Indiana FY 2018
Preventive Health and Health Services Block Grant

Work Plan

Original Work Plan for Fiscal Year 2018
Submitted by: Indiana
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Governor: Eric J. Holcomb
State Health Officer: Dr. Kristina Box
Block Grant Coordinator:
Katherine Hokanson
2 N. Meridian Street
Indianapolis IN 46204
Phone: 317-234-2865
Fax: 317-233-7761
Email: khokanson@isdh.in.gov
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Contents **Page**

Executive Summary

- On June 22 2018, the Advisory Committee reviewed and recommended programs for funding, contingent upon the receipt of funding for FY2018.

- On June 28 2018, the Public Hearing was convened.

- This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2018. It is submitted by the Indiana State Department of Health (ISDH) as the designated state agency for the allocation and administration of PHHSBG funds.

- **Funding Assumptions**: The total award for the FY2018 PHHSBG is $2,812,357. This amount is based on an allocation table distributed by CDC.

- Funding for FY2018 Sexual Assault-Rape Crisis (HO IPV 40) activities detailed in the Work Plan: $144,972 of this total is a mandatory allocation to the Office of Women's Health (OWH) at the ISDH which provides this funding to reduce the prevalence of sexual assault and attempted sexual assault among residents of the State of Indiana, particularly youth through sexual violence outreach and education and direct services. OWH will release a competitive solicitation for these funds with a targeted focus on statewide impact.

- **Program Title:** Office of Women's Health (OWH)
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  - IVP-40 Sexual Violence (Rape Prevention), $84,099 of this total will go towards developing a sexual assault nurse examiners (SANE) program to provide coordination of statewide efforts to train health care providers to conduct sexual assault forensic examinations which provide better physical and mental health care for survivors, better evidence collection, and higher prosecution rates.

- **Program Title**: Chronic Disease, Primary Care and Rural Health (CDPCRH)
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  - HDS-1 Cardiovascular Health, $495,470 of this total will be utilized to reduce the disparities and overall burden of chronic disease in Indiana. The section on Cardiovascular Health and Diabetes within CDPCRH seeks to monitor and reduce cardiovascular health (CVH) and Diabetes (DM) disparities and overall burden in Indiana; the Cancer Section within CDPC seeks to monitor and reduce cancer disparities and overall burden in Indiana; the Chronic Respiratory Disease Section in CDPC seeks to monitor and reduce disparities and overall Indiana burden related to asthma and other chronic respiratory diseases. CDPCRH also seeks to address disparities and overall burden of all chronic disease in Indiana through both organizational and public policy initiatives, health systems strategies to improve clinical care, convening statewide partners to address chronic disease, and statewide health communications.
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- A vendor to be determined will receive $295,470 to assist CDPCRH with the activities listed above.
- Crawfordsville Fire Department will receive $200,000 to assist CDPCRH with the activities listed above.

- **Program Title**: Food Protection Program
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  - FS-6 Food Preparation Practices in Food Service and Retail Establishments, $136,795 of this total will be utilized to measure and improve the compliance of fast-food and full service restaurants in Indiana with food safety sanitation requirements. Continue to expand the use of USA Food Safety, the

electronic system to capture and evaluate food safety inspection and investigation information. Support counties as they transition to the new system, and build electronic data links allowing counties to transmit data to USA Food Safety without the need for manual data entry.

- **Program Title**: Injury Prevention Program
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- IVP-11 Unintentional Injury Deaths, $181,591 of this total will be utilized to continue the process begun in 2011 of developing a comprehensive injury and violence prevention program at the state health department that provides focus and direction, coordinates and finds common ground among the many prevention partners, and maximizes injury and violence prevention resources. Continue to seek additional injury prevention grant funding and provide evidence-based primary prevention programs in Indiana, specifically related to child passenger safety and older adult falls.
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- Wisconsin Institute on Healthy Aging facilitates the evidence-based falls prevention program, Stepping On. They will receive $5,000 to assist the injury prevention program to complete these activities.
- Indiana will host the 2018 Midwest Injury Prevention Alliance conference. Conference to host state, regional, and national speakers to educate, engage, and leverage health department leaders, policymakers, partners, and collaborators to promote and improve evidence-based injury prevention programming. $5,000 will go towards the contract to support this conference.
- The University of Indianapolis – Center for Aging will receive $25,000 to assist the division with the activities listed above.
- IVP-4 Child Fatality Review of Child Deaths Due to External Causes, $50,000 of this total will be utilized to gain an understanding of the circumstances causing a child's death which will help prevent other deaths, poor health outcomes, and injury or disability in other children.

- A request for applications will go out to local child fatality review teams for $50,000 to assist the Child Fatality Review Program with these activities.

- **Program Title**: Nutrition and Physical Activity
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- NWS-2 Nutritious Foods and Beverages Offered Outside of School Meals, $45,182, increase the number of youth and adolescents at a healthy weight by employing a spectrum of evidence based strategies in schools, school districts and out-of-school care.
- PA-3 Adolescent Aerobic Physical Activity and Muscle-Strengthening Activity, $29,277, will increase the number of adolescents who meet the recommended level of physical activity per week.

- **Program Title**: Office of Public Health & Performance Management (OPHPM)
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- PHI-2 Continuing Education of Public Health Personnel, $172,266 of this total will be utilized to increase the workforce development and training opportunities for Public Health workers in Indiana utilizing the Indiana IN-TRAIN web-based training system and other eLearning tools.
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- The Indiana State Medical Association will receive $2,500 for ISDH to become a CME Accrediting body.
- The Public Health Foundation will receive $70,000 to provide Indiana access to the TRAIN platform.
- PHI-13 Epidemiology Services, $115,282 of this total will be utilized to increase analytical capacity of epidemiologists and data analysts using SAS through a SAS expert and increasing the number of surveys of BRFSS. $131,840 (Direct Assistance) will also be used to analyze and interpret data to

assess the burden of chronic disease, provide information on the distribution and risk factors for chronic diseases necessary for public health program planning and implementation, and assist in evaluating the success of public health programs.

- ICF Macro will receive $30,000 to supplement the 2018 BRFSS with additional surveys to increase the ISDH's ability to detect changes in trends and to improve the reporting of risk factors and chronic disease prevalence by race/ethnicity and age group.
- PHI-15 Health Improvement Plans, $178,257 of this total will be utilized to continue to increase the capacity for local health departments and nonprofit hospitals to conduct community health assessments and improvement plans by improving access to county level secondary data to all 92 counties in Indiana through the Indiana Indicators data dashboard website and by hiring staff to provide technical assistance.

- Indiana Business Research Center will receive $15,000 to assist the OPHPM program with these activities.
- PHI-16 Public Health Agency Quality Improvement Program, $192,013 of this total will be utilized to enhance the capability of Indiana health departments in the area of agency performance management and quality improvement utilizing Lean principles through a contract with Purdue Healthcare Providers and by building capacity among ISDH staff to conduct quality improvement work throughout the agency. OPHPM will track pertinent metrics for the agency is assist programs in monitoring performance measures.

- Purdue Healthcare Advisors will receive $25,000 to assist OPHPM with these activities.
- OPHPM will contract with the performance management vendor, VMSG, for $5,000 to help with these activities.
- PHI-17 Accredited Public Health Agency, $214,732 of this total will be utilized to author the State Health Assessment, State Health Improvement Plan, and other required plans to achieve public health accreditation; ensuring all required documentation and policies are gathered to support all Public Health Advisory Board standards and measures; provide technical assistance to local health departments interested in pursuing public health accreditation.

- Public Health Advisory Board will receive $22,000 to maintain accreditation status.
- There will be a request for applications for $15,000 so that local health departments can receive support in their efforts to improve quality and meet their performance management needs.

- **Program Title**: TB/Refugee Control Program
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- IID-31 Treatment for Latent TB Infection (LTBI), $131,394 of this total will be utilized to increase the number of LTBI cases reported as well as increasing the percentage of contacts to sputum smear-positive tuberculosis cases that complete treatment after being diagnosed with latent tuberculosis infection and initiated treatment.

- **Program Title**: Water Fluoridation Program
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- OH-13 Community Water Fluoridation, $242,449 of this total will be utilized to monitor fluoridation equipment and fluoride levels in drinking water in communities and schools on a regular basis.

- Administrative costs: associated with the Preventive Health block Grant total $266,738 which is 10% of

the grant. These costs include funding for the Office of Contracts and Grants Management at ISDH.

- The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention objectives in Healthy People 2020.

Funding Priority: Under or Unfunded, State Plan (2018), Data Trend

Statutory Information

Advisory Committee Member Representation:

Advocacy group, College and/or university, Community-based organization, Community health center, County and/or local health department, Medical society or organization, Schools of public-health, State health department, State or local government, Volunteer organization, Youth serving organization

Dates:

Public Hearing Date(s):	Advisory Committee Date(s):
6/28/2018	5/1/2018
	6/22/2018

Current Forms signed and attached to work plan:

Certifications: Yes
Certifications and Assurances: Yes

Budget Detail for IN 2018 V0 R0	
Total Award (1+6)	$2,812,357
A. Current Year Annual Basic	
1. Annual Basic Amount	$2,667,385
2. Annual Basic Admin Cost	($266,738)
3. Direct Assistance	($131,840)
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$2,268,807
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$144,972
7. Sex Offense Admin Cost	$0
(8.) Sub-Total Sex Offense Set Aside	$144,972
(9.) Total Current Year Available Amount (5+8)	$2,413,779
C. Prior Year Dollars	
10. Annual Basic	$0
11. Sex Offense Set Aside (HO 15-35)	$0
(12.) Total Prior Year	$0
13. Total Available for Allocation (5+8+12)	$2,413,779

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$2,268,807
Sex Offense Set Aside	$144,972
Available Current Year PHHSBG Dollars	$2,413,779
B. PHHSBG $'s Prior Year:	
Annual Basic	$0
Sex Offense Set Aside	$0
Available Prior Year PHHSBG Dollars	$0
C. Total Funds Available for Allocation	$2,413,779

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL Year PHHSBG $'s
Chronic Disease, Primary Care and Rural Health	HDS-1 Cardiovascular Health	$495,470	$0	$495,470
Sub-Total		**$495,470**	**$0**	**$495,470**
Food Protection	FS-6 Safe Food Preparation Practices in Food Service and Retail Establishments	$136,795	$0	$136,795
Sub-Total		**$136,795**	**$0**	**$136,795**
Injury Prevention Program	IVP-4 Child Fatality Review of Child Deaths Due to External Causes	$50,000	$0	$50,000
	IVP-11 Unintentional Injury Deaths	$181,591	$0	$181,591
Sub-Total		**$231,591**	**$0**	**$231,591**
Nutrition and Physical Activity	NWS-2 Nutritious Foods and Beverages Offered Outside of School Meals	$45,182	$0	$45,182
	PA-3 Adolescent Aerobic Physical Activity and Muscle-Strengthening Activity	$29,277	$0	$29,277
Sub-Total		**$74,459**	**$0**	**$74,459**
Public Health Performance Infrastructure	PHI-2 Continuing Education of Public Health Personnel	$172,266	$0	$172,266
	PHI-13 Epidemiology Services	$115,282	$0	$115,282
	PHI-15 Health Improvement Plans	$178,257	$0	$178,257
	PHI-16 Public Health Agency Quality Improvement Program	$192,013	$0	$192,013
	PHI-17 Accredited Public Health Agencies	$214,732	$0	$214,732
Sub-Total		**$872,550**	**$0**	**$872,550**
Sexual Assault Services (SAS) - Education and	IVP-40 Sexual Violence (Rape Prevention)	$229,071	$0	$229,071

Outreach				
Sub-Total		**$229,071**	**$0**	**$229,071**
Tuberculosis (TB) Control Program/Refugee Health	IID-31 Treatment for Latent TB	$131,394	$0	$131,394
Sub-Total		**$131,394**	**$0**	**$131,394**
Water Fluoridation Program	OH-13 Community Water Fluoridation	$242,449	$0	$242,449
Sub-Total		**$242,449**	**$0**	**$242,449**
Grand Total		**$2,413,779**	**$0**	**$2,413,779**

State Program Title: Chronic Disease, Primary Care and Rural Health

State Program Strategy:

Goal: Between October 2018 and September 2019, the Indiana State Department of Health (ISDH) - Division of Chronic Disease, Primary Care, and Rural Health (CDPCRH) seeks to reduce the disparities and overall burden of chronic disease in Indiana, and improve the quality of life of those individuals affected by chronic diseases. The Section on Cardiovascular Health and Diabetes within CDPCRH seeks to monitor and improve cardiovascular health (CVH) and Diabetes (DM) outcomes, and implement effective strategies for prevention; the Cancer Section within CDPCRH seeks to monitor and reduce cancer disparities and overall burden in Indiana, and improve prevention and screening behaviors; the Chronic Respiratory Disease Section seeks to monitor and reduce disparities and overall burden related to asthma and other chronic respiratory diseases. The CDPCRH also seeks to address disparities and overall burden of chronic diseases in Indiana through both organizational policies, health systems strategies to improve clinical care, convening of statewide partners to address chronic disease, and statewide health communications. Targets in burden reduction include increasing the percentage of individuals in targeted settings with their asthma, diabetes and hypertension under control to decrease morbidity and mortality associated with these conditions. Efforts to increase primary screenings for breast, cervical and colorectal cancers should reduce colorectal and cervical cancer incidence and mortality associated with these cancers. Additionally, clinical quality improvement activity will serve to reduce dependence on emergency department care for individuals with ambulatory sensitive conditions, specifically asthma, diabetes and hypertension.

Program Priorities:

• Improve surveillance, analysis, and communication of CVH, DM, Cancer, and Asthma indicators and risk factors in Indiana

• Lead coordinated statewide efforts to improve CVH, DM, Cancer, and Asthma outcomes.

• Advance evidence-based public health strategies to improve the chronic disease burden in community settings through systems-level change, policy, and health communications.

Primary Strategic Partnership(s):

• **Internal:** Division of Nutrition and Physical Activity and Tobacco Prevention and Cessation

• **External:** Indiana Minority Health Coalition, Indiana Cardiovascular Health and Diabetes Coalition, Indiana Cancer Consortium, Indiana Joint Asthma Coalition, American Heart Association, Indiana Institute on Disability and Community, American Diabetes Association, American Cancer Society, American Lung Association, Indiana Public Health Association, Indiana Primary Health Care Association, and Indiana Rural Health Association.

Role of PHHSBG Funds: Strengthen state ability to provide statewide data surveillance and analysis related to chronic disease; support strategies to prevent and control high blood pressure and diabetes; convene statewide organizational partners in order to develop collaborative systems and policy initiatives to improve the state's chronic disease burden; assess initiatives related to non-provider health professionals and their role in addressing chronic disease in Indiana; support implementation and evaluation of strategies to address disease prevention and control, medication therapy management, health systems quality improvement, and complex care management; and ensure evaluation methodology utilized by chronic disease public health staff address cost effectiveness of initiatives.

Evaluation Methodology: CDPCRH follows national evaluation guidelines as put forth by the CDC Framework for Evaluation and individual CDC evaluation guides for state-based chronic disease public health programs. Annual evaluation plans are utilized to monitor processes and impact of division and section initiatives. Additionally, in order to evaluate support provided to local communities for community-wide initiatives, an evaluation plan including process and intermediate outcomes measures will be implemented in collaboration with community partners. These evaluation methods will be operationalized in the following manner:

10 1. Address health disparities and improve outcomes by preparing workforce: Evaluation will occur via process and health indicator reporting, in-person learning sessions, process mapping and key-informant interviews. Outcomes and economic data will be collected and assessed. Projects involving complex care management, medication therapy management and non-provider community based interventions, including the use of non-traditional workforce members such as paramedics are being conducted as pilots so evaluation will focus on identifying best-practices, determining generalizability and portability of processes, and on developing an evaluation protocol for post-pilot implementation, spread and sustainability. Additionally, web-analytics will be used to assess convenience and effectiveness of internet-based resources and learning platforms.

10 2. Analytic capacity development and expansion: Evaluation will focus on measuring improvements in staff analytic skills, technical capacity and productivity. CDPCRH will work with internal partners (Maternal and Child Health, Tobacco Prevention and Cessation, Women, Infants and Children, and the Epidemiology Resource Center) to develop assessment instruments informed by Council of State and Territorial Epidemiologists and CDC competency standards. Findings will be reported to agency leadership with review by partners with the capacity to support ongoing staff development. Feedback processes will be put in place to act on the findings and further advance staff development. FTE supported through this objective will participate in agency performance evaluation processes.

10 3. Convene and mobilize state-level stakeholders to address critical health burdens related to chronic disease: Evaluation will be tailored for each stakeholder group and will address process and outcome assessment, as well as effectiveness of partnerships. The division will conduct surveys and key informant interviews with stakeholder organizations to assess reach, scope and effectiveness of activity.

Stakeholder activity will be linked to, and performance measures will be based on, HP2020 strategies and objectives. Success stories will be tracked for each organization represented. Monthly conference calls, quarterly progress reports and formal evaluation summaries will facilitate oversight of the respective groups.

State Program Setting:

Community based organization, Medical or clinical site, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO HDS-1 Cardiovascular Health

State Health Objective(s):

Between 10/2017 and 09/2018, reduce hospitalizations and emergency room admissions and increase self-management and prevention of cardiovascular disease, diabetes, asthma, and cancer and chronic obstructive pulmonary disease (COPD) by mobilizing statewide chronic disease partners, including subject matter coalitions and a 7-county hospital system. Five coalitions will develop and update plans to address Indiana's chronic disease burden and a hospital system will design and implement a training program for paramedics and emergency services personnel to serve nursing home and home-bound individuals with chronic diseases in non-emergent settings.

Baseline:
Indiana adults have high rates of hypertension (34%), smoking (22%), obesity (32%), asthma (10%), high

cholesterol (40%), and diabetes (11%). Additionally, the state demonstrates low percentages of screenings for breast (68%) cervical (73%), and colorectal cancer (63%). Surveillance indicates that 60% of hypertensives, 70% of diabetics, and 78% of asthmatics meet minimal standards of control.

Data Source:
ISDH records: Behavioral Risk Factors Surveillance System (BRFSS), hospital discharge data, mortality data, natality data, census, reporting from Indiana Primary Care Learning Collaborative

State Health Problem:

Health Burden:
Chronic diseases such as heart disease, stroke, cancer, chronic lower respiratory diseases and diabetes are the leading causes of death in Indiana. In 2014, more than 50% of all deaths were attributed to these five diseases. The financial impact of chronic diseases on Indiana's economy is substantial. In its milestone report, "An Unhealthy America: The Economic Impact of Chronic Disease," the Milken Institute (MI) illustrates the enormous economic cost of chronic diseases in the United States. Based on the 2015 America's Health Rankings by United Health Foundation and the American Public Health Association, Indiana is ranked 41 out of 50 states for overall health.

Economic Impact of Major Chronic Diseases in Indiana: (Annual estimated costs in billions)
Treatment Expenditures: **$8.4**
Lost Productivity: **$24.6**
Total Costs: $32.9

Common Chronic Diseases in Indiana:
Heart Disease and Stroke
-Heart disease was the leading cause of death (13,954 deaths) in Indiana in 2016
-Stroke was the fourth leading cause of death (3,040 deaths) in Indiana in 2016
-In 2015, 32.4% of Indiana residents reported having high blood pressure
-In 2015, nearly 39.1% of those screened reported having high blood cholesterol, a risk factor for developing heart disease and stroke
Cancer
-Cancer was the second leading cause of death (13,424 deaths) in Indiana in 2016.
-More than 31,000 new cancer cases were diagnosed in Indiana in 2014, which includes 4,611 new cases of breast cancer among women and 2,977 new cases of colorectal cancer.
-Early detection for breast and colorectal cancer improves long-term outcomes, but in populations 50-75 years of age, only 8% have had a blood stool test in the past 2 years and 62% have had a sigmoidoscopy or colonoscopy within the recommended time frame. Additionally, only 72% of women 50-74 years of age have had a mammogram within two years.
Diabetes
-Diabetes was the seventh leading cause of death (1,994 deaths) in Indiana in 2016. Although diabetes is considered to be under-reported as the primary cause of death, risk of death among people with diabetes is about twice as high as people of similar age without diabetes. In the same year, over 5,000 additional deaths in Indiana listed diabetes as a contributing cause.
-In 2015, 11.4% of adults, over 574,000 individuals 18 and older, reported being diagnosed with diabetes.
Asthma
Asthma affects an estimated 23 million people every year in the United States. In Indiana, approximately 1 in 10 (10.2%) adults (age 18 years or older) reported having asthma in 2016.
-There were 55 deaths due to asthma in 2016.
-There were 30,904 emergency room visits due to asthma in 2014 – a decrease of nearly 403 visits (1.3%) from 2013.
-Nearly 7,091 hospitalizations were recorded due to asthma in 2014, which decreased by 1.5 percent from

2013.

Target Population:
Number: 6,570,902
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,500,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau; BRFSS; hospital discharge; mortality records; natality records; IN Primary Care Learning Collaborative; Milken Institute On Unhealthy America:The Economic Burden of Chronic Disease

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Glynn LG, Murphy AW, Smith SM, Schroeder K, Fahey T. Interventions used to improve control of blood pressure in patients with hypertension. Cochrane Database of Systematic Reviews 2010, Issue 3.

Guide to Clinical Prevention Services (for screening); Health Affairs November 2010 issue: Designing Insurance to Improve Value in Health Care

How to Increase Colorectal Cancer Screening Rates in Practice: A Primary Care Clinician's* Evidence-Based Toolbox and Guide 2008: http://www5.cancer.org/aspx/pcmanual/default.aspx; http://www.cancer.org/acs/groups/content/documents/document/acspc-024588.pdf

NCI Patient Navigator Research Program http://crchd.cancer.gov/pnp/pnrp-index.html

Community Health Workers National Workforce Study. U. S. Department of Health and Human Services Resources and Services Administration Bureau of Health Professions. Community Health Worker National Workforce Study. 2007.
http://bhpr.hrsa.gov/healthworkforce/chw/

Asthma: A Business Case for Employers and Health Care

The Asheville Project http://www.pharmacytimes.com/files/articlefiles/TheAshevilleProject.pdf

Surgeon General's Call to Action to Promote Healthy Homes (www.surgeongeneral.gov/topics/healthyhomes/calltoactiontopromotehealthyhomes.pdf

Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness. JAMA. 2002; 288(14)1775-9.

Bodenheimer T, Wagner EH, Grumbach K. Improving Primary Care for Patients with Chronic Illness-Part Two. JAMA 2002; 288(15)1909-14. 2002.

Flex Monitoring Team. Briefing Paper No. 34—the Evidence for Community Paramedicine in Rural Areas: State and Local Findings and the Role of the State Flex Program. Portland, ME. 2014.

Community Paramedicine Evaluation Tool. 2012. U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy: Rockville, MD.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $495,470
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Advanced workforce development (ES8)

Between 10/2017 and 09/2018, Crawfordsville Fire Department will analyze **1** set of data from home visits provided by fire department paramedics.

Annual Activities:

1. Community paramedicine protocol and evaluation platform

Between 10/2017 and 09/2018, CDPCRH will work with community based fire department personnel to refine protocols, establish best practices, and develop evaluation processes for community paramedicine activity. Community paramedicine will capitalize on the healthcare capacity of paramedics and EMTs during non-emergent periods to maximize the reach of clinical practices and support self-management behaviors and serve as health coaches and physician extenders for targeted panels of patients to improve blood-sugar management in diabetics, improve compliance in hypertensive individuals, support pre-natal and postnatal care, mitigate fall risk in seniors, and reduce re-admission for conditions such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD), SIDS and SUIDS.

2. Community Paramedicine Summit

Between 10/2017 and 09/2018, hold a paramedicine summit for interested entities including hospitals, fire departments, and local health departments.

Objective 2:

Chronic Disease Coalitions (ES4)
Between 10/2017 and 09/2018, the Cardiovascular and Diabetes Coalition of Indiana, Indiana Healthy Weight Initiative, Indiana Joint Asthma Coalition, and the Task Force on Disability and Health with the oversight of CDPCRH will provide technical assistance (in the form of communication support, community-clinical linkages, data systems, economic analysis, evaluation, geospatial analysis and statistical analysis) to develop and implement strategic health improvement plans based on current disease burden and evidence-based practices to **5** groups of community-level stakeholders capable of influencing prevention, management and palliation associated with chronic diseases including asthma, cancer, cardiovascular disease and diabetes, and obesity, and populations experiencing health inequities.

Annual Activities:

1. Provide technical assistance to statewide chronic disease stakeholders to improve disease outcomes
Between 10/2017 and 09/2018, CDPCRH will convene and support community-based coalitions to provide technical assistance to **5** community-level stakeholder groups including those for cancer, asthma, obesity, cardiovascular health and diabetes, and disabilities. CDPCRH will work closely with statewide and community-based partners to ensure that strategic plans and activities are informed by scientific research, current surveillance evidence and represent best- or evidence-based practices; maximize the resources available to the coalition for purposes of coordination, communication, and effective work; and address long-term spread and sustainability of effective chronic disease partnerships. CDPCRH will provide technical assistance to the coalition partners in the areas of evidence-based public health programming, organizational policy to address the chronic disease burden in Indiana and health systems initiatives to improve chronic disease outcomes. Additional technical assistance related to data and surveillance, evaluation and geospatial analysis will be provided to coalitions.

2. Evaluation of progress associated w/ chronic disease strategic plans in asthma, cancer & obesity
Between 10/2017 and 09/2018, CDPCRH will provide technical assistance to 5 community partnerships to support their capacity to assess statewide progress associated with their respective disease state strategic plans, including the development of a summary report on current health status for these disease areas or special populations (disabled) impacted by these diseases, a communications platform for the information resulting from the evaluation, and strategies to further progress towards achieving long-term strategic objectives. Specific topics to be addressed include asthma (HP2020 RD-2,-3,-7), cancer (HP2020 C-9,-10,-11,-15,-16,-17,-18), diabetes (HP2020 D-5,-6,-7,-9,-10,-11,-14) and heart disease (HP2020 HDS-7,-12,-24).

3. Plan Implementation
Between 10/2017 and 09/2018, CDPCRH will work with 5 coalitions of statewide community organizations to implement strategic health improvement plans associated with asthma (HP2020 RD-2,-3,-7), cancer (HP2020 C-9,-10,-11,-15,-16,-17,-18), diabetes (HP2020 D-5,-6,-7,-9,-10,-11,-14) and heart disease (HP2020 HDS-7,-12,-24), as well as special populations impacted by these conditions (disabilities). Included in this activity will be comprehensive surveillance, communication, and evaluation activity, with special focus on public access dashboards such as Indiana Indicators.

State Program Title: Food Protection

State Program Strategy:

Goal: Between October 2018 and September 2019, the Indiana State Department of Health Food Protection Program (FPP) will have recently completed the rollout of the new USA Food Safety system, making it available to all counties willing to convert from a paper-based or older computer-based system. USA Food Safety has already proven itself as a reliable tool by internal inspectors within ISDH, and during this period, use of the tool will be expanded to counties statewide.

The USA Food Safety system is designed to improve business process, reporting capabilities, Geographic Information System (GIS) and mobile capabilities. ISDH went live with USA Food Safety for internal use only in 2017, and addressed production issues in 2017 and 2018.

ISDH is working with vendor Computer Aid Inc. (CAI) to add features that will ease the transition of counties to the new system. Foremost among these new features are:

1. A process to import existing facilities and inspections from a county's existing IT system. Importing potentially years of existing data will allow counties to avoid the countless hours of unnecessary typing to reenter data that is already an electronic form.
2. A web service for fast real time transmission of an inspection data from counties. This will be of interest to counties that wish to share data with the state electronically while keeping their existing food inspection software systems in place. These counties may use USA Food Safety for reporting, but will use the web data link in place of the web-based data entry module to transmit inspection data to ISDH.

ISDH envisions a three-phase rollout of USA Food Safety two counties:

- Phase 1: Those counties that have no need to import data. These are probably the counties that are not computerized.
- Phase 2: Those counties wishing to import their existing facilities and inspections into USA Food Safety, and start using the USA Food Safety web interface.
- Phase 3: Those counties that are satisfied with their existing IT Systems, and want to use the web services data link to transmit inspection data in real-time.

Program Priorities: The Senior Level Application System Analyst/Developer will work with local health departments and other interested submitters to set up web services data links. Educational sessions will be held to explain the benefits for a submitter considering moving to the new system, and user training will be provided. The developer will assist the helpdesk in providing user support for non-routine issues, as well as overflow support when the regular help desk is unavailable. The developer will serve as the main technical contact with Computer Aid Inc., the USA Food Safety vendor.

Primary Strategic Partnerships(s):

• **Internal:**

- ISDH's Food Protection Program
- ISDH's Office of Technology & Compliance
- Indiana Office of Technology

• **External:**

- Indiana local health departments and universities.
- Computer Aid Inc.

Evaluation Methodology: Included in the ISDH strategic plan, strategic priorities include decreasing disease incidence and burden; improving response and preparedness networks and capabilities; better use of information and data from electronic sources to develop and sponsor outcomes-driven programs; and

improving relationships and partnerships with key stakeholders, coalitions, and networks throughout the State and the nation. The development of a state-wide database of food inspection and investigation data will aid in addressing these priorities, and progress is tracked in program standards and cooperative agreement progress reports. These reports include specific objectives related to the functionality and growth of the system.

Work Plan – Goals/Mile Stones Activities for Year 2018 – 2019

1. Phase 1: October 2018 – May 2019
   Onboarding of counties using USA Food Safety interface (no data transfer) Conduct training sessions with counties, and bring them on board as new USA Food Safety users. This batch of counties will start using USA Food Safety with no historical facility inspection information imported from their previous computer systems.
   Continued development and testing of web services data link.

2. Phase 2: June 2019 – September 2019
   Onboarding of counties using USA Food Safety interface (with data transfer) This batch of counties will start using USA Food Safety following an import of facility and inspection data, which the counties will provide in CSV files that they have exported from whatever existing IT system they have.

3. Phase 3: June 2019 – September 2019
   Onboarding of counties using data link
   This batch of counties will not use USA Food Safety directly, at least not as their primary means of transmitting inspection information to ISDH. Instead, they will rely on a web services data link to transfer information on new inspections.

State Program Setting:

Local health department, State health department, University or college

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO FS-6 Safe Food Preparation Practices in Food Service and Retail Establishments

State Health Objective(s):

Between 10/2017 and 09/2018, measure and improve the compliance of fast-food and full service restaurants in Indiana with food safety sanitation requirements. Further develop use and import of data into an electronic system to capture and evaluate food safety inspection and investigation information.

Baseline:
Currently there is not a statewide database of food inspection and investigation data. Fast-food and full-service restaurants in Indiana operate under the jurisdiction of the Indiana State Department of Health, 93 local health departments, and 3 universities. The goal is to increase the capacity by moving to a more efficient and effective system that is already incorporating national program standards into a statewide food

inspection and investigation data system.

Data Source:
Healthy People 2020, Indiana State Department of Health

State Health Problem:

Health Burden:
Consumers continue to be impacted by foodborne illness outbreaks to the tune of 48 million cases, 128,000 hospitalizations, and 3,000 deaths in this country each year (2013 FDA Model Food Code, Scallan et al). Financial burden of $10-83 billion annually in lost productivity, pain and suffering, and medical costs is estimated (2013 FDA Model Food Code, Meade et al). The issue is that despite all of our efforts, we continue to experience illness and loss of life in Indiana. Gathering and analyzing comprehensive and current data in Indiana is critical so that resources can more effectively target foodborne illness risk factors. The following data was obtained from the Indiana State Health Improvement Plan (I-SHIP) 2014 updated version and the ISDH Epidemiology Resource Center 2016 Annual Report of Infectious Diseases.
Enteric illnesses are prevalent yet are underreported in Indiana as well as across the U.S. The table below describes confirmed cases of reportable enteric illnesses from 2010 to 2016 in Indiana residents.

Condition	2010	2011	2012	2013	2014	2015	2016	Average
Botulism	0	1	0	0	1	0	0	0.43
Campylobacteriosis	864	750	741	875	862	920	1043	865
Cryptosporidium	285	263	164	139	185	189	213	205.4
Giardiasis*	399	325	227	203	168	181	197	242.9
Hepatitis A	11	24	11	32	20	19	18	19.3
Hepatitis E	0	3	3	4	1	2	2	2.1
Hemolytic Uremic Syndrome (HUS)	0	2	11	9	7	10	11	7.14
Listeriosis	15	11	10	11	8	19	15	12.7
Salmonellosis	786	650	782	707	733	668	799	732.1
Shiga-toxin producing E.coli (STEC)	144	147	191	151	168	136	101	148.3
Shigellosis	64	91	161	117	1366	278	291	338.3
Typhoid Fever	0	4	0	4	5	6	7	3.7
Vibriosis	0	2	2	9	6	3	12	4.9
Yersiniosis	13	11	10	6	13	10	13	10.9

Sources:
- I SHIP 2014-2016

http://www.in.gov/isdh/25733.htm
- HUS rates 2013/2014 Epidemiology Resource Center ISDH
- ISDH Annual Report of Infectious Diseases
- http://www.in.gov.isdh/files/2016%20Annual%20Infectious%20Diseases.pdf

These enteric illnesses are identified by passive surveillance through identification by laboratory diagnosis or epidemiologic linkage. Indiana State Department of Health's (ISDH) current system is to follow-up with every reported case. Interviews are conducted by the local health department (LHD) in the county of residence to collect demographic, clinical, risk factor, and other pertinent information using a standardized questionnaire that is specific to the etiologic agent causing illness. These interviews are not dependent on serotype or pulsed-field gel electrophoresis (PFGE) results but are conducted upon initial notification. Information collected from LHD case interviews, reference laboratories, and the ISDH laboratory (serotype and confirmatory testing) is entered into the Indiana National Electronic Disease Surveillance System (INEDSS) for review by the Enteric Epidemiologist. Local clusters with common risk factors or serotypes are identified

at this time.
In addition to passive surveillance activities, ISDH also conducts outbreak investigations for enteric illnesses often initiated through received complaints. In 2015, the ISDH Food Protection Program, with the assistance of local health departments, investigated 331 total food related complaints, with 93 (28%) due to illness. In 2016, 275 total related complaints were investigated, with 66 (24%) due to illness.

Improvements in molecular laboratory testing methods of enteric bacteria have made it easier to identify foodborne disease outbreaks at a State and National level.

Target Population:
Number: 6,400,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 6,400,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: US Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Partnership for Food Protection - Business Process Evaluation and Improvement Tool for Inspection Systems (A Partnership for Food Protection Resource Document)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $136,795
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

USA Food Safety in Indiana, Expansion to Counties

Between 10/2017 and 09/2018, Senior Level Application System Analyst/Developer will maintain **1** new data system. Additional objective will be to expand the data system. Some of the important activities are data conversion, transition of current system users to new system, bring new users on board, and to develop standardized templates for those jurisdictions that are utilizing another application to accept their food inspection data electronically through web services to import data into the new system on scheduled basis. As time permits, this position will also support users in their installation and use of this inspection software.

Annual Activities:

1. Onboarding of counties using USA Food Safety interface (no data transfer)

Between 10/2017 and 09/2018, Timeline: October 2018 – May 2019

Conduct training sessions with counties, and bring them on board as new USA Food Safety users. This batch of counties will start using USA Food Safety with no historical facility inspection information imported from their previous computer systems.

Continued development and testing of web services data link.

2. Onboarding of counties using USA Food Safety interface (with data transfer)

Between 10/2017 and 09/2018, Timeline: June 2019 – September 2019

This batch of counties will start using USA Food Safety following an import of facility and inspection data, which the counties will provide in CSV files that they have exported from whatever existing IT system they have.

3. Onboarding of counties using data link

Between 10/2017 and 09/2018, Timeline: June 2019 – September 2019

This batch of counties will not use USA Food Safety directly, at least not as their primary means of transmitting inspection information to ISDH. Instead. They will rely on a web services data link to transfer information on new inspections.

State Program Title: Injury Prevention Program

State Program Strategy:

Goal: Between October 2018 and September 2019, continue developing an Injury Prevention Program for the State of Indiana that will ultimately lead to a reduction in the number of preventable injuries and deaths.
Program Priorities: The Indiana State Department of Health (ISDH) has continued to develop an organized Injury Prevention Program. The agency has maintained an injury epidemiologist to conduct injury surveillance, prepare epidemiologic reports related to injury and serve as a subject matter expert of injury incidence and risk factors. The ISDH will continue to prioritize the efforts needed to more fully develop an Injury Prevention Program for its citizens.
Primary Strategic Partners:
Internal:
Child Fatality Review Epidemiology Resource Center
Indiana Violent Death Reporting System Program Maternal and Child Health
Office of Women's Health Trauma Program
Vital Records
External:
Attorney General's Prescription Drug Abuse Prevention Task Force Bi-weekly Health User Group GIS
CDC Injury Center
Coroners
Great Lakes and Mid-Atlantic Regional Network Indiana Criminal Justice Institute
Indiana Department of Homeland Security Midwest Injury Prevention Alliance
Indiana Hospital Association Indiana Poison Control
Indiana State Trauma Care Committee Indiana Trauma Network
Safe Kids Safe States Alliance
Senator Head's Substance Abuse and Child Safety Task Force Indiana Injury Prevention Advisory Council
State and Local Child Fatality Review Teams State Epidemiology Outcomes Workgroup
Evaluation Methodology: The development of a core Injury Prevention Program that will ultimately lead to acquisition of data, analysis, and development of appropriate activities.
The Indiana Child Fatality Review (CFR) Program will monitor the success of the projects activities by:

- The number of trainings held, as well as the number of individuals trained.
- The percentage of teams receiving technical assistance regarding mortality/morbidity data and guidance on injury prevention programs/activities.
- The percentage of teams receiving assistance funding implementation of evidence-based injury prevention programs/activities.
- The number of teams receiving Indiana-specific CFR program manuals.
- The percentage of fatality cases with improved timeliness of identification to local teams.

The ultimate measure of the success of this program will be in a decrease in the number of preventable child deaths in Indiana. However, this will be long-term trend data and might not reflect within the 12- month grant period described here.

State Program Setting:

Community based organization, Local health department, State health department, Other: Child Fatality Review Teams

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO IVP-4 Child Fatality Review of Child Deaths Due to External Causes

State Health Objective(s):

Between 10/2017 and 09/2018, prevent an increase in death and hospitalization of children due to external causes through implementing best-practices needed to meet the National Center for the Review and Prevention of Child Deaths (NCRPCD) data quality standards which include reporting of timely and complete review, data entry, and quality assurance procedures so Child Fatality Review (CFR) data may be included in pediatric injury prevention and improved health outcomes.

Baseline:

In Indiana, injury is the leading cause of death for children ages 1-17 years. From 2012-2014 in Indiana, there were 681 children who died from injuries (ages 0-17 years). This is an average of 227 preventable deaths per year. The leading causes of injury and death--falls, transport-related, homicide, suicide, suffocation, and drowning--for children differ by risk factors such as age group, gender and geographic area.

Data Source:
Indiana State Department of Health, CDC, and National Center for the Review and Prevention of Child Deaths

State Health Problem:

Health Burden:
Injuries are a major public health problem across the United States and in Indiana. Injuries are not random chance events, but follow a predictable sequence of events, and can be prevented using specific strategies. In Indiana, injury is the leading cause of death for children ages 1-17 years and contribute to significant morbidity. From 2012-2014 in Indiana, there were 681 children who died from injuries (ages 0-17 years). This is an average of 227 preventable deaths every year. For every child that dies in Indiana, there are thousands of hospitalizations and hundreds of thousands Emergency Department (ED) visits. From 2011-2013, there were more than 6,000 hospitalizations and more than 430,000 ED visits. The human suffering and financial burden of pediatric injuries in Indiana is staggering.

Actionable knowledge is critical in implementing successful prevention strategies. Many child fatality teams in Indiana are newly formed, so helping to build capacity and assist in informing and implementing prevention strategies is crucial. Providing training to the teams on data quality improvement, and assisting them with using data to inform prevention strategies while helping them identify and implement evidence-based prevention programs and resources, will help catalyze and guide the teams to turn knowledge into action.

Target Population:
Number: 95,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 95,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: ISDH Vital Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $50,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Improve pediatric injury prevention programs and resources at the local level
Between 10/2017 and 09/2018, CFR program staff will provide assistance in implementing community level, evidence-based injury prevention programs and resources to **20%** of local CFR teams and member agencies.

Annual Activities:

1. Pediatric injury mortality and morbidity data
Between 10/2017 and 09/2018, provide statewide, regional and county specific, pediatric injury mortality and morbidity data to 100% of local teams.

2. Technical Assistance
Between 10/2017 and 09/2018, provide technical assistance to 5% of teams, or member agencies, to help analyze data, identify injury cause, mechanism trends and determine evidence-based injury prevention programs, activities and resources to address these issues.

3. Funding evidence-based injury prevention
Between 10/2017 and 09/2018, provide funding to 5% of local teams, or member agencies, and assist with the implementation of evidence-based injury prevention programs, activities and resources.

4. State Training
Between 10/2017 and 09/2018, provide training(s) for members of the local fatality review teams and member agencies. Develop a plan to record, publish and archive the statewide training materials for reference by

local teams and use by future child fatality review members. Develop a plan for collecting data from participants to determine success of the training and assess gaps in the training that will be addressed in future educational events.

Objective 2:

Train local child fatality review teams to improve the number and quality of cases reported entered

Between 10/2017 and 09/2018, CFR teams will increase the number of reports entered into the NCRPCD case reporting system (CRS) from 100 to **130**.

Annual Activities:

1. Regional trainings

Between 10/2017 and 09/2018, CFR program staff will provide regional trainings to 80% of local teams in appropriate data collection and data entry into the Child Death Review (CDR) database.

2. Indiana Child Fatality Review Program Guide

Between 10/2017 and 09/2018, based on information, suggestions and requests from local teams at the regional trainings, CFR program staff will author a program manual for Child Fatality Review (including data entry) for the state of Indiana.

3. Collaboration with DCS

Between 10/2017 and 09/2018, CFR program staff will collaborate with Department of Child Services (DCS) to improve timeliness of 80% of DCS fatality cases to be identified by local teams within 30 days of date of death.

4. Data report cards to local teams

Between 10/2017 and 09/2018, CFR program staff will analyze 100% of pediatric vital records death data to inform quality improvement of data at the local level and produce a data report to teams that outline number of cases entered into the NCRPCD CRS, updates, areas for improvement, etc.--a data report card to improve the quality of data reported to the Child Death Review database. This report card process will then continue to be used on a quarterly basis after the grant period has ended.

National Health Objective: HO IVP-11 Unintentional Injury Deaths

State Health Objective(s):

Between 10/2017 and 09/2018, the Division of Trauma and Injury Prevention will work toward reducing the number of unintentional injury deaths in Indiana by 10% through the continued development of a comprehensive injury and violence prevention program at the state health department. The program will provide prevention partners focus and direction from the state to maximize injury and violence prevention resources.

Baseline:

The age-adjusted mortality rate for Indiana in 2016 was 51.4 per 100,000. The Division of Trauma and Injury Prevention hopes to improve this rate by 10% to 46.4 per 100,000. The Healthy People 2020 goal is 36.0 per 100,000.

Data Source:

Centers for Disease Control and Prevention (CDC) Web-based Injury Statistics Query and Reporting System (WISQARS)

State Health Problem:

Health Burden:
Injuries are a serious public health problem in Indiana. Injuries often result in trauma, possible lifelong disabilities, or even death. In Indiana, unintentional injury is the leading cause of death among persons 1 to 44 years of age and the fifth leading cause of death overall following heart disease, malignant neoplasms (cancer), chronic lower respiratory disease and stroke. Fatality rates and hospitalization rates are highest among persons over the age of 75. The age-adjusted mortality rate for unintentional injuries in Indiana in 2016 was 51.4 per 100,000. The two leading causes of injury death in Indiana in 2016 were unintentional poisoning and unintentional motor vehicle traffic. Unintentional injuries contribute to the greatest years of potential life lost before age 65 in Indiana, meaning younger residents are more affected by injuries than other causes and residents older than 85 years have the highest death rate due to unintentional injuries at 323.8 per 100,000. Within the same year, more than 50,000 Indiana residents were hospitalized due to unintentional injury and an additional 498,000 were treated in emergency departments. In addition, injury fatalities caused by intentional acts, such as homicide or suicide were among the top four causes of death in Indiana in all age groups from age 5 to 54. Unfortunately, prior to 2011, Indiana lacked the resources to support a program devoted to injury prevention. Injury prevention is a key component of the developing statewide trauma system.

Target Population:
Number: 6,596,855
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 989,528
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census Bureau

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $181,591
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Injury Prevention Primary Programming
Between 10/2017 and 09/2018, Injury Prevention Program Coordinator will implement **2** primary prevention programs in the state of Indiana focusing on older adult falls and child passenger safety.

Annual Activities:
1. Injury Prevention Primary Programming - Master Trainer status
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator will achieve "Master Trainer" status in a variety of evidence-based prevention programs to reduce injury in Indiana's leading causes of injury by attending master trainer education events in areas focused on older adult falls and child passenger safety.

In order to become a certified child passenger safety technician instructor, one must:

- Become a certified technician and maintain your certification throughout your instructor candidacy
- Gain experience in the CPS field
- Gather the required information for the Application for Instructor Candidacy
- Participate in a Certification Course as a course assistant
- Register by paying the instructor candidate application fee after being a CPS technician for at least six months. At this time you also should contact a certified instructor to discuss who your mentor will be and which class you will participate in as part of your instructor candidacy.
- Submit the Application for Instructor Candidacy to Safe Kids at least six weeks prior to the registered course that you wish to participate in as an instructor candidate.
- Once you are approved as an instructor candidate, work with your mentor and lead instructor to prepare to teach.
- Teach a Certification Course within one year of being approved as an instructor candidate.
- The lead instructor and your mentor will determine if you have passed or failed instructor candidacy and will send Safe Kids your score along with the Instructor Candidate Evaluation. Upon successful completion of instructor candidacy, your status will change to Certified Instructor.
- Continue working to improve your technical and teaching skills, fulfill your obligations as an instructor, and eventually, consider becoming a lead instructor or a mentor.

In order to become a leader in the "Stepping On" Falls Prevention Program, one must:

- Attend an annual, 3-day leader workshop.
- Coordinate peer leaders in their community (adults older than 60).
- Facilitate the seven *Stepping On* workshop sessions.
- Recruit participants.
- Arrange, reserve and set up the room and equipment for the workshop sessions.
- Prepare materials needed for the sessions.
- Invite the guest experts.
- Prepare and send out the materials needed by the guest experts.
- Create the display.

Once the Injury Prevention Program Coordinator is a Stepping On leader, he will explore the possibility of the Indiana State Department of Health becoming a Sponsoring Organization: one that supports and works

with *Stepping On* Leaders and other partner organizations to ensure that workshops can take place in Indiana. The injury prevention program coordinator will also explore the requirements of becoming a Master Leader after becoming a Leader.

2. Injury Prevention Primary Programming - Technical Assistance
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator will work with the injury prevention coordinators around Indiana by providing technical assistance on their various projects and activities for the priority injury topics. The Injury Prevention Program Coordinator will work with community partners to implement and disseminate the CDC STEADI toolkit for falls prevention among older adults.

3. Injury Prevention Primary Programming - Collaboration
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator will participate in coalitions and work groups to help foster collaboration at the local level with the statewide goals and initiatives in injury prevention, including IN Falls Prevention Coalition and the Injury Prevention Advisory Council.

4. Injury Prevention Primary Programming - Continuing Education
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator and Injury Prevention Epidemiologist Consultant will attend conferences such as Safe States as a representative of Indiana. Attending these continuing education events will give the coordinator the opportunity to bring back findings to the local coalitions and work groups that can be implemented at the local level.

5. Injury Prevention Primary Programming - Social Media Outreach
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator will increase social media activities via Twitter and Facebook by creating actionable content that can be utilized at the local level by coalitions and work groups

6. Injury Prevention Primary Programming - Health Communications
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator will create communications working to update our website, distribute and share information with partners, grantees and the CDC.

7. Injury Prevention Primary Programming - Reporting
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator will help in the writing of any CDC-required report.

8. Injury Prevention Primary Programming - Grant Activities
Between 10/2017 and 09/2018, the Injury Prevention Program Coordinator will identify injury prevention grants and lead application process.

Objective 2:
Injury Prevention Resource Guide
Between 10/2017 and 09/2018, ISDH and the Injury Prevention Advisory Council (IPAC) will distribute the ISDH Injury Prevention Resource Guide to **250** injury prevention workers, specialists, health care workers, Indiana IPAC, Indiana Department of Child Services, and emergency departments in Indiana. The resource guide will be expanded to include other priority topics.

Annual Activities:
1. Conducting Injury Surveillance
Between 10/2017 and 09/2018, the State will conduct injury surveillance by expanding its data collection systems to include: Emergency Medical Services (EMS) (includes collecting naloxone/Narcan use), hospitals, INVDRS and rehabilitation facility databases. The injury prevention epidemiologist will provide analysis for motor vehicle injuries, fall-related injury data in collaboration with other State agencies, intentional injury data collected in the Indiana Violent Death Reporting System (INVDRS) database,

collecting naloxone/Narcan use and traumatic injuries, and analyzing poisoning and overdose data.

2. Maintain Partnerships in Support of Injury Prevention
Between 10/2017 and 09/2018, maintain partnerships with local community coalitions or organizations to promote safety, injury prevention, or violence prevention to develop injury prevention plan. The Indiana Injury Prevention Advisory Council's goal is to reduce the number and severity of preventable injuries in Indiana through leadership and advocacy. The goal is through improved collection and dissemination of data and coordination of injury prevention and control efforts, the Indiana State Department of Health will reduce injury-related morbidity and mortality in Indiana.

3. Yielding injury surveillance data
Between 10/2017 and 09/2018, the injury surveillance will yield data which we will use to drive the 5-year Injury Prevention Plan, communicate with injury prevention professionals and the general public through the development and publication of fact sheets regarding specific types of injuries, and be reported on the Trauma and Injury Prevention website of the ISDH and publish epidemiological reports related to injury such as: a tri-annual report on injuries in Indiana, an annual Fireworks Injuries report, trauma data accuracy report, etc.

4. Improving Coroner Data Collection
Between 10/2017 and 09/2018, provide training and resources to county coroner offices to improve coroner data collection. Training includes education on the Indiana Violent Death Reporting System data system. Resources may include kits to improve samplings collected by coroners.

State Program Title: Nutrition and Physical Activity

State Program Strategy:

Goal: Between October 2018 and September 2019, the Division of Nutrition and Physical Activity (DNPA) at the Indiana State Department of Health, seeks to reduce the disparities and overall burden of chronic disease in Indiana, and prevent incidence of overweight, obesity and the development of life-long debilitating chronic disease. As a sister division of the Division of Chronic Disease, Primary Care and Rural Health, DNPA is familiar with the burden and implications of failing to prevent the onset of leading causes of morbidity and mortality in Indiana. DNPA serves as the primary prevention of chronic disease in Indiana as it seeks to monitor and improve access to and consumption of healthy, nutritious foods, and access to and engagement in physical activity. DNPA addresses these tasks by working to change the *policies* of municipalities, organizations and communities, the *systems* in which Hoosiers interact, and the *environment* in which residents live, learn and work. DNPA works in domains across the life-span: from breastfeeding to aging in place. The group recognizes the importance of prevention in all settings. Currently, the group is active in: health promotion and marketing, built environment, access to healthy foods in the community, workplace wellness, access to physical activity in the community, early childcare settings, and school wellness.

Program Priorities:

- Lead coordinated statewide efforts to improve the weight status of adults, children and adolescents by increasing access to and consumption of healthy foods, and increasing access to and engagement in physical activity through systems-level change, policy, and health communications.
- Improve surveillance, analysis, and communication of overweight, obesity, breastfeeding, physical activity and nutrition indicators.

Primary Strategic Partnership(s):

Internal:

- Division of Maternal and Child Health
- Division of Chronic Disease, Rural Health and Primary Care
- Office of Women's Health
- Office of Minority Health

External:

- Indiana Minority Health Coalition
- Indiana Cardiovascular Health and Diabetes Coalition
- American Heart Association
- Indiana Institute on Disability and Community
- American Diabetes Association
- Indiana Public Health Association
- Indiana Healthy Weight Initiative

Evaluation Methodology: DNPA follows national evaluation guidelines as put forth by the CDC Framework for Evaluation and individual CDC evaluation guides for state-based chronic disease/NPAO public health programs. Annual evaluation plans are utilized to monitor processes and impact of the division and section initiatives.

Additionally, in order to evaluate support provided to local communities for community-wide initiatives, an evaluation plan including process and intermediate outcomes measures will be implemented in collaboration with community partners.

DNPA will evaluate the progress of our goals and objectives with the weight status, fruit and vegetable consumption, and physical activity data retrieved from the Youth Risk Behavior Survey (YRBS), the policies and practices retrieved from the School Health Profiles, number of training opportunities and number of schools/students reached from those trainings, and number of presentations at statewide or regional conferences.

State Program Setting:
Child care center, Schools or school district, State health department, Other: out-of-school care

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO NWS-2 Nutritious Foods and Beverages Offered Outside of School Meals

State Health Objective(s):
Between 10/2017 and 09/2018, increase the number of youth and adolescents at a healthy weight by employing a spectrum of evidence based strategies in child care settings, schools, and school districts. DNPA contract position will partner with the Indiana Department of Education, local education agencies, Office of Early Childhood and Out of School Learning, early care and education providers, and others to improve access to healthy foods and time to be physically active for the youth and adolescents in their care.

Baseline:
The baseline of 47.5% is the percentage of schools that do not sell less nutritious foods and beverages outside of school meals. DNPA will work to increase this percentage.

Data Source:
School Health Profiles, 2016

State Health Problem:

Health Burden:
According to the 2015 Youth Risk Behavior Survey (YRBS), 30.9 percent of Indiana adolescents are overweight or obese, with 12.6% of adolescents reporting they don't eat fruit one or more times per day and 7.3% don't eat vegetables one or more times per day. In addition, more than 1 in 5 (21.2%) children in Indiana are food insecure. Research tells us that youth that are overweight or obese are more likely to stay overweight/obese into adulthood. This predisposition is a risk factor for serious health conditions including cardiovascular disease, diabetes, hypertension and over a dozen types of cancers. According to the 2016 Behavior Risk Factor Surveillance System (BRFSS), 67.2 percent of Indiana adults are overweight or obese. Indiana currently has the 10th highest adult obesity rate in the nation. The 2015 BRFSS shows that 42.8% of adults report that they eat fruit less than one time a day and 26.7% report that they eat vegetables less than one time a day. Additionally, only 44.1% of adults meet aerobic physical activity recommendations and only 27.0% meet muscle strengthening recommendations.

Target Population:
Number: 1,550,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other

Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 335,219
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau; National Center for Children in Poverty, Kids Count Data Center

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Glickman, D. (2012). Accelerating progress in obesity prevention: Solving the weight of the nation. Washington, DC: National Academies Press.

Khan, L. K., Sobush, K., Keener, D., Goodman, K., Lowry, A., Kakietek, J., & Zaro, S. (2009). Recommended Community Strategies and Measurements to Prevent Obesity in the United States (Vol. 58, 1-26) (United States, CDC, National Center for Chronic Disease Prevention and Health Promotion). Atlanta, GA: Centers for Disease Control and Prevention.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $45,182
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Childhood Obesity Primary Prevention Programming
Between 10/2017 and 09/2018, Childhood Obesity Program Coordinator will implement **6** school district programs across the state to improve access to healthy foods in schools and access to physical activity during the school day, continue to provide technical assistance to any school district on wellness policy evaluations, and work to increase the number of early care and education providers that follow Child and Adult Care Food Program (CACFP) guidelines.

Annual Activities:

1. Childhood obesity primary prevention—technical assistance

Between 10/2017 and 09/2018, Program Coordinator will provide technical assistance and training to school districts and early care and education providers across the state on best practices regarding improving access to healthy food and places to be physically active.

2. Childhood obesity primary prevention—training

Between 10/2017 and 09/2018, Program Coordinator will assist with training opportunities (state-wide) on the topics of nutrition standards and food service training and schools in early care and education settings.

3. Childhood obesity primary prevention—Continuing Education

Between 10/2017 and 09/2018, Program coordinator will attend at least one national training event or conference on the topic of childhood obesity prevention, or a specific strategy with which to prevent it.

4. Childhood obesity primary prevention—Collaboration

Between 10/2017 and 09/2018, Program Coordinator will serve on three state-wide, regional, and local coalitions dedicated to childhood obesity prevention efforts. He or she will represent ISDH and promote the use of factual and evidence based strategies and efforts. Internally, Program Coordinator will collaborate with appropriate divisions including: Maternal and Child Health, Division of Chronic Disease, Rural Health and Primary Care, Office of Women's Health, Office of Minority Health. Additionally, Program Coordinator will ensure collaboration with the Indiana Department of Education, including their nutrition services department, school nurse department and physical & health education department.

5. Childhood obesity primary prevention—Statewide education

Between 10/2017 and 09/2018, Program Coordinator will present at a minimum of three statewide or regional conferences regarding evidenced based practice for school or early care and education professionals.

6. Childhood Obesity Primary Prevention Programming--Surveillance

Between 10/2017 and 09/2018, DNPA will provide incentives to schools and stipends to survey proctors in order to increase participation in in the Youth Risk Behavior Survey (YRBS), as DNPA relies heavily on this survey for childhood obesity surveillance.

National Health Objective: HO PA-3 Adolescent Aerobic Physical Activity and Muscle-Strengthening Activity

State Health Objective(s):

Between 10/2017 and 09/2018, The Division of Nutrition and Physical Activity (DNPA) will increase the number of adolescents who meet the recommended level of physical activity in a week. DNPA contract position will partner with the Indiana Department of Education, local education agencies, Office of Early Childhood and Out of School Learning, early care and education providers, and others to improve access to physical activity for the youth and adolescents in their care.

Baseline:

The baseline of 46.5% is the percentage of Indiana high school students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days prior to the survey), according to the Youth Risk Behavior Survey (YRBS). DNPA will work to increase this percentage.

Data Source:

Youth Risk Behavior Survey (YRBS).
Let's Move, Child Care Survey

State Health Problem:

Health Burden:
According to the 2015 Youth Risk Behavior Survey, the percentage of Indiana high school students who were physically active at least 60 minutes per day on 5 or more days (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey) was 46.5%.
The percentage of Indiana high school students who did not participate in at least 60 minutes of physical activity on at least 1 day (doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time during the 7 days before the survey) was 15.4%.

Target Population:
Number: 600,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 200,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census Bureau; National Center for Children in Poverty; Kids Count Data Center

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Glickman, D. (2012). Accelerating progress in obesity prevention: Solving the weight of the nation. Washington, DC: National Academies Press.

Khan, L. K., Sobush, K., Keener, D., Goodman, K., Lowry, A., Kakietek, J., & Zaro, S. (2009). Recommended Community Strategies and Measurements to Prevent Obesity in the United States (Vol. 58, 1-26) (United States, CDC, National Center for Chronic Disease Prevention and Health Promotion). Atlanta,, GA: Centers for Disease Control and Prevention.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $29,277
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Increase access to places to be physically active in Indiana
Between 10/2017 and 09/2018, Division of Nutrition and Physical Activity (DNPA) will conduct **10** professional development trainings on increasing access to physical activity for Indiana youth and adolescents.

Annual Activities:
1. Access to physical activity—training
Between 10/2017 and 09/2018, the Coordinator will be training school staff from a variety of school corporations, specifically, but not limited to, physical education teachers, out of school time organizations, and early care and education providers throughout the state. DNPA plans to reach 15 people per training.

2. Access to physical activity—Collaboration
Between 10/2017 and 09/2018, Program Coordinator will serve on three state-wide, regional, and local coalitions dedicated to childhood obesity prevention efforts. Internally, Program Coordinator will collaborate with appropriate divisions including: Maternal and Child Health, Division of Chronic Disease, Rural Health and Primary Care, Office of Women's Health, Office of Minority Health. Additionally, program coordinator will ensure collaboration with the Indiana Department of Education, including their physical and health education department.

3. Access to physical activity—policy development
Between 10/2017 and 09/2018, DNPA will work with local school districts, early care and education providers, and out-of-school-time caregivers and other community organizations on implementing site specific protocols on increasing the number of minutes of physical activity offered to youth and adolescents in their care.

State Program Title: **Public Health Performance Infrastructure**

State Program Strategy:

Goal: Between October 2018 and September 2019, the Office of Public Health Performance Management will continue to improve the overall quality and capabilities of Indiana's public health system. Specific focus will be on: executing the agency's strategic plan, workforce development plan, and quality improvement plan.
Program Priorities: Program priorities for this work-plan year include: preparing Indiana State Department of Health for public health accreditation, authorship of the state's health assessment and improvement plan, the agency's strategic plan, developing a performance management system, expanding workforce development opportunities, increasing the number and strength of quality improvement projects in the agency, and serving as an improvement resource for the agency.
Primary Strategic Partners: Indiana University, Purdue University, local health departments, Non-Governmental Organizations (NGO), and other state universities
Evaluation Methodology: Number of and quality of trainings, attendance at trainings, pre- and post-evaluations to compare and record knowledge gained from trainings and training quality.

State Program Setting:
Local health department, State health department

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: Eric Beers
Position Title: Workforce Development Coordinator & eLearning
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Patricia Truelove
Position Title: Accreditation Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Eden Bezy
Position Title: Director, Office of Public Health Performance Mgmt
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Cassondra Kinderman
Position Title: Quality Improvement Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: TBD
Position Title: GeoSpatial Analyst
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 5
Total FTEs Funded: 5.00

National Health Objective: **HO PHI-2 Continuing Education of Public Health Personnel**

State Health Objective(s):
Between 10/2017 and 09/2018,

- OPHPM will execute the newly authored ISDH Workforce Development Plan.

Baseline:
According to the 2017 Public Health Workforce Interests and Needs Survey (PH WINS), state health department employees need a robust menu of training. Topics such as policy analysis, business and financial management, social determinants of health, evidence-based public health and collaborating with diverse communities are all topics that employees are in need of more training. Understanding that the public health workforce is spread across the state, Indiana utilizes the TRAIN platform to provide free-to-the-user e-learning courses. Currently, approximately 14,800 users in Indiana are active users of TRAIN, with 5 distinct program areas developing new content for the training platform.

Data Source:

- Association of State and Territorial Health Officers (2017). *PHWINS*. Retrieved from astho.org. http://astho.org/phwins/National Summary Report of Workforce Data/

- TRAIN.org

State Health Problem:

Health Burden:
According the 2017 *Public Health Interest and Needs Survey (PHWINS)* Indiana has many areas of opportunity to train public health staff. According to the report, the top-five training needs for non-supervisory staff include: description of how funding mechanisms support agency programs and services, describing the value of agency business plan, describing financial analysis applicable to program service and delivery, describing the value of community strategic planning that results in a CHIP or CHA, describing the internal changes on organization practices. Supervisors and managers need training in: incorporating health equity and social justice, identifying funding mechanisms, implementing a business plan, using financial analysis, and assessing how agency policies, programs and services advance public health. Executive staff need training on: how to advocate for needed population health services and program, how to influence policies external to the health department that address social determinants of health, incorporate health equity and social justice principles, address drivers in the environment that influence public health programs and services, and finally how to leverage funding mechanisms.

The work plan includes offering continuing education opportunities to local health departments through health officer meetings, monthly webcasts, and public health nurses meetings and conferences. Additional opportunities will be developed through the ISDH partnership with the Public Health Foundation and the purchase of TrainingFinder Real-time Affiliate Integrated Network (TRAIN) (subscription maintenance is made possible through Block Grant). The Workforce Development Coordinator, who is funded through PHHS Block Grant, administers this system and will continue to develop future learning opportunities with both internal and external partners for public health in Indiana.

Resources:
US Department of Health and Human Services
Indiana Census Data
Indiana Local Health Department employee count

Target Population:
Number: 93
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Disparate Population:
Number: 65
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Board Standards and Measures
CDC

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $172,266
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Continuing education of public health personnel
Between 10/2017 and 09/2018, OPHPM will conduct **12** training/professional development events for the public health workforce in Indiana and at ISDH.

Annual Activities:
1. Provide access to INTRAIN e-learning platform
Between 10/2017 and 09/2018, ISDH will utilize the INTRAIN e-learning platform to provide online education tools. OPHPM will increase usage of INTRAIN by helping content area experts create custom TRAIN learning plans for the public health workforce on pertinent topics.

2. Expand and support agency mentorship program
Between 10/2017 and 09/2018, ISDH will expand and support a mentorship program for new agency staff modeled after successful mentorship programs in other state agencies.

3. Supervisor/Manager meetings
Between 10/2017 and 09/2018, ISDH will hold six supervisor/manager meetings to provide skill development for current supervisors/managers.

4. Employee engagement
Between 10/2017 and 09/2018, ISDH will begin to measure and increase employee engagement at ISDH through meaningful learning collaborative events.

5. Leadership at All Levels Training
Between 10/2017 and 09/2018, ISDH will provide leadership development training for staff at all levels of the agency through its three-tiered leadership curriculum.

6. Support Continuing Education Events
Between 10/2017 and 09/2018, support Public Health conference registration fees, including events such as the Indiana Environmental Health Association, for ISDH employees. Provide continuing education opportunities on and off site for ISDH and Local Health Department (LHD) staff.

7. CME Accreditation
Between 10/2017 and 09/2018, The ISDH is pursuing CME accreditation so that all ISDH-related conferences, meetings and events can have CMEs associated with them.

National Health Objective: HO PHI-13 Epidemiology Services

State Health Objective(s):

Between 10/2017 and 09/2018, increase the analytical capacity of the agency workforce through: technical/analytical support for Statistical Analysis Software (SAS) and Geographic Information Systems (GIS), regular in-house training's/demonstration's on SAS and GIS, the collection of additional public health data through Behavioral Risk Factory Surveillance System (BRFSS surveys), and the generation of timely datasets and statistical reports (Vital Statistics, Spatial Statistics) for use by agency epidemiologists and analysts.
CDR Claudine Samanic will assist the Indiana State Department of Health to use health data, especially population-based data, to perform the essential functions of chronic disease epidemiology through direct assistance assignment by the Centers for Disease Control and Prevention.

Baseline:

Our agency's epidemiologists and data analysts have a general knowledge of SAS and GIS, but have requested on-going support for working with data pertaining to their specific program area (e.g., removing duplicates, date formatting issues, spatial analysis); how to produce a variety of output (e.g., tables, graphs, maps); and how to program the SAS logic for complicated data extractions. Workforce members have been provided in-person seminars with SAS (Proc Tabulate and Operational Data Store, macros, and probabilistic matching) and GIS (ArcGIS On-Line tools, vulnerable populations, geoprocessing methods). These seminars/demonstrations must be reoccurring in order to ensure new workforce members are equipped with necessary skill sets. Additional trainings on data processing such as assessing data quality, debugging for common coding errors, conducting logic checks, and data vetting best practices will also be conducted.

Data Source:
Records kept by Matt Kaag, contract Senior Data Analyst/SAS Programmer
Records kept by CDR Claudine Samanic, CDC Epidemiology Advisor

State Health Problem:

Health Burden:
Timely and accurate data are required to monitor health outcomes. It previously took more than 14 months to produce final natality and mortality datasets, which delayed the analysis of trends over time and interventions in place to improve the health of residents. During the 2016-2017 grant year, preliminary natality and mortality datasets were provided for epidemiologist use by September, 2016, and final datasets were provided by November 2016. This marks a decrease of four months in the time required to produce the final natality and mortality datasets. Maintaining this reduced time to produce preliminary and final datasets will permit epidemiologists and data analysts' faster access to factors affecting health outcomes, including infant mortality, and deaths from drug overdose and chronic diseases. For example, new innovative

programs are being put in place to decrease infant mortality, especially for African Americans (Indiana had the second highest black infant mortality rate in 2013). Access to timely data is needed to monitor changes in such risk factors as smoking during pregnancy, access to care, prenatal visits and low birth weight in addition to the number of infant deaths. The sooner this information is available to analysts, the faster it can be determined what interventions reduce infant deaths in our state.
Chronic diseases, including heart disease, cancer, cerebrovascular incidents, and complications from diabetes and obesity are leading causes of morbidity and mortality in Indiana. In order to monitor health outcomes, timely and accurate data are required. Access to timely data is needed to monitor changes in risk factors for these diseases and prepare reports that drive policy and intervention. Substance abuse, particularly injection of opioids, has fueled increases in hepatitis C statewide and the emergence of an outbreak of human immunodeficiency virus (HIV) in 2015. Having epidemiologic capacity for chronic diseases and substance abuse is critical to creation, implementation, and evaluation of programs to address these conditions and decrease subsequent morbidity and mortality.

Target Population:
Number: 6,666,618
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants, Safety Organizations

Disparate Population:
Number: 2,500,000
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants, Safety Organizations

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Follow guidelines established by the National Center for Health Statistics in the production of mortality and natality datasets, reports and analysis. Adherence to CDC protocols for BRFSS data collection, analysis and reporting.

CDR Claudine Samanic will assist the ISDH to use health data, especially population-based data, to perform essential functions of chronic disease epidemiology as described in the CSTE 2004 paper: Essential functions of Chronic Disease Epidemiology in State Health Departments.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $115,282
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Essential Functions of Chronic Disease Epidemiology in State Health Departments.
Between 10/2017 and 09/2018, Claudine Samanic will provide technical support to **2** peer review panels to evaluate national grant applications regarding CDC funding related to chronic disease.

Annual Activities:

1. General Consultation and Assistance to ISDH
Between 10/2017 and 09/2018, provide general consultation and assistance to the ISDH Chronic Disease, Primary Care, and Rural Health Division, Environmental Health Division, and Trauma and Injury Prevention Division, among others, within the Indiana State Department of Health.

2. Collaboration and linkage at ISDH
Between 10/2017 and 09/2018, ensure collaboration and linkage between the ISDH Chronic Disease, Primary Care, and Rural Health Division in the use of data collection tools and development of various reports.

3. Surveillance and Evaluation Activities
Between 10/2017 and 09/2018, ensure collaboration with surveillance and evaluation activities among ISDH Chronic Disease, Primary Care, and Rural Health Division in data collection and reports.

4. Establishing a Peer Review System
Between 10/2017 and 09/2018, establish and maintain a peer review system for reviewing reports and documents distributed to various national audiences.

5. Manuscript Development
Between 10/2017 and 09/2018, develop manuscripts to be published in peer-reviewed scientific publications.

6. Conference Presentations
Between 10/2017 and 09/2018, deliver a presentation at the annual conference of the Council of State and Territorial Epidemiologists (CSTE) or one other professional meeting.

7. Meet professional requirements of the United States Public Health Service.
Between 10/2017 and 09/2018,

- When requested and deemed a national emergency, deploy for a period of no longer than two weeks.
- Participate in advisory committees and workgroups (example: Hispanic Officers Advisory Committee, Health Services Professional Advisory Committee, Epidemiology workgroup) to provide advice and consultation to the Surgeon General's office (OSG) on issues related to the corps.
- Participate in leadership and work development conference calls during working hours.
- Develop and contribute to the drafting of standard operating procedures and other PHS documents during working hours.
- Represent the PHS at professional meetings.
- Wear PHS uniform daily.

8. Participation in Workgroups
Between 10/2017 and 09/2018, participate in CSTE workgroups.

Objective 2:
Increase Analytic Capacity of Epidemiologists and Data Analysts
Between 10/2017 and 09/2018, the SAS data analyst will conduct **2** new SAS trainings to agency epidemiologists and data analysts in addition to a reprising at least 1 previously provided training. Matt will also provide SAS support and assistance to agency workforce members and program areas as requested.

Annual Activities:

1. Instruct SAS short courses
Between 10/2017 and 09/2018, The SAS Data Analyst will provide new 2 trainings for agency epidemiologists and data analysts on data management, analysis, and presentation using the SAS software platform.

2. Provide expert SAS technical consultation for all agency programs
Between 10/2017 and 09/2018, The SAS Data Analyst will provide one-on-one consultation/assistance as needed to epidemiologists and data analysts on SAS programming and analyses. The analyst will also develop ad-hoc programs to automate reporting tasks or to fulfill data requests.

Objective 3:
Increase analytic capacity of the agency workforce though the use of GeoSpatial (GIS) data analysis
Between 10/2017 and 09/2018, Geospatial Data Analyst will conduct **25** ad-hoc analysis of health data from agency program areas to assess geographic patterns and relationships. Results are summarized, visualized and disseminated to staff, partners, and the general public through various platforms, including both desktop and web-based tools. The analyst will also provide demonstration to agency workforce members on how to utilize GIS tools and apply spatial methodologies.

Annual Activities:
1. Provide geostatistical analysis, measurements, and reports for all health programs
Between 10/2017 and 09/2018, The GeoSpatial Data Analyst investigates agency health data resources to identify patterns and relationships through statistical measurements and geo-visualizations. The analyst develops and applies methodologies and mathematical models to derive statistics, maps and other diagrams to assist all program areas in data-driven decisions. The analyst also assists in necessary data collection, integration and maintenance in order utilize data within a geographic information system platform. A robust geo-analytical capacity is critical to the agency's mission as it identifies health-related indicators at a granular community level related to administration and agency priorities. The analyst works with agency workforce members to ensure analysis results are explained and utilized appropriately. This activity will also directly support the agency's ability to assess the state's data and present that data back to Indiana residents as required by the Public Health Advisory Boards Standard and Measures for accreditation.

2. Provide GIS demonstrations
Between 10/2017 and 09/2018, The GIS Data Analyst will provide at least 6 demonstrations for agency workforce members using Esri ArcGIS Desktop, Esri ArcGIS On-Line or other GIS concepts and tools.

Objective 4:
Increase number of surveys completed in the 2018 Indiana BRFSS survey
Between 10/2017 and 09/2018, the ISDH BRFSS Coordinator and contractor will conduct **666** surveys for the Indiana BRFSS.

Annual Activities:
1. Increase number of BRFSS surveys completed to increase data availability and demographic detail
Between 10/2017 and 09/2018, An estimated 666 landline and cell phone interviews will be added to the Indiana 2018 BRFSS survey via Indiana's BRFSS contractor. Over the past few years, the quality of the landline sample has declined while the quality of the cellphone sample has increased. In response, the CDC's Population Health division has increased its cellphone cap from 65% in 2016 to 80% for the 2018 data collection. We propose further increase of cellphone percentage from 50% in 2017 and 2018 to 60% for Indiana's 2019 sample. We do not propose an increase to the 80% maximum due to the higher cost associated with cellphone samples. These additional surveys will aid in the tracking of risk factors and

preventive actions, identify health disparities, and support strategic health improvement plans (HP2020 PHI-7, 8, 14, 15). The Advisory Committee voted to approve funding to be allocated for BRFSS data collection.

Objective 5:
Support production of the annual reports and datasets
Between 10/2017 and 09/2018, The SAS Data Analyst will develop **1** core file and create templates used to generate annual reports.

Annual Activities:
1. Download birth and death files from the Genesis application
Between 10/2017 and 09/2018, The SAS Data Analyst will download, at least monthly, Genesis, State and Territorial Exchange of Vital Events (STEVE), and resident out of state (ROOS) data and process the files in preparation for the ISDH Data Analysis Team use.

2. Produce datasets for ISDH epidemiologists
Between 10/2017 and 09/2018, The SAS Data Analyst will assist in the development of simple and detailed reports for the Epidemiology Resource Center during the transition from the current I-NEDSS (electronic disease surveillance system) to NBS (NEDSS Base System) to use internally for ISDH epidemiologists and externally for local health department end-users (the system was originally slated for completion in January 2018 but then pushed back to January 2019). Matt will also work to develop mortality and natality reports with data from the new Vital Records that is set to go live in January 2019. He will work with the Data Analysis Team to streamline the reporting for this new system so there are no reporting deficiencies cause by the transition. Matt Kaag will work with the Data Analysis Team Director to assess how to more fully utilize preliminary data in reporting. Matt will be responsible for generating provisional birth and death datasets and a final dataset within 12 months of year end. Datasets will be posted for internal use by agency epidemiologists and data analysts.

National Health Objective: HO PHI-15 Health Improvement Plans

State Health Objective(s):
Between 10/2017 and 09/2018, continue to increase the capacity of local health departments, other community stakeholders, and nonprofit hospitals to conduct community health assessments and improvement plans by developing and improving the Indiana Indicators data dashboard website, increasing ISDH's GIS capabilities and services, and providing training and technical assistance on accessing health improvement plan data.

Baseline:
ISDH and the Indiana Hospital Association have developed a central location for hospitals, local health departments to access county level data in one central location (www.indianaindicators.org). This website will house public health data, SES data and other resources for those doing health improvement plans, including information on best practices.

Data Source:
- Behavioral Risk Factor Surveillance System (BRFSS)
- Hospital Discharge Data
- County Health Rankings
- Vital records
- Census data
- Community economic data

State Health Problem:

Health Burden:
Many communities do not know the overall health burden of their community based on solid data. They also don't know what best practices are to address those health issues. This dashboard will provide national, state and local data to make the best improvement plan possible.

The 1,000,000 disparate populations include counties that do not have nonprofit hospitals or are very rural, small, and underfunded organizations. (US Census)

Resources:
BRFSS, Hospital Discharge Data, County Health Rankings, vital records, census data, community economic data

Target Population:
Number: 6,000,000
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants

Disparate Population:
Number: 1,000,000
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Standards and Measures

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $178,257
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Health Improvement Plan data availability
Between 10/2017 and 09/2018, ISDH, focusing on social determinants of health, will increase the number of county level publically available data represented in Indianaindicators.org. from 58 to **68**.

Annual Activities:
1. Development and maintenance of IndianaIndicators.org

Between 10/2017 and 09/2018, OPHPM will contract with Indiana Business Research Council to provide a platform to house data from a variety of sources for the use of community partners and LHDs in Indiana. The site will allow users to sort data by indicators, geography, compare counties to counties or nationally. Additionally, the site will allow users to save indicators they deem important to a report-style format in the site for use in health planning, reporting, and surveillance.

2. GIS Support
Between 10/2017 and 09/2018, ISDH will employ a GeoSpatial Analyst to collect and develop data for the Indiana Indicators (high-level presentation of selected county health statistics) and ISDH Stats Explorer websites (low-level data repository of published health statistics). The analyst will conduct ad-hoc assessments to identify at-risk populations within different contexts to support response and planning activities.

3. Health Improvement Plan technical assistance and training
Between 10/2017 and 09/2018, OPHPM will provide technical assistance to Local Health Departments on authoring health improvement plan and health assessments. OPHPM will direct them to the Indiana Indicators site as a means to access epidemiological indicators from trusted sources. Additionally, OPHPM will develop an online course through INTRAIN on using Indiana Indicators to its fullest capabilities (course will be evaluated) and provide four in-person training opportunities for internal and external partners.

National Health Objective: HO PHI-16 Public Health Agency Quality Improvement Program

State Health Objective(s):
Between 10/2017 and 09/2018, OPHPM will work to institutionalize continuous quality improvement in the state's public health system.

Baseline:

The Indiana State Department of Health (ISDH) is committed to ongoing performance improvement efforts. Performance management (PM) and quality improvement (QI) techniques are being utilized to varying degrees in the agency, and efforts have not been coordinated and monitored agency-wide. ISDH regularly assesses its PM system and culture an ongoing basis. ISDH completes a formal assessment every two years using an abridged version of the National Association of County and City Health Officials (NACCHO) Roadmap to a Culture of Quality self-assessment tool. Participants of the survey include executive leadership, managers and supervisors, as well as non-supervisors/front-line staff. According to the 2018 assessment, ISDH ranks overall as “Phase 3: Informal or Ad Hoc QI Activities” on the NACCHO Roadmap. This means discrete QI efforts are practiced in isolated instances throughout the agency, often without consistent use of data or alignment with the steps in a formal QI process

Data Source:
- ISDH documentation
- Purdue Healthcare Advisors Lean Six Sigma for Public Health
- Public Health Accreditation Board
- Public Health Foundation
- Indiana State Budget Agency
- Indiana Census Data

State Health Problem:

Health Burden:

As one of the least federally funded state public health departments, Indiana State Department of Health is continuing to be asked to do more with less. In an effort to be more efficient with our current funding, the agency has embarked on the process of being more quality improvement focused. Currently, the agency has a small cohort of employees trained in quality improvement. ISDH is seeking to increase this number, and in turn build the agency's capacity for this work.

Resources:
ISDH documentation
Purdue Healthcare Advisors
Public Health Accreditation Board
Public Health Foundation
Indiana State Budget Agency
Indiana Census Data

Target Population:
Number: 850
Infrastructure Groups: State and Local Health Departments

Disparate Population:
Number: 850
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Board
Public Health Foundation
Indiana Census

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $192,013
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Quality improvement availability and accessibility
Between 10/2017 and 09/2018, ISDH will obtain **1** Level 4 status in NACCHO's Culture of Quality Survey.

Annual Activities:
1. Use a performance management system to monitor achievement of organizational objective
Between 10/2017 and 09/2018, ISDH will utilize VMSG and Tableau to capture, track, and visualize agency metrics identified in its strategic plan.

2. ISDH Quality Improvement Activities
Between 10/2017 and 09/2018, increase the number of divisions in the agency participating in formal quality improvement projects.

3. Continuous quality improvement training
Between 10/2017 and 09/2018, OPHPM will provide 2 trainings for agency staff on how to incorporate continuous quality improvement in public health programming.

4. Employ a Quality Improvement Coordinator
Between 10/2017 and 09/2018, OPHPM will employ a Quality Improvement Coordinator responsible for overseeing and coordinating agency sponsored quality improvement events.

5. Employ a Half Time Performance Management/Data Analyst
Between 10/2017 and 09/2018, OPHPM will employ a half time performance management/data analyst to manage internal and external (strategic plan and the SHA/SHIP) performance metrics.

National Health Objective: HO PHI-17 Accredited Public Health Agencies

State Health Objective(s):

Between 10/2017 and 09/2018, the Office of Public Health Performance Management will work to achieve public health accreditation by meeting the standards and measures through the Public Health Advisory Board (PHAB). This includes authoring the State Health Improvement Plan, State Health Assessment, Agency Strategic Plan, Workforce Development Plan, and the Quality Improvement Plan. Additionally, OPHPM will provide encouragement and technical assistance to Local Health Departments as they seek PHAB accreditation.

Baseline:
ISDH has not achieved accreditation, and one county in Indiana (Rush) has achieved accreditation. Other counties are in various stages of the accreditation process.

Data Source:

- ISDH documentation
- Rush County Health Department
- Public Health Accreditation Board
- Association of State and Territorial Health Officers
- Indiana Public Health Association
- Fairbanks School of Public Health at Indiana University Purdue University Indianapolis (IUPUI)

State Health Problem:

Health Burden:
Although public health accreditation is currently voluntary, ISDH recognizes the importance of meeting standards and measures to ensure public health in Indiana is being practiced at the highest level of quality. Currently, ISDH has not achieved accreditation, and only one local health department is accredited. According to the Indiana Public Health Association, approximately half of local health departments are actively working towards accreditation standards.

Resources:
Public health advisory board

Indiana Public Health Association
IU Fairbanks School of Public Health
Rush County Health Department

Target Population:
Number: 93
Infrastructure Groups: State and Local Health Departments

Disparate Population:
Number: 93
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Board
Public Health Foundation
Association of State and Territorial Health Officers

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $214,732
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
State Health Department Accreditation
Between 10/2017 and 09/2018, ISDH will obtain **100%** of all 12 domains of the Public Health Advisory Board's standard and measures of achieve public health accreditation.

Annual Activities:
1. State Health Assessment/State Improvement Plan
Between 10/2017 and 09/2018, ISDH will convene the Indiana Health Improvement Planning team to track and monitor goals and metrics from the 2018-2021 Indiana State Health Assessment and State Health Improvement Plan.

2. Document Collection
Between 10/2017 and 09/2018, ISDH will continue to collect appropriate evidence for each standard and measure for voluntary public health accreditation.

3. Agency PHAB Application
Between 10/2017 and 09/2018, ISDH will complete the application process for voluntary public health accreditation.

4. Accreditation Technical Assistance
Between 10/2017 and 09/2018, ISDH will provide technical assistance and competitive funding awards to local health departments interested in seeking voluntary public health department accreditation.

5. Employ an Accreditation Coordinator
Between 10/2017 and 09/2018, ISDH will employ an accreditation coordinator with the responsibility to shepherding the agency through the accreditation process.

State Program Title: Sexual Assault Services (SAS) - Education and Outreach

State Program Strategy:

Goal: Between October 2018 and September 2019, continue to reduce the prevalence of rape and sexual violence in the State of Indiana.
Program Priorities: The Indiana State Department of Health will create a two-pronged approach to provide sexual violence prevention outreach and education statewide by:

- Developing a sexual assault nurse examiners (SANE) program to provide coordination of statewide efforts to train health care providers to conduct sexual assault forensic examinations which provide better physical and mental health care for survivors, better evidence collection, and higher prosecution rates; and,

• Releasing a competitive solicitation for funds to provide sexual violence prevention outreach and education statewide, and also provide referrals to direct services and other resources to victims of sexual violence.

Primary Strategic Partnerships(s): Indiana Hospital Association, Indiana State Nurses Association, Indiana Coalition to End Sexual Assault, Indiana Criminal Justice Institute
Evaluation Methodology: Evaluation methodology includes presentation evaluations and data on numbers reached through outreach and education, attendance at trainings, number of partnerships created

State Program Setting:

Medical or clinical site, Rape crisis center, State health department, Other: Indiana Criminal Justice Institute

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: TBD
Position Title: Statewide SANE Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 1
Total FTEs Funded: 1.00

National Health Objective: HO IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):

Between 10/2017 and 09/2018, The purpose of the SAS program remains to reduce the prevalence of sexual assault and attempted sexual assault and attempted sexual assault among residents of the State of Indiana, particularly youth through sexual violence outreach and education and direct services. A competitive solicitation for funds will be released to provide prevention outreach and education as well as direct services.

Baseline:

In order to most accurately reflect the number of rape/sexual assaults in the state, our researchers look at two numbers: 1) the available UCR data (raw data; not formulized by the FBI to fill in missing data) and 2)

the number of forensic medical exam claims submitted by hospitals for payment by the state Victims Compensation area.

• Reported rapes/sexual assaults

Year	Available UCR- (raw data not formulized)	Sexual Assault Claims submitted for payment
2009	1,604	2,357
2010	1,634	1,761
2011	1,601	2,357
2012	1,441	2,349
2013	1,224	2,437
2014	Not Available	2,597
2015	Not Available	2,106

- **Non-reports**

Since non-reports cannot be tracked, it is difficult to provide these numbers. Estimates on the number presenting to a hospital emergency room for a forensic medical exam and/or reporting to the police are between 25 to 47%. Using a 31% - 47% reporting rate, it can be *estimated* that 3,664 to 5,730 rapes could occur annually in Indiana.

Data Source:

Notartis Institutes of Biomedical Research (NIBRs), Indiana Criminal Justice Institute (ICJI) Victims Compensation Claims

State Health Problem:

Health Burden:

Practitioners and researchers estimate only three in ten victims actually report a sexual assault. Anecdotal evidence comes in from across the state of victims seeking counseling months and sometimes years following an unreported assault. However, for planning and funding purposes some sort of hard data is required. In that regard, the fact that Indiana is one of only two states without mandatory UCR data reporting somewhat handicaps our ability to provide quantitative hard data as other states can provide. Our data analysis center reports that approximately 40% of our 92 counties report and those cover more than 85% of the population of Indiana.

On December 14, 2011, the Center for Disease Control released the National Intimate Partner and Sexual Violence Survey which listed Indiana as having the **8th highest rate of interpersonal violence in the country.** IPV combines rape, physical violence and stalking. Indiana continues to deal with the serious problem of sexual violence. Anecdotally we hear from hospital staff and Sexual Assault Nurse Examiners (SANEs) that the number of child sexual assault cases is "exploding", to quote one SANE in the Indianapolis area.

In order to more clearly understand the social and environmental issues impacting this data, the Indiana Criminal Justice Institute contracted with Indiana University to research this issue. In August 2015, ICJI was presented with the final research report "*An Investigation into Adolescent Sexual Assault Underreporting in the State of Indiana"* by John Parrish-Sprowl, Ph.D – Director of the Global Health Communication Center at Indiana University. ICJI used state funds to follow up on the CDC report as well as a 2014 release prepared by Saint Mary's College, Notre Dame. This study found the number of Indiana high school girls who reported forced sexual activity was approximately **seven percent** higher than the national rate. Additionally, the CDC National Intimate Partner and Sexual Violence Survey provided an in-depth look into the struggles Indiana faces with Interpersonal Violence (IPV combines rape, physical violence and stalking).

As startling as the reports are, practitioners and researchers estimate only three in ten victims actually report sexual assault. Anecdotal evidence comes in from across the state of victims seeking counseling,

months - and sometimes years - following an unreported assault. However, for planning and funding purposes, there is a need for hard data. Unfortunately, Indiana is one of only two states without mandatory UCR data reporting. The lack of mandatory reporting handicaps our ability to provide quantitative hard data that other states are able to provide. Our data analysis center reports that approximately 40 percent of our 92 counties, covering approximately 85 percent of the population of Indiana, report UCR data.
Economic Costs: In 2008, National Institute of Justice researchers estimated that each **rape costs** approximately. $151,423 (Delisi .... Hidden **costs** in health care). The costs to the state of this public health problem include the following:

- potential costs of hospital/ER visits for exam
- rape kit
- testing and prophylactic medications
- cold storage of rape kits and evidence for one year
- transportation of evidence
    - advocacy services
    - therapeutic counseling
        - loss of income if the victim misses work or loses her job

There continues to be higher than average rates of sexual violence in Indiana and the need for prevention, intervention, and treatment programs is ever pressing. Access to SANEs is vital to survivors of sexual assault as they provide a bridge between the legal, law enforcement and healthcare systems. Many communities, however, lack experienced, trained, and qualified SANEs who are equipped with the skills and competencies necessary to perform medical forensic exams, especially in rural areas.
In addition, communities also experience high rates of turnover among SANEs. The funding will allow for the development of a sustainable program that will retain highly-skilled SANEs in the Indiana health workforce and allow for continued prevention outreach and education through the provision of direct services.

Target Population:
Number: 6,666,818
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 1,583,245
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: US Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)

Other: •Intervention to Reduce Distress in Adult Victims of Sexual Violence or Rape: a Systematic View

(2013 Regehr, Alaggia, Dennis).
•International Forensic Association of Nurses (IAFN) SANE-P and SANE-A Certifications; SANE Practice Standards and Guidelines (NSVRC)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $229,071
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $84,099
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Improve and enhance service and response initiatives to victims of sexual violence.
Between 10/2017 and 09/2018, the Statewide SANE Coordinator will provide 10 trainings to **25** forensic nurses focused on a variety of topics related to trauma-informed care that will include, but are not limited to, victim emergency response to a hospital to meet with a victim, to explaining the rape examination process to further medical and legal education.

Annual Activities:

1. Increase statewide collaboration
Between 10/2017 and 09/2018,

- The Statewide SANE Coordinator will serve on state-wide, regional, and local groups dedicated to sexual violence prevention efforts. Internally, the Statewide SANE Coordinator will collaborate with appropriate divisions including: Maternal and Child Health, Division of Chronic Disease, Rural Health and Primary Care, Office of Minority Health, and Division of Trauma and Injury Prevention.
- The Statewide SANE Coordinator will decrease SANE program isolation, creating opportunities for networking and building rapport among SANE programs, acting as a centralized contact for programs in the state.

2. Expand access to SANE continuing education.
Between 10/2017 and 09/2018,

- The Statewide SANE Coordinator will increase access to forensic examinations by conducting professional development trainings on relevant topics.
- Statewide SANE Coordinator will provide technical assistance to for existing and new SANE programs in the state.

3. Promote best practices in SANE nursing practice.
Between 10/2017 and 09/2018,

- The Statewide SANE Coordinator will identify sources of sexual assault health care access data for leverage in sexual violence prevention programming.
- The Statewide SANE Coordinator will research, identify and promote best practices, working to create consistency among programs, ensuring that recommended exam protocols and equipment are met, and supporting data collection and reporting.

4. Provide sexual violence prevention outreach and education.

Between 10/2017 and 09/2018,

- Sub-awards will be administered by state staff in the Office of Women's Health at the Indiana State Department of Health. Direct victim services will be provided by qualified staff of ISDH's SAS-funded sub-recipients. Some are rape crisis centers and others are dual domestic violence/sexual assault centers. The SAS-funded sub-recipients will provide services to **200** victims of sexual violence and conduct outreach through workshops and trainings on relevant sexual violence prevention topics that meet the needs of the community.

State Program Title: Tuberculosis (TB) Control Program/Refugee Health

State Program Strategy:

Goal: Between October 2018 and 9September 2019, one of the main goals for the Indiana Refugee Health Program (IRHP) is implement and enhance the Immigrant TB and All Refugee Application (ITARA). IRHP serves as a liaison between federal, state and county health departments to ensure CDC and Office of Refugee Resettlement (ORR) recommended domestic health screenings are provided to newly arriving refugees. The health screenings are provided to prevent infectious disease that pose a public health threat in Indiana. ISDH houses the ITARA database that serves to store and monitor the refugee health screening records. Maintenance and improvements to the database are essential to the IRHP in regards to refugee health.

Between October 2018 and September 2019, one of the main goals for the Indiana Refugee Health Program (IRHP) is implement and enhance the Immigrant TB and All Refugee Application (ITARA). IRHP serves as a liaison between federal, state and county health departments to ensure CDC and Office of Refugee Resettlement (ORR) recommended domestic health screenings are provided to newly arriving refugees. The health screenings are provided to prevent infectious disease that pose a public health threat in Indiana. ISDH houses the ITARA database that serves to store and monitor the refugee health screening records. Maintenance and improvements to the database are essential to the IRHP in regards to refugee health.

Program Priorities:

1. Early diagnosis of TB disease and infection
2. Completion of appropriate therapy for all cases of TB disease and infection
3. Prompt identification and evaluation of high and medium risk contacts through effective contact investigation activities
4. Prompt reporting of all newly identified TTBI cases
5. Screening and treatment of TB infection in persons in targeted high-risk populations
6. Managing and monitoring refugee health screening

Primary Strategic Partnerships(s):

- **Internal:** Indiana State Department of Health Laboratories
- **External:** Local Health Departments

Evaluation Methodology: The ISDH TB program follows national evaluation TB guidelines set by the CDC. Additionally, the program conducts internal quality assurance measures. In an effort to decrease TB morbidity and mortality, the program evaluation component will focus on evaluating treatment initiation and completion for both TB infection and TB disease persons. The program's TB database, TB Statewide Investigating, Monitoring and Surveillance System (SWIMSS), will be replaced with CDC NEEDS Base System (NBS). Reports will be developed in NBS to identify how many new LTBI patients were entered appropriately and completely evaluated, how many started and completed treatment within the recommended guidelines. Analysis will be conducted on the specific variables identified such as: number of patients, high risk groups, treatment start date, and treatment completed, etc. Additionally, the TB epidemiologist will review all data submitted individually, and any issues identified will be discussed with the submitting local health department (LHD) and the regional nurse consultants.

In Indiana, the local health departments (LHDs) with the technical support of ISDH are responsible for case management of TB patients. LHDs provide basic services tuberculosis which include tuberculosis screening, patient assessment and referral for medical care, delivery of anti-tuberculosis medicines, case management, contact investigations, and directly observed therapy. The state is responsible for surveillance, policy development, public education and strategic leadership. This partnership is critical in the control and elimination of TB in Indiana. On December 25, 2015, latent tuberculosis infection (LTBI)

became a reportable condition in Indiana. This is in line with national trends and the CDC's focus on successfully treating LTBI to prevent progression to TB disease. This new law means additional reporting for the LHDs. The TB program will be providing additional education and outreach on LTBI reporting to LHDs and community providers. Ongoing technical support will be needed to ensure information from electronic lab reports (ELR) are coming into NBS appropriately so that effective surveillance and investigation can follow.

The ISDH Refugee Health program monitors the number of refugees that receive their initial domestic health screening. Internal goals are to ensure that all refugees are screened within a specified timeline and that 100% of refugees coming into Indiana receive their health screening. Within the ITARA database, enhancements will be made to develop reports to assist the ISDH program as well as the clinics to monitor their data in a real-time basis. The reports that will be developed will include number of arrivals, time to initial screening, time to completion of screening, missing screenings, monthly reports, and screening outcome reports to send to ORR three times per year.

Success of progress goals will include:
1. Implementation of the new surveillance system, NBS.
2. Improved LTBI case reporting through additional education and outreach to LHDs on reporting all LTBI cases, not just those requesting medication through ISDH.
3. Increased data accuracy through the implementation of NBS as well as ELR improvements for NBS.
4. Improvements to the ITARA database to improve data quality and timeliness of health screenings.

The overall success of the project for the TB program will be evaluated by an increase in the number of persons that are reported as well as complete adequate treatment for TB infection. Overall success for the refugee health program will be evaluated by an improvement in screening timeliness and overall completeness.

State Program Setting:

Child care center, Community health center, Home, Local health department, Medical or clinical site, Schools or school district, Senior residence or center, State health department, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO IID-31 Treatment for Latent TB

State Health Objective(s):

Between 10/2017 and 09/2018, increase the percentage of contacts to sputum smear-positive tuberculosis cases that complete treatment after being diagnosed with latent tuberculosis infection (LTBI) to 93% for cohort 2016. Of those diagnosed with LTBI and started treatment, 85% for cohort year 2016 will complete treatment.

Baseline:
The baseline set for Healthy People 2020 is 81% (from 2015). Indiana's baseline for 2014 which is the most recent year for which data is available is 82%.

The baseline for the number of refugee arrivals who have a health screening initiated within 30 days is 82% in FFY 2016.

Data Source:
Aggregate Reports for Tuberculosis Program Evaluation; Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (CDC/NCHHSTP).
National TB Surveillance System (NTBSS)
Indiana Tuberculosis Control Program 2016 Annual Report
Indiana Refugee Health 2016 Annual Report

State Health Problem:

Health Burden:
TB cannot be eliminated in the United States and in Indiana without increased efforts to test and treat LTBI, especially among the high risk groups. Up to 13 million persons in the US have LTBI. Per CDC, The majority of cases of TB disease that occur in foreign born persons result from reactivation of LTBI rather than newly acquired infection. (Approximately 80% of the TB cases in the United States are reactivation TB which means the individuals went through a period of latent TB infection before progressing to TB disease). In Indiana, almost three-quarters of TB cases in 2016 (69.7%) were among foreign-born persons, which mirrors the disparity seen at the national level and is a significant increase from previous years in Indiana. Racial/ethnic minorities continue to be disproportionately affected by TB within the United States including Indiana. Asians continue to be the racial/ethnic group with the largest number of TB cases. In 2016, the majority of foreign-born persons with TB originated from the following five nations: Burma, Mexico, India, and the Philippines The higher proportion of TB cases occurring in foreign-born persons compared with U.S.-born persons illustrates the close relationship between the global TB burden and disease patterns in the United States. The established pattern of increasing proportions of TB cases occurring in the foreign-born population reaffirms the need to support and strengthen TB control efforts with both internal and external partners.

Eliminating TB therefore requires a new approach that will focus on the diagnosis and treatment of LTBI, especially in the high risk populations, and effective management of contacts to active TB patients. There is strong need for TB education and outreach to healthcare providers, TB stakeholders and community partners especially those servicing the high risk populations. Many of those at high risk for LTBI, who need to be reached and identified do not seek care traditionally at the local health departments, but are seen by private community providers and health care centers. ISDH and local health departments need to build partnerships with all these key TB stakeholders who often have access to this valuable information. Through the previous grant period, LTBI was to be reported accurately and timely to the ISDH TB Program via SWIMSS, the outgoing surveillance system. With the implementation of NBS, not only with LHDs have ability to report data, but local hospitals and clinics will now be able to report electronically. This addition should relieve some of the burden from LHDs and place come of it on community providers. With the new communicable disease reporting rule *(410 1AC 1-2.5-76)*, local health departments are required to report LTBI. Much work is need to continue to do further education and outreach to improve data reporting of LTBI.

The initial domestic health screening for refugees that come into Indiana is a vital aspect to improving the overall health of refugees in Indiana. Refugees endure a long process of resettlement and often come from high stress environments that can be ideal for the spread of infectious, not to mention the mental stresses. The stress brought on by this plight can lead to individual becoming more susceptible to physical and mental illnesses. If this population receives the proper health screenings and follow-up treatment that is necessary to mitigate public health threats, Indiana stays healthier and refugees are able to become productive members of the community.

Target Population:

Number: 6,633,053
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 961,793
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: United States Census Bureau--http://quickfacts.census.gov/qfd/states/18000.html

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Infectious Diseases Society of America Guideline for Diagnosis of Tuberculosis in Adults and Children
Infectious Diseases Society of America Guideline for Treatment of Drug Susceptible Tuberculosis

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $131,394
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Enhancement of the ITARA database
Between 10/2017 and 09/2018, the contract program developer will develop **2** custom reports for both ISDH as well as the LHDs and clinic users working with the TB/Refugee epidemiologist. Additional enhancements to ITARA that will improve functionality and cross collaboration with the Indiana Family and Social Services Administration (FSSA) will be developed to incorporate an automated Medicaid check for clinic and grant

reimbursement purposes.

Annual Activities:

1. Develop ITARA reports

Between 10/2017 and 09/2018, the IT programmer will develop custom reports to include number of arrivals, time to initial screening, time to completion of screening, missing screenings, monthly reports, and screening outcome reports to send to ORR three times per year. The developer will also be responsible for training the end users. The IT program will also develop Medicaid report to send to FSSAA to ensure reimbursements are conducted appropriately.

2. Develop enhancements to IT application

Between 10/2017 and 09/2018, the IT programmer will enhance databases to come into compliance with 64 bit and migrate to new gateway servers.

Objective 2:

Implementation of NBS

Between 10/2017 and 09/2018, Contract program developer--Aatif Munshi; TB director--Kelly White; TB epidemiologist--Sang Thao; regional nurses--Wendi Hollowell, Sandi Morse, and Jill Brock will conduct **1** ongoing implementation and training for NBS. NBS is planned to be implemented in January 2019; however, ongoing training with LHDs and community providers will be needed. In coordination with the LHDs, the regional nurses will also be providing outreach and training to community providers on evaluating and reporting LTBI patients.

Annual Activities:

1. Analyze 2015-2016 LTBI data for the entire state

Between 10/2017 and 09/2018, the TB/Refugee Epidemiologist will develop a baseline for LTBI data in the state. The baseline data will be used to compare to national LTBI prevalence estimates.

2. Develop and/or implement functionality in NBS to improve medication management

Between 10/2017 and 09/2018, the IT programmer will work with the TB/Refugee Epidemiologist, and OTC to develop and learn best practices for LHDs and the TB regional nurses to utilize NBS in ordering their prescription TB and LTBI medications through the contracted pharmacy.

3. Provide training and outreach to reporting organizations and LHDs on TB reporting

Between 10/2017 and 09/2018, the regional nurses in coordination with the LHDs will provide outreach to reporting entities to ensure that they are reporting LTBI cases appropriately and also providing as much clinical evaluation as possible before being transferred to the care of LHDs. The IT developer will work with OTC to ensure that ELR and reporting data are coming into NBS effectively.

4. Identify providers/clinics through the state that can assist in evaluation

Between 10/2017 and 09/2018, the IT developer will work with OTC to ensure that ELR data and case data are being reported effectively in NBS. The regional nurses will work with LHDs to identify resources in the community to establish community partnerships to assist in the evaluation of LTBI cases.

State Program Title: Water Fluoridation Program

State Program Strategy:

Goal: Between October 2018 and September 2019, the goal of the Water Fluoridation Program is to promote water fluoridation and monitor water fluoridation systems across the state to assure that the majority of the population of the state of Indiana continue to receive the benefits of water fluoridation
Program Priorities:
> Inspect water fluoridation systems in communities and schools across the state to ensure they maintain optimum fluoride levels.
>Educate mayors, town councils, water system boards and citizens as to the benefits, cost effectiveness and safety of water fluoridation to prevent the elimination of water fluoridation in communities.
Primary Strategic Partnerships(s):

- **Internal:** ISDH Oral Health
- **External:** Indiana Dental Association, Indiana Dept. of Environmental Management Drinking Water Division, Centers for Disease Control and Prevention

Evaluation Methodology: The field staff is expected to make at least 200 inspections of water fluoridation systems per year and to respond to any high fluoride levels (2.0ppm or above) within five business days. Field staff is expected to train any new water fluoridation system operators within 10 business days of being notified of the new operator and to retrain existing operators as needed. Field staff is also required to attend at least two professional water treatment operators meetings in order to keep up with water treatment technology and network with water fluoridation operators. The staff is also required to input up to date data into the Water Fluoridation Reporting System (WFRS). The program will evaluate progress through regular reports to the program director.

State Program Setting:

Schools or school district, State health department

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Name: James Powers
Position Title: General Sanitarian Supervisor 4/6NF4
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Fred Finney
Position Title: Water Fluoridation Consultant III/1LK3
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Eric Newlon
Position Title: Water Fluoridation Consultant III/1LK3
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 3
Total FTEs Funded: 3.00

National Health Objective: HO OH-13 Community Water Fluoridation

State Health Objective(s):

Between 10/2017 and 09/2018, monitor water fluoridation programs in communities and schools on a regular basis.

Baseline:

In Indiana there are 245 fluoridated community water systems, 17 fluoridated rural school water systems and 118 consecutive water systems that purchase water from a fluoridated system. The objective of this program is to monitor all fluoridated water systems through surveillance visits and lab test results, and prevent the reduction in the number of fluoride systems that operate at optimum levels and maintain the 94% of the state's population that are served by a water system that has an optimal level of fluoride.

Data Source:
Results from the tests run on weekly samples submitted to the state laboratory.

State Health Problem:

Health Burden:
Over the last five years there have been 19 towns, cities, or water districts that have eliminated their water fluoridation programs due to budget issues or anti-fluoridation activities. Another 7 communities have considered eliminating their fluoride programs but decided to continue after hearing presentations from representatives of this program with support from local dentists, local health departments and the Indiana Dental Association. Studies have shown that when a community discontinues water fluoridation, the decay rates return to pre-fluoridation levels. Maintaining water fluoridation programs in communities prevents an increase in dental decay levels, which contributes to the overall health of those who live in those communities.

Target Population:
Number: 4,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 4,000,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: US Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The fluoridation program follows the CDC guidelines for fluoride system operation by working with

fluoride system operators to maintain fluoride at the optimal levels and perfecting testing procedures. Recent changes in the recommended level of fluoride in drinking water implemented by HHS have led the CDC to prepare operational tolerance guidance that will be implemented by the Indiana Fluoridation Program.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $242,449
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Maintain Water Systems with Optimal Fluoride Levels
Between 10/2017 and 09/2018, James Powers will maintain **94%** - the percentage of people in Indiana on public water supplies that have access to fluoridated water.

Annual Activities:
1. Monitor Fluoride Samples
Between 10/2017 and 09/2018, staff will monitor fluoride samples from all water supplies for optimal levels. Staff will respond when out of range by reviewing, on a weekly basis, the test results from all the fluoride samples sent in to the state lab for that period. When a community's test results indicate that the fluoride level is out of range, the fluoridation field staff schedule a visit or contact the community water plant operator to resolve the issue as soon as possible.

2. Consultations with town/city official or waste district board members
Between 10/2017 and 09/2018, when city/town officials or a water district board is considering the discontinuation of fluoridation, staff will meet with them to discuss the public health benefits of continuing. Staff will also recruit local dentists in the area to help.