Commission on Improving the Status of Children in Indiana
11/8/17

Agenda

- Welcome and Introductions
- Approval of Minutes from meeting on August 16, 2017

Agenda

- Strategic Priority: Mental Health & Substance Abuse
  - Cathy Graham, IARCA: Report on Legislative Assignment to study "Licensing requirements as barrier contributing to shortage of child care and child abuse providers" including **recommendations**
  - Mindi Goodpaster, MCCOY: Report from Task Force on additional mental health related **recommendations**

Mental Health & Substance Abuse Task Force Report and Recommendations

Cathleen Graham, MSW, LCSW, IARCA

Mindi Goodpaster, MSW, MCCOY

Service Access & Availability

- Report on Study of Licensing Requirements as Barrier – Response to Legislative Council Resolution 17-01
- Committee reviewed the charge and developed strategy to collect information regarding the shortage of providers and workforce.
- Survey conducted by IN Association of Resources & Child Advocacy (IARCA) with the IN Coalition of Family-Based Services
- 54 agencies responded to the survey. They provide home-based services, foster care, and residential treatment to abused/neglected/ delinquent children and their families.

Service Access & Availability

- Respondents reported 1,136 staff members who were required to be licensed. 715 were Master's level therapists; 255 were case managers; 166 were other staff members.
- Average wait time for a temporary license was reported at 30-60 days.
- Average wait time for initial 2-year license was reported at 30-60 days.
- Some licenses took more than 180 days.

Service Access & Availability

- Factors that delayed licensure and % of 54 agencies who selected the factor :
  - Had to wait more than 2 weeks to take the exam (69%)
  - Had to submit a syllabus to verify coursework (67%)
  - Had to submit additional paperwork to verify internship hours (49%)
  - Had to complete additional classes for LMHC licensure (47%)
  - Had to submit additional paperwork to verify clinical supervision hours (40%)

Service Access & Availability

- Factors delaying licensure (con't)
  - IPLA phones were not answered/callers placed on hold for several minutes (40%)
  - License application lost within IPLA and had to be resubmitted (38%)
  - Other (35%) – examples included variation in response time from IPLA, lost documents (other than the application) and test results, delays regarding determination of needed information to complete the process.

Service Access & Availability

Factors delaying licensure (con't)

- Had to complete additional internship hours for LMHC licensure (25%)
- Had to complete additional classes for another type of license (other than LMHC) (20%)
- Had an issue on the agenda of the BH & HS Board, but Board ran out of time and response to issue was delayed (20%)
- Had to complete additional internship hours for another type of license (other than LMHC) (11%)

Service Access & Availability

- 82% of respondents agreed that ability to use virtual supervision for part of the required face-to-face supervision (up to 50% of required hours) will be helpful to their staff in achieving clinical licensure.
- Currently, applicants seeking clinical licensure may be required to seek supervision outside of their agency or geographic area (particularly rural areas) if not supervised within the agency by the required qualified supervisor for licensure purposes (e.g. LCSW supervising LCSW applicant).

Service Access & Availability

- Recommendations which will address the barriers identified:
  - Amend IC 25-23.6-8.5-3(2) regarding LMHC licensure to delete “and one (1) advanced internship of three hundred hours…” and replacing wording of “at least one hundred (100) hours of face to face supervision” with “at least sixty-six (66) hours of face to face supervision.”
  - This amendment will bring Indiana in line with accrediting requirements for many Master’s degreed programs and with other states’ licensing requirements for LMHCs, with 700 hours of internship and 66 hours of supervision during Master’s level graduate study.

Service Access & Availability

- Amend IC 25-23.6-5-3.5 (a) to add a sentence “Virtual supervision by a qualified supervisor may account for up to 50% of the required supervision hours.” Add the same language to IC 25-23.6-8-2.7 (b); IC 25-23.6-8-5-4 (b); and IC 25-23.6-10.5-7 (a).
- This amendment will permit those seeking clinical licensure to more easily obtain post-graduate supervision by a qualified supervisor by removing barriers related to distance for up to one-half of the required hours (requirement is 96 -100 hours).

Service Access & Availability

- Concerns regarding insufficient staffing for Behavioral Health and Human Services licensing have been addressed by IPLA's addition of one customer service representative to the current staffing.
- Concerns regarding phone responses have been addressed by IPLA changing their phone system to roll to another customer service representative if the wait time reaches 3 minutes.

Service Access & Availability

- The Committee, and subsequently the Task Force, also recommends that there be a study of the ability of licensed clinical social workers, mental health counselors, marriage and family therapists, and addiction counselors to diagnose and provide treatment as independent practitioners.
- Currently, there is a shortage of HSPPs and Psychiatrists to diagnose and sign off on treatment plans, especially in the health professional shortage areas. This results in delays of several weeks for treatment for children and their parents.
- In addition to other tasks, the Committee continues its work with community mental health centers (CMHCs) to identify the availability throughout the state of CMHC school-based programs and barriers to further access in schools.

SYSTEM GAPS SUBCOMMITTEE

Summary

- Post one-page guide on www.in.gov that outlines how to select evidence-based programs for youth in the Department of Correction and on-line resources to find those programs
- Require a survey for all licensed mental health professionals when they renew license to gather data regarding services

Background – DOC Guide

- Marc Kniola, Youth Services Program Director, DOC
  - DOC professionals need assistance understanding what constitutes "evidence-based" and how to select an appropriate program
  - Florida has a comprehensive published guide – use that as a model
  - Posting the guide on www.in.gov would enable all DOC staff, and others, to access the resource

Elements of DOC Guide

- The Substance Abuse and Mental Health Service Administration's National Registry of Evidence-based Programs and Practices <www.nrepp.samhsa.gov>;
- Blueprints for Violence Prevention (and Drug Prevention) Project at the Center for the Study and Prevention of Youth Violence at the University of Colorado <www.colorado.edu/cspv/blueprints>;
- The Office of Juvenile Justice and Delinquency Prevention's Model Programs Guide <www.ojjdp.gov/mpg>;
- National Institute of Justice / Office of Justice Programs / Crime Solutions review website <www.crimesolutions.gov>; and
- The Florida Department of Juvenile Justice, Office of Program Accountability, Bureau of Quality Improvement's EBP Sourcebook, 2015 <http://www.djj.state.fl.us/docs/quality-improvement/sourcebook2015.pdf?sfvrsn=4>.

Elements of DOC Guide

- A program that is “based” upon one or more empirically-supported treatments is not as effective as a program rated evidence-based in and of itself.
- A program that is a “promising practice” is not as effective as one that has been rated highly effective; however, the promising practice still could be used, as it is in the process of being validated. Each review organization defines its terms and levels of rating evidence and effectiveness to assist.
- A program originally designed for adults and rated as evidence-based and effective cannot be used as is for juveniles and still be considered evidence-based and effective. It must be rated separately for a juvenile population.
- A program designed and rated for youth ages 12-15 cannot be called evidence-based and effective if used with youth ages 16-18.
- A program rated as prevention program should only be used in that capacity.
- If a program requires facilitation by mental health professionals, licensed professionals, and/or staff who have been officially certified in delivering the program, a provider must follow those guidelines.
- All programs must be facilitated with fidelity to the model as presented in order for a provider to claim that the program is being utilized effectively.

Background – Mandatory Survey

- Bowen Center for Health Workforce Research & Policy presentation to Task Force – 8/2/17
- Meeting with Bowen Center staff – 9/6/17
  - Senator Randy Head, Mindi Goodpaster, Dr. Hannah Maxey, Courtney Randolph, & Lacy Foy
- Discussion surrounded not having enough data regarding who are providing services, where, to whom and how accessible/affordable those services are
  - Other states have required surveys that provide that data
  - Data could then be used to apply for federal Health Professional Shortage Area (HPSA) funding

Potential Survey Elements

- Questions:
  - Currently providing services?
  - Geographic area of service?
  - Demographics of population(s) they serve?
  - Use of telemedicine?
  - Any other relevant data TBD
    - i.e. fee structure, insurance, etc.

Benefits of Survey

- Mandatory vs optional means more comprehensive data on service availability and gaps
- Bowen Center has capacity to collect and analyze the data
- Data can help leverage federal HPSA funds for loan repayment and other incentives to bring professionals into areas of higher need
- Can utilize models created in other states (e.g. Vermont)

Potential Statutes Affected

- IC 25-1 – mandatory license renewal statutes
  - Legislative Services Agency have not determined whether to add a new section or amend into existing

Agenda

- Strategic Priority: Child Safety & Services
  - Martha Allen, ISDH: Report on Legislative Assignment to study "infant mortality and children born with an addiction"

Indiana's Infant Mortality Rate and Drug Exposed Newborns

Martha Allen, MSN, RN, NE-BC
Director of Maternal and Child Health
Indiana State Department of Health

Indiana State Department of Health

Infant Mortality Defined

The death of a baby before his/her first birthday

The Infant Mortality Rate (IMR) is an estimate of the number of infant deaths for every 1,000 live births

Large disparities in infant mortality in Indiana and the United States exist, especially among race and ethnicity

Infant Mortality is the #1 indicator of health status in the world

Indiana State Department of Health

Indiana's Infant Mortality

Indiana is consistently ***worse*** than the U.S. and the national goal

- IN = 7.3 deaths per 1,000 live births
- U.S. = 5.9 deaths per 1,000 live births
- Healthy People 2020 Goal = 6.0 deaths per 1,000 live births

Black infants die ***2.1 times*** more often than White infants in Indiana.

Indiana's rate of SUIDs deaths is typically ***worse*** than the national rate.

(https://www.healthypeople.gov/2020/)

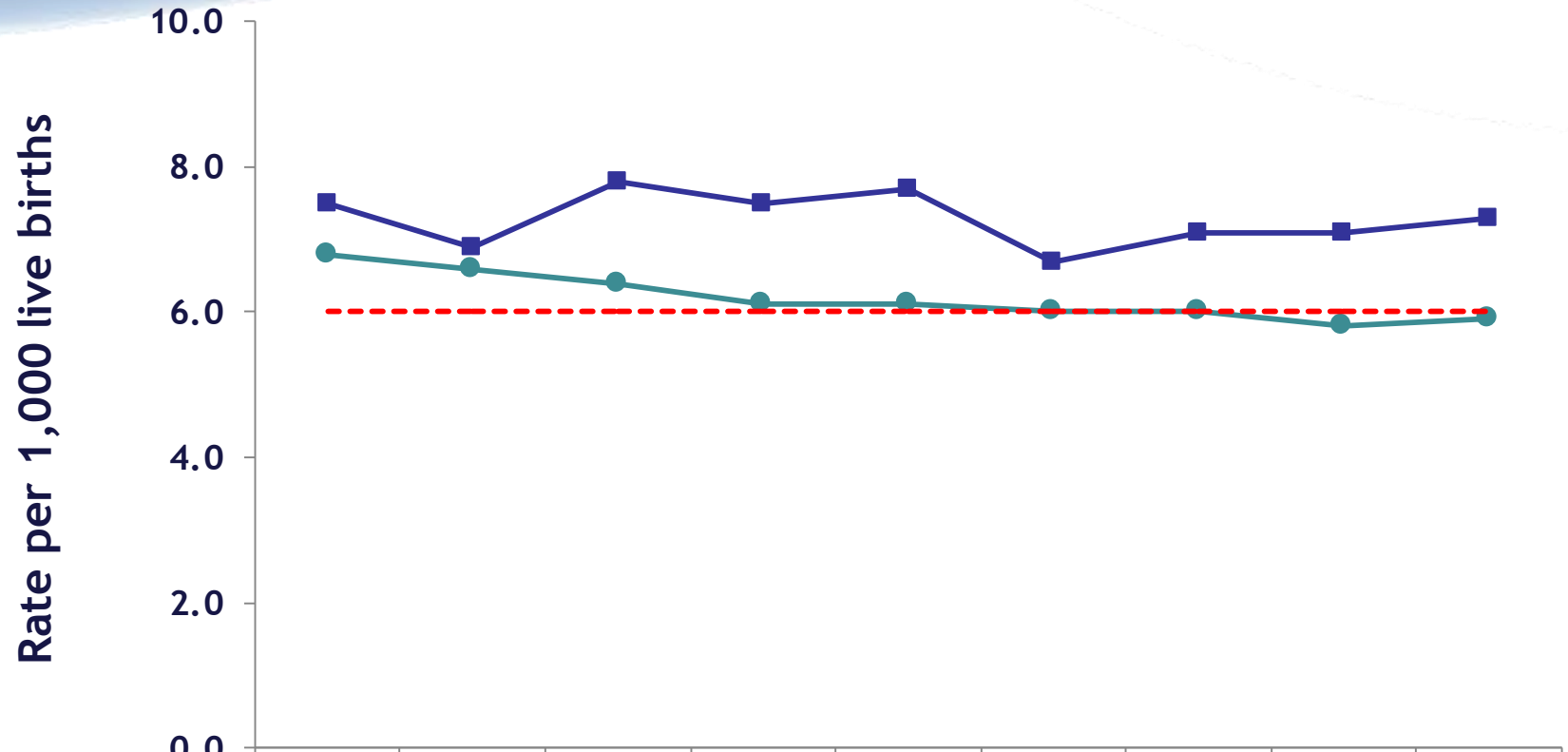
Infant Mortality in Indiana

- 613 Hoosier babies died before their 1st birthday
  - Over 50 babies EVERY month
  - Nearly 12 babies EVERY week
- Over 3,000 infant lives lost in the last 5 years
  - Nearly 42 school buses at maximum capacity

Indiana State Department of Health

Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

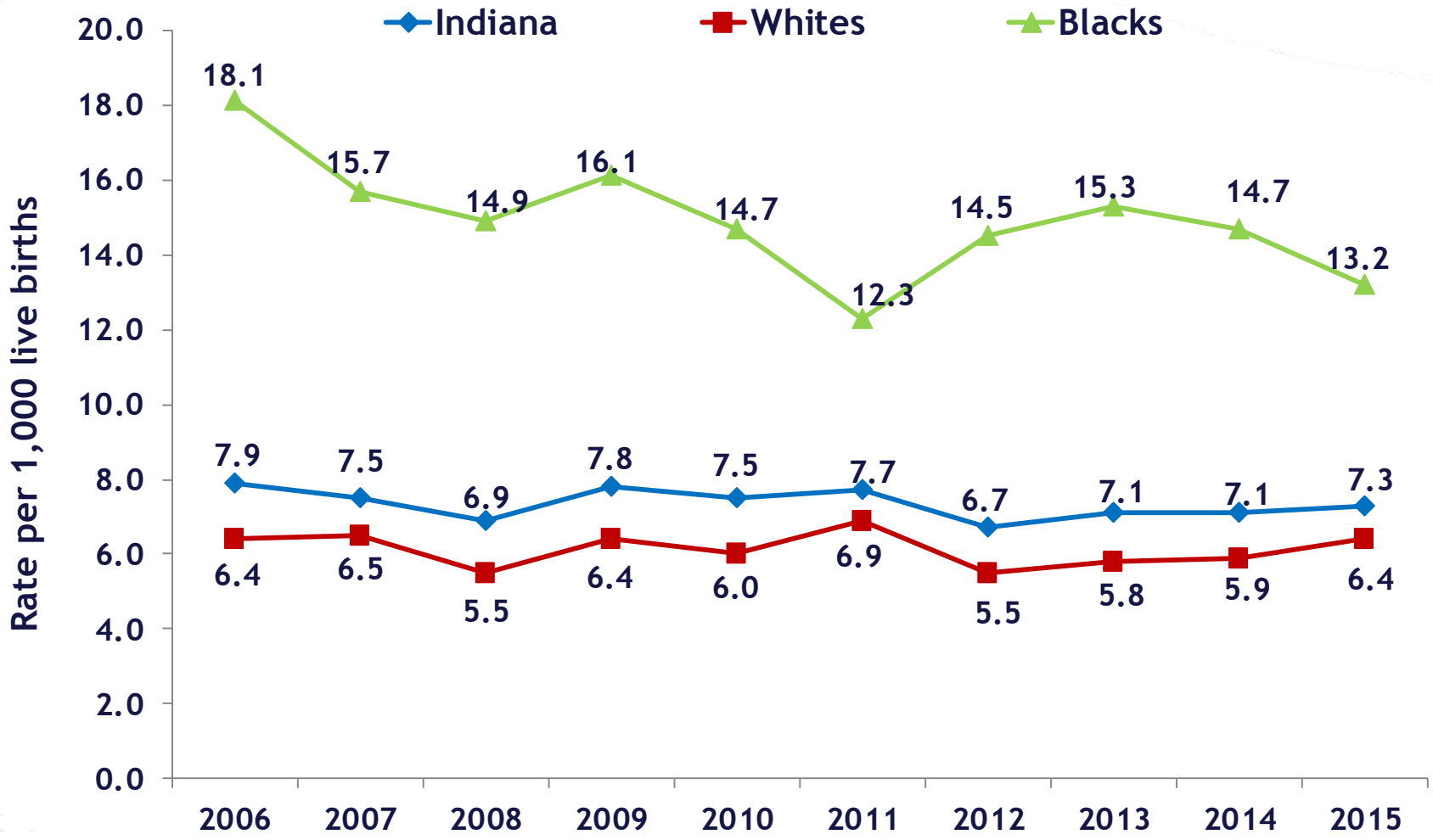
Infant Mortality Rates
Indiana, U.S. and Healthy People 2020 Goal
2007 - 2015



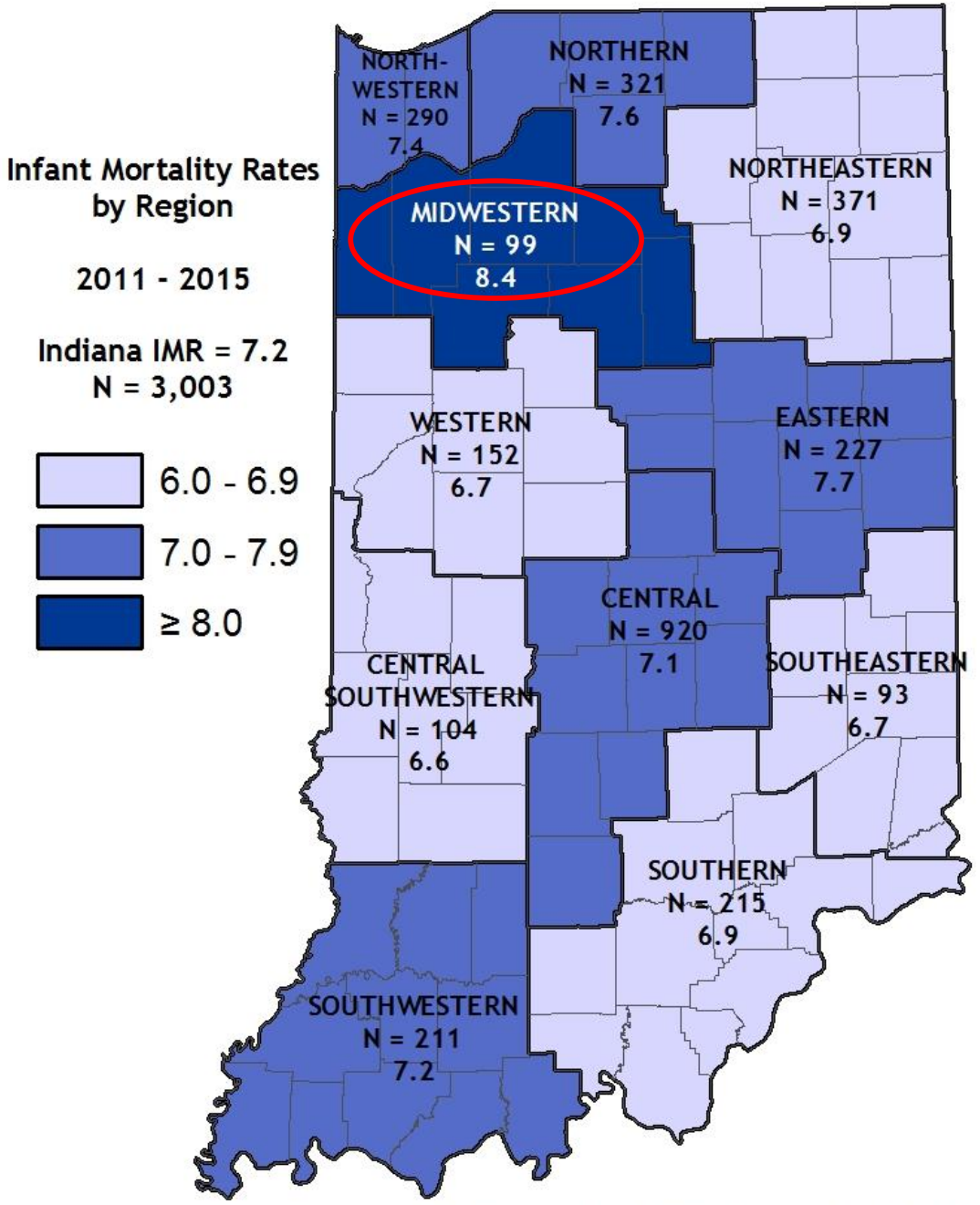
	2007	2008	2009	2010	2011	2012	2013	2014	2015
Indiana	7.5	6.9	7.8	7.5	7.7	6.7	7.1	7.1	7.3
U.S.	6.8	6.6	6.4	6.1	6.1	6.0	6.0	5.8	5.9
HP 2020 Goal	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0

Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
United States Original: Centers for Disease Control and Prevention National Center for Health Statistics
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

Infant Mortality Rates by Race
Indiana
2006 - 2015



Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team



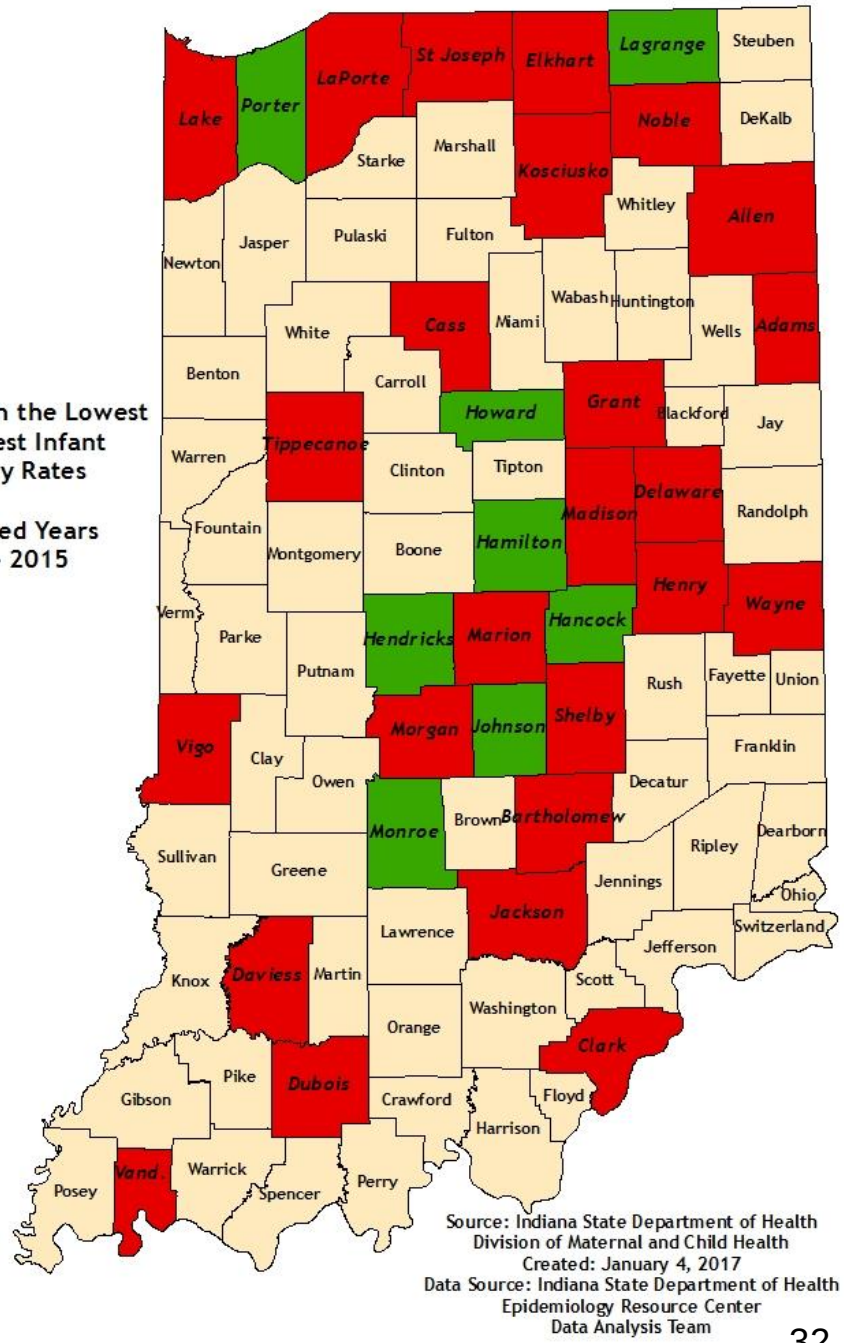
Source: Indiana State Department of Health, Division of Maternal and Child Health
Created: January 4, 2017
Data Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

Indiana State Department of Health

Infant Mortality Rates County Level, All Races 2011 - 2015

HIGHEST Infant Mortality Rates in Indiana

- Bartholomew, 10.7
- Grant, 9.5
- Wayne, 9.0
- Daviess, 8.6
- Marion, 8.6
- LaPorte, 8.5
- Cass, 8.4
- Delaware, 8.4
- Henry, 8.4
- Lake, 8.3
- Shelby, 8.3
- Kosciusko, 8.1



2011 - 2015
Infant Mortality Rates by Zip Code

Zip Code	County	Births	Deaths	Infant Mortality Rate (IMR)	White IMR	Black IMR
46312	Lake	2,479	41	16.5	12.8*	**25.2**
46953	Grant	1,392	20	14.4	14.9*	**
46806	Allen	2,372	34	14.3	9.0*	**21.9**
46324	Lake	1,478	21	14.2	17.0*	16.5*
46226	Marion	3,488	49	14.1	7.0*	**16.9**

*Numerator less than 20, the rate is unstable.
**Rate has been suppressed due to five or fewer outcomes.
^ = Zip code did not have an IMR above 10.0 for the combined years 2010 - 2014

Zip Code	County	Births	Deaths	Infant Mortality Rate (IMR)	White IMR	Black IMR
47909	Tippecanoe	3,279	27	8.2	7.6	18.9*
47905	Tippecanoe	3,216	25	7.8	6.6*	14.1*
47906	Tippecanoe	3,046	20	6.6	6.4*	38.0*

*Numerator less than 20, the rate is unstable.
**Rate has been suppressed due to five or fewer outcomes.

Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

Demographics of Mothers in Indiana

- Average age = 27.5 years (Range: 11 - 51)
- Education
  - 43.7% of mothers have a high school diploma or less
  - 20.9% of mothers have some college education, but no degree
  - 35.3% of mothers have a college degree (Associate's, Bachelor's, Master's, Ph.D.)
- Income = 43% of births were to women with Medicaid
- Marital status
  - 56% of mothers were married
- Average month prenatal care began = 3 (range: no care – 9th month)
- Average number of prenatal visits = 12 (range: 0 - 49)
- 37.6% of all births were to first-time mothers
- 10% of all births were to foreign-born mothers
  - As high as nearly 25%

Indiana State Department of Health

Source: Indiana State Department of Health, Division of Maternal & Child Health [January 24, 2017] Indiana
Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

Factors Contributing to Indiana's Infant Mortality

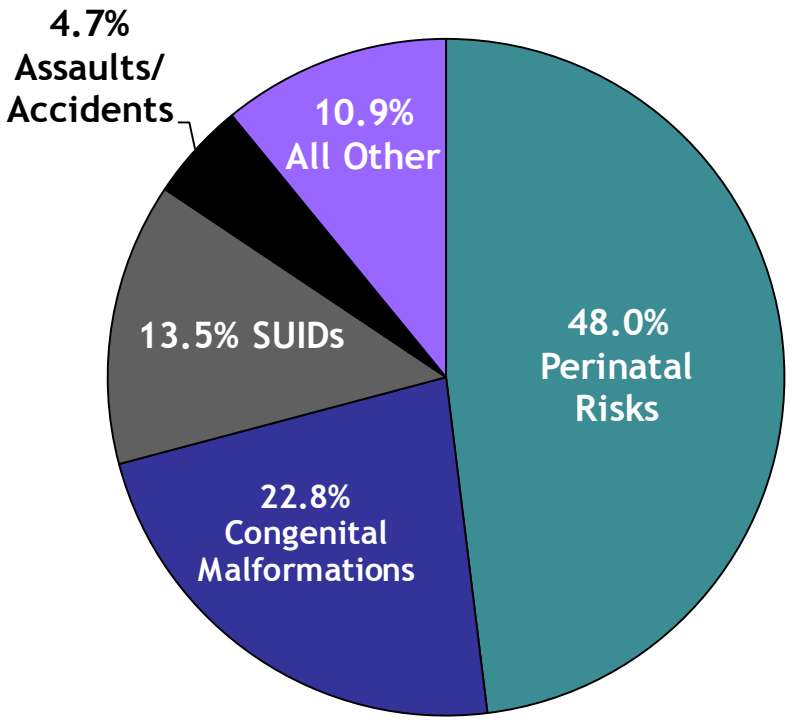
- **Obesity**
  - If woman is obese = 25% chance of delivering premature infant
  - If woman is morbidly obese = 33% chance of delivering premature infant
  - Indiana is 15th most obese state in U.S.
- **Smoking**
  - 14.3% of mothers smoke during pregnancy (TWICE the U.S. average)
  - 24.7% of mothers on Medicaid smoke
- **Limited Prenatal Care**
  - Only 69.3% of mothers receive prenatal care during the 1st trimester
- **Unsafe Sleep Practices**
  - 13.5% of infant deaths in 2015 can be attributed to SUIDs

Indiana State Department of Health

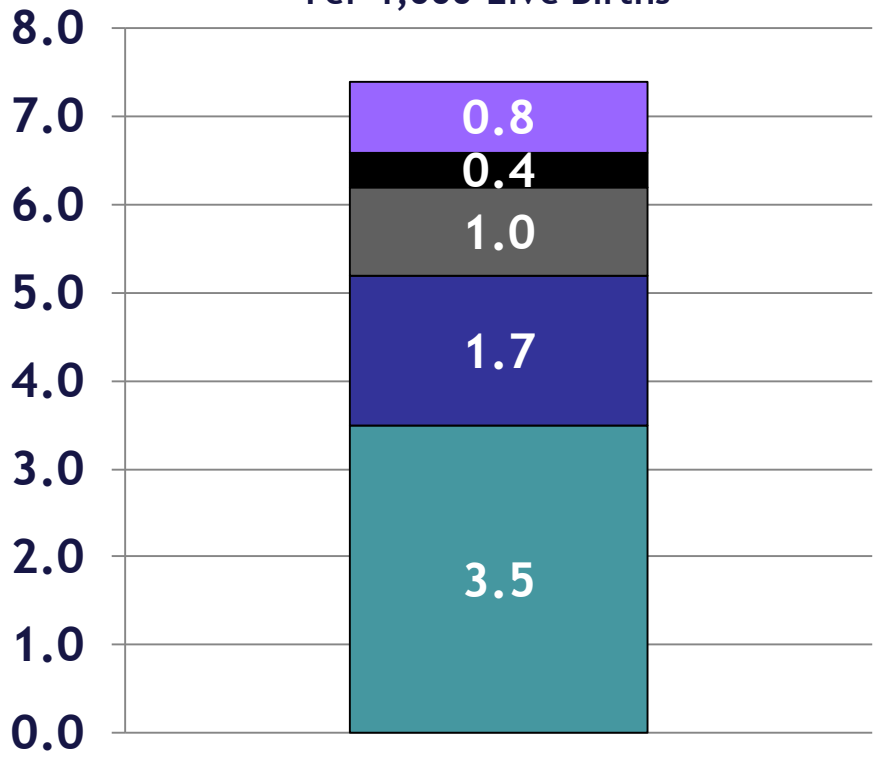
Source: Indiana State Department of Health, Maternal & Child Health Epidemiology Division [January 24, 2017]

Infant Mortality Distribution by Cause
Indiana
2015

% Distribution of Infant Deaths
N = 613

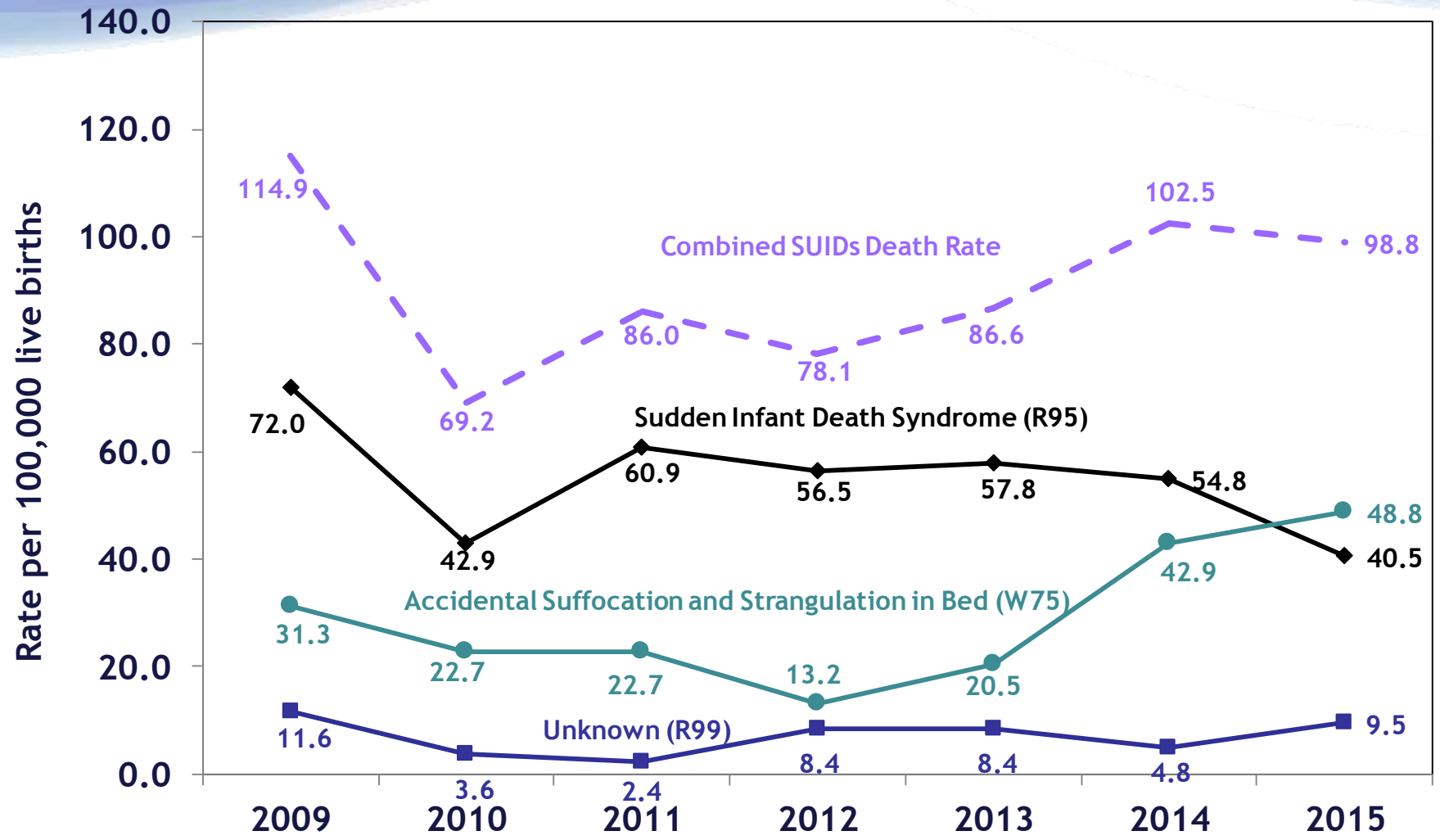


Cause Specific Mortality Rates*
Per 1,000 Live Births



*Note: Cause specific mortality rates may not exactly equal the overall infant mortality rate due to rounding.
Source: Indiana State Department of Health, Division of Maternal & Child Health [January 24, 2017] Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

SUIDs Rates by Cause
Indiana, 2009-2015

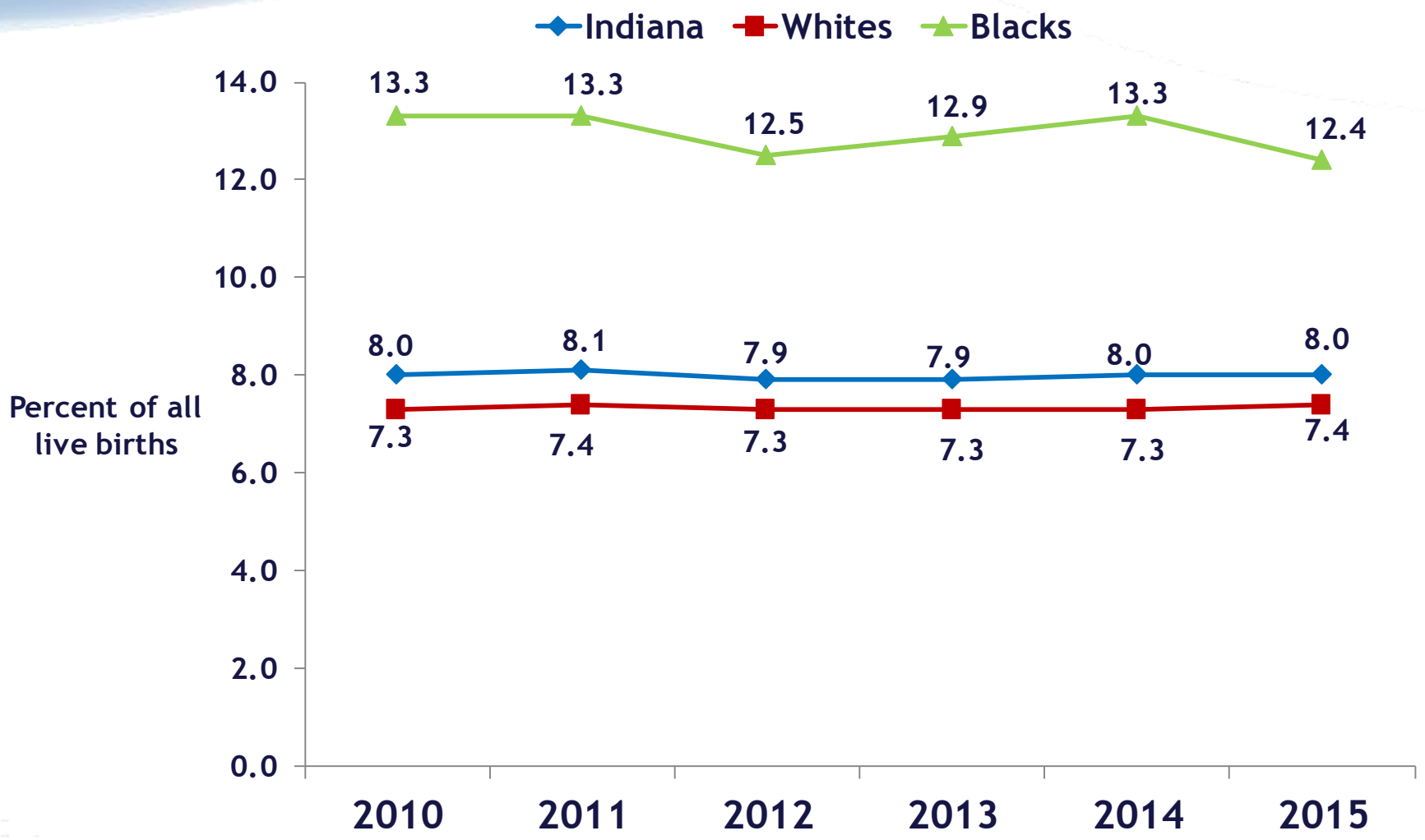


SUIDS = W75, R95, R99

Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]

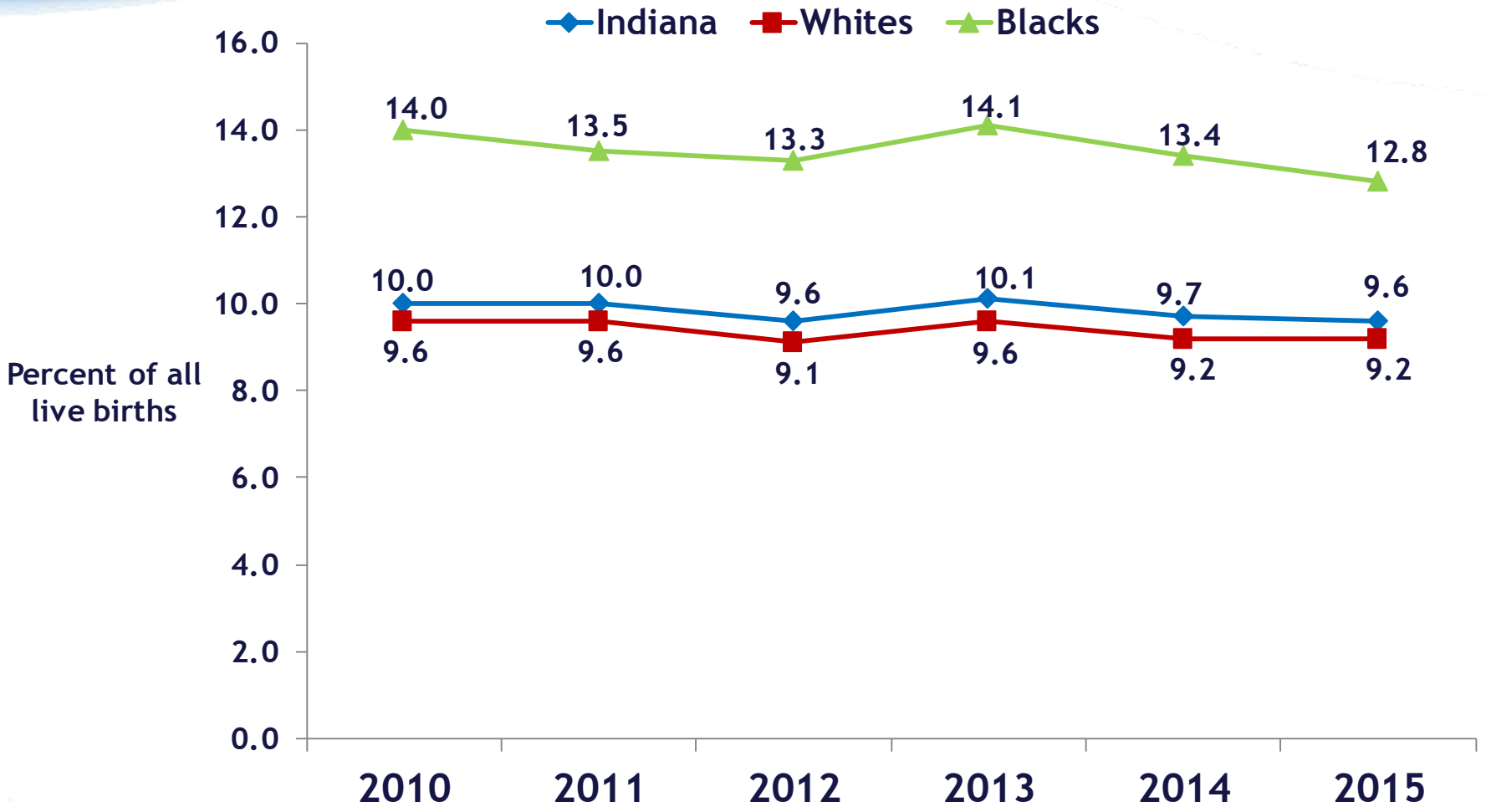
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

% Low Birthweight Births (<2,500 grams) Indiana, by Race 2010 - 2015



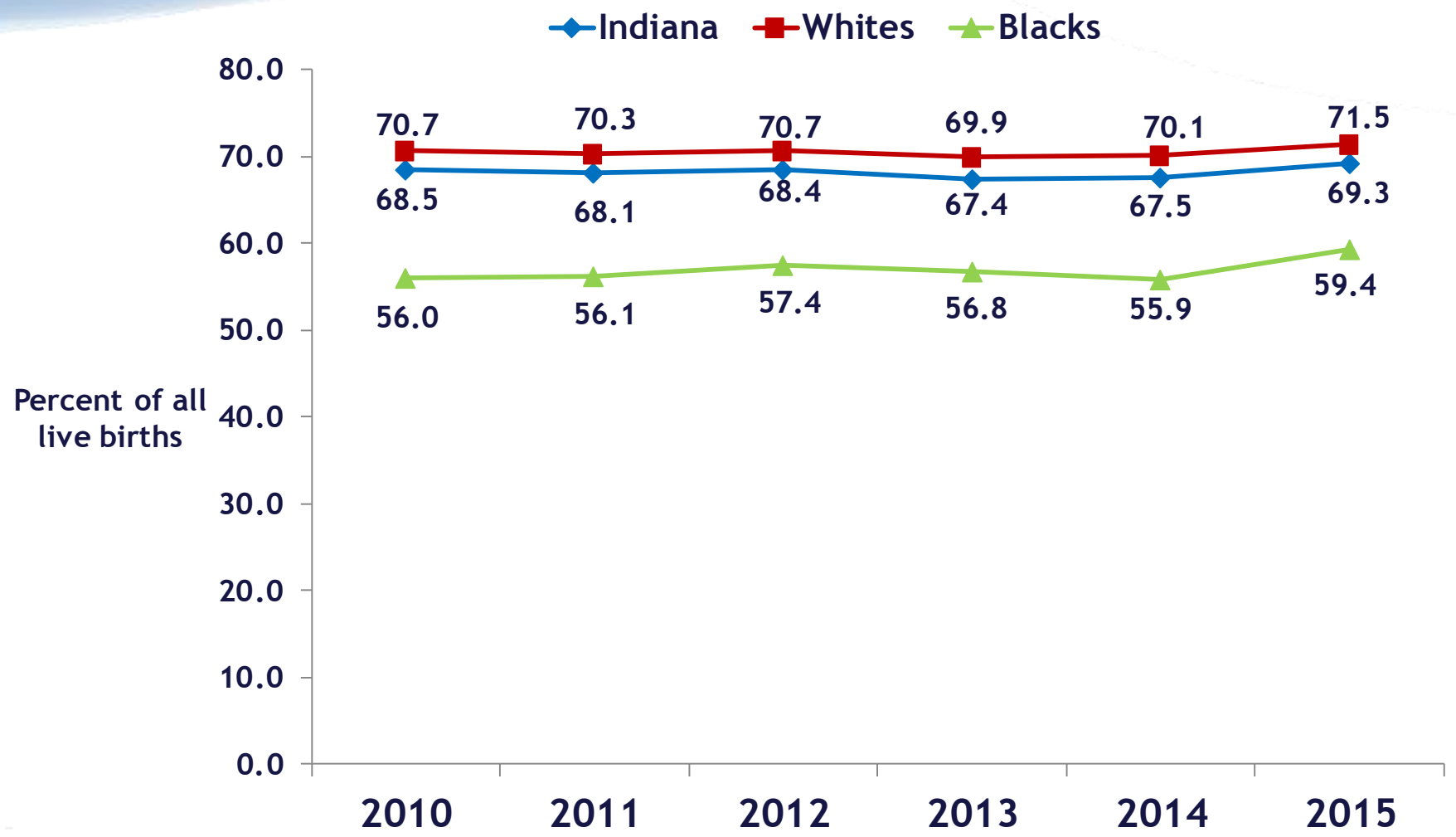
Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

% Preterm Births- Obstetric Estimate (< 37 weeks gestation) Indiana, by Race 2010 - 2015



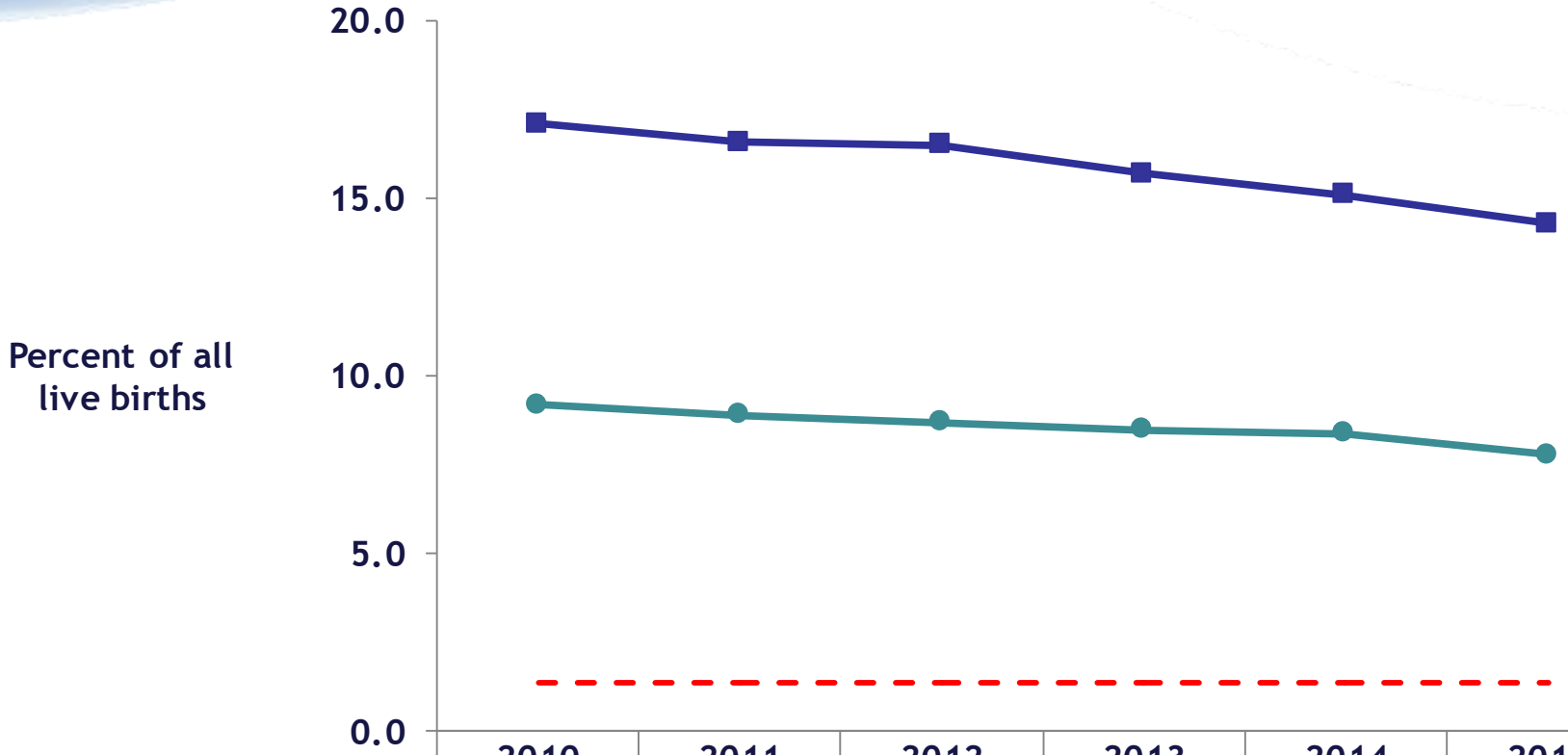
Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

% Women Receiving Prenatal Care 1st Trimester Indiana, by Race 2010 - 2015



Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

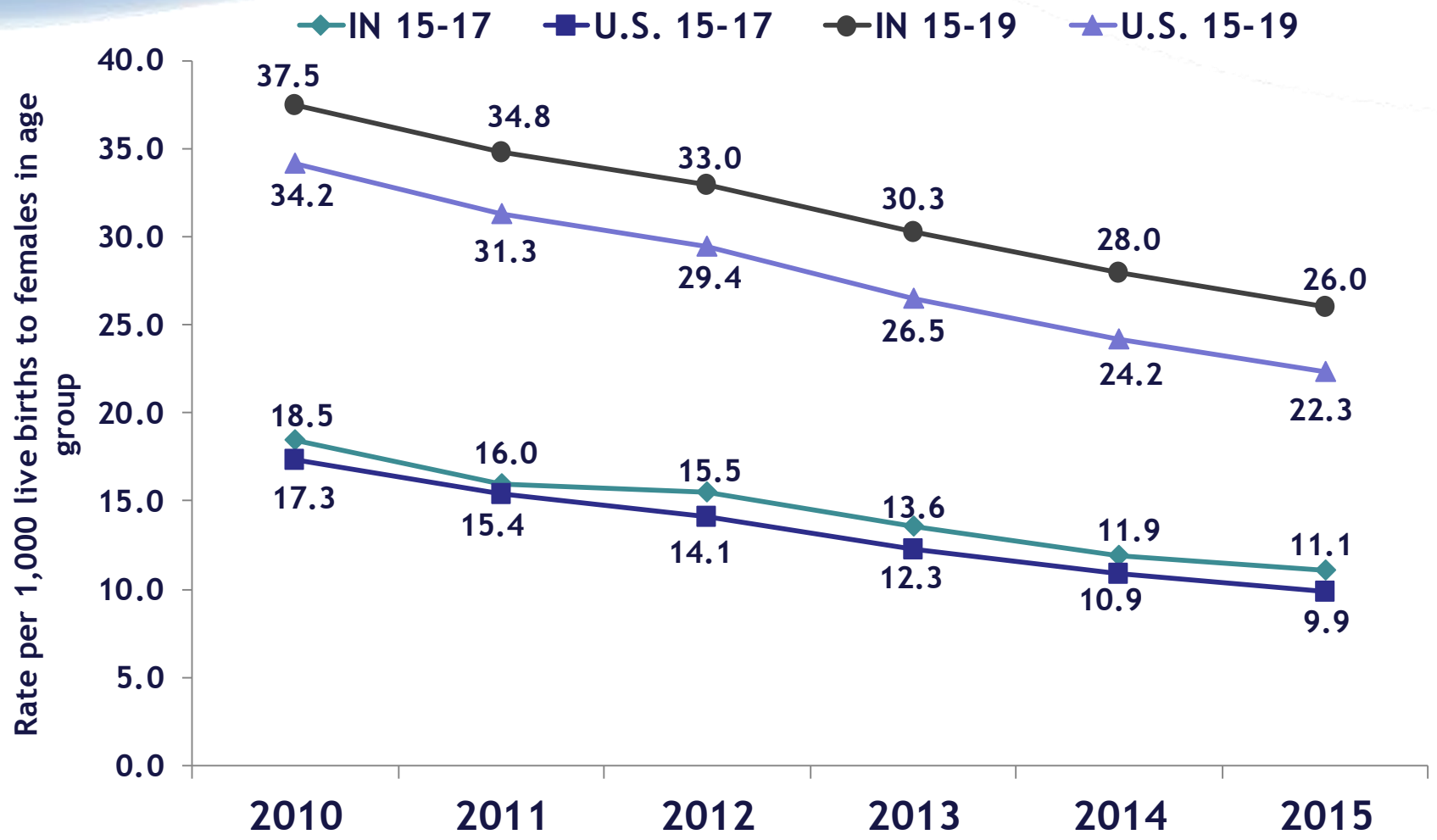
% Women Smoking During Pregnancy
Indiana, U.S. and Healthy People 2020 Goal
2010 - 2015



	2010	2011	2012	2013	2014	2015
United States	9.2	8.9	8.7	8.5	8.4	7.8
Indiana	17.1	16.6	16.5	15.7	15.1	14.3
Healthy People 2020 Goal	1.4	1.4	1.4	1.4	1.4	1.4

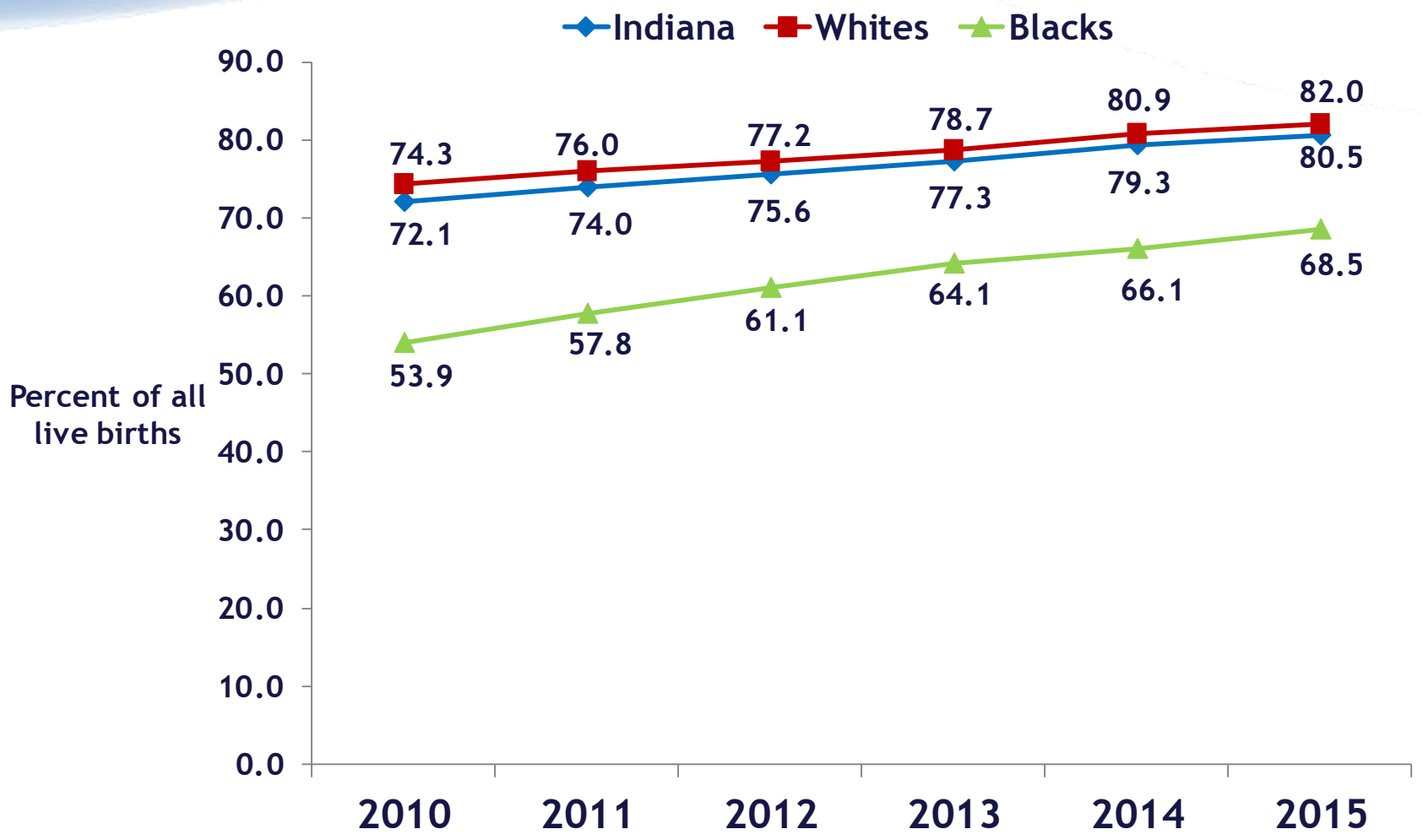
Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
United States Original: Centers for Disease Control and Prevention National Center for Health Statistics
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

Age-Specific Birth Rates for Teen Mothers Indiana and U.S. 2010 - 2015



Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

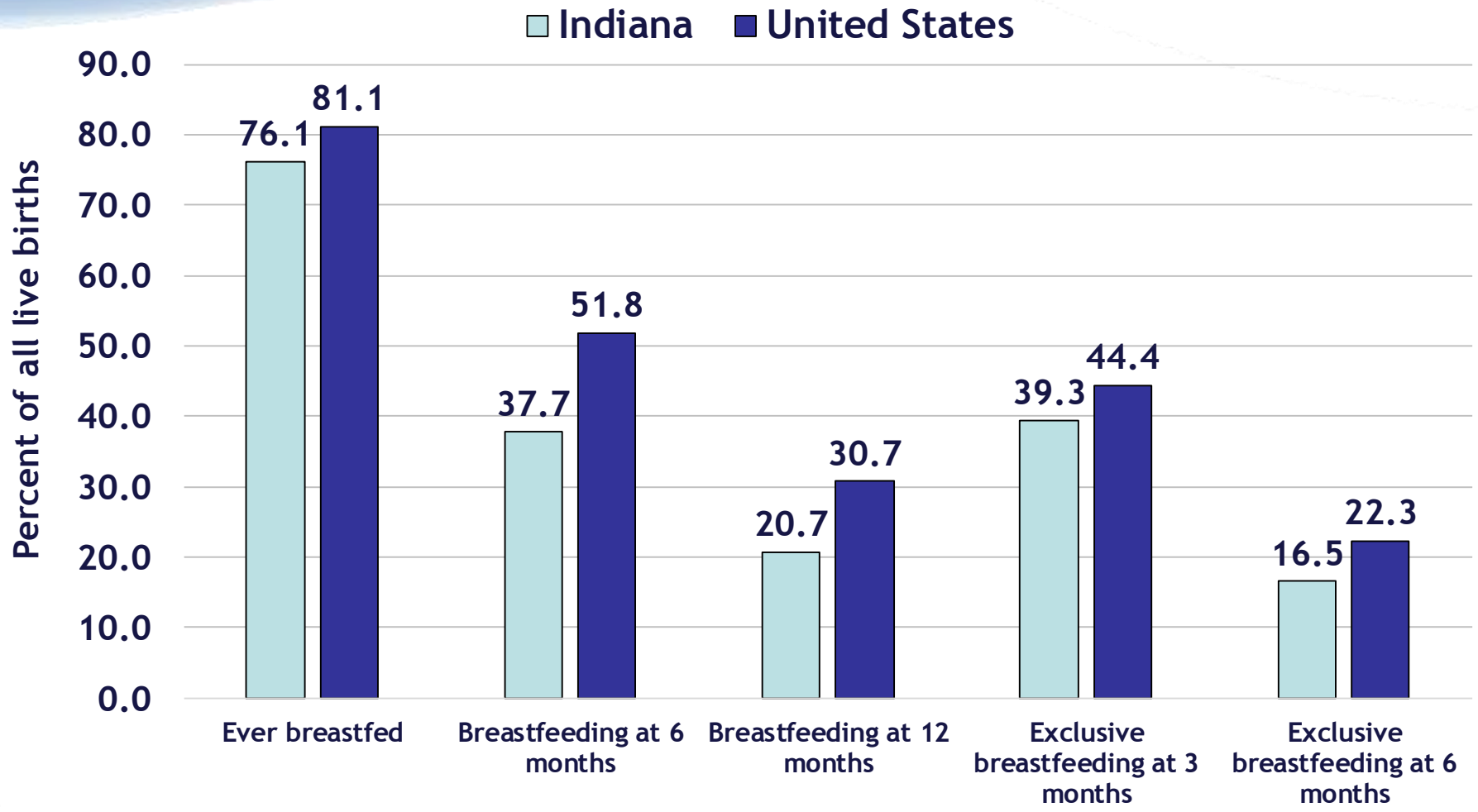
% Women Breastfeeding at Hospital Discharge Indiana, by Race 2010 - 2015



Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

Breastfeeding Exclusivity and Duration Indiana and United States

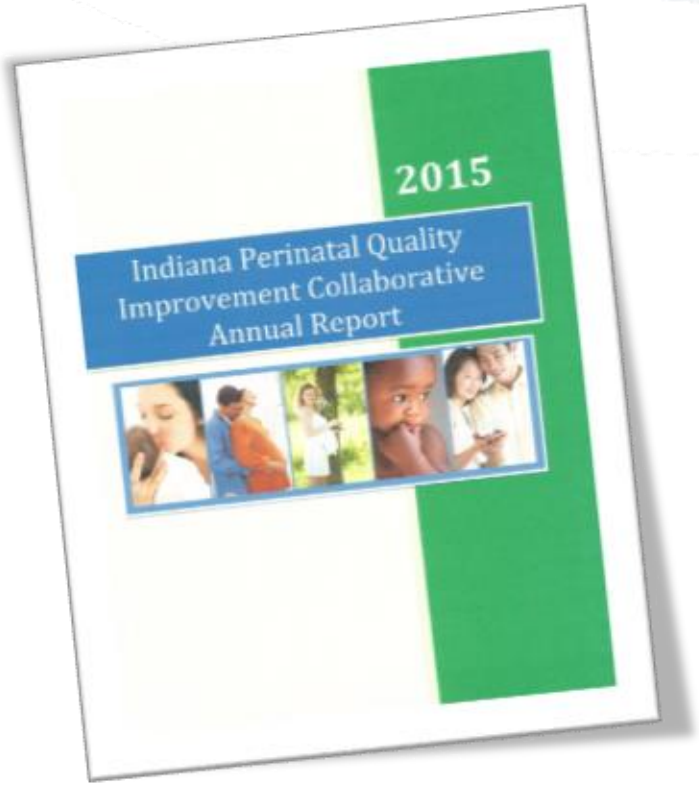
*based on 2013 births



Source: Indiana State Department of Health, Division of Maternal and Child Health [April 28, 2017]
United States Original: Breastfeeding Report Card 2016, National Center for Chronic Disease Prevention and Health Promotion
Indiana Original Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

ISDH Initiatives Recommended by IPQIC

- Early Elective Deliveries: July 2014, Medicaid stops paying for non-medically indicated inductions before 39 weeks
- 17P: June 2015, development of recommendations for utilization of progesterone therapies to prevent prematurity
- Neonatal Abstinence Syndrome (NAS): 26 Indiana hospitals are participating in a substance use prevalence study
- Breastfeeding and Safe Sleep guidelines
- Long Acting Reversible Contraceptives (LARC) toolkit



Source: http://www.in.gov/laboroflove/664.htm

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Pregnancy Mobile Application

- As part of the statewide efforts to reduce Indiana infant mortality rates, ISDH has contracted with Indianapolis-based technology solutions company eimagine to create and implement a pregnancy mobile application.
- The application will provide valuable health resources to parents, caregivers and to women of child bearing age who are pregnant or planning to be pregnant.
- The main goal is to improve the health of mothers and their children.
- Launch at the Labor of Love Summit on November 15.

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Perinatal Substance Use Study

Permissive language in the legislation to develop a pilot process for appropriate and effective models for identification, data collection and reporting related to NAS

2016: 4 Indiana hospitals volunteered to test the pilot process

2017: 26 Indiana hospitals are working on drug screening

2018: Plan to spread the established practice statewide

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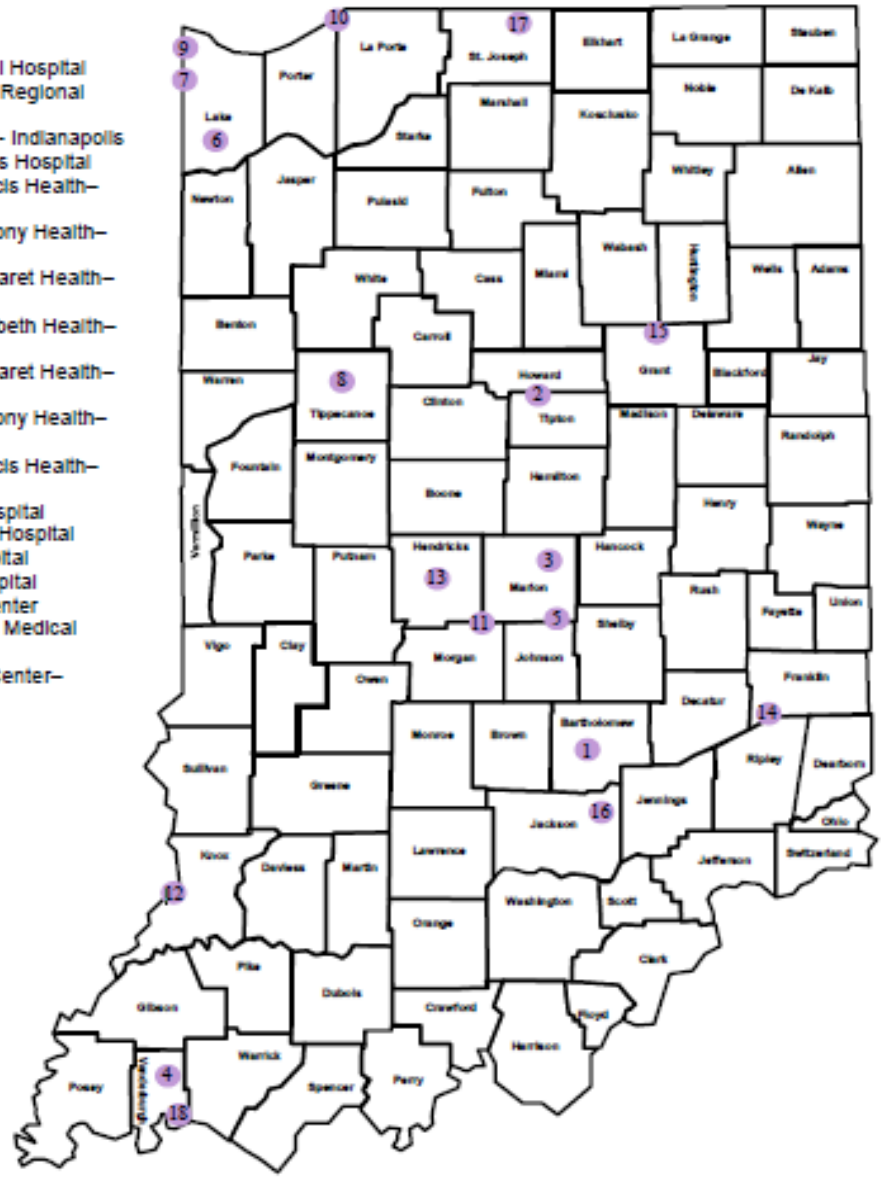
Perinatal Substance Use Pilot Hospitals

1. *Columbus Regional Hospital
2. Community Howard Regional Health
3. Community Hospital- Indianapolis
4. Deaconess Women's Hospital
5. Franciscan St. Francis Health– Indianapolis
6. Franciscan St. Anthony Health– Crown Point
7. Franciscan St. Margaret Health– Dyer
8. Franciscan St. Elizabeth Health– Lafayette East
9. Franciscan St. Margaret Health– Hammond
10. Franciscan St. Anthony Health– Michigan City
11. Franciscan St. Francis Health– Mooresville
12. Good Samaritan Hospital
13. Hendricks Regional Hospital
14. Margaret Mary Hospital
15. Marion General Hospital
16. Schneck Medical Center
17. St. Joseph Regional Medical Center– Mishawaka
18. St. Mary's Medical Center– Evansville



*Data not included in testing results.

Source: Indiana State Department of Health, Division of Maternal and Child Health
[Updated November, 2017]

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Neonatal Abstinence Syndrome Definition

A drug withdrawal syndrome that presents in newborns after birth when the transfer of harmful substances from the mother to the fetus abruptly stops at the time of delivery.

NAS most frequently is a result of opioid use in the mother but may also occur as a result of exposure to benzodiazepines and alcohol.

Prevalence of NAS in the United States

The incidence of NAS has increased significantly:

- 2000 rate per 1,000 births = 1.2
- 2009 rate per 1,000 births = 3.4

Maternal opiate use has increased even more dramatically:

- 2000 rate per 1,000 births = 1.19
- 2009 rate per 1,000 births = 5.63

The cost to care for infants diagnosed with NAS:

- 2000 = $190 million
- 2009 = $720 million

Indiana State Department of Health

Patrick S, Schumacher R, Benneyworth B, *et al*. "Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009." *JAMA*. 2012. 307(18):1934-40.

Perinatal Substance Use Data Collection

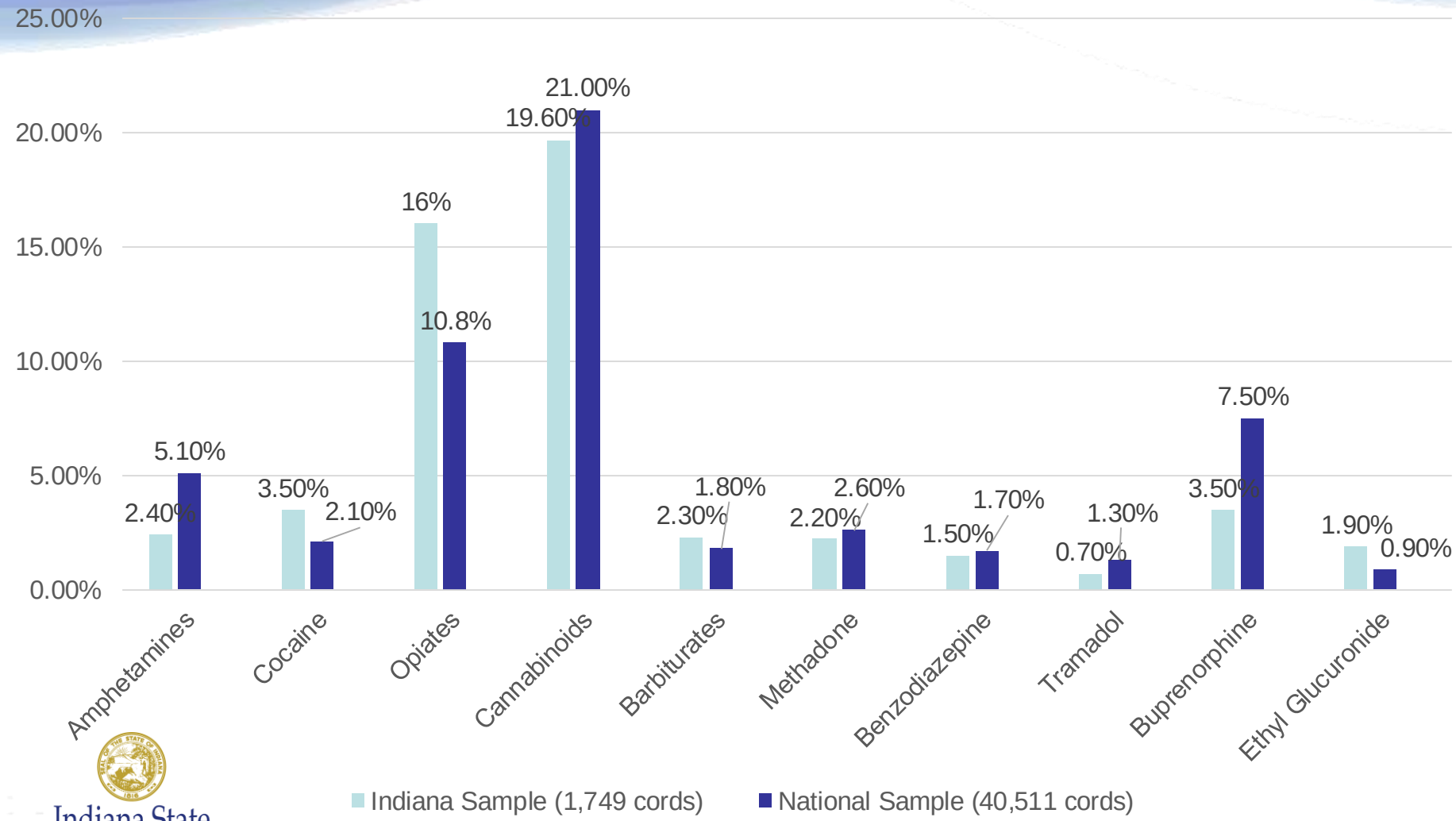
- Number of cord samples sent for prenatal positive screens
- Number of cord samples positive for drug exposure
- Substances identified and reported as state rates
- Data collection conducted to determine state prevalence rates

Indiana State Department of Health

Perinatal Substance Use Study Findings

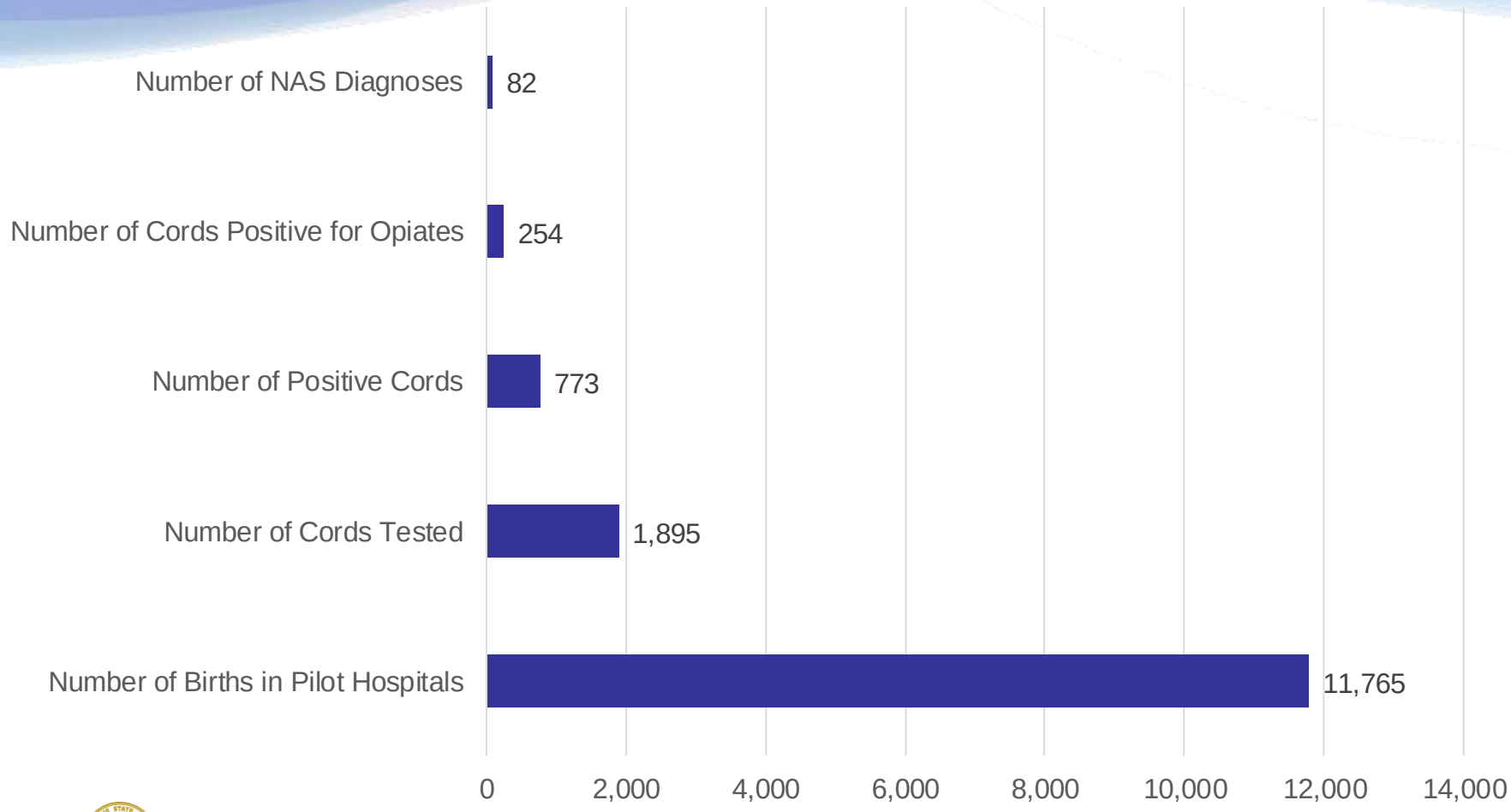
- Drug of choice varies depending on location
- Comorbidities can affect the outcomes
- Lack of treatment programs for mothers
- Interruption in care when a referral is made
- Support services are needed during and after pregnancy
- Need to change the culture of providers and pregnant women

Perinatal Substance Use Positivity Report
January 1 – September 30, 2017



Indiana State Department of Health

Screening Data
January - September 2017



Indiana State Department of Health


Each pair of baby booties represents an Indiana child who died before reaching age one.
Labor of Love
Helping Indiana Reduce Infant Death
Labor of Love
Labor of Love

Agenda

- Strategic Priority: Educational Outcomes
  - Patrick McAlister, Report from IDOE on ESSA plan and how it supports the Commission's objectives

Working **Together** for Student Success

Indiana DEPARTMENT OF EDUCATION

Overview of the Every Student Succeeds Act (ESSA)

-Bipartisan law passed by Congress and signed into law in 2015

-Replaced No Child Left Behind (NCLB)

-Indiana submitted its ESSA Plan to the U.S. Department of Education on September 18, 2017

Source: ObamaWhiteHouse.Archives.gov

ESSA and the work of the Commission

- Long-Term Goals
- Accountability & School Improvement
- Supporting All Students

ESSA Long-Term State Goals

- Goal Areas
  - ❖ Academic Achievement (Proficiency)
    - ➢ E/LA and Math
  - ❖ English Language Growth to Proficiency
    - ➢ E/LA and Math
  - ❖ Graduation Rate

ESSA Long-Term State Goals

- Cut the Proficiency Gap in Half by 2023 (By Subgroup)
  - Subgroups Defined
    - All Students
    - American Indian
    - Asian
    - Black
    - Hispanic
    - Multiracial
    - Native Hawaiian/Pacific Islander
    - White
    - Special Education
    - English Learners
    - F/R Price Meal

ESSA Accountability

- Implementation: 2017-2018
- Summative Letter Grade
- New Weights for the Accountability System (Under SBOE Rulemaking)

Weighting for Students K-8	
Indicator	**Weight**
Proficiency on the State Assessment	42.5 %
Growth on the State Assessment	42.5 %
English Language Growth to Proficiency	10 %
Chronic Absenteeism	5 %

Weighting for Students 9-12	
Indicator	**Weight**
Graduation Rate	30 %
College and Career Ready Rate	30 %
Proficiency on the State Assessment	15 %
Growth on the State Assessment	15 %
English Language Growth to Proficiency	10 %

ESSA Accountability

Chronic Absenteeism:

- Non-Academic Indicator (Applies to Grades K-8)
- Two Levels
  - Persistent Attendees- 96% Attendance
  - Improving Attendee- Increase Attendance by 3% (From Previous Year)
- Goal: 80% of Students Attain One of the Two Attendee Threshold
  - Students Included: 90% of the School Year

Weighting for Students K-8	
Indicator	**Weight**
Proficiency on the State Assessment	42.5 %
Growth on the State Assessment	42.5 %
English Language Growth to Proficiency	10 %
Chronic Absenteeism	5 %

ESSA Accountability

Climate and Culture Survey

- Pilot in 2018-2019 school year
- Survey students, parents and teachers
- Possibility of adding to accountability system, but serious questions remain

ESSA School Improvement

- Two Areas
  - Comprehensive Support
    - Lowest 5% of Title I
    - Title I “F” Schools
    - High Schools-Federal Grad Rate of 67% or Below
    - Title I Chronically Low Performing Subgroups
  - Targeted Support
    - 1+ Underperforming Subgroups
    - After 5 Years: Moved to Comprehensive

ESSA Supporting Students

- New Funding Opportunity: Title IV
  - Fund Innovative Approaches to Support the Whole Child
  - Focused IDOE Academic Objectives
    - STEM
    - CTE
    - Reading
    - DC/IB/AP (College Credit Bearing Courses)

Patrick McAlister
pmcalister@doe.in.gov

Stay Connected with the Department Through
Dr. McCormick's Weekly Update
doe.in.gov

Agenda

- CISC Operational Plan Updates
  - Julie Whitman, CISC Executive Director

Agenda

- Legislative Updates
  - Jennifer McCormick, Indiana Department of Education

Agenda

- Communication Updates
  - Kathryn Dolan, Indiana Supreme Court, and Julie Whitman, CISC Executive Director: Communications Plan presented for approval

Commission on Improving the Status of Children in Indiana

Communication Plan

Purpose of Communication Plan

- Support CISC in achieving its goals
- Promote alignment of CISC stakeholders
- Prioritize communication to support CISC and its strategic plan
- Ensure resources for communication are utilized effectively

Plan Goals

- **Goal A (INTERNAL): strengthen communication among the Commission, Task Forces, Standing Committees, and Partners**

- **Goal B (EXTERNAL): Advance the work of the Commission through strong communication with external audiences**

Key Audiences: External & Internal

Internal Audiences

- CISC members and Executive Committee
- Task Forces & Standing Committees
- Indiana Government

External Audiences

- Media
- General public
- Non-governmental youth workers

Key Messages

- Mission and Vision
  - Every child in Indiana will have a safe and nurturing environment
  - We have leadership committed to our mission
- Goals and Strategic Plan
  - Adopted strategic plan in 2016
  - Four key goals over the next four years
- Collaboration
  - Across branches and regions over shared priorities
- Impact
  - CISC is making a positive difference in the lives of children in Indiana

Goal A:
Strengthen communication among Commission

Objective A1: facilitating communication

- Establish vehicles for updates between the Executive Director, Executive Committee, Commission, Task Forces, and Committees
- Establish specific vehicles for Task Forces to regularly update the Executive Director on outcomes, communication requests or other items as needed
- Establish communication as a standing item on Task Force, Subcommittee and Standing Committee agendas to capture items they would like would like communicated

Goal A:
Strengthen communication among Commission

Objective A2: leverage stakeholder networks

- Identify commission stakeholder networks
- Develop a process and criteria for determining which messages and outcomes need to be communicated through the stakeholder networks,
- Develop process to determine whether messages should come from the CISC Executive Director or the CISC members
- Develop a process for how information will be shared throughout partner agencies

Goal B:
Strengthen communication with external audiences

Objective B1:

- Develop vehicles to effectively communicate with the work of the commission

Agenda

- Discussion: Future Meeting Topics or other Items from Commission Members
- Next Meeting: February 14, 2018, Indiana State Library

2018 Meeting Dates-Indiana Government Center South

February 14 (Indiana State Library)
May 16
August 15
November 7