My Healthy Baby

Connecting Indiana Families to Pregnancy & Infant Support

2020 Annual Report

Indiana Department of Health

Indiana Family & Social Services Administration

Indiana Department of Child Services

Background and Statistics

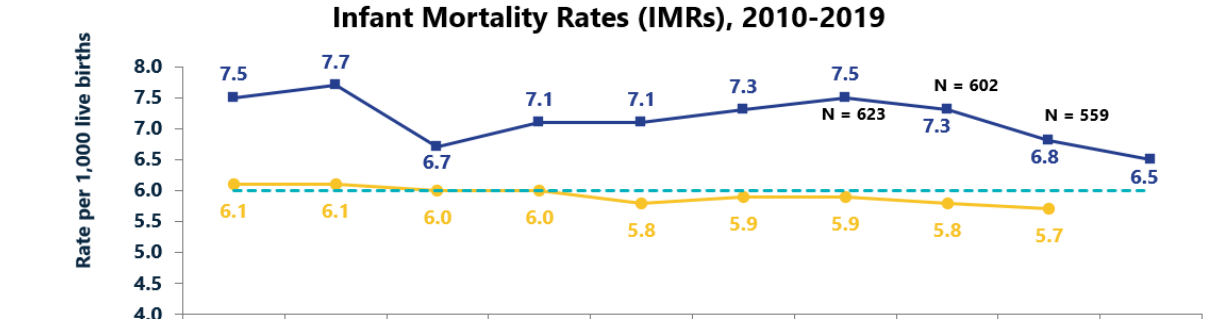
In 2019, Governor Holcomb issued a challenge to Indiana to be the Best in the Midwest for infant mortality by 2024. This challenge emerged from a review of data showing that over the past several years, Indiana's infant mortality rate had typically been higher than the national rate and the rate of its Midwest neighbors.

For the past 20 years, more than 550 Hoosier infants have died each year. Infant mortality, defined as the death of a baby before his or her first birthday, is the number one indicator of health status of a population in the world. Infant mortality rate (IMR) refers to the number of infant deaths for every 1,000 live births.

In 2018, the United States had an infant mortality rate of 5.7 per 1,000 live births, while Indiana had an IMR of 6.8. This ranked Indiana as the 11th highest overall IMR in the U.S. and 13th in number of infant deaths (CDC, 2020). In 2018, 559 Hoosier babies died before their first birthday. This is more than 46 babies every month and nearly 11 babies every week. In the last five years, almost 3,000 infant lives were lost. If those babies had lived, they would have filled nearly 42 school buses at maximum capacity.

Based on the 2017 data available when Governor Holcomb issued his challenge, Indiana would need to prevent 200 infant deaths per year by 2024 to meet the challenge and be the best in the Midwest. Figure 1 below shows Indiana's infant mortality rate from 2010 to 2019 in comparison to the U.S. rate and the Healthy People 2020 goal.

Figure 1: Infant Mortality Rates (2010 – 2019)



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Indiana	7.5	7.7	6.7	7.1	7.1	7.3	7.5	7.3	6.8	6.5
U.S.	6.1	6.1	6.0	6.0	5.8	5.9	5.9	5.8	5.7	*
HP 2020 Goal	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0

***National data not yet available.**

Source: Indiana State Department of Health, Maternal & Child Health Epidemiology Division [October 20, 2020]
United States Original Source: Centers for Disease Control and Prevention National Center for Health Statistics
Indiana Original Source: Indiana State Department of Health, Vital Records, ERC, DAT

Birth outcomes, including infant death, are influenced by many factors, including biological, social, environmental, and physical. As a result, the IMR differs among races and ethnicities, regions, counties, ZIP codes, maternal age, levels of income, and more. The confounding factors that influence the health of infants and mothers highlight the complexity and long-term nature inherent in the goal of reducing infant mortality and promoting healthier families.

Further analysis by race and ethnicity, cause of infant death, prenatal care access by insurance type and race and ethnicity, and smoking during pregnancy provides insight into disparities and the need to address the contributing factors. Figures 2-6 provided below show some of these disparities and the need for an intervention in Indiana.

Figure 2: Indiana Infant Mortality Rate by Race and Ethnicity (2010-2019)

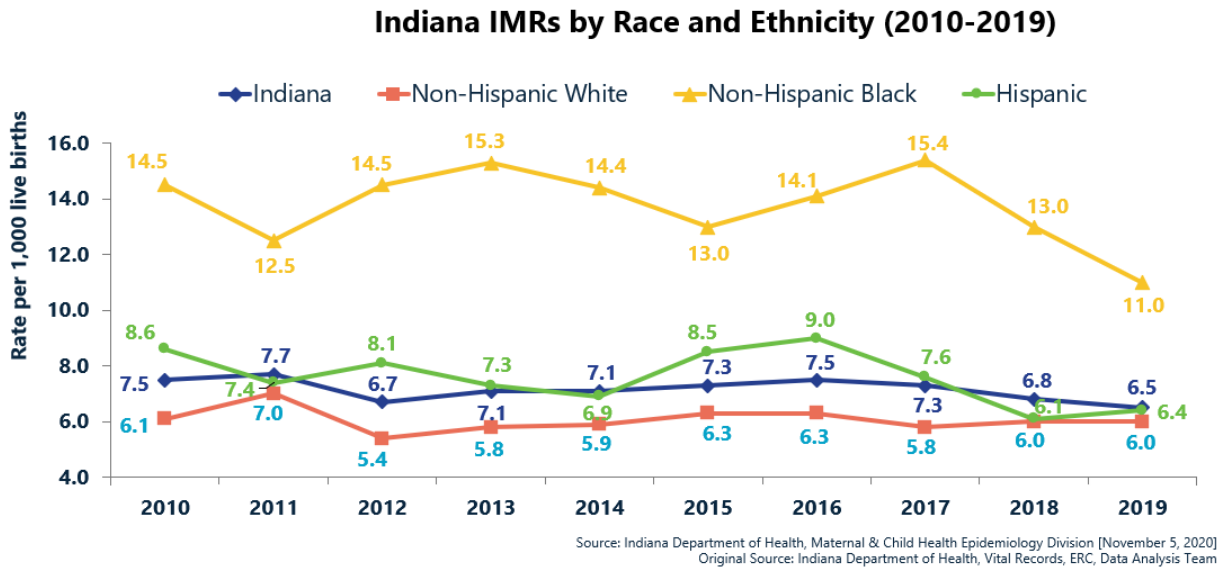


Figure 3: Infant Mortality Rate by Race & Ethnicity and Cause of Death (2019)

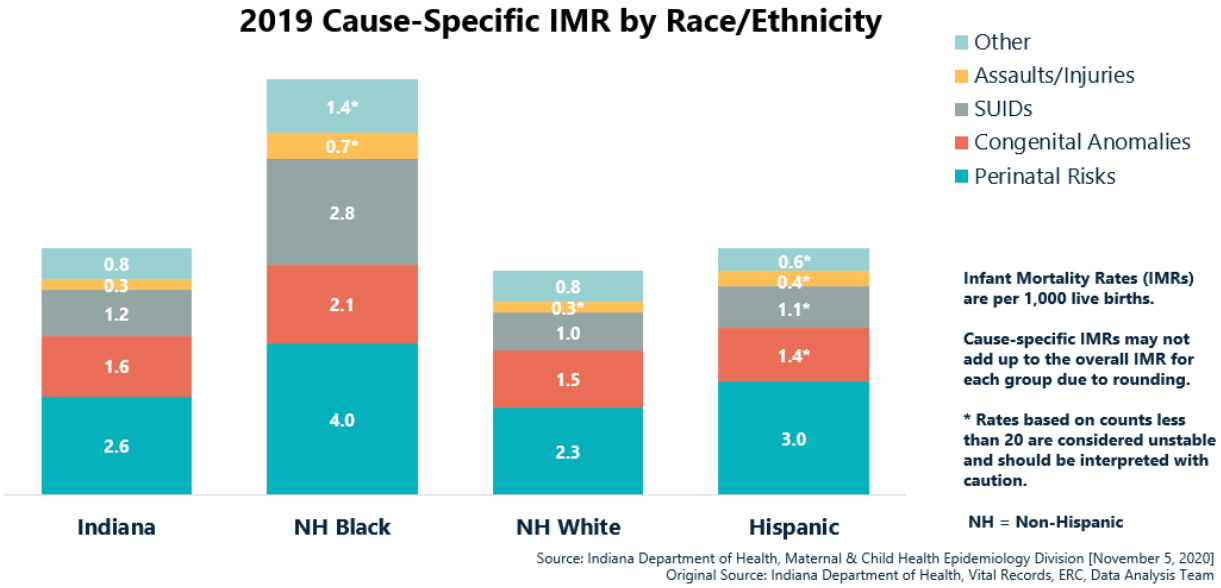
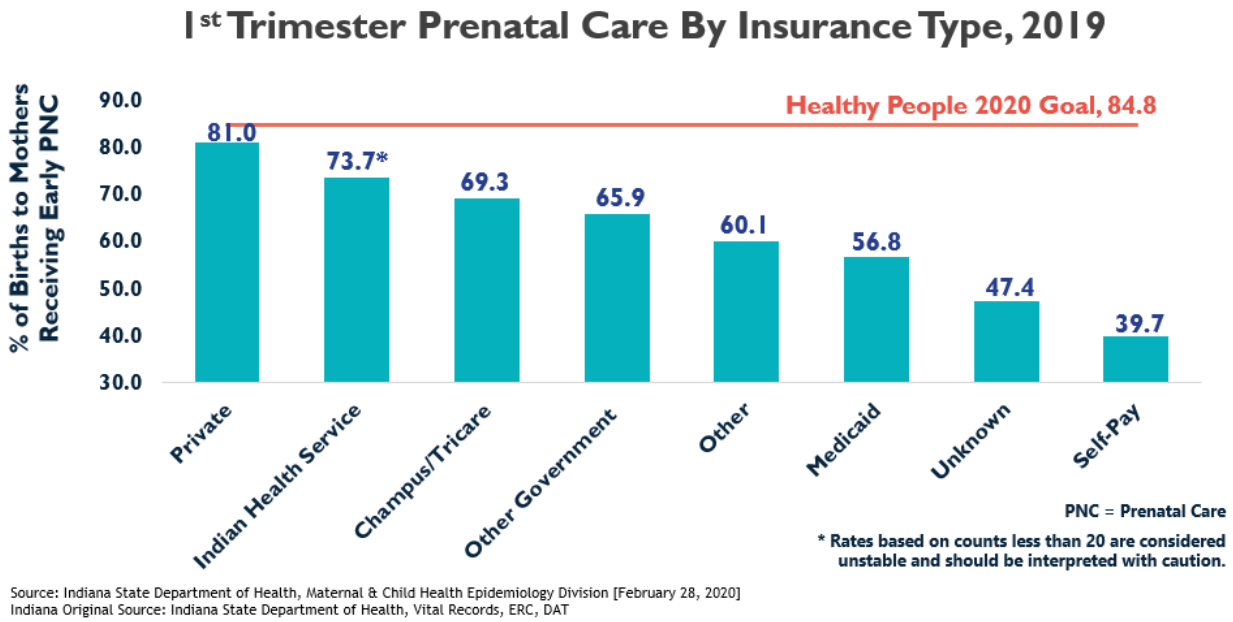
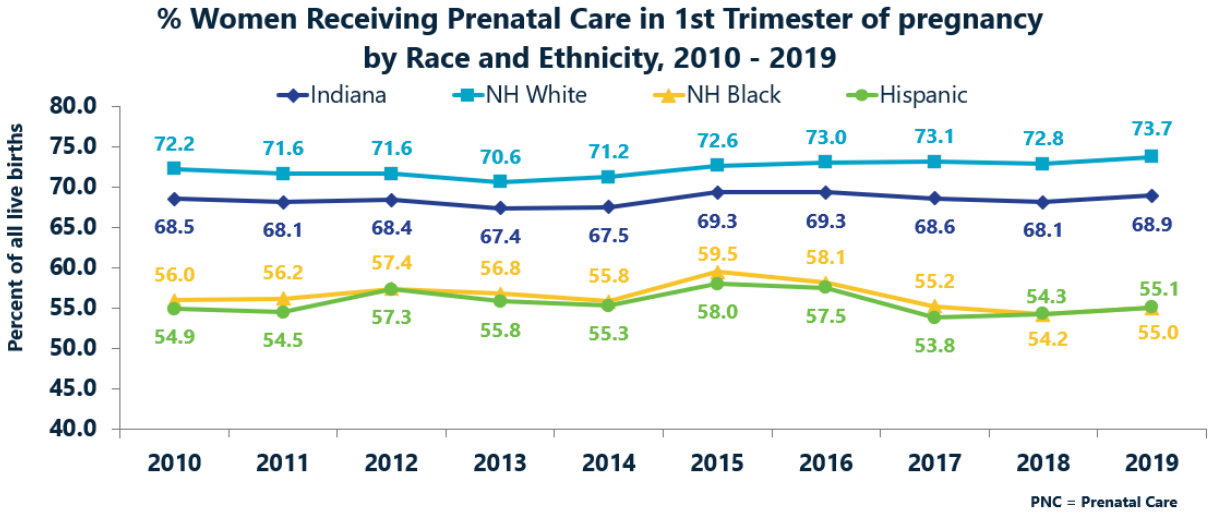


Figure 4: 1st Trimester Prenatal Care by Insurance Type (2019)



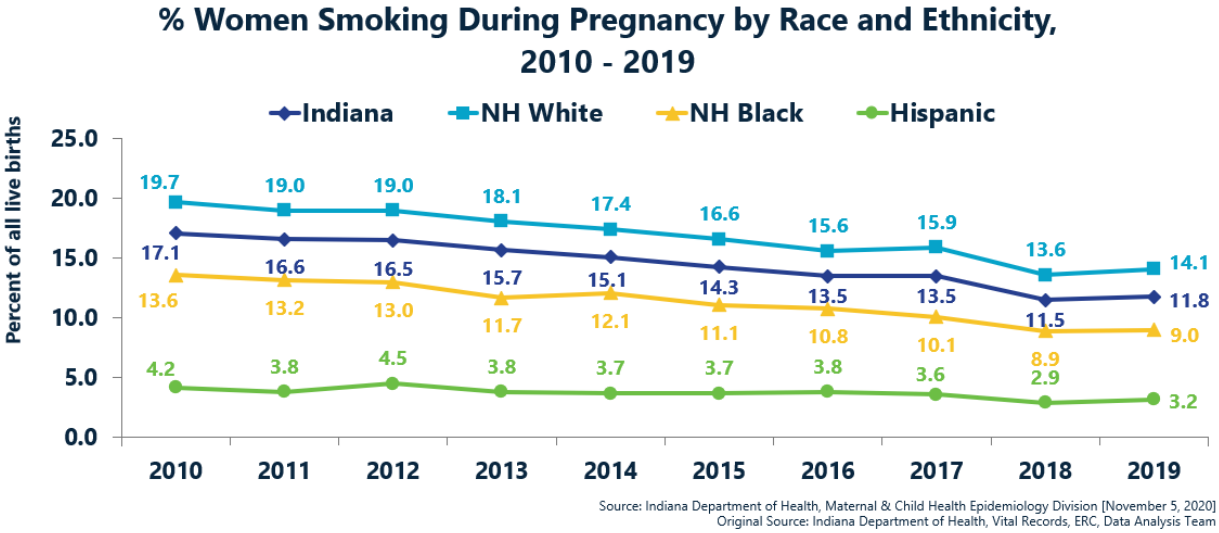
Source: Indiana State Department of Health, Maternal & Child Health Epidemiology Division [February 28, 2020]
Indiana Original Source: Indiana State Department of Health, Vital Records, ERC, DAT

Figure 5: Percent of Women Receiving Early Prenatal Care by Race and Ethnicity in Indiana (2010-2019)



Source: Indiana Department of Health, Maternal & Child Health Epidemiology Division [November 5, 2020]
Original Source: Indiana Department of Health, Vital Records, ERC, Data Analysis Team

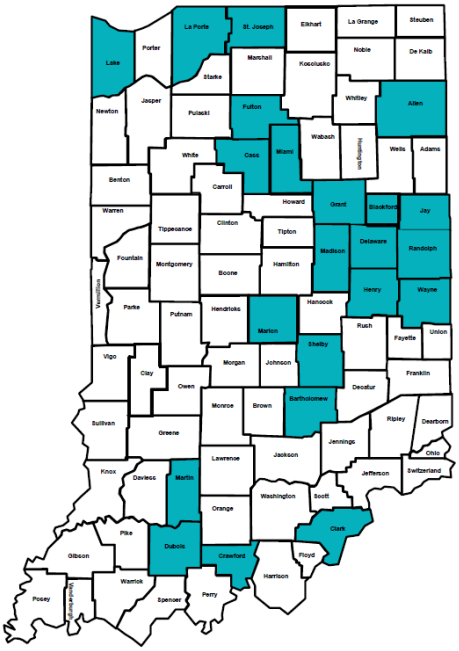
Figure 6: Percent of Women Smoking During Pregnancy in Indiana by Race and Ethnicity (2010-2019)



Cross-Agency My Healthy Baby Approach

As part of the effort to ensure Indiana would be Best in the Midwest by 2024, Governor Holcomb signed House Enrolled Act 1007 into law on May 8, 2019. This states that "The state [health] department shall establish a perinatal navigator program for the purposes of engaging pregnant women in early prenatal care and providing referrals to pregnant women for wraparound services and home visiting programs in the local community." This led to the development of the cross-agency OB Navigator Initiative, a collaboration between the Indiana Department of Health (IDOH), Family and Social Services Administration (FSSA), and the Department of Child Services (DCS). In October, based on feedback from focus groups, the Initiative changed its name to My Healthy Baby.

Figure 7: My Healthy Baby Counties, 2020



My Healthy Baby seeks to reach out to women as early in their pregnancy as possible and offer a connection to local home visiting programs. Research and information show that early connection to these services can address family needs and factors contributing to poor birth outcomes.

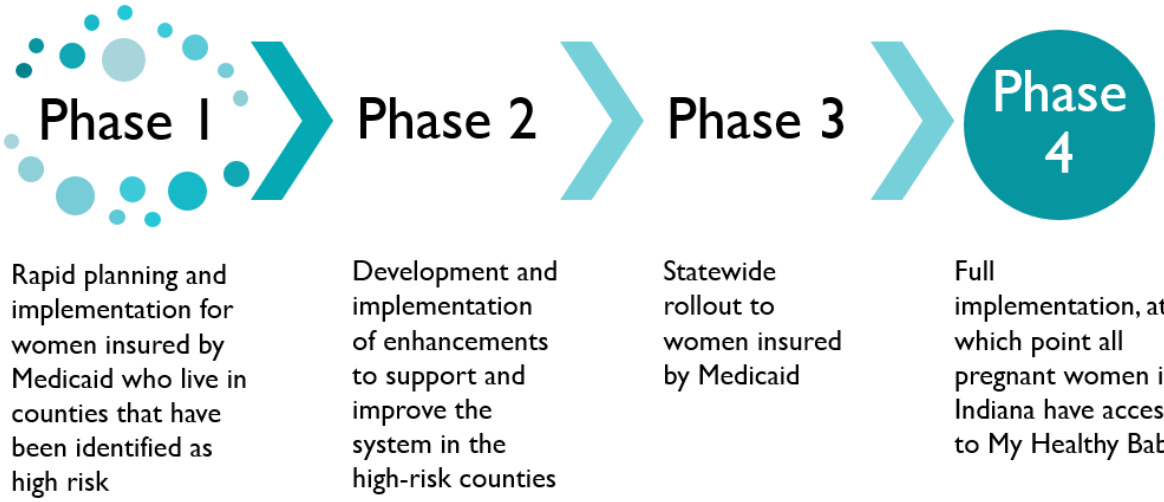
Due to the complexity of the project, implementation is being conducted in phases. The phases start small, identifying a subset of the target population in prioritized service areas, then moving toward a more comprehensive implementation statewide for all pregnant women. Phase 1 focused on rapid planning and implementation for women insured by Medicaid who live in 22

counties that were identified as high risk based on 2017 infant mortality and birth outcome data, including low birthweight and preterm birth, smoking during pregnancy, early prenatal care utilization, and Sudden Unexpected Infant Deaths. (See map in Figure 7.)

Phases 2 and 3 focus on strengthening the system and expanding beyond initial target counties. Phase 4 will focus on making the service available for every pregnant woman in Indiana. All four phases are represented in figure 8 below.

For a detailed description of the work involved in Phase 1, see Appendix 1.

Figure 8: Four Phases of My Healthy Baby Implementation



The project set a soft launch date in November 2019 with Allen County, and then launched in the additional counties on a rolling basis throughout 2020. Allen County officially went live on January 24, 2020, and the last three counties went live on October 19, 2020. For a full list of go-live dates, see Appendix 2.

Similarly, client identification data sources were implemented on a rolling schedule. In 2020, the initiative identified clients from three sources within Medicaid. The first identification source implemented was approval for Presumptive [Medicaid] Eligibility for Pregnant Women (PEPW). Between May 18 and June 8, clients who indicated pregnancy on any new Medicaid application were added. Finally, women who were already insured by Medicaid at the time they became pregnant were added between August 31 and November 2. In addition, clients continue to have the ability to call in, request resources, and be connected to a home visiting provider based on their eligibility. These clients are categorized as self-referrals in the data below.

Project Design

Overall, the My Healthy Baby initiative focuses on three areas to achieve its goal of saving an additional 200 babies each year. The three areas include:

1. **Early identification**: Identify or find pregnant women as early as possible in their pregnancies.
2. **Referral system**: Inform women about available resources and assist in connecting them to home visiting providers in their communities.

3. **Home visiting**: Home visiting programs provide support, education and services that promote a healthy pregnancy, birth, and postpartum care for both mom and baby.

For a more detailed logic model, see Appendix 3.

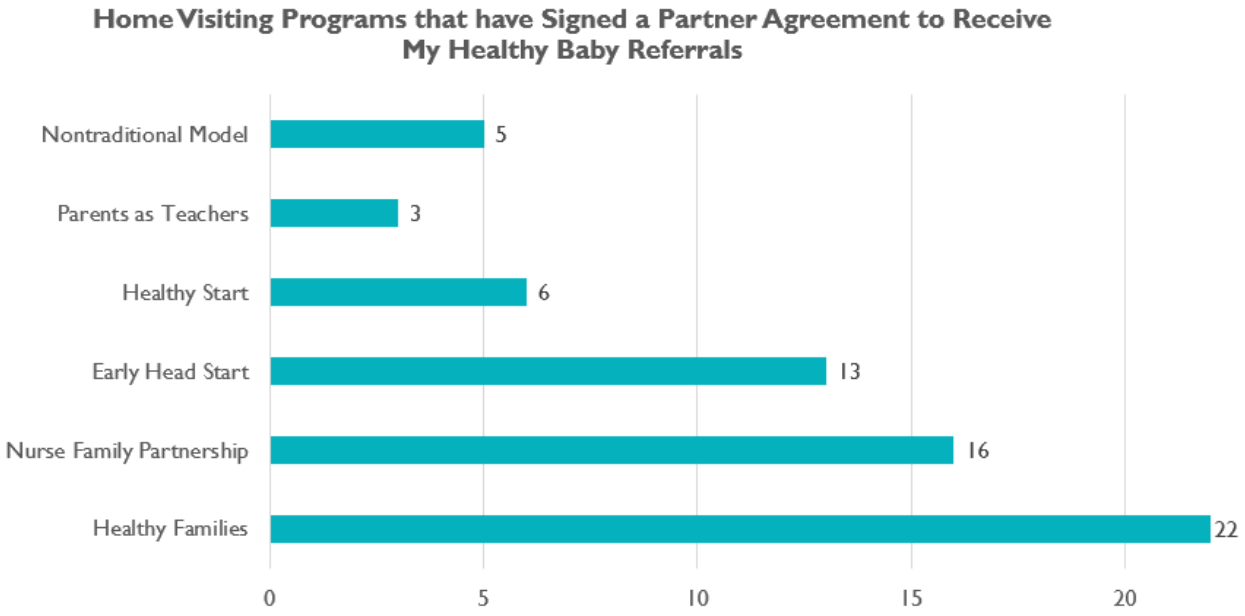
Why home visiting?

Decades of scientific research have shown home visiting to be an effective supportive service in improving the health and well-being of families. Based on research and best practice, several home visiting models have been created, implemented, and studied. Although the different models are unique in their own way, they all provide inclusive family support that is individualized to each family's desires and needs. One study found that prenatal and infant/toddler nurse home visitation service was effective in reducing preventable infant deaths and all causes of maternal deaths (Olds, et al., 2014). This study was conducted by examining the results of a two-decade follow-up of a randomized clinical trial. Similar studies have been conducted for various models, including Nurse Family Partnership and Healthy Families America.

Participating Home Visiting Program Types

In the 22 counties where My Healthy Baby has been implemented, 71 program sites have signed partner agreements to receive referrals. These program sites provide a variety of options to fit the needs of the target population, but all address core topics, including tobacco cessation, breastfeeding, and safe sleep. Some of the program sites implement national models (such as those referenced above), while others utilize Indiana-developed models. The Indiana-developed models are included in the nontraditional model category in this report. Figure 9 below highlights the breadth of program types in the 22 My Healthy Baby counties; the program sites represented are those that have signed a partner agreement to accept referrals from My Healthy Baby (note: some counties may have more than one of a given program type).

Figure 9: Home Visiting Programs Distribution (2020)



Note that Healthy Families Indiana sites and Nurse Family Partnership sites together comprise over half of all participating home visiting sites in the 22 counties where My Healthy Baby is live. For more information about these two programs, including an overview of the research showing positive outcomes, as well as data specific to Indiana, see Appendix 4.

The My Healthy Baby Process

The referral process begins with the identification of pregnant women and transfer of their contact information from FSSA to IDOH.

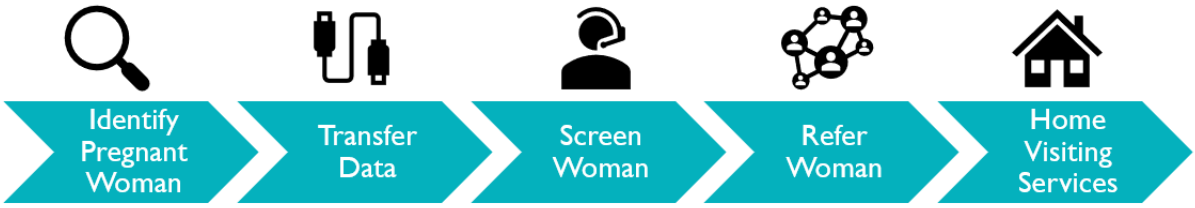
After receiving contact information for potential clients, communication specialists at IDOH initiate contact attempts, which include direct phone calls and mailed letters. Three call attempts are made for those clients with a working phone number, and letters are mailed for those clients who do not answer the phone or who have no working phone number. It is important to note that during contact and screening, there are many clients that IDOH is unable to successfully contact.

Successful contact occurs when the communication specialist is able to speak with the client. Since participation is voluntary, a client may decline to proceed with the screening process. Clients that agree to continue with the screening process are asked a set of questions that assist in assessing the clients' needs.

Based on the assessment, a client is offered a referral to a home visiting program in her community. The client responds by accepting the home visiting referral, opting out, or requesting information only. Very rarely, a client may be found ineligible; this occurs if eligibility criteria are not met for any available home visiting provider. All screened clients are also offered one-on-one assistance with health insurance navigation and other local resources, including assistance in finding a prenatal care provider.

Figure 10 below shows the process from identification to client enrolling in a home visiting program.

Figure 10: My Healthy Baby Process Steps from Identification to Enrollment in Home Visiting Program



For more detail about how this process was developed during this first year, please see Appendix 1.

Outcomes

Priority indicators for the first year of implementation were selected to reflect the three focus areas: early identification, referral system, and home visiting. Selection of these indicators was also influenced by availability of data during the program's first year.

Identification and referral data are mostly collected and stored within the state Department of Health. After a referral has been made to the home visiting programs, client enrollment is described by conversion rate. The data required to calculate conversion rate are collected and stored by the home visiting programs and provided (in aggregate) to the My Healthy Baby evaluation team.

The following data analyses relate to Phase 1: the rapid planning, implementation, and growth of the My Healthy Baby Initiative in 2020. More specifically, most of the analyses in this report use data from the seven-month period from January 1, 2020, through July 31, 2020. During that time, the project went live in the first 13 counties (see Appendix 2 for the schedule). During this entire period, My Healthy Baby was calling women who had just been approved for PEPW. PEPW applications can only be submitted by a health care provider. Pregnant women who submitted Medicaid applications were added near the end of the period, in late May and early June.

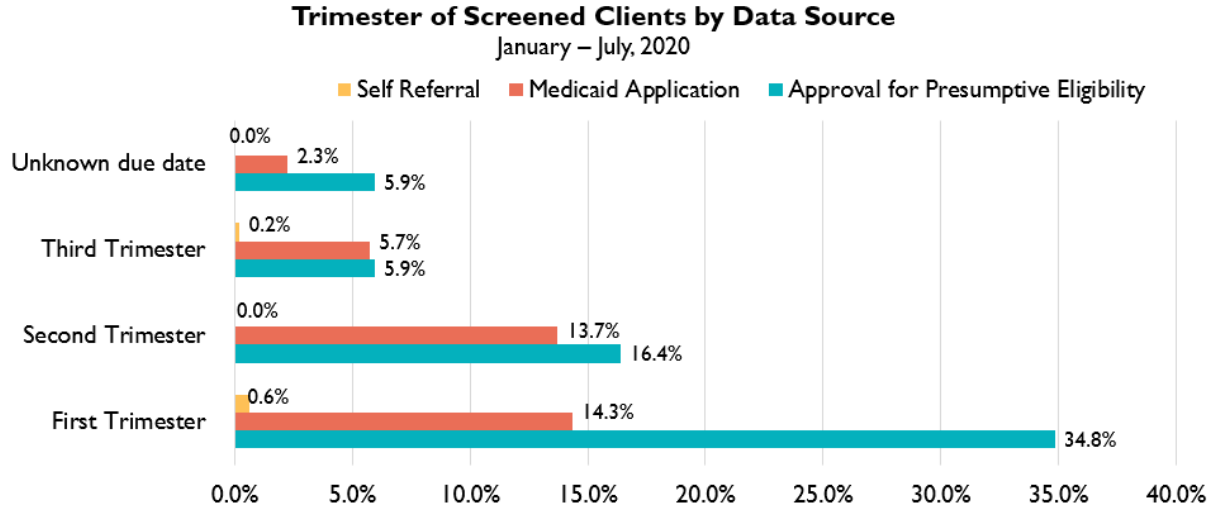
Early identification

Identification data include the number of women who were identified as possible participants of the initiative. As stated in previous sections, one of the primary goals is to connect pregnant women to home visiting as early in their pregnancy as possible. This is crucial as studies have indicated better outcomes when interventions are provided early in pregnancy.

For My Healthy Baby, as for general infant mortality analyses, early in pregnancy is considered the first trimester (first 13 weeks of pregnancy). Figure 11 below indicates the trimester distribution of women identified for My Healthy Baby between January 1, 2020, and July 31, 2020, using Medicaid PEPW application data, Medicaid application data and self-referral. A total of 488 clients screened indicated they are pregnant, and 448 clients provided their due

date. In addition, 49 screened clients indicated they were not pregnant; of these, 59 percent had already delivered.

Figure 11: Trimester Distribution of Clients Screened, January through July 2020



Note: Total for whom these data were available = 488 (out of 571 total screened clients)

Referral system

Figure 12 below visualizes the possible client outcomes after identification. Figure 13 presents the percent of clients who fall into each category. Figure 14 shows the interaction outcomes for screened clients.

Figure 12: Contact and Screening client outcomes.

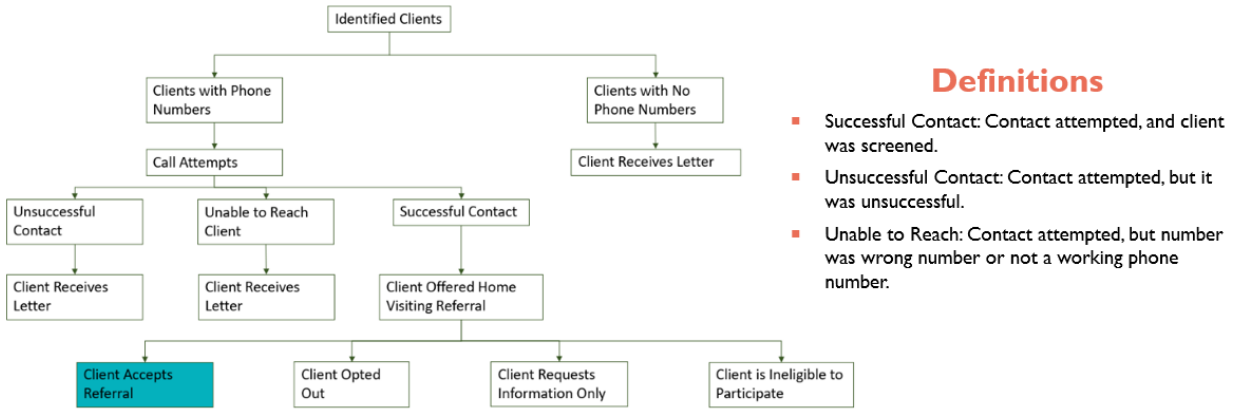


Figure 13: My Healthy Baby Key Performance Indicators (January 1, 2020 – July 31, 2020)

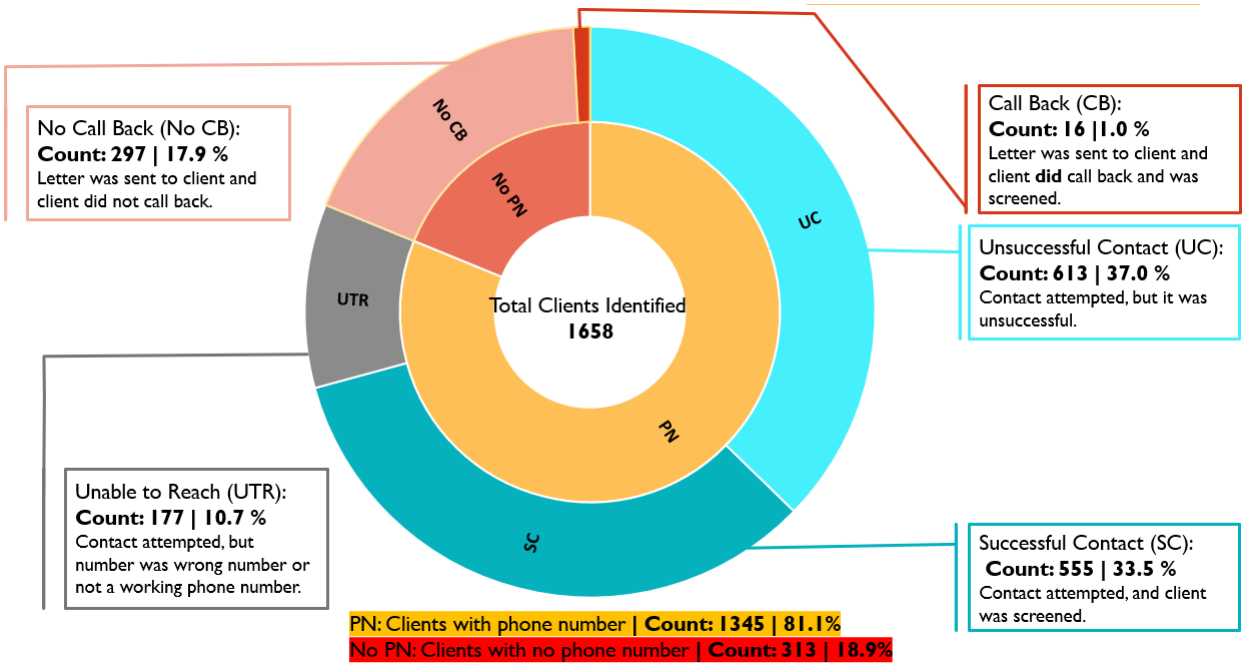
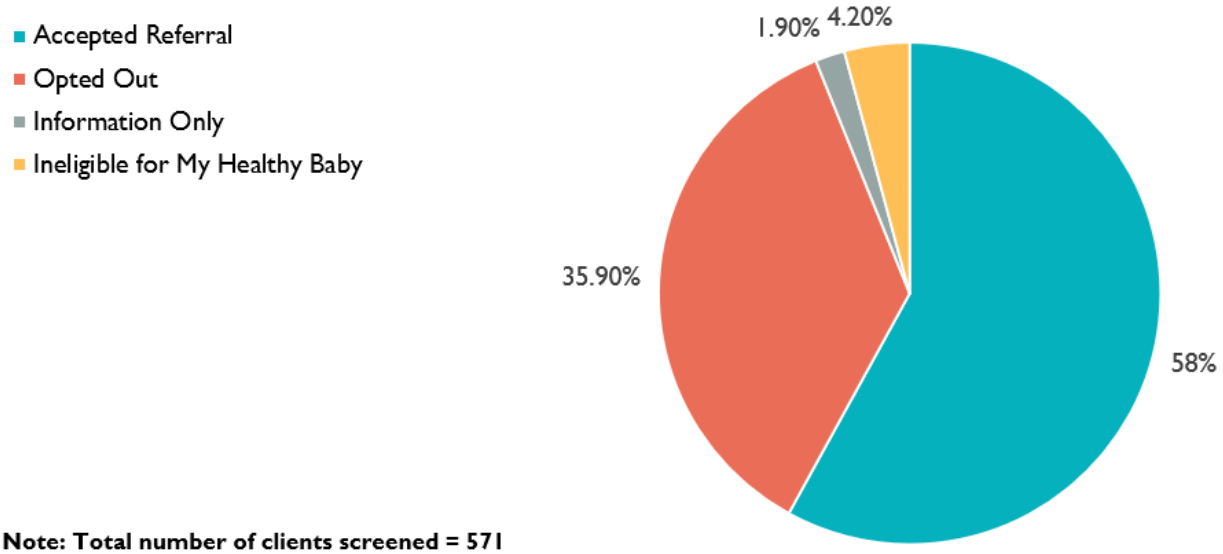


Figure 14: Interaction Outcome of Screened Clients (January 1, 2020 – July 31, 2020)

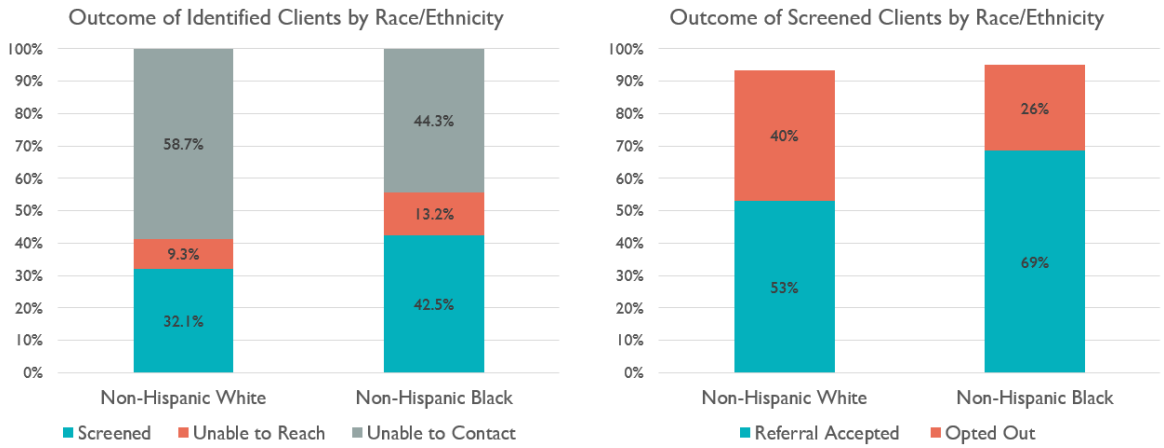


Note: Total number of clients screened = 571
Includes women reached as a result of both phone and letter outreach (SC and CB on the previous slide)

From January – July 2020, 1,658 women were identified as potential clients for My Healthy Baby. Of these, 24.2% were Non-Hispanic (NH) Black and 44.9% were NH White. During that sevenmonth period, 42.5% of NH Black clients and 32.1% of NH White clients were successfully reached and screened. Of the NH Black clients who were screened, 68.6% accepted a referral for My Healthy Baby home visiting, while 26.3% declined the referral. Of the NH White clients who were screened, 53.1% accepted a referral for My Healthy Baby home visiting while 40.2% declined the referral. (see Figure 15)

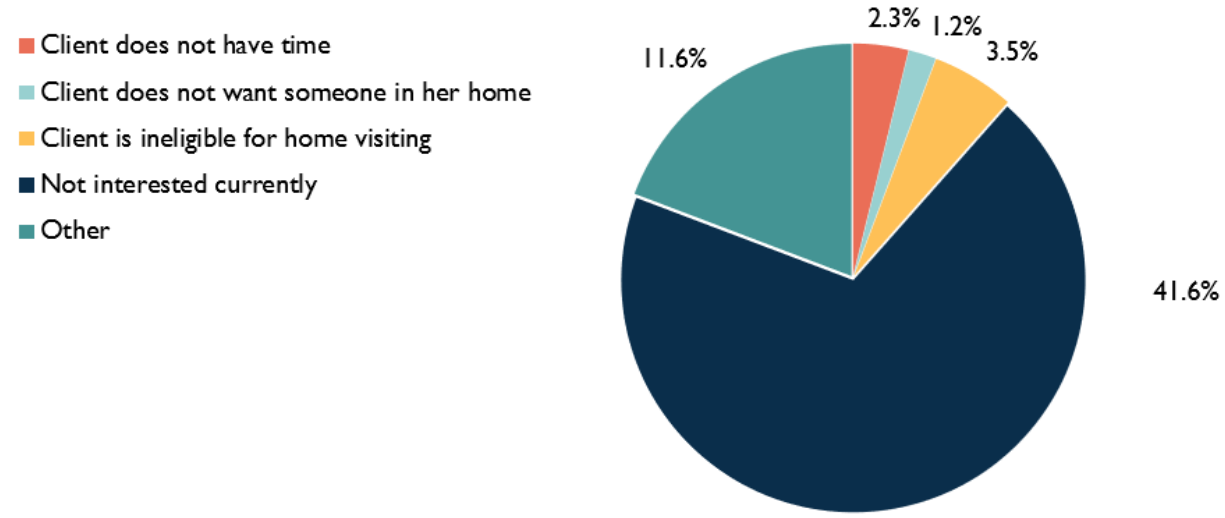
Note: Race and Ethnicity analysis was confined to Non-Hispanic White and Non-Hispanic Black due to small counts of other racial and ethnic groups during the time period.

Figure 15: Outcome by Race/Ethnicity



The clients who opted out from being connected to a home visiting service were asked a follow-up question to understand the reasons behind their decisions. For the 205 clients who opted out from a referral between January 1, 2020, and July 31, 2020, a percentage distribution of reasons given for opt-out is provided for 177 clients below in Figure 16.

Figure 16: Opted Out Reason for Clients that Opted Out

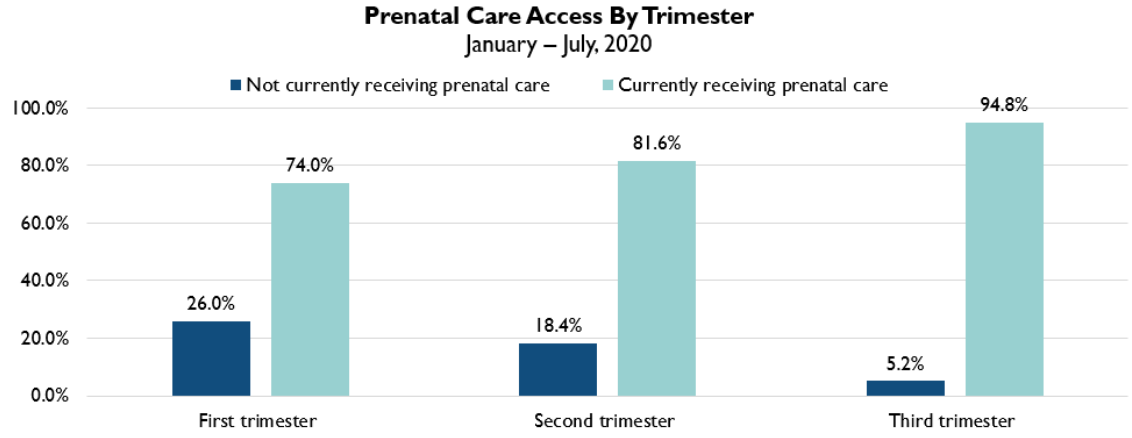


Note: Of the 205 clients who opted out, data on reason for opt-out were available for 177.

Prenatal Care Utilization

As indicated above, the communications specialists at IDOH assess prenatal care utilization and offer to assist in finding a prenatal care provider. Out of the 447 clients asked about prenatal care utilization, 354 clients indicated they are currently receiving prenatal care. Figure 17 below provides the percentage breakdown by clients' trimester of pregnancy.

Figure 17: Prenatal Care Access by Trimester



Notes:
These data represent the 447 clients that have been screened and have data available for both trimester and prenatal care access (out of 571 total screened clients).
Data represents primarily clients who had just been approved for PEPW; new applicants for Medicaid added in May and June.

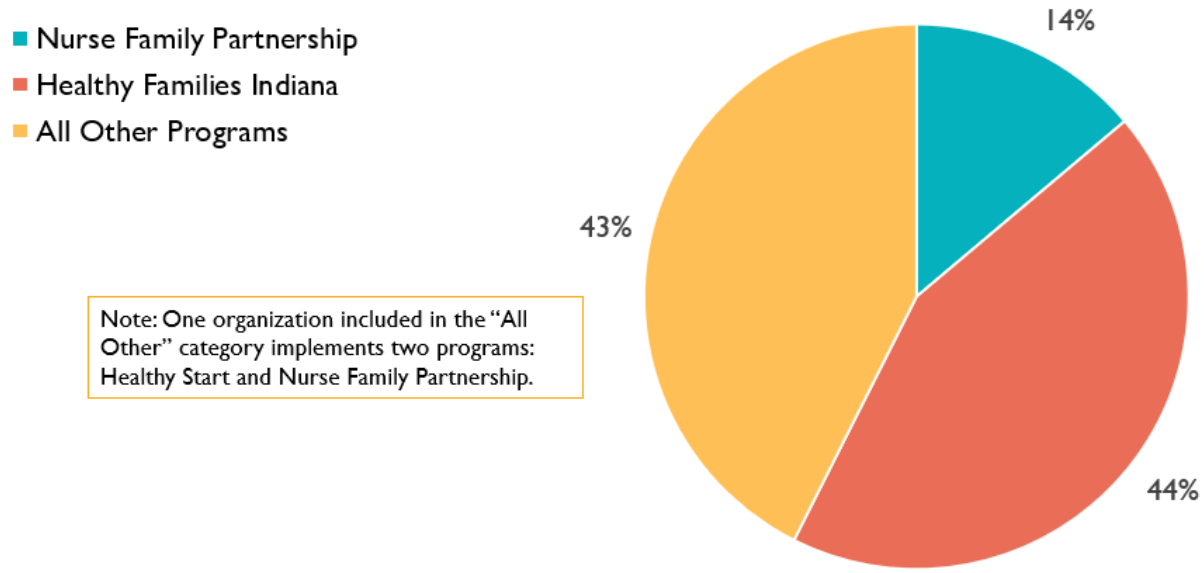
Previous Pregnancy Complication

As part of the screening process, clients are asked about previous pregnancy complications. Between January 1, 2020, and July 31, 2020, 15 clients indicated previous preterm births, 35 clients indicated previous miscarriage, 111 clients indicated other previous pregnancy complication and 13 clients had experienced pregnancy loss.

Home Visiting: Referral Distribution

As indicated above, My Healthy Baby referred 331 clients to home visiting programs in 13 target counties from January 1, 2020, to July 31, 2020. The referral distribution by home visiting program type is provided below in Figure 18.

Figure 18: Referral Distribution by Home Visiting Program Type



Home Visiting: Conversion Rate

The next step in the process is the enrollment of the referrals that have been sent to the home visiting sites. For the My Healthy Baby project, conversion rate is defined as the percentage of all referred clients who have enrolled in the home visiting programs.

$$\text{Conversion Rate \%} = \frac{\text{Number of My Healthy Baby Clients Enrolled in the Home Visiting Program}}{\text{(Total Number of My Healthy Baby Referrals to the Home Visiting Program)} - \text{(Total Number of Duplicated My Healthy Baby Referrals to the Home Visiting Program)}}$$

There are several considerations to note when looking at conversion rate, some of which are listed below:

- Given the voluntary nature of the programs, clients are not obligated to enroll and/or engage.
- The target population faces many challenges, sometimes making it more difficult for home visiting programs to successfully reach a referred client.
- Some My Healthy Baby referrals are duplicates of referrals already received from another entity. These clients will typically not be counted as My Healthy Baby enrollments.
- After a home visiting program receives a referral, the program contacts the client and conducts an eligibility screening. Some clients may not meet the national and/or local eligibility criteria, which can result in some clients not enrolling.
- The referrals represented in the data below may enroll in the program after the reporting period used for this report. Thus, conversion rate calculations show a higher percentage when data is analyzed over a longer period.

Programs with a pre-existing data-sharing relationship with a state agency: January – July 2020

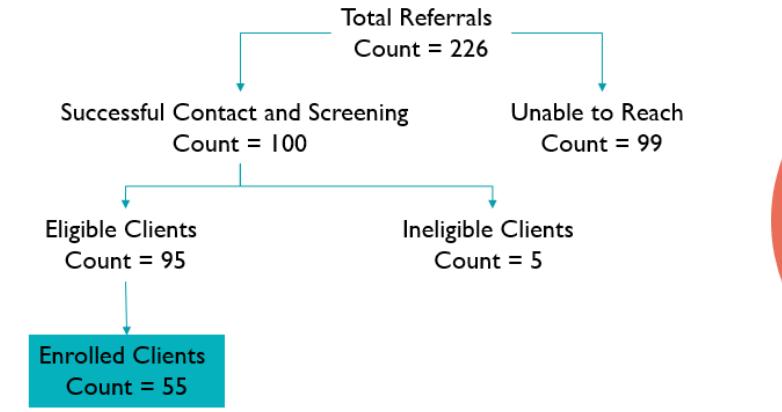
Some home visiting programs in Indiana have pre-existing data-sharing relationships with a state agency. Specifically, the Department of Child Services maintains the data for Healthy Families Indiana, and the Indiana Department of Health has access to the data for Nurse Family Partnership in Indiana (including one Nurse Family Partnership that is run together with a Healthy Start Program).

My Healthy Baby was able to gain approval to access de-identified data through these existing relationships. Moreover, these programs were able to add a flag to indicate referrals from My Healthy Baby. The following analysis for these programs includes all clients that were flagged as coming from My Healthy Baby between January 1 and July 31, 2020. (Note: Because the flag was added partway through the reporting period, the analysis may not include every My Healthy Baby referral to these programs.)

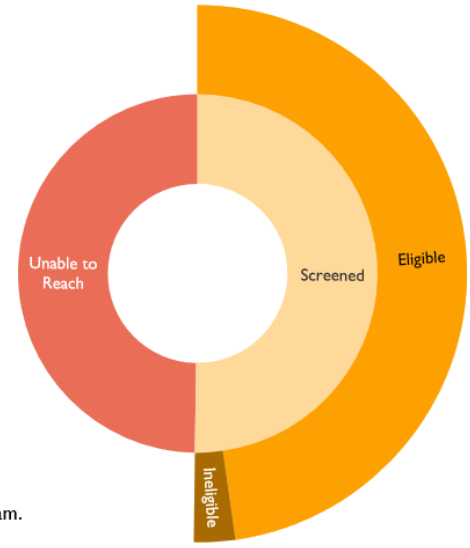
The combined conversion rate for these programs is 27.2 percent. If analyzed separately, the conversion rate for My Healthy Baby referrals to each program type was higher than the average conversion rate for that program type in 2019.

For a graphic representation of My Healthy Baby enrollments into these programs, see Figure 19.

Figure 19: My Healthy Baby Enrollments in Programs with Existing Data Sharing, January – July, 2020



These data include Healthy Families, Nurse Family Partnership, and one Healthy Start program.

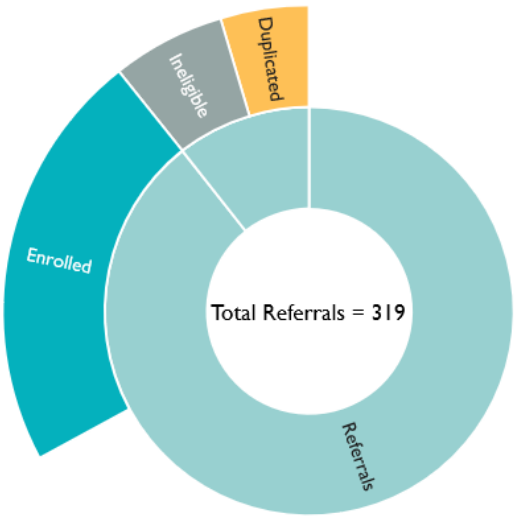


Community Developed Home Visiting Programs: July-Nov 2020

As noted, because of pre-existing relationships, accessing data from HFI and NFP was relatively straightforward, but a novel approach had to be developed to collect conversion rate data from other programs. This data collection began in July, with data now compiled monthly. Out of 25 participating home visiting programs included in My Healthy Baby, an average of 19 programs submitted conversion rate data each month. According to the data obtained from July 1, 2020, to November 30, 2020, these sites received 319 referrals, with an overall conversion rate for these programs of 23.3% during this period; Figure 20 below indicates the distribution of the outcomes of the referrals. Because these timeframes do not match the timeframes for data collected from Healthy Families Indiana and Nurse Family Partnership, an overall conversion rate calculation across all program types is not possible at this time.

Figure 20: Referral outcome for home visiting programs that are not state administered, July 1 – November 30, 2020

Total Referrals:	319
Duplicated Referrals:	15
Ineligible Clients:	19
Enrolled Clients:	71



Future Direction for Evaluation

In the future, My Healthy Baby intends to improve measurement of referral outcomes, including conversion rate. Another goal is to measure outcomes for My Healthy Baby referred clients that are enrolled in home visiting programs, including breastfeeding at 6 months postpartum, tobacco cessation referrals, safe sleep practice and birth spacing. These four metrics have been shown to impact infant mortality and morbidity in Indiana, and three of these four have also been well established through national home visiting research. The ability to analyze My Healthy Baby clients within these home visiting programs requires access to data from home visiting sites. Access to data requires the incorporation of data agreements, appropriate client consent forms, and technical systems for data sharing. To achieve this level of system coordination, multi-agency strategies will be required.

Another challenge to this level of analysis is the lack of data standardization within each home visiting site, including NFP and HFI. The differences among home visiting data collection and definitions require in-depth access and understanding of each data source to standardize, compile, and analyze data elements across each home visiting program. As a result, this process, which is currently in the very early stages, will require significant collaboration, support, and time.

As an extended analysis, the My Healthy Baby evaluation team also hopes to match vital records data to client data obtained from Medicaid to further assess birth outcomes. These outcomes will be compared between the group of women successfully referred to a home visiting program and the group that opted out of the home visiting service.

These are areas of focus for evaluation and ongoing improvement of My Healthy Baby as the project moves into Phase 2.

Appendix 1: Building the System during Phase 1

In 2020, My Healthy Baby focused heavily on Phase 1 of implementation. The scope of phase 1 was to plan, design, build, and implement a process and system that would enable early identification of pregnant women insured by Medicaid who live in high-risk counties, and referral of these women into home visiting services. The first step in phase 1 was the formation of a cross-agency project team.

Strategic and comprehensive stakeholder engagement was also prioritized. A series of 13 engagement events was completed around the state to have discussions with communities and obtain community buy-in. Each event included targeted conversations with the public, medical providers, and home visiting providers. At the medical and community meetings, the State Health Commissioner presented data on local causes of infant mortality to inform the public of the problem and provided an overview of the My Healthy Baby initiative before asking for community input. The meetings with the home visiting providers focused more heavily on logistics, including development of referral decision-making processes specific to each county; these meetings also contributed to the building and strengthening of relationships with home visiting programs across the state. In total, 578 attended the community meetings, 337 attended meetings for medical providers, and 159 attended meetings for home visiting providers.

The project formed a My Healthy Baby advisory committee to allow home visiting programs to continuously advise the project. In 2019 and 2020, the advisory committee met several times to develop a shared understanding of the home visiting structures in place, gaps in service, and training needs to inform the work of My Healthy Baby. Members of the advisory committee represented various home visiting program types across the state, managed care entities, and agency staff from DCS, IDOH, and FSSA. Moving forward, a formal advisory committee will continue to meet and provide input and expertise on standards, policies, training, benchmarks, and data.

A key feature of the rapid build included technical solutions to allow for regular data transfer. Because of the importance of identifying pregnant women as early as possible in their pregnancies, My Healthy Baby paved the way in developing and implementing a technical solution to enable weekly data transfers from FSSA to IDOH. By streamlining this data transfer, women identified through these sources were able to be contacted and offered services quickly after the initiating event at FSSA. This streamlining was made possible by building a secure application programming interface (API) between FSSA and IDOH.

After selecting target counties, engaging community partners, identifying data sources, and building the data transfer capability, a screening process had to be established. The screening is conducted by the Indiana Department of Health Maternal and Child Health MOMs Helpline team (MHL). In preparation for the screening process, additional MHL staff were hired, specific trainings were implemented, detailed scripts were established, and technical systems were built and enhanced.

The next step in the process was putting together referral algorithms. These algorithms use a series of questions to assess eligibility and need of the client. These questions are further broken down by income, pregnancy number, pregnancy stage, maternal age, and medical or

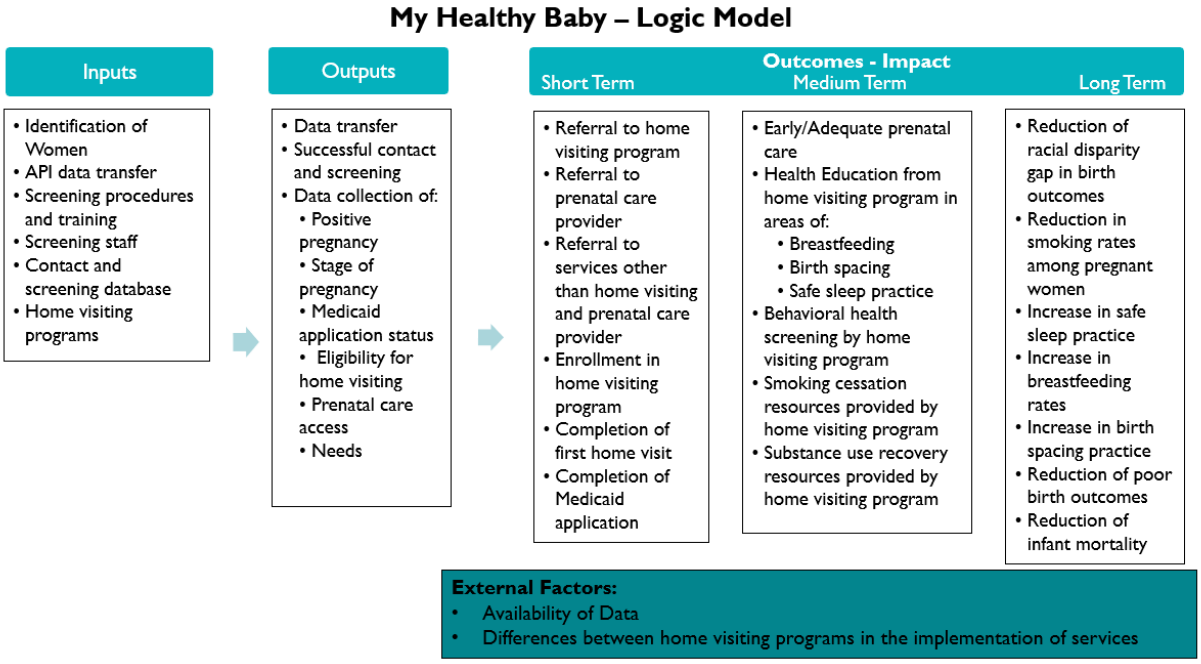
pregnancy complications. Specific community discussions with home visiting providers informed the process logic that is built in the referral algorithms.

Appendix 2: My Healthy Baby Go-Live Schedule

- **Went live** January 24: Allen
- **Went live** February 24: Clark
- **Went live** March 24: Grant, Delaware, Madison, and Henry
- **Went live** April 28: Lake
- **Went live** May 26: May: Martin, Dubois, and Crawford
- **Went live** June 23: St. Joseph and LaPorte
- **Went live** July 14: Marion
- **Went live** August 24: Shelby and Bartholomew
- **Went live** September 19: Blackford, Jay, Randolph, and Wayne
- **Went live** October 19: Cass, Fulton, and Miami

Appendix 3: Logic Model

To visualize the My Healthy Baby initiative's activities, resources, and intended outputs, the following logic model was created and utilized for program monitoring and evaluation planning. The inputs include the resources and activities needed for program implementation while the outputs define deliverables and tangible products resulting from the activities. The outcomes include the changes that occur because of the initiative and the intended impact.



Appendix 4: Nurse Family Partnership and Healthy Families America

Background and Research

Research on Nurse Family Partnership consistently demonstrates the program's success in keeping children healthy and safe, as well as improving the lives of moms and babies (Nurse Family Partnership, n.d.). The program ensures that families who enroll will be able to attain the same outcomes achieved in the original trials and the ongoing research by continuously implementing the program with fidelity to the model. Similarly, Healthy Families America provides impact briefs on the positive influence it has on infant morbidity and mortality (Healthy Families America, n.d.). The impact briefs reference research that consistently confirms that providing education and support services to parents around the time of a baby's birth and continuing for months or years afterwards significantly reduces the risk of child maltreatment and contributes to positive, healthy child-rearing practices. Families receiving this type of intensive, home visitor service also show other positive changes such as consistent use of preventive health services, increased high school completion rates, higher employment rates, lower welfare use, and fewer pregnancies.

Both programs have been proven to have high return on investment. A study done on the return investment of Nurse Family Partnership indicated a reduction in Temporary Assistance for Needy Families payments, person-months on Medicaid and costs if on Medicaid (Nurse Family Partnership, 2017). The same study indicated the effectiveness of the home visiting model in the reduction of smoking during pregnancy, preterm births, and infant mortality. Similarly, a study on the effectiveness of Healthy Families America (n.d.) indicated a reduction in low birthweight rates, an increase in breastfeeding rates, and reduction in child maltreatment. Healthy Families America has also been proven to be a cost-effective intervention (Dumont et al., 2010). The cost effectiveness analysis also indicated that the return on investment from the services are underestimated because some of the outcomes are non-monetized results.

Healthy Families Indiana

Healthy Families America (HFA) is a national, voluntary, evidence-based home visiting program designed to provide services to families beginning prenatally or at birth and continuing through age five. HFA utilizes an infant mental health/relational development approach to achieve its mission of preventing child abuse and neglect as well as other adverse childhood experiences. Healthy Families Indiana (HFI) has been accredited by Healthy Families America (HFA), the national home visitation model, since 1994. The program systematically identifies families that could benefit from education and support services prenatally or immediately after birth. HFI enrolls low-income families (defined as below 250% poverty level) prenatally and postnatally within three months of the birth of the child and continues to serve families until the target child's 3rd to 5th birthday (length of service offered may vary by program). Level of service provided may vary based on time of enrollment, length of participation in the program, etc.

The primary goals of Healthy Families Indiana are to:

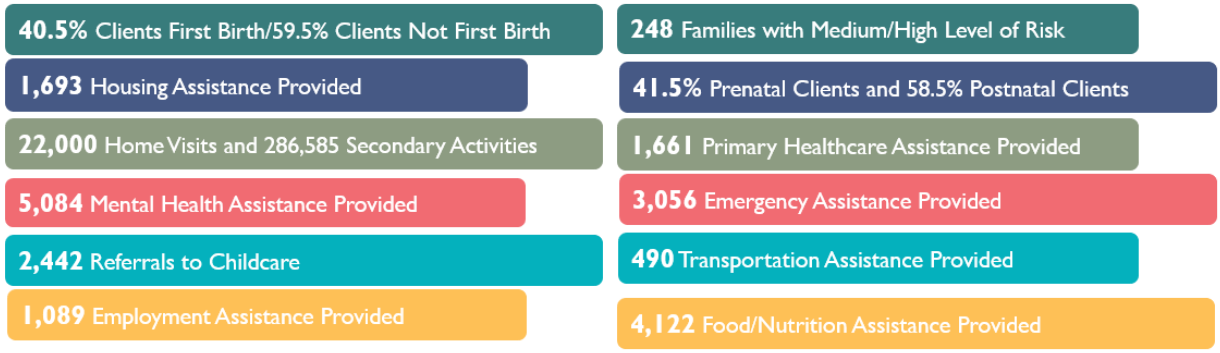
- Systematically engage families with multiple stressors in home visiting services prenatally or at birth and sustaining community partnerships.
- Promote safe environments for children and families.
- Cultivate and strengthen nurturing parent-child relationships.

- Promote healthy childhood growth and development through parent engagement.
- Enhance family functioning by reducing risk and building protective factors for optimal childhood outcomes.
- Provide staff with the training and support needed for their professional well-being.

The HFI model is designed to promote healthy families and healthy children through a variety of services including child development, access to health care, and parent education. Strategies used are relationship based, culturally sensitive, family centered, strength based and grounded in the parallel process. The HFA/HFI model consists of 12 Critical Elements, including, but not limited to, enrollment criteria, assessment of families using a standardized tool, supervision of staff, and training expectations.

HFI is a multi-site statewide system that is administered by the Indiana Department of Child Services. HFI is active in all 92 counties in Indiana, which includes the 22 counties targeted by My Healthy Baby in 2020. The Department of Child Services funds Healthy Families Indiana programs through Temporary Assistance for Needy Families (TANF), Maternal, Infant, Early Childhood Home Visiting (MIECHV), and state funds, as well as local funds provided to the HFI sites. Figure 21 below provides an overview of HFI statewide outcomes in 2019.

Figure 21: Healthy Families Indiana Statewide 2019 Outcomes Data



Nurse Family Partnership in Indiana

Nurse Family Partnership (NFP) is a national evidence-based, community health program with over 40 years of evidence showing significant improvements in the health and lives of first-time moms and their children. NFP empowers families to transform their lives and futures by having trained nurses regularly visit first time moms-to-be starting early in pregnancy and continuing through the child's second birthday. The program consists of three phases, including the pregnancy phase (enrollment to birth), the infancy phase (birth to 12 months), and the toddler phase (12 months to 2 years). The nurses are trained to provide support specific to their current phase. The primary goals of the program are to:

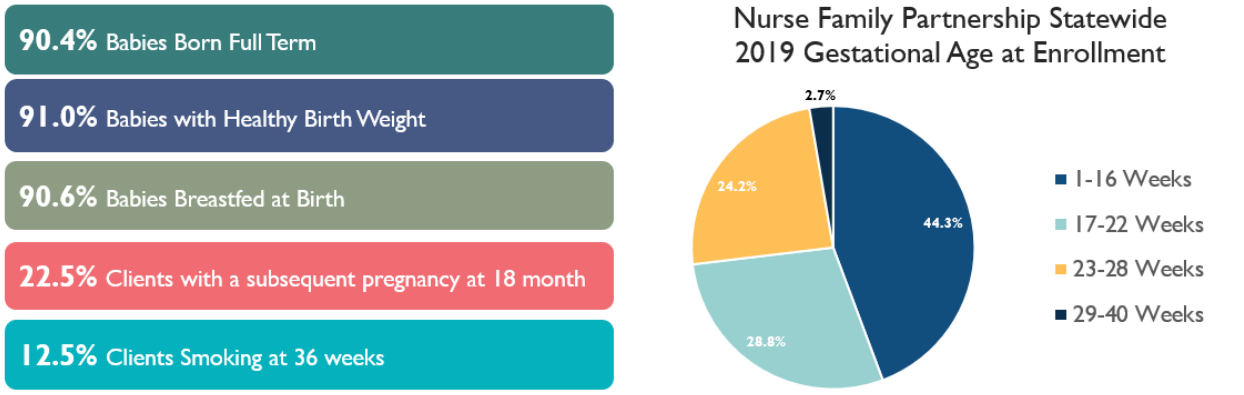
- Improve pregnancy outcomes.
- Improve child health and development.
- Improve families' economic self-sufficiency.

The NFP model consists of specific model elements related to enrollment criteria, intervention context and application, nursing and clinical supervision requirements, the monitoring/use of data, and expectations of Local Network Partners (LNP) implementing the model in local communities. The NFP nurses receive support from their LNPs, Indiana Department of Health, and the NFP National Service Office to ensure that the program goals are met through fidelity to these model elements.

In Indiana, Nurse Family Partnership is administered in part through the state Department of Health in partnership with the NFP National Service Office and Local Network Partners (LNP). NFP is currently implemented by four LNPs in 39 counties. Three of the LNPs and 16 of the 39 NFP counties are included in the 22 counties targeted by My Healthy Baby in 2020. NFP is funded through a variety of funds ranging from private, state, and federal funds, with most of the funding provided through IDOH, including dedicated state and federal funds.

NFP Nurses work closely with community partners across Indiana to ensure clients have access to additional resources outside of the program. In 2019, NFP in Indiana made 19,468 referrals to government and community services. Some examples of services included: government assistance, crisis intervention, mental health services, substance abuse services, health care, and education. Figure 22 below provides more statewide data points from 2019.

Figure 22: Nurse Family Partnership Statewide 2019 Outcomes Data



[1]Full term birth: ≥ 37 weeks gestation [2]Healthy birth weight: ≥ 2500 grams (5.5lbs) [3]Number of clients that answered "Yes" to "Since you have had [child's name] have you been pregnant?" at 18 months postpartum

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