of the steering committee to implement strategies to meet the breastfeeding goals of the Indiana Healthy Weight Initiative' State Obesity Plan.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Pursue insurance coverage for lactation consultation and supplies.				X
2. Create a registry of International Board Certified Lactation Consultants in the state.		X		X
3. Continue to build and support local coalitions around the state.				X
4. Continue to provide expert advice to businesses and employees on the implementation of The Business Case for Breastfeeding for lactation support in the workplace.				X
5. ISDH, IPN, and ISBC hosting a third invitation-only hospital summit for administrators of all birthing hospitals in the state 9/14/2012.		X		X
6. ISBC will build a coalition website and have IPN's and DNPA's breastfeeding pages link to it.		X		X
7. Increase the number of local black breastfeeding coalitions.				X
8.				
9.				
10.				

b. Current Activities

ISBC will continue to pursue insurance coverage for lactation consultation and supplies, and to create a registry of International Board Certified Lactation Consultants in the state.

SBC will continue to build and support local coalitions around the state, serving as the liaison between the ISBC and the local coalitions.

SBC will continue to provide expert advice to businesses and employees on the implementation of The Business Case for Breastfeeding for lactation support in the workplace.

Additional workgroups will be formed to address barriers and solutions in the following areas: clinical, community outreach, minority health, childcare, and educating the provider.

WIC will have their own action group and will interface with the other groups on WIC-related issues. The meetings previously held monthly will be held quarterly and action groups will meet during the off-months.

ISBC plans to develop a coalition website and have IPN's and DNPA's breastfeeding pages link to it.

Continue to increase the number of local black breastfeeding coalitions.

c. Plan for the Coming Year

Continue to increase, support and maintain local breastfeeding coalitions.

Continue to provide technical assistance to hospitals pursuing Baby Friendly designation. Increase the number of hospitals that begin the Baby Friendly process.

Continue to increase the number of hospitals with new breastfeeding policy and practice. Work with hospitals to provide discharge bags for breastfeeding mothers without formula or formula information.

Continue to assist hospitals with completion of mpinc surveys, assessment of results, and quality improvement activities

State Performance Measure 3: *Percentage of pregnant women on Medicaid who smoke.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					29.5
Annual Indicator		30.0	28.9	28.9	28.8
Numerator		11656	11342		
Denominator		38842	39270		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	28.7	28.7	28.6	28.6	28.5

Notes - 2011

Data is based on a trend analysis

Notes - 2010

Data is based on a trend analysis.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

MCH continued to participate as a member of the Promoting Smoke-Free Pregnancies in Indiana Coalition. The main focus of the coalition in 2011 was regional provider and consumer trainings in areas where over 30% of pregnant women smoked. Trainings were provided in Putnam County 2/2011; Daviess County 3/2011; Porter County 4/2011; Dekalb and Delaware Counties 5/2011. A webinar of the trainings was completed May 23, 2011 for providers not able to attend regional trainings to access the information on screening and brief intervention techniques for pregnant women that smoke. The Medicaid Managed Care Entities made the DVD available to their prenatal care providers. Smoke-Free Indiana and MCH both provided smoking statistics to the group members for planning purposes. It was noted that calls by pregnant women to the Indiana Quit Line had not increased significantly as a result of regional trainings. The coalition realized that if we were to really make a difference we needed to increase membership, resources, and develop a new plan of action. The coalition began working on a new plan of action for 2012.

The MCH perinatal coordinator continued to represent ISDH on the Office of Medicaid Policy and Planning (OMPP) Neonatal Quality Committee. MCH and OMPP monitored the data from the Notification of Pregnancy (NOP) assessment form for number of pregnant women smoking, number of women ready to quit and number of women referred to the Indiana Quitline. Due to poor results in 2010 OMPP added a new metric to the MCEs 2011 contract that incentivized the MCEs to encourage providers to council members about smoking cessation. However, a review of 2011 NOP smoking data shows that 32.8% of pregnant women on Medicaid with a completed NOP, currently used tobacco. This is higher than the last two years. OMPP and MCH decide that just referring women to the Quitline was not enough and that the MCE providers needed to follow-up on the referrals to identify barriers to completing the referral. Each MCE has developed their own smoking cessation program but at this time have few members enrolled. Monitoring use of reimbursable tobacco screening and cessation counseling procedure codes by prenatal care providers reveals that despite training and incentives to MCEs, providers are not utilizing the codes. This makes the referrals to smoking cessation noted on the NOP suspect. Providers state they really do not have time to screen and counsel their pregnant women for smoking cessation. Training of the whole office staff was discussed as a next step.

All MCH Title V funded projects are mandated to ask all pregnant women if they smoke assist smokers to quit. Ongoing trainings with trainings with Title V funded projects and Prenatal Substance Use Prevention Programs (PSUPP) continued.

In 2011 an in-depth review of perinatal outcomes by hospitals revealed that a total of 19.1% of IN residents delivering in Indiana smoked during pregnancy in 2007. Of the 16,426 women who smoked, 2,584 (15.7%) quit smoking by delivery; 13,842 (84.3%) continued to smoke throughout the pregnancy; 2.1% quit smoking in the 1st trimester; 10.9% quit in the 2nd trimester, and 2.7% quit in the 3rd trimester.

MCH and partners do not have resources to provide a state wide consumer media campaign. We will look for possible grants to assist with this needed activity. All projects have been asked to provide smoking-free pregnancy messages locally.

State funding for the Indiana Tobacco Prevention and Cessation (ITPC) organization was cut and the state program came under ISDH. MCH will continue to work with this program to get messages out to pregnant women on the dangers of smoking while pregnant. Other state and local MCH programs have been encouraged to include prenatal smoking messages with their program messages to reach a broader audience

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Members of the PSPI training subcommittee will continue to provide regional trainings throughout the year for health care providers working with pregnant women.		X		
2. Implement new cessation techniques to include assessing triggers, assessing and treating mental health issues.		X		
3. Conduct ongoing assessment of prenatal smoking data using monthly NOP data; vital records, Title V funded project quarterly reports, by county, race, Medicaid versus Non-Medicaid.			X	
4. Create and disseminate prenatal smoking data briefs to prenatal care provider, local health departments, and community policy leaders.			X	
5. Create and disseminate best practice models to decrease smoking among women of childbearing age across the lifespan.				X
6. Prenatal Substance Use, including cigarette smoking has been added as an Indiana Perinatal Quality Improvement Collaboration committee.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Provide training and materials to prenatal Medicaid providers through each MCE to achieve at or above the 76th percentile the number of members who are advised to quit.

Members of the PSPI have developed an action plan that will move the coalition in a new direction. Activities will education of residents and other providers, letters to legislators on prenatal smoking rates and need for non-smoking laws, conducting focus groups and interviews with prenatal care providers on prenatal smoking screening and intervention, and development of an effective message and communication strategy.

Implement new cessation techniques to include assessing triggers, assessing and treating mental health issues.

Conduct ongoing assessment of prenatal smoking data using monthly NOP data; vital records, Title V funded project quarterly reports, by county, race, Medicaid versus Non-Medicaid.

Create and disseminate prenatal smoking data briefs based on age, race/ethnicity, insurer, and geographical location of the targeted population.

MCH and IPN will use data briefs to educate health care providers, local health department staff, community policy leaders, and consumers about the prevalence of smoking during pregnancy, including the consequences of smoking before, during and after pregnancy, best practice models for awareness activities to target low income women, and proposed best practice models to decrease smoking among women of childbearing age across the lifespan.

c. Plan for the Coming Year

Bring the PSPI Coalition under the umbrella of the Indiana Perinatal Quality Improvement Collaborative (IPQIC) Prenatal Substance Abuse Committee.

Explore best practices for treating smoking as a co-morbidity adverse health behavior with mental health problems. Provide training to prenatal care providers on assessment of mental health problems in all patients that smoke.

Encourage Medicaid to add mental health assessment for high risk pregnant women who continue smoke during pregnancy.

Encourage prenatal care providers to code smoking in pregnancy as a substance use disorder when appropriate and refer to local Department of Mental Health and Addictions programs for treatment.

Work with local health departments to increase the number of counties that become smoke-free.

Continue to be a member of the Promoting Smoke-Free Pregnancies in Indiana Coalition. Provide data analysis, policy recommendations, and assist with provider trainings.

Continue to increase smoking cessation among pregnant women on Medicaid as a member of the OMPP Neonatal Quality Committee. Monitor MCE performance metrics on smoking cessation and provide technical assistance and consultation on program improvements.

Find funding for consumer media campaign.

Monitor vital record data for number of pregnant smokers who quit before delivery.

Develop a perinatal website to display smoking statistics, provider tool kits and resources.

State Performance Measure 4: *The percent of black women (15 through 44) with a live birth whose prenatal visits were adequate.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	64	59	59	55	55
Annual Indicator	58	54.1	55.7	56	56.5
Numerator		5654	5668		
Denominator		10447	10168		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	56.5	57	57.5	57.5	58

Notes - 2011

Data is provisional and based on a trend analysis.

Notes - 2010

Data is provisional and based on a trend analysis.

Notes - 2009

See Form notes for additional information.

The data is final.

a. Last Year's Accomplishments

Indiana State Department of Health (ISDH) assisted Allen and St. Joseph Counties with conducting PPOR. Black infant mortality has historically been higher in these counties than the

rest of the state. Results found a significantly higher rate of black women delivering extremely premature babies that died in the early neonatal period.

MCH provided technical assistance to the St. Joseph Minority Health Coalition to partner with a new prenatal clinic that opened within a Title X clinic in a large minority community. The prenatal clinic enrolls women into prenatal care early in their pregnancy through use of presumptive eligibility and support services provided by the minority health coalition.

Marketed the Free Pregnancy Test Program to local minority health coalitions in counties with high minority populations to facilitate the number of black women entering prenatal care in the first trimester.

MCH promoted the National Healthy Mothers, Healthy Babies Coalition's Text4baby educational program and the "A Healthy Baby Begins With You" program with local Minority Health Coalitions. MCH was not able to implement the collaboration with the National Fatherhood Initiative due to loss of the staff person responsible for this activity.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Market the MCH Free Pregnancy Test Program in counties with high disparity rates.			X	
2. Promoting Text4baby educational program included as a MCH best practice in Request for Proposals for Pregnant and Parenting Adolescent Support Services, and all Title V funded services.			X	
3. MCH is evaluating counties where adequate prenatal care percentages have decreased and are collaborating with Medicaid, the Medicaid Managed Care Entities, and IPN to promote Presumptive Eligibility in these counties.				X
4. Continue to implement and promote "A Healthy Baby Begins with You", at Black Expo.			X	
5. Partner with the March of Dimes to increase implementation of Centering Pregnancy in counties with a high black disparity in perinatal outcomes.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Examine the feasibility of increasing the number of Free Pregnancy Test sites in counties that are lower than the state average in terms of black women entering prenatal care in the first trimester. Promoting Text4baby educational program included as MCH best practice in Request for Proposals for Pregnant and Parenting Adolescent Support Services, and Title V funded services. MCH is evaluating counties where adequate prenatal care percentages have decreased and are collaborating with Medicaid, the Medicaid Managed Care Entities, and IPN to promote Presumptive Eligibility in these counties.

Continue to implement and promote "A Healthy Baby Begins with You", at Black Expo.

Partner with the March of Dimes to increase implementation of Centering Pregnancy in counties with a high black disparity in perinatal outcomes.

Early entrance into prenatal care through certified nurse midwife Early Start clinic is being promoted as a MCH best practice in Request for Proposals for Title V funded services in high disparity counties.

c. Plan for the Coming Year

MCH will continue to work with Allen and St. Joseph/Elkhart Counties to provide technical assistance and support to continue the PPOR process and implementation of relevant interventions.

Funding for Text4baby marketing to the African American population given to the Indiana Minority Health Coalition (IMHC). Activities so far include town hall meetings, and sharing infant mortality statistics.

Meet with the 17 county Minority Health Coalitions, during bi-annual state meeting, to share vital statistic information about life course influences on pregnancy outcomes. Coalitions will be encouraged to implement a fatherhood program, Text4baby, Free Pregnancy Test program, or other program that affects life course in their county.

MCH will explore the use of patient navigators in neighborhood clinics within black neighborhoods.

MCH will add Black early preterm birth to the Indiana Perinatal Quality Improvement Collaborative to assure equitable prenatal care such as 17P, steroids, culturally competent prenatal care.

State Performance Measure 5: *The percentage of children less than 72 moths of age with blood lead levels (BLL) equal to or greater than 10 micrograms per deciliter.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	2.4	0.8	0.7	0.6	0.6
Annual Indicator	0.8	0.8	0.9	1.1	1.0
Numerator	573			777	740
Denominator	72798			69830	71125
Data Source		ISDH - LEAD	ISDH - Lead	ISDH - Lead	ISDH - Lead
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1	0.9	0.8	0.7	0.6

Notes - 2011

Data is based on trend analysis.

Notes - 2010

Data is final.

Notes - 2009

Data is final. Indicator is from ISDH - Lead

a. Last Year's Accomplishments

ISDH worked with the Indiana Lead-Safe Task Force and the Indiana General Assembly to introduce comprehensive lead legislation focusing on preventing retaliatory evictions issues surrounding lead hazards in rental properties.

ISDH decreased the number of children with elevated blood lead levels by increasing primary prevention activities including increasing the overall number of environmental inspections and investigations.

ISDH increased the number of lead-safe housing units.

ISDH assisted partners with increasing the availability of lead hazard remediation grants for Hoosier citizens.

ISDH improved training and increased the number of licensed lead professionals.

IN improved enforcement of existing abatement regulations.

IN increased the number of Medicaid-eligible children that were screened.

IN improved data collection and analysis.

The ISDH Lead and Healthy Homes Program (ILHHP) Division improved case management of lead-poisoned children by continuing the systematic training of local health department staff; overseeing radon professional licensing and staffing Radon Hotline; and expanding the program mission to include an overall healthy homes approach.

Article 32 of Indiana Administrative Code Title 410 was enacted in 2010 to formalize definitions and enforcement for the lead-based paint program. Indiana is committed to defining roles and responsibilities and enforcement of these rules to meet Healthy People 2020 objectives set forth by the US Department of Health and Human Services. The primary objective is to reduce mean blood-lead levels of children by 10% and ultimately the elimination of elevated blood lead levels in children. In 2010, ILHHP revised its statewide Childhood Lead Poisoning Elimination Plan to reflect these targets. The program also worked with retailers, contractors, business owners, landlords and homeowners to comply with the Environmental Protection Agency's (EPA) Renovation, Repair and Painting (RRP) rule² which went into effect in April 2010.

The IN ECCS initiative, Sunny Start, contracted with Improving Kids' Environment (IKE), a children's environmental advocacy group, to produce a series of children's environmental health fact sheets for families with young children. The fact sheets were translated into Spanish and posted on the website for public access.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ILHHP conducts training on the revised administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.				X
2. ILHHP works to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.				X
3. ILHHP works to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.		X		
4. ILHHP continues efforts to affect an increase in the percent of Medicaid screened children by encouraging Medicaid reimbursement for testing, case management, and environmental inspection.			X	
5. ILHHP improves data collections and comparisons with other programs such as Medicaid and WIC, use of the I-LEAD web application to produce consistent and effective risk assessments and environmental follow-up.				X
6. ILHHP increases awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Due to pending CDC funding cuts, the ILHHP Director, Lead Epidemiologist & the Lead Health Educator positions were vacated. Lead Case Management staff joined MCH in March 2011. Activities continue to include the identification of housing-related health data, the development of data cleaning and dissemination plans; assessment of housing conditions in high-risk areas; identification of at-risk populations for health issues related to housing; assessment of current regulatory authorities related to healthy homes; oversight of licensing radon professionals; staffing Radon Hotline; & training environmental investigation staff to oversee radon mitigation activity. Sunny Start received funding from the IN Head Start State Collaboration Office to reproduce a documentary on Lead Poisoning Prevention produced in conjunction with the Marion County Health Department, the local PBS affiliate, ISDH, and IKE. IKE added an additional CD of resources containing info @ rights & responsibilities of homeowners, renters & property owners in preventing lead poisoning. The DVD sets are being distributed to all IN Head Start and Early Head Start facilities, & child care facilities in targeted high risk areas. Sunny Start will release an addendum to the 2011 State of the Young Hoosier Child data report. The 2012 Child Environmental Health report delves into the impact the environment has on young Hoosiers. It includes chapters on indicators of children's health such as healthy housing & neighborhoods.

c. Plan for the Coming Year

Work will continue by the MCH Division Lead Case Management staff and the Environmental Public Health Division staff to include:
The assessment of existing healthy housing partners and identification of potential new partners that focus housing-related health issues;
The identification of housing-related health data variables to be collected and the development of data cleaning and dissemination plans;
The identification of an assessment tool to collect data and to document housing-related health hazards;
Assessment of housing conditions in high-risk areas;
Identification of at-risk populations for health issues related to housing;
Development of a technical assistance/training process to address the needs of staff, coalitions and partners involved with healthy homes programming;
Development of risk communication/health education activities that support housing-based primary prevention strategies targeted to high-risk areas and populations;
Identification of barriers frequently associated with the case coordination process and development of a protocol to assure that appropriate follow-care is provided;
Assessment of current regulatory authorities relating to healthy homes; and oversight of licensing radon professionals; staffing Radon Hotline; training environmental investigation staff to oversee radon mitigation activity.

State Performance Measure 6: *The percentage of births that occur within 18 months of a previous birth to the same birth mother.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	17	16	15	14	36.1
Annual Indicator	17	36.0	35.4	35.2	35
Numerator		18607	17768		
Denominator		51685	50188		
Data Source		ISDH ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC

Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	35	34.9	34.8	34.7	34.6

Notes - 2011

Data is final.

Changes are because the data now represents Indiana residents, not edited for birthweight or gestation, and not restricted to singleton births.

Source of data: ISDH ERC

Notes - 2010

Data is based on a trend analysis.

Notes - 2009

Data is final.

Changes are because the data now represents Indiana residents, not edited for birthweight or gestation, and not restricted to singleton births.

Source of data: ISDH ERC

a. Last Year's Accomplishments

MCH developed a state Family Planning work group in collaboration with the Indiana Family Health Council Title X program and the Indiana Perinatal Network to assist MCH in development of statewide preconception and interconception program. The coalition planned a women's health conference geared toward health care providers for October 7, 2011.

MCH collected and evaluated best practice models for improving birth spacing and decreasing unintended pregnancies. Updates on preconception best practice models and new family planning methods were included in the Title V 2012-2013 RFP. The RFP was sent to current Title V funded projects and new agencies that could provide preconception and interconception activities to impact Indiana's high rate of births that occur before 18 months of previous delivery. Applicants that chose birth spacing and unintended pregnancies to address had to use best practice models included in the RFP.

The topic of contraception and reproductive life planning was incorporated into the Indiana Perinatal Network (IPN) 2011 Regional Training series with the addition of "Everything You Need to Know about Contraception but Were Afraid to Ask". The trainings were facilitated by physicians from the IU School of Medicine's Department of Adolescent Medicine. IPN also collaborated on the submission of an abstract that was presented at IAFP annual meeting in July, 2011. The Fall 2011 issue of Perinatal Perspectives focused on reproductive health and was distributed to over 3,100 health care providers statewide. Plans to integrate preconception and interconception health into regional prenatal care coordinator trainings during this year were changed due to the prenatal care coordination program being eliminated by Medicaid.

MCH encouraged all Title V grantees, ISDH Division partners, and work group partners to integrate reproductive health messages into existing state health promotion programs.

Collaborated with the Indiana Family Health Council (IFHC) Title X program to identify and/or develop provider educational materials and presentations and consumer/grassroots awareness materials regarding the reproductive life plan and child spacing.

National attention has focused on HB 1210, which ends the use of public funds for Planned Parenthood of Indiana (PPIN), and prohibits Medicaid patients from accessing PPIN services. On June 1, the US Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) rejected the Indiana Office of Medicaid Policy and Planning (OMPP) request to block Medicaid recipients from receiving care at PPIN, saying that such a provision is in violation of federal law.

Language regarding Indiana's long-standing attempts to implement a family planning waiver was incorporated into SB 461, Health Care Reform Matters, which states before January 1, 2012, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human

Services for approval of a state plan amendment (SPA) to expand the population eligible for family planning services. The SPA must include women and men, set income eligibility at 133% of the federal income poverty level, and incorporate presumptive eligibility for services to this population

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate a state summit to educate health care providers on promoting healthy women to include preconception, interconception, birth spacing, and unintended pregnancies.				X
2. Increase the awareness of health providers, through state summits, guidelines, and tool development regarding the importance of addressing preconception health among all women of childbearing age in their practices.				X
3. MCH and IPN will work with OMPP to implement the OMPP state plan amendment (SPA) to expand the population eligible for family planning services when final approval is received.				X
4. Follow-up on provider summit in October 2011 with surveys and focus groups of attendees to measure change in practice, increased knowledge, and change in beliefs.		X		
5. Implement interconception follow-up of low and very low birthweight infants and their mothers into new neonatal guidelines.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Facilitate a state summit to educate health care providers on promoting healthy women to include preconception, interconception, birth spacing, and unintended pregnancies. The health summit; "Healthy Women, Healthy Hoosiers" occurred October 7, 2011.

Increase the awareness of health providers (primary care providers, pediatricians, OB/GYN, family planning), through state summits, guidelines, and tool development regarding the importance of addressing preconception health among all women of childbearing age in their practices.

MCH and IPN will work with OMPP to implement the OMPP state plan amendment (SPA) to expand the population eligible for family planning services when final approval is received.

Follow-up on provider summit in October 2011 with surveys and focus groups of attendees to measure change in practice, increased knowledge, and change in beliefs.

Implement interconception follow-up of low and very low birthweight infants and their mothers into new neonatal guidelines.

Plan a second annual Healthy Hoosier Women summit with a sexual health focus.

Include recommended guidelines for preconception / interconception screenings, interventions, and health promotion after delivery and prior to hospital discharge at the 3rd annual birthing hospital summit.

c. Plan for the Coming Year

Conduct consumer-focused research to identify preconception terms the public understands and develop culturally appropriate messages promoting preconception health and reproductive awareness.

Implement the OMPP state plan amendment for family planning services by December 30, 2012. Create and disseminate best practice models on pre / interconception services, and consumer education to Medicaid Managed Care Entities (MCE) to include in new member packets. Train MCE provider reps to include best practice pre / interconception recommendations to all provider offices visited through the grant year. Include birth spacing, unintended pregnancies, preconception health in the annual school nurse and public health nurse conferences. Plan and hold third Healthy Hoosier Women Summit targeting healthcare providers. Include CDC preconception recommendations in at least one Perinatal Focus magazine. Try to get a MCE, provider organization; INACOG, INAAFP, INCNM to adopt the "Every Woman Every Time" campaign. Provide best practice models to local minority health coalitions to implement "Every Woman Every Time".

State Performance Measure 7: *Percentage of preterm births*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					13
Annual Indicator		13.3	11.8	11.8	11.8
Numerator		11762	10192		
Denominator		88585	86126		
Data Source		ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	11.8	11.7	11.7	11.6	11.6

Notes - 2011

Data is based on a trend analysis.

Notes - 2010

Data is based on a trend analysis.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

Held the second annual birthing hospital summit on 9/23/2011. At the first hospital summit, 9/24/2010 a tool kit with policies to decrease inductions and late preterm birth without medical reason was given to each hospital. A survey monkey of hospitals prior to the second summit revealed 88% of hospitals had an elective induction policy compared to 62% in 2010; 34% initiated a new policy or practice change since the 2010 hospital summit. The Levels of Hospital Care Standards were shared with each hospital and comments were solicited. A follow-up to implementation of the exclusive breastfeeding protocols from last year's summit was conducted. Increase the awareness and knowledge of prenatal health care providers on the effects of prematurity due to scheduled induction and cesarean.

Create and maintain committees to work on the Preterm Birth Quality Improvement recommendations. Committees have been created to work on the Preterm Birth Quality Improvement recommendations of 1) provider education, 2) consumer education, 3) identification

of data sources, and evaluation of interventions, 4) creation of policy, standards, and tools to drive system change and improve birth outcomes. It was decided to start with the issue of late preterm births.

Bring together additional partners to increase membership in the Indiana Preterm Birth Quality Improvement Collaborative.

MCH worked with the Indiana Perinatal Network to increase the awareness and knowledge of prenatal health care providers on the effects of prematurity due to scheduled induction and cesarean births through regional trainings and targeted hospital trainings. Tools to facilitate practice change at the hospital level were shared at the trainings.

A collaborative of state agencies to impact <39 weeks of pregnancy was formed 9/30/2011, between MCH, Indiana Hospital Association (IHA), March of Dimes, and the Office of Medicaid Policy and Planning (OMPP). Each agency has defined their role in the collaborative. MCH will lead the implementation of the Indiana Perinatal Quality Improvement Collaborative which brings several task forces together under one umbrella. The IHA will include the <39 weeks protocol as part of their safety collaborative with hospitals throughout the state. March of Dimes will implement the March of Dimes' 39 weeks toolkit in hospitals in Indiana. Duke Energy will supply funding for 5 hospitals to participate with the national program; OMPP wants to provide physician and patient education about waiting for 40 weeks of pregnancy. Each member of the group agreed to support each other in their efforts.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH will continue to work with Medicaid through the Neonatal Quality Committee to impact preterm births.				X
2. Increase public awareness of all aspects of prematurity.		X		
3. Develop protocols and provider education around the use of 17P for premature birth prevention.		X		
4. Encourage centering groups for pregnant women at high risk for preterm birth.				X
5. Collaborative of state agencies to impact <39 weeks of pregnancy.				X
6. Third birthing hospital summit.				X
7.				
8.				
9.				
10.				

b. Current Activities

MCH will continue to work with Medicaid through the Neonatal Quality Committee to impact preterm births through policy changes and data assessment. OMPP has initiated pay for performance contracting with Medicaid Managed Care Entities on cesarean delivery rates.

Focus: Improve birth outcomes. Members of the group will continue to discuss and analyze data from the Presumptive Eligibility for Pregnant Women and Notification of Pregnancy projects.

MCH will work with OMPP to develop a 40 Weeks of Pregnancy toolkit for Medicaid prenatal providers that will include causes of early and late preterm delivery, induction and/or cesarean delivery with no medical reason, brain development of the fetus, the long term effects of prematurity on the newborn, and use of March of Dimes media messages that are culturally appropriate, literacy appropriate and are targeted to state and local audiences.

Assist March of Dimes in implementation of the 39 week initiative in Indiana hospitals.

Develop data gathering tools with the Indiana Perinatal Quality Collaborative (IPQIC) data committee to improve data collection and analysis to inform program and policy decisions, identify needs and strategies, evaluate strategies and monitor progress in reducing prematurity and

neonatal mortality and morbidity.

Third hospital summit is scheduled for September 21, 2012. Attendance is by invitation only of two to three executive/managers from each of the delivering hospitals, MCH, IPN, IHA, and OMPP.

c. Plan for the Coming Year

Begin work on a Perinatal Hospital System of Care with perinatal centers and affiliate hospitals. Create maternal and infant transport policies and assure all areas of the state are covered. Assure every prenatal care provider, every infant care provider, every hospital regardless of level of care utilizes best practice policies, receives technical assistance and training to improve care and outcomes.

Activate the Alcohol, Tobacco and Other Drug committee to begin addressing newborn abstinence syndrome.

Begin a simple OB quality improvement project.

Continue to work with the ISDH Division of Vital Records to improve data collection.

State Performance Measure 8: *The percentage of women 18 to 44 who are overweight/obese.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					61
Annual Indicator			60.9	52.1	52
Numerator			3294	2819	
Denominator			5408	5410	
Data Source			BRFSS	BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	52	52	51	51	51

Notes - 2011

2011 data not available, based on trend analysis.

Notes - 2010

Data is final.

Notes - 2009

Data is final.

a. Last Year's Accomplishments

The Division of Nutrition and Physical Activity (DNPA) is continuing to promote the state plan for obesity prevention that was unveiled in January 2011 and addresses issues related to childcare, school settings, and special populations.

MCH is working with the Division of Nutrition and Physical Activity (DNPA) on the re-formation of teams to address implementation of the Indiana Healthy Weight Initiative on a statewide basis.

MCH collaborated with DNPA and school systems in the administration of the Youth Risk Behavior Survey (YRBS) and the collection and dissemination of data. The 2011 YRBS section on dietary behaviors revealed that Indiana had the lowest percent of students that ate fruit or drank 100% fruit juices three or more times/day (14.5%) among all states that participated in the YRBS survey. Indiana also ranked last for the percentage of students that ate vegetables three or more times a day (9.0%). The percentage of female high school students who described

themselves as overweight was 37.3%. More female students (63.2%) stated they were trying to lose weight.

All state prenatal care coordinators and Title V funded clinics are mandated to assess and provide intervention for all women of child bearing age with a BMI >30. Trainings on BMI, how to conduct a nutrition assessment and referral/intervention resources were provided to all prenatal care coordinators and Title V funded clinics.

A tool kit for providers on nutrition assessment and intervention was developed and provided at trainings around the state.

MCH dietician worked with IU Health physicians to set up a high risk prenatal obesity clinic.

An analysis of BMI category pre-pregnancy and at time of delivery found the greater the BMI the greater the risk that a Cesarean delivery, gestational diabetes, and fetal intolerance of labor. Fifty percent of class three obese women required a cesarean section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All Title V grantees for 2012 are expected to weigh every patient, identify patients overweight or obese and provide some type of intervention.	X		X	
2. Continue to collaborate with DNPA on the Healthy Weight Initiative as it applies to women of childbearing age.			X	
3. Work with the ISDH Office of Women’s Health to promote healthy preconception weight.				X
4. Collaborate with the Indiana Family Health Council Title X director to assure all women of childbearing age attended family planning clinic receive weight assessment and education on healthy weight.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH will continue to update this performance measure to be more inclusive of overweight/obesity as an issue. Trends indicate that overweight/obese adolescents are at risk for becoming overweight/obese adults. Overweight/obesity carries greater risk for poor outcomes when women become pregnant. The adolescent program will address obesity through school-based health clinics, and through website messages.

MCH will work with epidemiologists to determine best data source to track overweight and obesity in women of childbearing age.

MCH will work with DNPA and the Indiana Healthy Weight Initiative to promote achieving and maintaining a healthy BMI in women of childbearing age.

MCH will work to form an advisory team to assess needs of clinicians as well as clientele served to determine tools and resources required to promote achieving and maintaining a healthy BMI prior to pregnancy.

MCH will use advisory team to assess needs of clinicians as well as clientele served to determine tools and resources required to promote healthy weight gain during pregnancy (gestational weight gain).

MCH will collaborate with advisory team members to create toolkit of aids and resources to educate providers and women of childbearing age on the importance of achieving/maintaining a healthy BMI with some methods to do so.

MCH will work with advisory team to establish realistic targets for obesity reduction in women of childbearing age.

c. Plan for the Coming Year

Examine the link of obesity in pregnancy to maternal and infant mortality.
 Charge the expert panel of the Indiana Perinatal Quality Improvement Collaborative (IPQIC) with development of best practice guidelines for all birthing hospitals for assessment and treatment of obese women presenting for labor and delivery.
 Work with the IU Center of Women's Excellence to include ongoing promotion of healthy weight among women of child bearing age.
 Encourage the MCH adolescent program, perinatal program, home visiting programs, family planning programs, and women's health programs to work together to develop a tool kit for weight management across the life span of women of child bearing age.
 Provide trainings on intervention programs to Title V grantees, community health centers, local health departments and Medicaid Managed Care Entities yearly.

State Performance Measure 9: Percentage of high school students who become infected with STI.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					1
Annual Indicator		0.5	0.8	1.2	1.1
Numerator		2044	3883	5710	
Denominator		451711	460787	460000	
Data Source		ISDH - STD/HIV	ISDH - STD/HIV	ISDH - STD/HIV	ISDH- STD/HIV
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	1	1	0.9	0.9	0.8

Notes - 2011

Rate based on trend analysis.

Notes - 2010

Nominator is final. Denominator is provisional and based on a trend analysis. rate is final.

a. Last Year's Accomplishments

State Adolescent Health Coordinator (SAHC) partnered with the Indiana Family Health Council (IFHC) and its delegate agencies to promote screening for Chlamydia and gonorrhea among adolescents.

Maternal and Child Health (MCH) and the HIV/STD Division at the Indiana State Department of Health (ISDH) provided accurate, timely data on the prevalence of Chlamydia, gonorrhea, and other STIs to grantees and community members and via reports on the ISDH web site.

MCH partnered with Health Care Education and Training (HCET) to support the text messaging campaign aimed at adolescents to promote screening and positive sexual health behaviors.

MCH funded 11 community-based grantees through the Indiana Reduces Early Sex and

Pregnancy by Educating Children and Teens (RESPECT) program. These grantees provide teen pregnancy prevention programs, which also address the prevention of STIs. MCH considered revisions to the Indiana RESPECT initiative for future funding of community-based grantees to be more evidence-based and data-driven in its efforts to prevent STIs and teen pregnancy.

MCH supported the HIV/STD Division in efforts to reduce the contraction of STIs among adolescents and young people.

SAHC worked with and supervised the Youth Risk Behavior Survey Coordinator (YRBS) to disseminate data findings from the 2009 survey as well as assist with the administration of the 2011 YRBS survey. YRBS provides Indiana with valuable data regarding the sexual behaviors of Hoosier high school students.

SAHC facilitated the Indiana Coalition to Improve Adolescent Health (ICIAH) which has addressing reducing STIs among adolescents as one of its priorities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ISDH will continue to partner with IFHC and its delegate agencies to promote screening for Chlamydia and gonorrhea among adolescents.	X		X	X
2. MCH will partner with HCET to develop a texting method for parents to talk to their kids about STIs and sex.			X	X
3. MCH will contract with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free STI screening and counseling on sex.	X		X	
4. Upon state approval, SAHC will conduct a media marketing campaign with the RESPECT program to ensure that teens have access to relevant, reliable, and accurate information regarding STIs.			X	X
5. SAHC will continue supervising the YRBS Coordinator to disseminate data findings from the 2011 survey, which include information on STIs.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SAHC is serving as the consultant for family planning services in Indiana. ISDH is partnering with the IFHC and its delegate agencies to promote screening for Chlamydia and gonorrhea among adolescents.

MCH and the HIV/STD Division are providing accurate, timely data on the prevalence of Chlamydia, gonorrhea, and other STIs to grantees and community members and via reports on the ISDH web site.

MCH is partnering with HCET to promote the text messaging campaign aimed at adolescents to encourage screenings for STIs and positive sexual health behaviors.

MCH is partnering with the HIV/STD Division to support any outreach or educational activities that reach the adolescent population.

SAHC is supervising the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assist with the administration of the 2013 YRBS survey.

SAHC continues to identify new projects and activities to be implemented by the Indiana

RESPECT initiative and incorporate the prevention of STIs as a focus area for these funds.

c. Plan for the Coming Year

SAHC will continue to serve as the consultant for family planning services in Indiana. ISDH is partnering with the IFHC and its delegate agencies to promote screening for Chlamydia and gonorrhea among adolescents.

MCH and the HIV/STD Division will continue to provide accurate, timely data on the prevalence of Chlamydia, gonorrhea, and other STIs to grantees and community members and via reports on the ISDH web site.

SAHC will continue supervising the YRBS Coordinator to disseminate data findings from the 2011 survey as well as assist with the administration of the 2013 YRBS survey.

SAHC will continue to identify new projects and activities to be implemented by the Indiana RESPECT initiative and incorporate the prevention of STIs as a focus area for these funds.

SAHC will conduct a media marketing campaign with the RESPECT program to ensure that teens have access to relevant, reliable, and accurate information regarding STIs.

SAHC will contract with the Center of Excellence in Women's Health at Indiana University to send a Wellness on Wheels (WOW) bus to rural Indiana to provide free STI screening and counseling on sex.

SAHC will contract with Health Care Education and Training (HCET) to develop a texting method for parents to talk to their kids about STIs and sex.

State Performance Measure 10: *Build capacity for promoting social and emotional health in children from birth to age 5.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					0.1
Annual Indicator				0.1	0.2
Numerator				5	22
Denominator				92	92
Data Source				ISDH/LHCS	ISDH/LHCS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	0.1	0.2	0.3	0.3	0.4

Notes - 2011

Data is final.

The Numerator is the number of counties that have endorsed or certified early childhood mental health providers for families. The denominator is the total number of counties in the state.

Notes - 2010

This is the first year for this new performance measure. The Numerator is the number of counties that have endorsed or certified early childhood mental health providers for families. The denominator is the total number of counties in the state.

Notes - 2009

This is a new performance measure.

a. Last Year's Accomplishments

The MI-AIMH Endorsement, a set of competencies and a credentialing process in infant mental health, was adopted. IAITMH accepted applications to be endorsed in Indiana at Level 1 and 2.

The Social Emotional Committee met regularly and was led by the Chair of the Indiana Association for Infant & Toddler Mental Health. Annual conference and continuing education opportunities were available to early childhood providers. The April 2011 Healthy Families Institute included an ECCS sponsored Early Childhood Mental Health Consultation Planning Institute facilitated by Mary Mackrain, an early childhood mental health consultant, who led a day long planning/training session on high quality early childhood mental health consultation (ECMHC) approaches. A cadre of providers received intensive training over a one year period on infant mental health, increasing competencies needed for MI-AIMH Endorsement. To be admitted to the program, applicants must be licensed mental health professionals (e.g., social worker, marriage and family therapist, mental health counselor or psychologist, psychiatrist) who are employed by a Community Mental Health Center in an area of state that needs service. ISDH and the IU School of Social Work supported the development of graduate level courses in infant mental health that began in June 2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. The MI-AIMH Endorsement, a set of competencies and a credentialing process in infant mental health, was adopted in Indiana.				X
2. Twenty five providers; including Healthy Families workers, child care providers and Early Head Start home visitors will earn Level I endorsement.				X
3. Thirty additional providers; including Healthy Families workers, child care providers and Early Head Start home visitors will earn Level I endorsement.				X
4. Twelve Infant Toddler Specialists will earn Level II endorsement.				X
5. Twenty five additional providers; including First Steps providers and DCS workers will receive a Level II endorsement.				X
6. Ten providers who are currently members of the IAITMH Infant Mental Health Task Force will earn Level III endorsement, increasing the workforce capacity to provide direct services to families with young children who need a mental health intervention.				X
7. Ten providers who are employed at Community Mental Health Centers will participate in an intensive infant and early childhood mental health training experience, resulting in eligibility for Level III endorsement and increasing the workforce capacity.				X
8. Five to ten additional providers will earn Level IV endorsement making them available to provide reflective supervision to providers seeking Level I-IV endorsements.				X
9. A university-based early childhood mental health certificate program will grow a pool of providers with education, training, and supervision required to meet criteria for Levels III and IV, resulting in increases in both direct services options.				X
10. Annual Conference and Continuing Education Opportunities.				X

b. Current Activities

Two additional graduate level courses covered assessment, diagnosis and intervention. In addition, the formal certificate program includes some practicum experiences. Working toward twenty five (25) providers; including Healthy Families workers, child care

providers and Early Head Start home visitors to earn Level I endorsement
A cohort of Level 3 and 4 applicants have completed testing and will be awarded their endorsement in June 2012. A second exam will be offered in September, 2012.
A financial commitment for a third and final year has been extended by the Department of Mental Health and Addiction to train ten additional providers who are employed at Community Mental Health Centers throughout Indiana in an intensive infant and early childhood mental health training experience to help prepare them for Level 3 Endorsement. Several participants from Years 1 and 2 have now applied for the Endorsement.
Annual conference and continuing education opportunities are available to early childhood providers including Introduction to Infant Mental Health training to Healthy Families Workers which began in Fall 2011.

c. Plan for the Coming Year

Efforts will continue to encourage Head Start, child care, home visitors, early intervention, and other providers to apply to obtain a Level 1 or 2 Endorsement. There continues to be great support of the Endorsement from various Sunny Start (ECCS) partners resulting in a commitment to market the opportunity to a wide variety of providers. Financial support from several partners allows providers to access training as well as the Endorsement application and IAITMH membership annual fee for the first year.

A third and final year of support from the Division of Mental Health and Addictions will allow an additional ten to twelve mental health practitioners from all areas of Indiana to participate in an intensive training experience to help them prepare for Level 3 or 4 Endorsement. The goal of a cadre of providers across Levels and throughout the state makes access to mental health services for very young children more available.

Work on the Strategic Plan regarding Child Care Consultation will continue to be implemented. The Social Emotional Committee of Sunny Start is charged with overseeing progress on this activity.

A critical component of the Endorsement system is "reflective supervision." To support the availability of reflective supervision throughout the state, training and consultation will be sought in 2012-13. Several partners have agreed to support this activity as part of the effort to expand the number of endorsed individuals. Reflective supervision is considered different from administrative supervision and is characterized as regular, ongoing, and focused on relationships between clients and with the provider. The use of reflective supervision is expected to improve practice and outcomes for children and families.

E. Health Status Indicators

Health Status Indicators

11: Percent of the State population at various levels of the federal poverty level.

12: Percent of the State population aged 0 to 19 years at various levels of the federal poverty level.

The Indiana State Department of Health- Maternal and Child Health Division (MCH) has been diligently working on further developing and enhancing its Life Course Health Framework in efforts to reduce and eliminate health disparities for Hoosiers throughout Indiana. MCH is specifically focusing on addressing the root causal factors associated with poor health outcomes, such as poverty. MCH believes that alleviating economic deprivation will help to lead to improved health outcomes for all Hoosiers.

Instead of focusing on differences in health patterns one disease or condition at a time, MCH is utilizing the Life Course Theory (LCT) because it points to broad social, economic, and

environmental factors as underlying causes of persistent inequalities in health for a wide range of diseases and conditions across population groups. A life course approach studies the chronic disease risk of physical and social exposures during gestation, childhood, adolescences, young adulthood, and later adult life (Ben- Shlomo & Kuh, 2002). MCH is specifically focusing on the influences in regard to maternal and child health, perinatally and into adolescence. Based on the relationship between experience and the biology and psychology of development, the LCT framework offers a conceptual model for health development and a more powerful approach to understanding diseases" (Halfon & Hochstein, 2002). LCT is population focused and firmly rooted in social determinants and social equity models. MCH is focusing on the key life course concepts in its attempt to decrease poverty levels for children and families in Indiana.

Key life course concepts (HRSA- MCHB, 2010)

- Today's experiences and exposures influence tomorrow's health (Timeline)
- Health trajectories are particularly affected during critical or sensitive periods (Timing)
- The broader community environment- biologic, physical, and social- strongly affects the capacity to be healthy (Environment)
- While genetic make-up offers both protective and risk factors for disease conditions, inequality in health reflects more than genetics and personal choice. (Equity)

MCH aims to build upon protective factors and reduce risk factors, by building and enhancing environments that support healthy and thriving communities. MCH understands that health and socioeconomic status of one generation directly affects the health status of the next generation, causing intergenerational inequity. Our view of disease causation and pre-disease pathways has also broadened, as it has become clear that health risks are created and maintained by social systems and that the magnitude of those risks is largely a function of socioeconomic disparities and psychosocial gradients" (Halfon & Hochstein, 2002).

MCH recognizes that addressing the issue of poverty in the state of Indiana is vital to improving health outcomes of its citizens. Of particular interest are Health Status Indicators 11 and 12.

11: Percent of the State population at various levels of the federal poverty level.

12: Percent of the State population aged 0 to 19 years at various levels of the federal poverty level.

Health Status Indicators 11 and 12 represent the percent of the state population at various poverty levels and the percent of the state population aged 0 through 19 years at various poverty levels, both of which are an issue in Indiana. The poverty guidelines and thresholds determined by the U.S. Department of Health and Human Services are based on the number of persons in a family and are represented in total yearly income. A variety of federal programs use the poverty guidelines to help determine eligibility, including many that serve the maternal and child health population such as Head Start. In 2010, the federal poverty threshold for a family of four was \$22,050. A family of four said to be living at 50% of poverty makes at or below \$11,025, while a family living at 100% of poverty makes at or below the poverty threshold of \$22,050. A family of four at 200% of poverty means they make at or below \$44,100 yearly.

Addressing the issue of poverty is essential in Indiana due to the increasing number of Hoosier children and families currently living in poverty. In 2010, 15.3 % of Indiana's total state population was living poverty and 21.7 % of the children in the state were also living in impoverished conditions. In 2006, 8 % of children in Indiana lived in extreme poverty (50 % poverty level), 28% lived at or below 150% of the poverty level and 39% lived at or below 200% of the poverty level. Increases in economic hardship, resulted in 10% of children living in extreme poverty (50% of the poverty level), 35% living at or below 150% of the poverty level, and 47% living at or below 200% of the poverty level in 2010.

MCH is also aware of the health, social, and economic disparities amongst Hoosiers and how various sub- populations are affected differently. In Indiana, various groups are more likely to be

living in poverty compared to their counterparts. In 2010, 31% of children in immigrant families were living in poverty compared to 21% of those in U.S. born families. These were significant increases from 2006, when 23% of immigrant families and 17 % of non immigrant families lived at or below poverty levels. Statistics also indicate that there are differences between age groups, specifically children. In 2010, 25% of children aged 0-5 years lived in poverty compared to 20% of children aged 6-17 years. There were also more children in single-parent families living in poverty compared to children in married-couple families (37% and 8% respectively) in 2010.

In addition to disparities among sub-populations, many disparities also exist between different race and ethnic groups. For example, high socioeconomic status or prenatal care may not confer the same benefits on African- American women as they do on white women" (Lu & Halfon, 2003). In 2006, 33.4% of black, 12.2% of Asian, and 26.9% of Hispanic children lived in poverty compared to 10% of white children. Over time these disparity gaps have widened with 41.8% of black children, 24.2% of Asian children, and 34.7% of children of Hispanic origin living in poverty compared to 17.9% of white children in 2010.

MCH is aware of the magnitude of these health disparities and aims to reduce health and socioeconomic disparities among all Hoosiers. MCH aims to address determinants that promote quality of life, healthy behaviors, and healthy development across all life stages. MCH's mission to reduce disparities and end poverty is in conjunction with the Healthy People 2020 overarching theme of achieving health equity, eliminating disparities, and improving the health of all.

MCH is working in collaboration with the Indiana University School of Medicine to reduce the health disparities and levels of poverty that exist in Indiana through a project called Circles Indiana. Through this program, we want to reduce the number of those living in poverty, and also raise those in extreme poverty to a higher level. The Circles(r) National Development Center, established in Indianapolis, is working with community organizations, including the Indianapolis hospitals, churches, United Way and schools, to implement and offer training programs focused on empowering people who strive to get out of poverty.

This collaboration seeks to encompass the overarching Healthy People 2020 theme of creating social and physical environment that promote good health for all by addressing social determinants of health. Families living in poverty who are highly motivated to improve their situations go through in-depth training and are matched with trained middle or upper class "Allies" who become intentional friends and accountability partners to help them move toward their goals.

A two-year, \$500,000 grant from the Indiana Department of Health has seeded the center in Indianapolis, which also has received additional funds from private sources to reach an anticipated initial investment of \$800,000. The center is expected to generate \$23.5 million in new Circles program funds over the next seven years and reach more than 4,000 families.

References

- Ben- Sholomo, Y. & Kuh, D. (2002). A life course approach to chronic disease epidemiology: conceptual models, empirical challenges, and interdisciplinary perspectives. *International Journal of Epidemiology*, 31:285-293.
- Conley, D. & Bennett, N.G. (2000). Is Biology Destiny? Birth Weight and Life Chances. *American Sociological Review* 65: 458-467.
- Duncan, G.J., Brooks-Gunn, J., Yeung, W.J., & Smith, J.R. (1998). How much does childhood poverty affect the life chances of children. *American Sociological Review*, 63: 406-423.
- Halfon, N. & Hochstein, M. (2002). Life Course Health Development: An Integrated Framework for Developing Health, Policy, and Research. *Oxford Journals*, 80 (3): 433-479.
- Hobcraft, J. & Kiernan, K. (2001). Childhood poverty, early motherhood, and adult social exclusion. *British Journal of Sociology*, 52 (3): 495-517.
- Lee, H., Harris, K.M., & Gordan- Larsen, P. (2009). Life Course Perspectives on the Links

Between Poverty and Obesity During the Transition to Young Adulthood. Population Res Policy Rev, 28 (4):505-532.

Lu, M.C., & Halfon, N. (2003). Racial and ethnic disparities in birth outcomes: a life course perspective. Maternal and Child Health Journal, 7: 13-30.

F. Other Program Activities

In terms of maternal and child health, the effectiveness of our interventions and programs is an overriding issue. Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this phenomenon, it is an issue we are addressing in a number of ways as discussed in the following paragraphs.

As discussed in Section III, State Overview, Indiana is near the bottom of all states in receipt of federal health dollars. Indiana ranks 48th for the amount of federal funding for public health from the CDC in FY 2009, 50th for Federal funding from HRSA, and 47th for the amount states provide for public health services. This lack of funding adversely impacts capacity. To combat these low funding levels, we will be examining all funded projects in the coming year to ensure their effectiveness.

Additionally, we are aggressively seeking additional grants that will allow Indiana to supplement Title V funding for maternal and child health programs. Examples of grants for which we are applying include:

Teen Outreach Program (TOP) -- The Indiana State Department of Health (ISDH), in partnership with the Indiana Department of Education (DOE), Health Care Education and Training, Inc. (HCET) and the Center for Sexual Health Promotion (CSHP) at Indiana University recently submitted an application to the newly created federal Office of Adolescent Health to implement the Teen Outreach Program (TOP), an evidence-based, youth development and community service focused program to prevent teen pregnancy. This program is proposed to be implemented in 19 counties state-wide that have the highest rates of births among teens ages 15-19. Two goals of TOP are to reduce pregnancy rates and increase high school graduation rates. /2012/Indiana was not awarded this grant./2012//

Innovative Social Media -- The purpose of this grant is to improve birth outcomes through socially interactive educational media. The media will improve understanding of the consequences of behavioral and environmental life choices on pregnancy outcomes. Socially interactive media will provide engaging, challenging and educational experiences that will be able to be spread beyond the original participants through shared media access.

MCH is proposing to develop and implement The Social Immersive Media Project for Life-course Education (SIMPLE). SIMPLE is an innovative social marketing approach to increase public awareness of the importance of integrating the life-course perspective into preconception/interconception planning and care; to reduce adverse outcomes and improve reproductive health; and to increase public awareness of the importance of preparing couples for transitioning into their roles as new parents./2012/Grant was awarded. Program has been implemented. See Title V capacity section for more details./2012//

ACA Maternal, Infant and Early Childhood Home Visiting Program Application -- Research indicates that healthy human development is connected to preventing poor outcomes that occur during the youngest years of a child's life. Early health indicators, including birth weight, immunization rates, and parental knowledge of proper child development, all are significant predictors of school performance and social engagement in later years. Problems apparent at this young age have been accurate predictors of IQ, educational attainment, criminal behavior, and even the probability of becoming a teenage mother. Programs that focus on comprehensive family-based programs have yielded strong outcomes for children, especially when they begin as

early as possible. Home visitation programs that train new parents to be the "first teachers" of their young children have been very successful, especially if these programs work with parents over a period of several years.

In keeping with the partnership between HRSA and ACF, Indiana's Governor, the Honorable "Mitch" Daniels, has also recognized that the goal of an effective, comprehensive early childhood system is broader than the scope of any one agency. He has designated The Indiana State Department of Health (ISDH), through the Maternal and Child Health (MCH) Title V Division, and the Indiana Department of Child Services (DCS) as co-lead agencies for the State of Indiana's application for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Indiana will use this funding for two programs. Specifically, Indiana proposes to expand Healthy Families services within the already existing statewide network of Healthy Families providers, and to pilot the Nurse-Family Partnership home visiting services through a public-private partnership between ISDH/MCH and Goodwill Industries of Central Indiana./2012/Updated State Plan was completed as well as one formula grant and one competitive grant./2012// **/2013/Competitive funding in the amount of \$9 million was awarded to Indiana./2013//**

We are also defining and implementing an evidence-based, life course health perspective that supports the knowledge that health is more than the absence of disease. As MCH moves in this direction, we are addressing a life course approach at the organizational level; developing and testing programs that incorporate a life course perspective; promoting pilot projects to test models that can be adopted and adapted in other locales; and sharing strategies and outcomes with non-traditional partners such as Goodwill Industries to further enhance knowledge, theory and practice./2012/See Title V capacity section for how this program is developing./2012//

/2012/MCH was awarded the Pregnant and Parenting Teen grant. The award amount is \$2 million a year for three years. With this award, MCH is providing four large subawards for direct services to pregnant and parenting teens 15 to 19 years old and funding research to identify effective ways to deliver health messages. MCH also completing a needs assessment to identify high risk communities. In August 2011, MCH will be seeking additional input from the community through a facilitated process./2012//

/2013/MCH has applied for a Project LAUNCH grant and has entered into a contract with the IU Division of Pediatrics to develop the first regional center, Circles of Indiana, to help people get out of poverty. MCH has also applied for an Abstinence Education Grant./2013//

G. Technical Assistance

National Fatherhood Initiative

Indiana State Department of Health (ISDH) is requesting technical assistance for Best Practices training for new fathers on the basics of child health and safety. This will teach fathers how to take care of their children during the pregnancy and after they are born. Early involvement of males in the pregnancy has positive benefits well beyond the birth of the child. For example, trainings engaging new dads and fathers in addressing the babies needs while in the womb and after delivery have shown to assist mothers in receiving early, continuous, and adequate prenatal care. This can be due to the fact that the mothers have a support system from the start.

Unmarried mothers, or mothers where the fathers are absent from the home, are less likely to obtain prenatal care and more likely to have a low birth-weight baby. Researchers find that these negative effects persist even when they take into account factors such as education, which often distinguish a single parent from two-parent families. Expectant fathers can play a powerful role as advocates for prenatal care. Research has shown that 2/3rds of women whose partners attended a breastfeeding promotion class initiated breastfeeding. When the father or other family male(s) were involved, the mother received more prenatal care once enrolled.

ISDH is requesting technical assistance regarding the National Fatherhood Initiative (NFI). NFI offers Best Practices curriculums that actively involve fathers in the child's health care from conception and throughout childhood. Their curriculums include a variety of tools and resources for supporting fathers in many diverse settings. For example, they offer military programming, school-based programming, correctional programming, and Christian-based programming. For our purposes, we are interested in their health care programming which includes but is not limited to "Doctor Dad", "When Duct Tape Won't Work", and "Daddy Pack" (Exclusively for New Dads).

Bright Futures

ISDH is requesting training on the usage of the Bright Futures developmental tools for families and providers to address social and emotional health in children 0 through 5. This training should address each child's uniqueness due to the fact that all children face social and emotional challenges in early childhood, including learning how to control their emotions and tantrums and learning how to share, take turns, and play with others. With the use of Bright Futures tools, providers and families can begin a conversation together about how best to support healthy social and emotional development in infants, children, and teens. The tools encourage families who have any questions or concerns about their child's development to "check it out" and offer a number of tips for when, where, and how to seek assistance from local, state, or national resources.

Customized training, consultation, and technical assistance are available from Bright Futures at Georgetown University and the National Technical Assistance Center for Children's Mental Health. Through these organizations, ISDH would be able to utilize these tools in a variety of settings and for multiple purposes.

Capacity building for coalitions

ISDH is requesting technical assistance for infrastructure building and capacity building for coalitions. The Indiana Coalition to Improve Adolescent Health (ICIAH) was formed in late 2006. In May 2009, ICIAH released the state's first adolescent health plan. The focus of ICIAH is on the implementation of this plan with and through its partner organizations. However, ICIAH is struggling to get buy-in and commitment from its partners to take greater ownership in the implementation of the plan and promotion of ICIAH's work.

Cultural Competency Training

General issue-cultural competency training for MCH and its partners would be beneficial because Maternal and Child Health (MCH) faces diversity and health disparities among the population it serves. ISDH did provide annual training opportunities and refresher courses on cultural competency; however, such opportunities are no longer available. It is important for MCH staff and those we partner with and fund to have skills in this area in order to provide the best services for its clients. This type of training is available through MCHB and the National Center for Cultural Competency./2012/ MCH would like to focus on this training in FY12.//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	11770865	10859542	11770865		11662428	
2. Unobligated Balance <i>(Line2, Form 2)</i>	781000	911323	1985939		910310	
3. State Funds <i>(Line3, Form 2)</i>	17877130	14690312	17877130		15795389	
4. Local MCH Funds <i>(Line4, Form 2)</i>	250317	889823	889823		889823	
5. Other Funds <i>(Line5, Form 2)</i>	2696549	2312108	2312108		2312108	
6. Program Income <i>(Line6, Form 2)</i>	2923311	2795620	2795620		2795620	
7. Subtotal	36299172	32458728	37631485		34365678	
8. Other Federal Funds <i>(Line10, Form 2)</i>	2462219	2725367	2755805		9061151	
9. Total <i>(Line11, Form 2)</i>	38761391	35184095	40387290		43426829	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	5389351	5333516	5663424		5601748	
b. Infants < 1 year old	2442372	2472019	2429785		2423081	
c. Children 1 to 22 years old	8016995	7983267	8398315		8393237	
d. Children with	19802771	16022243	20389961		17215212	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	647683	647683	750000		732400	
g. SUBTOTAL	36299172	32458728	37631485		34365678	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	92090		88601		65357	
c. CISS	0		0		0	
d. Abstinence Education	0		0		1047703	
e. Healthy Start	0		0		150000	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	1554529		1484604		155650	
j. Education	0		0		0	
k. Home Visiting	0		0		4592841	
k. Other						
INSTEP/HD	0		0		400000	
PPASS	0		0		2000000	
PSUP	0		0		400600	
UNHS	275000		250000		249000	
ECCS	140000		132000		0	
INSTEP	0		400000		0	
PSUPP	400600		400600		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	16285863	16673977	16252811		16729029	
II. Enabling Services	7478809	4814182	7138101		5247328	
III. Population-Based Services	6198615	4811705	5547532		5208239	
IV. Infrastructure Building Services	6335885	6158864	8693041		7181082	
V. Federal-State Title V Block Grant Partnership Total	36299172	32458728	37631485		34365678	

A. Expenditures

Indiana continues to implement cost cutting initiatives that include elimination of non-crucial State positions and to require that all new or replacement State positions be approved by the State Strategic Hiring Committee, regardless of funding source. The long-term impact will result in significant expenditure reductions for both state and federal funds. Additionally, there is significant difference is budgeted versus expended funds due to a required increase in state reserves. This has greatly impacted the amount of funds that were allowed to be expended in the over state/federal Title V partnership. See Forms 3, Form 4 and Form 5.

In FY 2011, Indiana maintained its initiative to hold costs steady by only funding priority projects and has continued to fund local projects for Children with Special Health Care Services (CSHCS). In FY2011, Indiana reinitiated grants to Community Health Centers. None of Indiana's community grantees received increases in total amounts awarded to them.

Maintenance of State Effort

Indiana's Maintenance of State Effort is \$11,539,520.00. In FY 2011, the MCH expected award was \$11,770,865.00 and the state had available \$36,761,391.00. The State support is comprised of state and local funds that CHCS is authorized to spend on behalf of children with special health care needs. It also includes money for the 30% match required of local projects.

B. Budget

For FY 2013, Indiana has budgeted \$3,349,450.00 or 28.7% of its annual budget for services to pregnant women, mothers and infants up to age one. Indiana has budgeted \$3,615,353.00 or 31% of its annual budget for family-centered, community-based, coordinated care and the development of community-based systems of care for children with special health care needs and their families. Indiana has budgeted \$3,965,225.00 or 34.0% of its annual MCH budget to provide services to preventive and primary care services for child and adolescents. Also included in this amount is \$732,400.00 or 6.3% for Administrative Costs. This is 100% of the total MCH grant award.

\$16,729,029.00 has been budgeted for Direct Medical Care Services which includes all community grants that provide direct services and projected medical claims for CSHCS.

\$5,247,328.00 has been budgeted for Enabling Services which include all community grants that provide enabling services, and all other CSHCS state funds not projected for direct medical care services.

\$5,208,239.00 has been budgeted for Population Based Services these services include all community grants that will provide population based services, Newborn Screening funds, and Indiana RESPECT funds.

\$7,181,082.00 has been budgeted toward Infrastructure Building Services and these funds include salaries for all staff and other operating expenses, less insurance premiums and community grant funds, the statewide needs assessment, data systems, and the Indiana Perinatal Network.

FY'13 Unobligated Funds

The projected unobligated balance for FY'13 is \$910,310.00. These funds are a combination of funds that were unable to be expended due to the overall statewide cost cutting measures.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.