

**INDIANA MATERNAL AND CHILD HEALTH TITLE V BLOCK GRANT**  
**Indiana State Department of Health**  
**Title V – Maternal and Child Health Block Grant**  
**FY 2009 Application/FY 2007 Report**  
**Advisory Panel Summary**

**Purpose**

Title V Maternal and Child Health (MCH) Block Grant funds are to be used to improve the health status of women, infants, children, adolescents and children with special health care needs in the State of Indiana. Although MCH programs are available to all women, infants and children and many other programs are available to families with children, emphasis is placed on women of childbearing age, low-income populations and those who do not have access to health care.

**Mission**

The Title V Grant Application is integrated with the mission of the Indiana State Department of Health (ISDH): “The Indiana State Department of Health supports Indiana’s economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities.”

ISDH has also developed the following priority health initiatives:

1. Data drives efforts for both health conditions and health systems initiatives
  - Effective, efficient, and timely data collection.
  - Evidence-based and results-oriented interventions based on best practices
2. INShape Indiana
  - Promotion of prevention and individual responsibility especially in the areas of obesity prevention through good nutrition and exercise and smoking cessation.
  - Participation in this effort with all components of communities – collaborative partners.
  - Integration of INShape opportunities in all programming and communications.
3. Integration of medical care with public health
  - Appropriately targeted access to care for underserved Hoosiers.
  - Opportunities for Medicaid demonstration projects to showcase successful public health-based interventions.
  - All direct and enabling services providers must be Medicaid providers.
4. Preparedness
  - Continual scanning for developing public health threats regardless of cause of the threat (particularly direct medical care projects).
  - Planning and training for poised and effective response to threats that cannot be prevented.
  - Coordination through Local Public Health Coordinators.

The ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

### **State Summary Profile**

Indiana's FY 2009 Title V Block Grant allocation is estimated at \$11,890,821. Federal mandates that at least 30% of the grant be spent on preventative and primary care services for children and at least 30% of the grant be spent on services for children with special health care needs (CSHCN).

The Indiana State Department of Health administers the Title V grant through Maternal and Children's Special Health Care Services (MCSHC), a division of the Human Health Services Commission (HHSC). MCSHC administered programs include: Prenatal Substance Use Prevention Program, Indiana Perinatal Network, SIDS, Preventive and Primary Child Health Care, Indiana RESPECT (Reducing Early Sex and Pregnancy by Educating Children and Teens), Indiana Child Care Health Consultant Program, Family Care Coordination, Prenatal Care Services, Prenatal Care Coordination, Adolescent Health Centers, Family Planning Services, and the Genetic Diseases Program. MCSHC also administers Children's Special Health Care Services (CSHCS), the state program for children with special health care needs. Other programs administered within the Commission include: Indiana Childhood Lead Poisoning Prevention Program, Immunization, Injury Prevention, Oral Health, and Genomics and Newborn Screening, which includes Universal Newborn Hearing Screening, Newborn Metabolic Screening, and the Sickle Cell Program.

During FY '07 MCSHCS used the Title V grant to fund 11 family planning projects, 5 genetics centers, 12 infant health projects, 14 prenatal care clinics, 12 child health projects, 6 school-based adolescent health grantees, 1 high risk infant follow-up program, 26 prenatal care coordination programs, 5 Prenatal Substance Use Prevention Programs, and 14 family care coordination programs.

(2006 Data Has Been Used When 2007 Data Was Unavailable)

### **Priority Health Needs for the MCSHC population, 2006-2011**

1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality racial and ethnic disparities in pregnancy outcomes.
2. To reduce barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families.
3. To build and strengthen systems of family support, education and involvement to empower families to improve health behaviors.

4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects.
5. To decrease tobacco use in Indiana.
6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs.
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity.
8. To reduce obesity in Indiana.
9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana.
10. To improve racial and ethnic disparities in women of childbearing age, mothers, and children's health outcomes.

### **National "Core" Performance Measures**

1. The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
2. The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)
3. The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
4. The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN survey)
5. Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN survey)
6. The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)
7. Percent of 19 to 35 month olds who have received a full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of births (per 1,000) for teenagers aged 15 through 17 years.
9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
11. The percent of mothers who breastfeed their infants at 6 months of age.
12. Percentage of newborns who have been screened for hearing before hospital discharge.

13. Percent of children without health insurance.
14. Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85<sup>th</sup> percentile.
15. Percentage of women who smoke in the last three months of pregnancy.
16. The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

### **State “Core” Performance Measures**

1. The number of data sets, including the NBS, UNHS, Lead, IBDPR, Immunizations, CSHCS, and First Steps Data, that are completely integrated into the Indiana Child Health Data Set.
2. The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old.
3. The percent of live births to mothers who smoke.
4. The percent of black women (15 through 44) with a live birth whose prenatal visits were adequate
5. The percentage of children age 0 to 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter
6. The proportion of births occurring within 18 months of a previous birth to the same birth mother.
7. Number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities
8. The percentage of high school students who are overweight or at risk

### **MCSHC Performance Measures including Performance for FY 2007, Current Status of Activities for FY 2008, and Plans for FY 2009**

**PERFORMANCE MEASURE # 1** The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Status: 100% of screen positive received timely follow-ups.

#### **a. FY 2007 Accomplishments**

FY 2007 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical

management for condition(s) mandated by their State-sponsored newborn screening programs.

Activities to impact this performance objective include:

- 100 % newborns whose screens were invalid, abnormal, or positive received follow-up.
- All infants with confirmed positive results were referred to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the CSHCS programs.
- NBS provided 8 in-service training to Public Health Nurses, midwives, hospitals, and birthing centers.
- NBS began to develop the NBS Datamart beginning with the EDHI program in the Operational Data Store to allow more efficient and effective tracking and follow-up of babies who received a positive heel-stick for certain conditions.
- The genomics NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

#### **b. Current Activities for FY 2008**

FY 2008 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Activities to impact this performance objective include:

- NBS is continuing to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.
- NBS is continuing to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, Cystic Fibrosis Foundation certified clinics and labs, First Steps, and the Children's Special Health Care Services (CSHCS) programs.

- NBS is continuing to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. An updated presentation for Public Health Nurses is near completion for implementation online.
- NBS is continuing to develop the NBS Datamart in the Operational Data Store. This system will allow more efficient and effective tracking of all babies ensuring all receive a valid screen and appropriate follow-up.
- NBS added Cystic Fibrosis to the NBS panel on January 1, 2008
- The genomics NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Activities to impact this performance objective include:

- NBS will continue to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.
- NBS will continue to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the Children's Special Health Care Services (CSHCS) programs.
- NBS will continue to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. An updated presentation for Public Health Nurses is near completion for implementation online.
- NBS will begin pilot testing of the NBS (Heelstick) Datamart in the Operational Data Store. This system will allow more efficient and effective tracking of all babies ensuring all receive a valid screen and appropriate follow-up.
- The genomics NBS Director will continue to participate in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

**PERFORMANCE MEASURE # 2** The percent of children with special health care needs age 0 to 18 years whose family's partner in all levels of decision-making and are satisfied with the services they receive.

FY2007 Performance Objective: The percent of children with special health care needs ages 0 to 18, whose families partner in all levels of decision-making were satisfied with the services they receive, will be determined based on National Survey of Children with Special Health Care Needs (NS-CSHCN) data, for which FY07 results are not yet available. 59.3 % per 2005/2006 CSHCN Chart book.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- CSHCS developed a satisfaction survey for parents/guardians of the program's participants to determine how they feel services can be improved. The survey was distributed. 28% of the surveys sent were responded to, and of that 28% over 84% listed their experience as good or great, with over 57% saying Great. Only 1% of all respondents rated their experience as Poor/Bad.
- CSHCS distributed the FEMA brochure, "Preparing for Disaster for People with Disabilities and other Special Needs", to all participants in 2007 was completed.
- CSHCS mailed notices of the "Inspiring Abilities Expo 2007", to all participants in Hancock and surrounding counties. This event was held 3/10/07 in Greenfield, Indiana, and provided an opportunity for families to connect with service providers, non-profit agencies, public services and vendors of products and services which might benefit children.
- CSHCS mailed "The CSHCS Winter Newsletter" to all participants.
- CSHCS mailed Developmental Calendars to all participants age 0-5 years of age.
- CSHCS developed a Transition Manual as a resource for CYSHCN age 12-21 and provided a copy to all participants.
- CSHCS participated as an Exhibitor in 4 Conferences throughout the state for CYSHCN.
- CSHCS grants funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities. Activities include the following:
  1. Parent to parent contact through the telephone was available to families for questions related to health care coverage, education, early intervention,

community resources, training and other issues. During FY 07, a total of 2,466 new families and professionals were served by ASK staff. In addition, 3,711 families and professionals were contacted through ASK's follow-up protocols throughout the year.

2. ASK connected on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in practice.
3. ASK offered trainings to families and professionals about special education and health care financing. Scholarships are available to families who cannot afford to attend these trainings.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of children with special health care needs ages 0 to 18 whose families partner in decision-making at all levels, who will be satisfied with the services they receive, will remain at 64% based upon NS-CSHCN data.

Activities to impact this performance objective include:

- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) was convened in February 2008, to create a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community-based and culturally competent.
- The C.I.S.S. Committee has a sub-committee titled "Family/Professional Partnerships"; whose focus is to enhance systems of care for CYSHCN that enables families to partner in decision-making at all levels, and be satisfied with the services they receive. The sub-committee will make recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve community-based service systems around Family/Professional Partnerships.
- CSHCS updated their English and Spanish versions of the CSHCS Program Brochure.
- CSHCS has finalized its review and update of the CSHCS Participants Manual and the Transitions Manual. Both are being reviewed by ASK parents. CSHCS will mail all participants a new copy of the updated manuals in FY 08.

- CSHCS produced a Spanish language version of the Participants Manual. CSHCS plans to mail the manuals in FY 08.
- CSHCS grants funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities. Current activities include the following:
  1. Parent to parent contact through the telephone is available to families for questions related to health care coverage, education, early intervention, community resources, training and other issues. During FY 08 (data only available through April 28, 2008), a total of 2,649 new families and professionals were served by ASK staff. In addition, 4,186 families and professionals were contacted through ASK's follow-up protocols throughout the year.
  2. ASK connects on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in practice.
  3. ASK offers trainings to families and professionals about special education and health care financing. Scholarships are available to families who cannot afford to attend these trainings.
  4. ASK produces a monthly e-newsletter that is sent out to more than 1,000 families and professionals each month. The e-newsletter contains information pertinent to both professionals and families.
  5. ASK began sending out CHSHCS program applications from its office during this grant cycle.
- Medical Director will be working with ISDH Disaster Preparedness to assure needs of CSHCN are included.
- CSHCS participated in 9 statewide Roadshows with members of the Indiana State Transition Team where we presented information about the CSHCS program
- CSHCS will continue to participate in statewide conferences and exhibitions to promote the CSHCS program.

**c. Planned Activities FY 2009**

FY 2008 Performance Objective: The percent of children with special health care needs ages 0 to 18 whose families partner in decision-making at all levels, who will

be satisfied with the services they receive, will remain at 64% based upon NS-CSHCN data.

Activities to impact this performance objective include:

- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community – based and culturally competent.
- The C.I.S.S. sub-committee titled “Family/Professional Partnerships” (whose focus is to enhance systems of care for CYSHCN that enables families to partner in decision-making at all levels, and be satisfied with the services they receive) will continue its work.
- CSHCS will produce and mail a Summer and Winter CSHCS Newsletters to all participants.
- CSHCS will provide the updated CSHCS Program Brochures to all CSHCS providers, parent support agencies and other community-based systems that care/support CYSHCN.
- CSHCS will continue to provide Developmental Calendars, Transition Resources-including the CSHCS Transition Manual and Health Care financing options to all its participants.
- ASK will continue to receive grant funding from CSHCS and will increase the total number of families and professionals served through its staff and programs.
- ASK will work with CSHCS to collect information from families and from professionals about their understanding of a medical home. Following this survey, ASK will assist CSHCS in identifying steps to take toward furthering the medical home concept in Indiana.
- ASK will participate with the Indiana State Department of Health on advisory committees to special projects, insuring that the family perspective is always present throughout the planning processes.
- ASK will continue to send an e-newsletter and anticipates that readership will reach over 1200 during the coming year.
- CSHCS will continue to participate in statewide conferences and exhibitions to promote the CSHCS program.

**PERFORMANCE MEASURE # 3** The percent of children with special health care needs age 0-18 who receive coordinated, ongoing, comprehensive care within a medical home.

FY 2007 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home was maintained at 56% in FY 2007 (per NC-CSHN data).

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC completed the Universal Newborn Hearing Screening (UNHS) and Sickle Cell program datamarts within the Operational Data Store (ODS) and began developing the Newborn Screening datamart. These datamarts will allow the NBS staff to better track clients in these programs as to whether they have a medical home.
- MCSHC completed the updates and will begin marketing the Medical Passports for use in Children with Special Health Care Service (CSHCS).
- The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families; for the purpose of having a parent representative visit various community based medical practices to begin teaching about community resources and the medical home. A total of 28 medical staff were trained through these efforts.
- ASK connected on a monthly basis with pediatric residents who are being trained at Indiana University. Residents were taught about community resources and the importance of sharing this information with families who they will be seeing in practice.
- MCSHC distributed an educational brochure for parents regarding Medical Homes in mailings to consumers from the NBS.
- MCSHC hired a manager in May 2007 whose focus will be on integrating services and medical home for children with special health care needs.
- MCSHC began to evaluate five projects that are providing Medical Home models to determine how they are meeting the Children and Youth Special Health Care Needs (CYSHCN) performance measures.
- MCSHC will develop a strategic plan to integrate community services for CYSHCN including objectives on Medical Home.

**b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be maintained at 56% in FY 2008

Activities to impact this performance objective include:

- MCSHC will develop and distribute an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH and Indiana Family Helpline (IFHL) programs.
- MCSHC will continue to market the Medical Passports for use in Children with Special Health Care Service (CSHCS).
- ASK continues to provide on a monthly basis to pediatric residents who are being trained at Indiana University. Information about community resources and the importance of sharing this information with families who they will be seeing in practice.
- ASK has begun participation on the Community Integrated Service Systems (CISS) advisory committee and also has representation on three of the subcommittees of this project. Initial work has begun to develop surveys for medical professionals and for families about medical home.
- MCSHC will select or develop a brochure for physicians about the medical home concept.
- MCSHC will continue to evaluate five projects that are providing Medical Home models to determine how they are meeting the Children and Youth Special Health Care Needs (CYSHCN) performance measures.
- MCSHC convened The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) in February 2008, to create a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community-based and culturally competent.
- The C.I.S.S. Committee "Medical Home" sub-committee will make recommendations to coordinate for INDIANA the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the goal of coordinated, ongoing, comprehensive care within a Medical Home.

- MCSHC began an In-house Care Coordination System in April 2008. The Care Coordinators link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

### **c. Planned Activities FY 2009**

- MCSHC will continue to distribute an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs.
- MCSHC will continue to market the Medical Passports for use in Children with Special Health Care Service (CSHCS).
- ASK will continue to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in practice.
- CSHCS will continue to facilitate the Community Integrated Systems of Services (C.I.S.S.) advisory committee and have ASK participate on the Medical Home subcommittee of this project to further the plan for spreading the medical home concept more broadly in Indiana.
- CSHCS will work with ASK to collect information from families and from professionals about their understanding of a medical home. Following this survey, ASK will assist CSHCS in identifying steps to take toward furthering the medical home concept in Indiana.
- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community – based and culturally competent.
- The C.I.S.S. sub-committee titled “Medical Home” will make recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana.
- MCSHC will continue the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept

where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

**PERFORMANCE MEASURE # 4 Percent of Children with Special Health Care Needs, age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.**

FY 2007 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be maintained at 67% in FY 2007.

Status: NS-CSHCN data

**FY 2007 Activities Accomplished**

Actual figures, based upon information in the Agency Claims and Administrative Processing System (ACAPS), of participants in Indiana's CSHCS program who have either private or public health insurance is 91.01%. Of that total percentage, 51.41% of participants have some kind of private health insurance and 39.60% have Medicaid.

- CSHCS tracked insurance utilization in ACAPS. This activity allowed for denial of claims for which other insurance coverage is available.
- CSHCS monitored the activities and progress of the Health Insurance for Indiana Families Committee, a group of state leaders charged with developing no-or low-cost options to provider services for the uninsured.
- CSHCS monitored the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of children and adults who benefit from federal and state health care coverage programs.
- The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. As a part of this grant, ASK staff members spoke with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and helped families navigate through the complex systems.
- ASK offered trainings to families and professionals that outline the various public health insurance programs. Follow-up with an ASK Parent Liaison helped families determine which of these programs will serve their children the best.

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

### **Current Activities for FY 2008**

FY 08 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will increase to 69% in FY 2008.

Status: Insurance information for FY 07 indicates the CSHCS program has exceeded that percentage of participants who carry private or public health information.

- CSHCS will be updating ACAPS to utilize insurance information for processing electronic pharmacy claims. Electronic COB processing of pharmacy claims has been accomplished and we are currently working on electronic COB processing for medical claims.
- CSHCS will be sending information to providers which clarifies our reimbursement methodology as it relates to other insurance and the maximum allowable payment. A provider bulletin has been sent to providers.
- CSHCS is in the process of updating both the Provider and Participant Manual and will be issuing these revised manuals later in this year. Both of these manuals are now in the final stages of production.
- The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. As a part of this grant, ASK staff members speak with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and can help families navigate through these complex systems.
- ASK offers trainings to families and professionals that outline the various public health insurance programs. Follow-up with an ASK Parent Liaison can help families determine which of these programs will serve their children the best.
- ASK serves as Indiana's Family to Family Health Information and Education Center (F2FHIC). As Indiana's F2FHIC, ASK has the opportunity to meet quarterly with stakeholders from the state, community and families. The purpose of the F2FHIC is to create health care change in the state.
- ASK currently has representation on the C.I.S.S. subcommittee addressing uninsured and underinsured children in our state.
- ASK is currently revising its public health insurance training

- CSHCS program will continue to send all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.
- The C.I.S.S. Committee sub-committee "Access to Adequate Health Insurance" whose focus is to enhance systems of care for CYSHCN around the issues of adequate health insurance will make recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the above goal.

### **Proposed Activities for FY 2009**

FY09 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will increase to 70% in FY 2009.

- CSHCS will be mailing out final copies of both the Provider and Participant manuals.
- CSHCS will complete the electronic COB process for medical claims which will allow medical claims to be processed more quickly.
- CSHCS will review and follow-up on system reports that were created to identify coordination of benefit issues for electronic pharmacy claims.
- ASK will continue to serve on the CISS subcommittee addressing uninsured and underinsured children and will work with the committee to develop a plan of action related to this topic.
- The new ASK public health insurance training curriculum will be publicized and offered to both families and professionals in the coming year. The new curriculum will feature a "menu" of topics that the requesting party can select from so that the training can be customized.
- CSHCS program will continue to send all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.
- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue to work services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community-based and culturally competent.
- The (C.I.S.S.) sub-committee titled "Access to Adequate Health Insurance" will complete recommendations to coordinate the development, implementation and

evaluation of a State Integrated Community Services Plan to achieve the adequate health insurance.

**PERFORMANCE MEASURE # 5** The percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they use them easily. (CSHCS survey)

FY 2007 Performance Objective: 80% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. ASK is supported, in part by CSHCS. ASK assists families navigating the complex systems of community resources in the following ways:
  1. ASK has an online resource directory that highlights local, statewide, and national resources specifically for children with special health care needs. The directory is searchable by topic area, county and by keyword and can be accessed at any time through the internet.
  2. ASK works one on one with families who need assistance navigating through the complex system of community resources. This one on one assistance comes from the ASK Parent Liaison staff who guide each individual to the resources that are appropriate for their families.
  3. With funding assistance from the Indiana State Department of Health, ASK developed community resource pads and a community resource poster that has been distributed to health care settings, and through various information fairs throughout the state. Key community resources were selected for listing on these materials and they were made “user-friendly” so that they could easily be utilized.
- MCSHC maintained an 800 Family Help Line with V/TDD capabilities and bilingual support and referred families to community-based services.
- CSHCS provided community based-training to First Steps providers and The Division of Family Resources (DFR) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.

- CSHCS will continue to reimburse families for in-state and out-of-state transportation for CSHCS participants to medical facilities for services.
- CSHCS provided outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.
- To facilitate receipt of CSHCS applications CSHCS promoted Single Points of Entry (SPOE) early intervention sites, and used local Offices of Family Resources to take CSHCS applications.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: 82% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

Activities to impact this performance objective include:

- MCSHC began an In-house Care Coordination System in April 2008. The Care Coordinators assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.
- CSHCS will fund and collaborate with About Special Kids (ASK) and its statewide network of family-to-family peer support.
- ASK has continued to add resources and to update resources in its directory and during this year, added a for profit component to the directory (previously, the directory only included nonprofit resources). In this section, for profit companies, who are specifically addressing the needs of children with special health care needs, are listed for a fee. A disclaimer is offered to families so that they know that the organization does not endorse any specific for profit entities.
- ASK has helped over 6,000 families access appropriate community resources during this grant year.
- With funding assistance from the Indiana State Department of Health, ASK updated the Marion County community resource pads and also the statewide community resource poster that has been distributed to health care settings, and through various information fairs throughout the state. Key community resources were selected for listing on these materials and they were made “user-friendly” so that they could easily be utilized.

- MCSHC convened The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) in February 2008, that created a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community-based and culturally competent.
- The C.I.S.S. Committee sub-committee titled “Organization of Community Services for Easy Use By families”( whose focus is to enhance systems of care for CYSHCN around the issues of community-based service systems that are organized so families can use them easily) will make recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the above goal.
- MCSHC maintains an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.
- CSHCS provides current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.
- CSHCS continues to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.
- CSHCS provides outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.
- CSHCS promotes Single Points of Entry (SPOE) early intervention sites, and use local Offices of Family Resources to take CSHCS applications.
- CSHCS continues using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.
- CSHCS publishes a bi-yearly (Summer and Winter) newsletter which includes informative articles and any program updates that affect participants (i.e., policy changes, new mileage reimbursement rates, etc.).
- CSHCS will begin to evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to study how well they assist families in using community based services.

**c. Planned Activities FY 2009**

- MCSHC will continue the In-house Care Coordination System. The Care Coordinators will continue to assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.
- CSHCS will continue to fund and collaborate with About Special Kids (ASK) and its statewide network of family-to-family peer support.
- ASK will continue to update existing resources in its online directory and will add new resources as they become available.
- ASK will continue to serve families on a one on one basis and will continue to provide follow-up to these families to insure that they are accessing the appropriate resources.
- ASK will continue to seek funding to update additional counties’ community resource cards.
- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue working with the statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community –based and culturally competent.
- The C.I.S.S. sub-committee titled “Organization of Community Services for Easy Use By families” (whose focus is to enhance systems of care for CYSHCN around the issues of community-based service systems that are organized so families can use them easily) will continue its work and make recommendations to coordinate the development, implementation and evaluation of the State Integrated Community Services Plan to achieve the above goal.
- MCSHC will maintain an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.

- CSHCS will provide current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.
- CSHCS will continue to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.
- CSHCS will provide outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.
- CSHCS will continue to promote Single Points of Entry (SPOE) early intervention sites and local Offices of Family Resources to take CSHCS applications.
- CSHCS will continue using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.
- CSHCS will continue to published a bi-yearly (Summer and Winter) newsletter which includes informative articles and any program updates that affect participants (i.e., policy changes, new mileage reimbursement rates, etc.).
- CSHCS will continue to evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to study how well they assist families in using community based services.

**PERFORMANCE MEASURE # 6** The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

FY 2007 Performance Objective: 8% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey).

Status: Underway

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- Children's Special Health Care Services (CSHCS) developed a Transition Manual and distributed it to 100% of participants, age 12-21.

- Children's Special Health Care Services (CSHCS) staff received ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.
- CSHCS published a newsletter for CSHCN families and participants with listings for community resources and support systems.
- Children and Youth with Special Health Care Needs (CYSHCS) worked with interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.
- The Children and Youth with Special Health Care Needs (CYSHCN) Transition Project has been initiated and is developing protocols for transitioning youth with special health care needs to adult care.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: 8% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey).

Activities to impact this performance objective include:

- Children's Special Health Care Services (CSHCS) continues to distribute the Transition Manual to 100% of participants that age off (turns 21) of the program. Children's Special Health Care Services (CSHCS) distributes the Transition Manual at health and transitional fairs that it attends as an exhibitor.
- Children's Special Health Care Services (CSHCS) staff continues to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.
- CSHCS publishes a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.
- CSHCS and CSHCN transition clinic continue to develop transition assistance for clients and training for providers.
- CYSHCS works with interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.
- The CYSHCN Transition Project works with health care providers statewide on transitioning youth with special health care needs to adult care.
- Materials and tools developed at the CYSHCN transition clinic continue to be distributed to other providers.

### c. Planned Activities FY 2009

FY 2009 Performance Objective: 8% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey).

Activities to impact this performance objective include:

- Children's Special Health Care Services (CSHCS) will continue to distribute the Transition Manual to 100% of participants that age off (turns 21) of the program.
- CSHCS will continue to distribute the Transition Manual at health and transitional fairs that it attends as an exhibitor.
- Children's Special Health Care Services (CSHCS) staff will continue to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.
- CSHCS will continue to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.
- CSHCS and CSHCN transition clinic will continue to develop transition assistance for clients and training for providers.
- CYSHCS will continue to work with interagency initiatives regarding transition for disabled individuals from school to work or youth to adult health services.
- The CYSHCN Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.
- Materials and tools developed at the CYSHCN transition clinic will continue to be distributed to other providers.

**PERFORMANCE MEASURE # 7** Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B as measured by the National Immunization Survey (NIS) conducted by the Centers for Disease Control and Prevention (CDC).

FY 2007 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase to 82% in 2007, based on data collected for the National Immunization Survey (NIS) conducted by the Centers for Disease Control and Prevention (CDC).

Status: 2007 NIS data will not be available until August 2008; interim data shows 79.7%, which is a 0.2% increase over 2006.

#### **a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- The ISDH Immunization Program provided all Advisory Committee on Immunization Practices (ACIP) recommended vaccines to all MCSHC sites enrolled in the Vaccines for Children (VFC) program.
- The ISDH Immunization Program conducted Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at all VFC enrolled MCSHC sites this year to assess implementation of ACIP recommendations and compliance with VFC policies.
- The ISDH Immunization Program worked with MCSHC to increase the number of sites using reminder/recall systems of needed immunizations to 75%. (Not limited to VFC enrolled if all could use the Children and Hoosiers Immunization Registry [CHIRP] and benefit from CHIRP training)
- The Immunization Program worked with MCSHC to integrate the Federal Resource and Enabling Data system (FRED) with CHIRP (Children and Hoosiers Immunization Registry Program) so that all MCSHC served children's immunization records will be in CHIRP.
- MCSHC provided funds for the immunization program to provide additional needed vaccines for children.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase to 83% in 2008.

Activities to impact this performance objective include:

- The ISDH Immunization Program continues to provide all Advisory Committee on Immunization Practices (ACIP) recommended vaccine to MCSHC sites enrolled in the Vaccines for Children (VFC) program.
- The ISDH Immunization Program continues to Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at all VFC enrolled MCSHC sites each year to assess implementation of ACIP recommendations and compliance with VFC policies.

- The ISDH Immunization Program works with MCSHC to increase the number of sites using reminder/recall systems. (This function is not limited to VFC enrolled, but is a function available to CHIRP enrollable providers who could use the Children and Hoosiers Immunization Registry [CHIRP] and benefit from CHIRP training)
- MCSHC Health Systems Development (HSD) staff will participate on the Indiana Immunization Coalition.
- The legislature increased cigarette tax by 44 cents of which a portion will be used to buy vaccines.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B, and Varicella (4:3:1:3:3:1) will increase to 84% in 2009.

- The ISDH Immunization Program will continue to provide all Advisory Committee on Immunization Practices (ACIP) recommended vaccine to MCSHC sites enrolled in the Vaccines for Children (VFC) program.
- The ISDH Immunization Program will conduct Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at all VFC enrolled MCSHC sites each year to assess implementation of ACIP recommendations and compliance with VFC policies.
- The ISDH MCSHC will work with the Immunization Program to increase the number of sites using reminder/recall systems. The ISDH Immunization program will continue to provide CHIRP training for MCSHC sites and include training on the use of the reminder recall features to increase the number of site aware of the reminder recall functionality.
- MCSHC Health Systems Development (HSD) staff will continue to participate on the Indiana Immunization Coalition.
- The ISDH Immunization Program will work with MCSHC to increase the number of sites enrolled as VFC and or CHIRP providers.

**PERFORMANCE MEASURE # 8:** The rate of birth (per 1,000) to teenagers aged 15-17 years.

FY 2007 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 19.0 in FY 2007.

Status: The birth rate per 1,000 females for ages 15-17 was 20.8 for 2006. (Please note: this data is provisional.)

**a. FY 2007 Accomplishments**

- The State allocated funding to support Indiana RESPECT (Reduces Early Sex and Pregnancy by Educating Children and Teens), the state's teen pregnancy prevention initiative. These funds were awarded to 26 community-based grantees throughout the state who provided sexuality education and teen pregnancy prevention programming to adolescents and teens. Indiana RESPECT has also partnered with Indiana University School of Medicine, Section of Adolescent Medicine to work on an evaluation of the community-based grantee program. This evaluation will look at a variety of factors such as populations served, type of program (in-class, mentoring, etc.), and conduct a review of medically accurate information regarding pregnancy and sexually transmitted infections included in the curriculum of choice for each grantee.
- The state adolescent health coordinator (SAHC) authored the Federal FY07 Section 510 Abstinence Education Program Grant. A grant was awarded due to this application. With the funding received, the State was able to support a statewide media campaign that reinforces the consequences of sexual activity, including teen pregnancy, and advocates for teens abstain and wait to have sex. In addition to the media campaign, the State also funded 25 community-based grantees throughout the state to provide abstinence education programming to adolescents and teens.
- The SAHC monitored the progress and effectiveness of the abovementioned abstinence media campaign. The SAHC disseminated educational materials to all interested community members that requested such information. The SAHC worked with an advertising agency to complete an update of the content of the Indiana RESPECT. In addition to the update in content to the site, interactive elements were added to make the site more teen friendly. These included activities such as a quiz, STD matching game, and baby cost calculator. The website for RESPECT can be found at [www.IndianaRESPECT.com](http://www.IndianaRESPECT.com)
- With the FY 06/07 Indiana RESPECT community grants program contracts ending, the SAHC oversaw the FY 08/09 Indiana RESPECT community grant program application and review process. A total of 61 applications were received. The SAHC reviewed all applications and made funding recommendations for 20 grantees for the FY 08/09 grant cycle.
- The Indiana RESPECT program had a presence at the Indiana Black Expo Minority Health Fair, a four day event in July, and Fiesta Indianapolis, a one-day

community event that brings together people from all cultures that allows programs the opportunity to provide information on health issues and services available to the public. These events outreach to minority populations throughout the state. They provided the program an opportunity to reach out to these populations with the message of abstinence and delaying parenting and pregnancy among teens. At both of these events, a short survey was administered which promoted conversation between teens and adults on the topic of abstinence and pregnancy prevention.

- The SAHC collaborated with the Coordinated School Health Program Directors from the Indiana State Department of Health and the Department of Education to administer surveys for the 2007 Youth Risk Behavior Survey (YRBS). Once the data was collected and analyzed, the SAHC developed the fact sheet for the data specific to sexual behavior among high school students.
- The SAHC is the chair of the planning committee for the Indiana Coalition to Improve Adolescent Health. The coalition worked on identifying health priorities impacting adolescents to include in the state's first adolescent health plan. Of the health priorities to be included in the plan, sexual activity and sexually transmitted infections are of importance among this population.
- The SAHC attended a conference in March 2007 for the National Network of State Adolescent Health Coordinators. This meeting included breakout sessions specific to teen pregnancy and adolescent sexual behaviors.
- The SAHC was on the planning committee for a statewide two-day summit held in September 2007 which focused on unintended pregnancies. This summit provided the opportunity to hear local and national speakers discuss the complex factors associated with unintended pregnancies and explore common-ground solutions at the state and local level.
- The SAHC promoted the 2007 National Day to Prevent Teen Pregnancy. Materials regarding the National Day and Indiana RESPECT were sent out to all middle schools, high schools, private schools in Indiana; to current and past Indiana RESPECT grantees; and to school-based clinics throughout the state. A link to take the National Day quiz was posted on the Indiana State Department of Health website. The SAHC also ensured a press release was developed on this event.
- The Indiana State Department of Health's Maternal and Children's Special Health Care (MCHSC) Division funded 5 school-based adolescent health centers during the fiscal year. These clinics provide a variety of care to adolescents including prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student. The SAHC contacted each clinic quarterly to discuss the types of services being provided, provide technical assistance, and offer educational materials, including those relating to teen pregnancy prevention and abstinence.

- MCHSC enabled Free Pregnancy Test Program (FPT) agencies to provide counseling and referrals to health care providers, or provide abstinence or family planning information to sexually active teens with negative pregnancy tests. FPT was offered at three of the five funded school-based health centers.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 18.9 in FY 2008.

- The state adolescent health coordinator (SAHC) had submitted a letter for continuation of the Abstinence Education Program funds to support Indiana RESPECT for FY08. This has been approved.
- The SAHC will be providing all Indiana RESPECT grantees with a training opportunity in May on program adaptation. This training will allow grantees to learn how to improve and more appropriately tailor their curriculum being used for programming. The training will be conducted by one of our partner organizations, Health Care Education and Training, Inc. (HCET).
- The SAHC will continue to monitor the progress and effectiveness of the Indiana RESPECT abstinence media campaign. Educational materials will continue to be disseminated to those who submit a request.
- The Indiana RESPECT program hopes to have a presence again at the Indiana Black Expo Minority Health Fair and Fiesta Indianapolis. These events reach out to minority populations throughout the state and provides the program an opportunity to spread the message of abstinence and delaying parenting and pregnancy among teens.
- The Maternal and Children's Special Health Care Services (MCSHC) Division will continue to fund the school-based clinics which are a source of prenatal care coordination and/or on-site referral for prenatal care coordination for any pregnant student who comes to the clinic, and for support for "at risk" youth. The SAHC serves as the liaison between the school clinics and the MCSHC. The clinics are contacted quarterly and report on the services being provided to pregnant students. The SAHC will be working throughout the fiscal year to do site visits to each clinic.
- MCSHC will continue to enable the Free Pregnancy Test program to provide counseling and referrals to healthcare providers, or provide abstinence or family planning information to sexually active teens with negative pregnancy test.
- The SAHC promoted the 2008 National Day to Prevent Teen Pregnancy. Materials regarding the National Day and Indiana RESPECT were sent out to all

middle schools, high schools, private schools in Indiana; to current and past Indiana RESPECT grantees; and to school-based clinics throughout the state. A link to take the National Day quiz was posted on the Indiana State Department of Health website. The SAHC also ensured a press release was developed on this event.

- The SAHC will continue to lead the Planning Committee for the Indiana Coalition to Improve Adolescent Health as work is being done to author the state's first adolescent health plan. Of the 10 adolescent health priorities featured in the plan, one priority is specific to adolescents' sexual risk behaviors. The SAHC held meetings of the coalition in January and April 2008. Another meeting is scheduled for July, with one more meeting to be held before the end of calendar year 2008.
- The SAHC attended the Healthy Teen Network's Annual Conference in November 2007. The focus of this conference was finding new ways to reach teens on their turf and on their terms, using methods that connect with and involve youth in their communities. The SAHC attended a pre-conference training on teen pregnancy prevention and learned about science-based approaches to prevent teen pregnancy.
- The SAHC attended the Association of Maternal and Children's Health Programs in March 2008. Several of the breakout sessions were specific to issues in adolescent health and included data and information on teen sexual behaviors and pregnancy.
- The SAHC currently is a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy, STD's, and HIV among adolescents; translate this research into user-friendly materials; broadly disseminate these materials to the field; and work directly with the target groups to increase their capacity to promote, select, and implement science-based approaches.
- The SAHC collaborated with the Coordinated School Health Program Directors from the Indiana State Department of Health and the Department of Education to administer surveys for the 2007 Youth Risk Behavior Survey (YRBS). Once the data was collected and analyzed, the SAHC developed the fact sheet for the data specific to sexual behavior among high school students. All data and fact sheets were released in December 2007.
- The SAHC was part of the planning committee for the first youth summit held in the state. The event took place in March 2008 and attracted nearly 600 students statewide. The summit offered breakout sessions to students on healthy relationship and evaluating one's relationships.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 18.8 in FY 2009.

- The state adolescent health coordinator (SAHC) will author and submit the fiscal year 2009 Section 510 Abstinence Education Program grant application. If funded, the State will be able to continue to support community-based grantees and a statewide media campaign promoting sexual abstinence.
- With the FY2008-2009 Indiana RESPECT community grant program contracts ending, the SAHC will oversee the FY 2010-2011 Indiana RESPECT community grant program application and review process. SAHC will update the grant application for Indiana RESPECT. A technical assistance meeting will be held for all interested applicants to provide instruction on writing the grant and to clarify or answer questions regarding the application components.
- The SAHC will continue to monitor the progress and effectiveness of the statewide abstinence media campaign and continue to disseminate all new media and educational materials to community-based grantees, teens, parents, and other youth-serving organizations.
- The SAHC will partner with the Department of Education to assist in administering the 2009 Youth Risk Behavior Survey (YRBS) and data dissemination activities.
- The SAHC will attend two professional development conferences in FY 2009.
- The SAHC will continue to lead the Indiana Coalition to Improve Adolescent Health in the development, dissemination and implementation of the state's first strategic plan for adolescent health, which includes a priority on adolescent sexual behaviors.
- The SAHC will promote the 2009 National Day to Prevent Teen Pregnancy. Materials regarding the National Day and Indiana RESPECT will be sent out to all middle schools, high schools, and private schools in Indiana. A link to take the quiz associated with the National Day will be posted on the Indiana State Department of Health ISDH homepage. The SAHC will work to have a press release developed for this event.
- The Maternal and Children's Special Health Care (MCHSC) funds school-based adolescent health clinics that can provide either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student. The SAHC serves as the liaison between the school centers and MCHSC. SAHC will contact each school-based health center quarterly to learn more about the types of services

being provided, provide technical assistance, and offer educational materials. The SAHC will conduct site visits during the 2009 calendar year.

- The Free Pregnancy Test Program (FPT) through the MCHSC enables agencies to provide counseling and referrals to health care providers, or provide abstinence or family planning information to sexually active teens with negative pregnancy tests. FPT is will be offered at the school-based health centers.

**PERFORMANCE MEASURE # 9** Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

FY 2007 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 47% in FY 2006.

Status: Unable to determine Due to staff transition no Oral Health Services (OHS) survey of third graders in selected schools occurred.

**a. FY 2007 Accomplishments**

Activities that impacted this performance were:

- As of June 2007, MCSHC Medical Director was acting as Interim Oral Health Director. The dental director position was vacant from June 2007 until the end of December 2007.
- Interim medical director and one of the former dental directors with the dental hygienist concentrated efforts on writing the State Oral Health Plan with Interventions for the future while responding to requests from the public and dental professionals until the current dental director was hired in December 2007.
- Due to staff shortage, standard operating procedures included basic operations public and partner relations and responding to emergency complaints.
- OHS promoted community-based dental sealant programs, and collaborated or consulted with the Indiana University (IU) School of Dentistry Community sealant placement program, St Mary's Mobile and Smile Indiana's Mobile Program encouraging sealants and fluoride prevention services to school children. The Indiana State Department of Health (ISDH) Director of Oral Health Services served on the Board and planning committee of the IU School of Dentistry Mobile Dental Sealant Program.

- OHS met quarterly with the members of the Oral Health Task Force (OHTF) and collaborated with these community experts on developing the State Oral Health Plan, which will increase dental services to the underserved.
- OHS coordinated and met quarterly and as needed with the Office of Medicaid and Policy Planning (OMPP) on oral health issues.
- OHS provided oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish. The American Dental Association provided more Spanish samples which are needed due to the expansion of the Hispanic population in the state.
- OHS helped communities gain designation as Dental HPSA and collaborated with ISDH Office of Primary Care and the Primary Care Officer (PCO) to accomplish this.
- OHS collaborated with the Indiana Rural Health Association, the Indiana Primary Health Care Association and other partners in the community to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 47% in FY 2008.

Status: Using statistics provided by IU Seal Indiana, St Mary's Mobile, the Marion County Smilemobile and Smile Indiana Mobile Program, this goal may be achievable in selected schools.

Activities to impact this performance objective include:

- OHS promotes community-based dental sealant programs, and collaborates with the IU School of Dentistry Community Dentistry's sealant placement program, St Mary's Mobile Unit, Smile Indiana Mobile Program and the Marion County Smilemobile Program. The ISDH Director of Oral Health Services serves on the Board and planning committee of the IU School of Dentistry Mobile Dental Sealant Program and OHS provides consulting to the other mobile programs.
- OHS encourages dental providers to participate in Hoosier Healthwise and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

- OHS meets quarterly with the members of the Oral Health Task Force (OHTF) and collaborated with these community experts on developing the State Oral Health Plan, which will increase dental services to the underserved..
- OHS consults regularly by meeting quarterly or as needed with the Office of Medicaid and Policy Planning (OMPP) on oral health issues.
- OHS promotes the use of pit and fissure sealants to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.
- OHS distributes oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish and provides educational training presentations upon request.

### **c. Planned Activities for FY 2009**

FY 2009 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 48% in FY 2009.

Activities to impact this performance objective include:

- OHS will utilize grant dollars to enhance and support sealant projects already in existence in Title V schools by current dental mobile providers.
- OHS will promote community-based dental sealant programs, among existing programs and will continue to collaborate with the IU School of Dentistry Community Dentistry's sealant placement program to develop specific pilot school programs to help increase sealant placement to third graders.
- OHS will utilize grant dollars to develop specific sealant projects in rural schools to begin in FY2010.
- OHS will encourage dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.
- OHS will continue to consult with Office of Medicaid and Policy Planning (OMPP) on oral health issues by attending quarterly meetings or as needed to accomplish the business at hand.
- OHS will promote the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry, and all Dental Hygiene Programs (5) and to current practitioners throughout the state.

- OHS will continue to provide oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish.
- OHS will collaborate with partners such as the IU School of Dentistry, Indiana Dental Association, Indiana Dental Hygienists Association, Indiana Rural Health Association, Indiana Primary Health Care Association and other partners in the state to develop an Indiana Oral Health State Plan that will benefit the underserved, underinsured, working poor as well as dental professionals.
- OHS will help communities gain designation as a Dental HPSA and collaborate with ISDH Primary Care Officer (PCO) to accomplish this.
- OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

**PERFORMANCE MEASURE # 10** The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

FY 2007 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.3 in 2007. (Baseline of 3.38 in 2005)

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC began funding a part-time injury epidemiologist position to support the ISDH Injury Prevention Program.
- ISDH maintained the Injury Prevention Advisory Council, which meets quarterly, to share information on injury prevention programs and activities across the state.
- ISDH facilitated the draft State Injury Prevention and Control Plan, but was unable to finalize the Plan due to lack of resources/personnel. Of the five injury problems addressed in the Plan, one objective is to reduce the number of deaths in teens secondary to motor vehicle crashes.
- ISDH is began development of a brief data report on Indiana teen motor vehicle crashes to promote this as one objective within the State Adolescent Health Plan that is under development.
- ISDH maintained a web-based Injury and Violence Prevention Resource Center as a resource for injury prevention information for Indiana.

- ISDH continued to communicate with the Indiana Automotive Safety Program for Children as well as the Safe Kids Program in the promotion of automotive safety.
- ISDH maintained linkage with state and national safety and injury prevention groups.
- ISDH shared new developments related to childhood automotive safety with MCSHCS projects.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.2 in 2008. (Baseline of 3.38 in 2005)

Activities to impact this performance objective include:

- MCSHC continues to fund a part-time injury epidemiologist for the ISDH Injury Prevention Program through September 30, 2008.
- ISDH continues to coordinate periodic meetings of the Injury Prevention Advisory Council.
- ISDH will complete work on an updated version of "Injuries in Indiana" data report, which has one section that focuses on motor vehicle crashes and issues related to adolescent driving.
- ISDH will coordinate information on preventing deaths and injuries from teen motor vehicle crashes as one topic area in the current development of an Indiana Adolescent Health Plan.
- ISDH is promoting automotive safety through participation in relevant local/state programs.
- ISDH has a web-based Injury and Violence Prevention Resource Center to provide injury prevention information for Indiana, however this has not been updated due to a lack of resources/personnel.

#### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 3.1 in 2009 (baseline of 3.38 in 2005).

- MCSHC will continue to fund a part-time injury epidemiologist for the ISDH Injury Prevention Program through September 30, 2008. Funding for this position will be transferred to another division within ISDH at that time.
- ISDH will continue to benefit from the information sharing about statewide programs and activities by coordinating the Injury Prevention Advisory Council, which meets periodically.
- ISDH will continue to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as one topic area in the current development of an Indiana Adolescent Health Plan.
- ISDH will promote automotive safety through participation in relevant local/state programs involved in automotive safety.

**PERFORMANCE MEASURE # 11** Percentage of mothers who breastfeed their infants at 6 months of age.

FY 2007 Performance Objective: The percentage of mothers who breastfeed their infants at 6 months of age will be 35% in FY 2007.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- The Indiana Breastfeeding Alliance (IBFA) was formed from the members of the State Breastfeeding Task Force and IPN Breastfeeding sub-committee and includes representatives from: the Indiana Perinatal Network, the American Academy of Pediatrics (AAP) Chapter Breastfeeding Coordinator, La Leche League, Indiana Mothers' Milk Bank (IMMB), ISDH MCSHC Services Division, the Indiana Women Infants Children (WIC), ISDH Division of Nutrition and Physical Activity (DNPA), as well as some hospitals and local health departments. The Alliance began restructuring their group to align with new responsibilities and a new focus due to the forming of local coalitions and the shift from writing the state breastfeeding plan to implementing it.
- Plans were made to hire a new state breastfeeding coordinator to be the point person to make contact with local coalitions around the state and coordinate efforts at the state level. Due to changes in personnel at the state level and in anticipation of the hiring of a new state breastfeeding coordinator in early 2008, there was no annual meeting held for breastfeeding coalitions in 2007.
- A breastfeeding training course was conducted in February/March, 2007 by Indiana WIC in partnership with Ball Memorial Hospital in Muncie, in an ongoing effort to provide more skilled lactation consultants to assist Hoosier

mothers. This course met the requirement of the International Board of Lactation Consultant Examiners for 40-45 hours of training prior to applying to sit for the International Board Certified Lactation Consultant (IBCLC) exam.

- The State Breastfeeding Media Campaign materials were still being finalized, due to turnover in staff at ISDH and in anticipation of the hiring of a new state breastfeeding coordinator.
- The state AAP Indiana Chapter Breastfeeding Coordinator concluded CATCH Grant activities and gave a presentation at the AAP national conference on Indiana's Breastfeeding Plan and activities in recognition of the progress made in the state.
- Two Milk Depots were opened, at WIC sites in Michigan City and Muncie, to collect milk donations for the IMMB.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percentage of mothers who breastfeed their infants at 6 months of age will be 35% in FY 2007.

Activities to impact this performance objective include:

- Indiana was selected by HRSA in January 2008, as a pilot state to launch The Business Case for Breastfeeding. This coincided with the Indiana Legislature passing a new law requiring businesses with at least 25 employees to support their breastfeeding employees in being able to pump their milk at work. The new law takes effect July 1, 2008.
- A State Breastfeeding Coordinator was hired in January, 2008. She already has identified a number of coalitions from around the state, most of which were non- or only minimally- functioning.
- The annual coalition conference was held in May, 2008 with representatives of sixteen coalitions from around the state attending. The graphic pieces of the State Breastfeeding Media Campaign were presented, with printer-ready versions to be distributed to coalitions around the state via disk and internet download in time to be used for World Breastfeeding Week, August 1 – 7. HRSA's The Business Case for Breastfeeding also was presented and materials handed out for use by the coalitions in their communities. IPN will offer a training opportunity in accordance with HRSA specifications, to individuals wishing to actively assist in this project.

- The IBFA has been working to formalize bylaws and update the Breastfeeding Consensus Statement. They will seek key partners and form standing committees in their continued effort to support breastfeeding in the state.
- The IBFA has continued to collaborate with ISDH in pursuing funding to create a Breastfeeding Center for Excellence.
- ISDH has maintained the breastfeeding website for consumers and professionals. Due to changes in personnel, it has not yet been updated to include coalition information. Those changes are in the planning stages. In the interim, a blog has been created by IPN to facilitate communication between the State Coordinator, the coalitions and the IBFA.
- Grandmother's teas to promote African American breastfeeding were not held due to the early stages of formation of the coalitions. (IBBC) in early 2007 and seeks to 'promote, empower, embrace, and encourage mothers, fathers, infants, and family members in the African American community through community outreach, education, and advocacy for breastfeeding and the use of human milk'.
- The Indiana 'Women's' Prison (IWP), a facility of the Indiana Department of Corrections (IDOC), opened a new program, called the Wee Ones Nursery (WON) to facilitate bonding between qualifying incarcerated mothers and their infants. This program will also serve as a vehicle for breastfeeding promotion and support among this population as they go forward.

### **Planned Activities FY 2009**

#### **FY 2009 Performance Objective:**

- The state breastfeeding media campaign will continue, with coalitions individualizing pieces for use in their own communities. The State Breastfeeding Coordinator will also create a "brand" for breastfeeding in Indiana which will be used throughout the state.
- The IBBC will continue to strengthen their coalition and expand their work in the African-American community to improve breastfeeding support. Other communities have expressed a desire to form similar coalitions and this effort will be encouraged and supported by the IBBC, IPN and ISDH.
- The State Breastfeeding Coordinator in collaboration with the IBFA will continue efforts to increase numbers of active breastfeeding coalitions around the state and coordinate activities. The ISDH will also update the breastfeeding website so that it can serve as a communications vehicle for the coalitions and other breastfeeding supporters around the state.

- The Indiana Perinatal Network will work collaboratively with the IBFA, the State Breastfeeding Coordinator, and individual coalitions to implement and promote The Business Case for Breastfeeding, the HRSA project to promote worksite support of breastfeeding. The IBFA, in collaboration with ISDH and the AAP Chapter Breastfeeding Coordinator, will continue to pursue funding for a Breastfeeding Center of Excellence, which will set standards of care for breastfeeding in the state, and serve as a training and research facility.
- The IBFA will complete an update of the Breastfeeding Consensus Statement and begin updating the Breastfeeding Resource Guide.
- The IWP will implement a breastfeeding support program, facilitated by the Wee Ones Nursery Program, and will track outcomes.

**PERFORMANCE MEASURE # 12** Percentage of newborns who have been screened for hearing impairment before hospital discharge.

FY 2007 Performance Objective: Improve universal newborn hearing screens to 98.7% in FY 2007.

Status: The data used for this objective refers to the most recent data that the Early Hearing Detection and Intervention (EHDI) program reported on the Centers for Disease Control (CDC) Annual Survey in January, 2008. 97.8% of newborns were screened prior to hospital discharge in Calendar Year (CY) 2006. Preliminary data from CY 2007 suggests that at least 98.7% of newborns were screened prior to leaving the birthing center.

**a. FY 2007 Accomplishments**

Activities that impacted this performance were:

- EHDI received contact information for all licensed Ear, Nose and Throat physicians in the state and sent out letters educating them regarding their responsibility to report any child with hearing loss to the Indiana Birth Defects and Problems Registry (IBDPR), via the IBDPR Reporting Form.
- EHDI received contact information for all licensed ENT physicians and sent out letters informing them of their responsibilities related to reporting to the IBDPR in March, 2007.
- Maternal and Children's Special Health Care (MCSHC) provided education regarding Universal Newborn Hearing Screening/Early Hearing Detection and Intervention (UNHS/EHDI) to the Amish communities in northeastern and southwestern parts of Indiana.

- EHDI staff communicated with a large birthing center, the New Eden Birthing Center in the Amish community of Topeka, Indiana, in mid 2006 and early 2007 in preparation for a training conducted there in early 2007. The staff was very receptive to the training and expressed interest in securing loaner equipment through the EHDI program. A Memorandum of Understanding (MOU) was submitted to ISDH legal to review. A follow-up training visit to this center will be conducted once the MOU is in place.
- The State Audiology Coordinator provided presentations to the Indiana Midwives Association.
- EHDI staff presented at the Indiana Midwives Association annual meeting in Fall, 2006. As a result of that presentation, two midwifery clinics have expressed interest in providing newborn hearing screening. One issue of concern indicated by this group is reimbursement for this screening.
- The EHDI Parent Consultant began part-time work at the Indiana State Department of Health (ISDH) in June, 2007. Follow-up activities (i.e. phone calls, letters and file documentation) on babies who did not receive UNHS, who did not pass or who or who have risk factors for hearing loss are the primary responsibilities of this position. The Consultant's assistance in locating information on CY 2006 babies, whose hearing status had not been confirmed, significantly decreased the number of Indiana babies who had been at risk for being lost to follow-up or documentation. Indiana's 2006 lost to follow-up or documentation rate was calculated to be 15% as compared to the rate of 35% in 2005.
- The effort of EHDI to partner with the Indiana Chapter of Hands & Voices to modify the Indiana Family Resource Guide for Families with Children with Hearing Loss, to translate it into Spanish, and to make it available electronically has been moved to FY 2009 due to staff vacancy.
- The Hearing Head Start ECHO project is an initiative of the National Center on Hearing Assessment and Management (NCHAM). The Department of Education convened a task force that involved assessing the feasibility of bringing ECHO to Indiana. The task force has only met one time. Additional discussion between Outreach Services and EHDI led to a decision to place this project on hold until further collaborative work could be conducted. The Department of Education indicated that they would contact both agencies when ready to reconvene.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: Improve universal newborn hearing screens to 98.8% in FY 2008.

Activities to impact this performance objective include:

- EHDI (State EHDI Coordinator, the EARS Consultant, and Regional Consultants) is training hospitals in the new datamart reporting system (EARS).
- MCSHC is in the process of establishing a reporting mechanism with ISDH Vital Records to be notified of home births.
- A Memorandum of Understanding (MOU) is being developed to be used with Regional Audiology Diagnostic Centers to improve the quality of pediatric diagnostic testing in the state, to improve the number of children diagnosed with hearing loss that are reported to the EHDI Program, and to reduce the number of infants lost to follow-up.
- EHDI is continuing to provide education presentations to hospitals, Public Health Nurses (PHN), students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and procedures.
- EHDI is continuing to train pediatric audiologists regarding equipment requirements for Level 1 status.
- EHDI is continuing to mail EHDI materials to all Public Health Departments to improve Public Health Nurse (PHN) understanding of goals, objectives, and follow-up procedures for the EHDI program.
- EHDI is continuing to target communities with large Amish populations to begin assisting these communities in having UNHS screenings completed.
- EHDI is continuing to dialogue with the Midwifery facilities and is in the process of completing a Memorandum of Understanding (MOU) that will allow for the loan of equipment to assist these facilities in beginning UNHS programs.
- EHDI staff is continuing efforts to educate physicians regarding follow-up from screening and sending physician packets to any primary care physician who has a child with documented hearing loss in his/her care.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: Improve universal newborn hearing screens to 98.9 % in FY 2009.

- EHDI (State EHDI Coordinator, the EARS Consultant, and Regional Consultants) will continue to train hospitals in the new datamart reporting system (EARS).

- EHDI will continue to provide education presentations to hospitals, Public Health Nurses (PHN), students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and procedures.
- EHDI will continue to train pediatric audiologists regarding equipment and test procedure requirements for Level 1 status.
- EHDI will continue to mail EHDI materials to all Public Health Departments to improve Public Health Nurse (PHN) understanding of goals, objectives, and follow-up procedures for the EHDI program.
- EHDI will continue to target communities with large Amish populations to assist these communities in having UNHS screenings completed.
- EHDI will continue to target midwifery facilities to assist these facilities in having UNHS completed.
- EHDI staff will continue efforts to educate physicians regarding follow-up from screening and will send physician packets to any primary care physician who has a child with documented hearing loss in his/her care.
- EHDI will continue to partner with the Indiana Chapter of Hands & Voices to modify the Indiana Family Resource Guide for Families with Children with Hearing Loss, to translate it into Spanish, and to make it available electronically.

**PERFORMANCE MEASURE # 13 Joel (In process of completion)**

**PERFORMANCE MEASURE # 14** Percentage of children ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85<sup>th</sup> percentile

FY 2007 Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85<sup>th</sup> percentile will be 22%.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- WIC health professionals screened all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHC clinics serving this age group screened all clients for height and weight.
- WIC clinics objective is to increase the number of children who were assigned Risk Factor 113 at the previous certification who do not have that risk factor at

the time of recertification by 1% and Risk Factor 114 by 2%. (Measurement was found to be inaccurate and was discontinued.)

- WIC health professionals assessed WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHC clinics assessed project clients for nutrition and feeding practices.
- WIC provided or referred families of WIC eligible children for counseling that includes as appropriate, physical activity ideas, reduced sedentary activities, and healthy eating. MCSHC clinics referred families for counseling on nutrition/physical activity if children were assessed as “At Risk for Overweight” or “Overweight”.
- WIC and MCSHC projects continued to display posters/bulletin boards on physical activity, feeding relationship and foods choices and their importance.
- MCSHC provided INShape Indiana magnets that promote physical exercise and good nutrition, and bookmarks to public health clinics including WIC.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be 21%.

Activities to impact this performance objective include:

- WIC health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals are also screening all children for “Overweight” (BMI equal to or > 95%) and “At Risk for Overweight” (BMI 85% to < 95%) status using height for weight BMI.
- WIC health professionals are assessing WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHCS clinics are also assessing children’s diets for nutrition and eating habits that would impact growth patterns.
- When appropriate WIC are providing counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. When appropriate, MCSHCS clinics are providing guidelines on healthy eating habits and physical activity to families and children.
- WIC is displaying posters/bulletin boards on physical activity, nutrition and healthy eating. MCSHCS clinics are displaying posters and creating bulletin

boards communicating information on physical activity, nutrition and healthy eating habits.

- WIC is providing educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics are providing educational information (handouts/fliers) on healthy eating and physical activity.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be < 21%.

Activities to impact this performance objective include:

- WIC health professionals will screen all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals will also screen all participants for “Overweight” (BMI equal to or > 95%) and “At Risk for Overweight” (BMI 85% to < 95%) status using height for weight BMI.
- WIC health professionals will assess WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHCS clinics will assess children’s diets for nutrition and eating habits that would impact growth patterns.
- When appropriate WIC is providing counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCSHCS clinics will provide guidelines on healthy eating habits and physical activity to families and children.
- WIC is displaying posters/bulletin boards on physical activity, nutrition and healthy eating. MCSHCS clinics will display posters and create bulletin boards communicating information on physical activity, nutrition and healthy eating habits.
- WIC will provide educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics will provide educational information (handouts/fliers) on healthy eating and physical activity.

**PERFORMANCE MEASURE # 15** Percentage of women who smoke in the last three months of pregnancy.

FY 2007 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 16.0 in FY 2007.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC contracted to have in-depth epidemiology analysis of maternal smoking and birth outcomes data. This was completed and posted on ISDH Web
- MCSHC completed the on-site training of OB providers and offices staff in Crawford, Clark, Scott, Jefferson, and Perry Counties. Smokefree Indiana, in collaboration with the Indiana State Department of Health (ISDH), Indiana Tobacco Prevention and Cessation and the Indiana Rural Health Association (IRHA), on March 23, 2007, launched a Prenatal Cessation Pilot Project, designed to educate rural prenatal healthcare providers in counties with high maternal smoking rates about the Indiana Tobacco Quitline and the fax-referral system. Counties included in the pilot were Clark, Jefferson, Scott, Crawford, and Perry. The project was designed to overcome two common problems: many healthcare providers can not attend trainings away from their office; and pregnant smokers are not seeking cessation services. This project was loosely modeled after a pharmaceutical representative's position. Three consultants/ reps were hired and trained to visit healthcare provider offices in the five pilot rural counties, through a collaborative contract between the ISDH and IRHA. Reps received training on basic prenatal cessation, ACOG in office prenatal cessation training, and the Indiana Tobacco Quitline fax-referral system, which is designed to assist healthcare providers in implementing the 5A's of cessation support. A series of three (3) office contacts were made to assess provider current cessation practices, determine if the entire staff needed additional training in smoking cessation for pregnant women, and to educate providers about the Indiana Tobacco Quitline fax referral system and how to incorporate this into their office practice. The pilot project ended 8/07. A full pilot evaluation report was completed 10/07 and is available for review.
- MCSHC defined common measures and processes to be applied across all funded projects to capture data identifying pregnant smokers at the time they enter prenatal care and at each subsequent trimester of pregnancy to establish changes in smoking status during the pregnancy.
- Indiana birth certificates have information on women who smoke in the last three months of pregnancy for calendar year 2007. First year smoking data is not consistent among counties. Training needs are being explored. Data will be available in fiscal year 2008.
- MCSHC postponed providing training on Federal Resource Enabling Data system (FRED) to all funded prenatal projects on correct data entry on smoking usage per trimester until 2008.

- PSUPP/MCSHC collaborated with Indiana Tobacco Prevention Cessation (ITPC) to reach a broader audience and have greater impact on smoking cessation with pregnant women. Smoking cessation coalitions formed by the Indiana Tobacco Prevention Cessation (ITPC) program in all 92 counties were brought in for training and returned to their counties to train health professionals, social service agencies, school personnel and other community persons working with pregnant women on the effects of smoking during pregnancy on the mother and fetus.
- MCSHC contracted with the Indiana Chapter of the American Lung Association to provide workshops in 5 smoking focus counties. The train the trainer cessation curriculum of “Freedom From Smoking For You and Your Baby” was presented in Newton, Stark, Grant, Fayette, and Knox counties.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.9 in FY 2008.

Activities to impact this performance objective include:

- ISDH began facilitating a legislative commission on prenatal smoking, alcohol, and drug use to develop a strategic plan. The first meeting was held October 9, 2007 and meets every other month.
- The ISDH Prenatal Substance Use Prevention Program (PSUPP) will identify 4700 high risk, chemically dependent pregnant women and provide counseling and intervention.
- PSUPP/MCSHC will continue to collaborate with ITPC to reach a broader audience and have greater impact on smoking cessation with pregnant women. Smoking cessation coalitions formed by the Indiana Tobacco Prevention Cessation (ITPC) program in all 92 counties will be brought in for training by and return to their counties to train health professionals, social service agencies, school personnel and other community persons working with pregnant women on the effects of smoking during pregnancy on the mother and fetus and the Indiana Tobacco Quit Line.
- PSUPP and all MCSHCS funded prenatal clinics will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.
- MCSHC continues to collaborate with the Indiana Lung Association in training for smoking cessation cessation in 3 focus counties for prenatal clients.

- MCSHC analyzes the rate of smoking in the third trimester on a quarterly basis to determine further training needs. Quarterly reports are received from Title V funded projects and training provided as needed.
- PSUPP will distribute 27,000 informational items about the impact of substance use among pregnant women to the public.
- PSUPP clinics (3) Terre Haute, Evansville and Jeffersonville will provide support groups for women in substance use cessation.
- MCSHC staff will work with Hoosier Healthwise & Contracted MCO's health care providers and outreach workers on smoking cessation. Training of physician representatives of all 3 MCO's on evidence based assessment tools, the 5A's, 5R's and the Indiana Tobacco Quitline.
- MCSHC will replicate prenatal office trainings in 5 more counties with significant prenatal smoking rates. All ITPC County Coalitions have been trained and are replicating the in office training in 80 counties.
- MCSHC will work with Indiana ACOG to disseminate information on prenatal smoking cessation and one IPN Newsletter will be dedicated to prenatal smoking.
- Baby First Packets will be sent to Prenatal IFHL callers that includes information on smoking cessation.
- Dr. Judith Monroe, Health Commissioner, implemented a collaboration with Indianapolis Women's Magazine to insert health focus inserts in each magazine. The April 2008 edition was Power over Addiction including smoking.

### **c. Planned Activities FY 2009**

#### FY 2009 Performance Objective:

- ISDH will continue with legislative commission on prenatal smoking, alcohol, and drug use to develop a strategic implementation plan.
- MCSHC will continue to collaborate with the ITPC in training for smoking cessation in focus counties for prenatal clients.
- All MCSHC Title V funded prenatal services will be mandated to address Federal Performance Measure 8. mandated activities include: 1) 100% of clients will be asked if they smoke or are exposed to second hand smoke at time of enrollment and smoking status documented in chart, 2) All clients who state they are smoking at time of enrollment will be assessed using the stages of change model\* and documented in chart, 3) All clients who state they are smoking at time of

enrollment will be monitored at each visit for smoking status, 4) 100% of pregnant women will receive information on the hazards of smoking during pregnancy, 5) All patients smoking at time of enrollment will be enrolled in a cessation/treatment program or referred to a program if not available on site.

- MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine further training needs.
- The ISDH Prenatal Substance Use Prevention Program (PSUPP) will; 1) identify high risk, chemically dependent pregnant women and provide counseling and intervention, 2) distribute informational items about the impact of substance use among pregnant women to the public, 3) provide support groups for women in substance use cessation in 3 clinics, 4) educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy, 5) expand where and when possible.
- MCSHC will continue as a partner in the Coalition to Promote Smokefree Pregnancies to assist Clarion in obtaining a grant from ITPC to provide media campaigns targeted to women of child bearing age in all counties with a prenatal smoking rate of  $\geq 29$ .
- MCSHC will work with Indiana ACOG to disseminate information on prenatal smoking cessation and one IPN Newsletter will be dedicated to prenatal smoking.
- Baby First Packets will be sent to Prenatal IFHL callers that includes information on smoking cessation.

**PERFORMANCE MEASURE # 16** The rate per 100,000 of suicide deaths among youths aged 15-19.

FY 2007 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.8 in FY 2007. (Baseline rates of 9.1 in 2002 and 6.6 in 2003).

Status: Negotiated Performance Measure for the Indiana Suicide Prevention Coalition (ISPC): 30% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC continued to fund the part time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional coalitions.

- ISDH was unable to finalize the draft of the State Injury Prevention and Control Plan (which includes youth suicide as one of five objectives) due to lack of personnel in the ISDH Injury Prevention Program.
- ISDH began work on a new version of the well-received data report on Suicide in Indiana.
- ISDH continued to collaborate with the Indiana Suicide Prevention Coalition to implement the State Suicide Prevention Plan. Coalition accomplishments include:
  1. Mass distribution of a suicide prevention awareness brochure and continued maintenance of a statewide listserv.
  2. Presentations at numerous conferences and meetings, along with distribution of pertinent information about suicide prevention, including conducting a web conference on youth suicide for 150 people through the Indiana Youth Institute.
  3. Continued promotion of gatekeeper training programs for schools and community agencies.
  4. Collaborated with a Northeast Indiana Area Health Education Center (AHEC) to incorporate suicide prevention awareness into their monthly Prevention Clinic.
  5. Reviewed and began updating and editing the Student Suicide manual to be distributed to Indiana schools by the Indiana Department of Education.
  6. Provided technical assistance to a host of individuals, organizations and communities to help them prevent suicide.
  7. Worked with Muncie, which had one of the higher county suicide rates in 2005, to jumpstart a suicide prevention council.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.7 in FY 2008.

Negotiated Performance Measure for ISPC: 50% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

Activities to impact this performance objective include:

- Injury Prevention MCSHC continues to fund the part time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional Coalitions.
- ISDH was unable to finalize the draft of the State Injury Prevention and Control Plan, which includes youth suicide as one of five objectives, secondary to budgetary constraints.
- ISDH completed an updated data report on Suicide in Indiana, to be published electronically through the ISDH Program website.
- ISDH continued its collaboration with the Indiana Suicide Prevention Coalition (ISPC) to implement the State Suicide Prevention Plan. Planned Coalition activities supporting goals in the Plan included:
  1. Collaborated with the Indiana Area Health Education Centers to incorporate prevention awareness/education and activities into their Prevention Clinic.
  2. Continue to collaborate with the Indiana Department of Education to plan for prevention services in school-based mental health programs. Currently utilizing an MSW student to update the IDOE's Student Suicide manual.
  3. Collaborated with the Indiana Department of Education to include prevention content in annual school conferences, specifically the Safety Specialist Academy
  4. Continue to establish local or regional prevention councils in underserved areas of the state, with Muncie and Jeffersonville being the newest additions.
  5. Help existing local/regional suicide prevention councils utilize the results from the statewide needs assessment in their planning efforts (planned for Summer 2008)
  6. Bring the Suicide Prevention Resource Centers (SPRC) "Community Core Competencies for Suicide Prevention" course to Indiana for local/regional suicide prevention councils and other interested persons to build skills in suicide prevention. Do not have the funds and/or resources to implement this activity.
  7. Continue to provide technical assistance to organizations and individuals throughout Indiana regarding suicide prevention.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.6 in FY 2009.

Negotiated Performance Measure for ISPC: 60% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

Activities to impact this performance objective include:

- MCSHC will continue to fund the part time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional Coalitions.
- ISDH will continue to collaborate with the Indiana Suicide Prevention Coalition to implement the State Suicide Prevention Plan. Planned Coalition activities supporting goals in the Plan include:
  1. Increase knowledge and awareness of suicide as a public health issue.
  2. Disseminate the Needs Assessment Survey data to communities for planning.
  3. Provide presentations and printed information about youth suicide at other public events.
  4. Provide workshops related to suicide prevention in at least 2 regions of Indiana.
  5. Increase community involvement in recognizing and working to prevent youth suicide.
  6. Continue to assist in building local and regional suicide prevention councils.
  7. Increase the number of individuals working in youth-serving organizations who have skills in youth suicide prevention.
  8. Provide evidence-based gatekeeper skills training sessions across the state.
  9. Collaborate with the Indiana DOE to finalize and disseminate an updated of its suicide prevention manual to schools.
  10. Increase access to resources related to suicide prevention.
  11. Provide technical assistance to Indiana individuals and communities related to suicide prevention.
  12. Support and provide technical assistance to the 12 local/regional suicide prevention councils around the state.

**PERFORMANCE MEASURE # 17** Percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates.

FY 2007 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 81% in CY 2007.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC will update the Hospital Levels of Care document through review of hospital services by September 2008. This was delayed as we were waiting for the new guidelines from ACOG/AAP. The survey of hospitals has currently been completed by 88 of 100 hospitals and the Levels of Care document will be published in 2008.
- The updated Indiana Prenatal Care Guidelines were delayed as we were waiting for the new guidelines from ACOG/AAP and will be completed in 2008.
- MCSHC and IPN provided technical assistance to hospitals wanting to improve their level.
- Birth data by hospital is being reviewed by a MCH epidemiologist and consultant for appropriate deliveries and transport of high-risk deliveries and neonates. MCSHC will notify counties of any problems. A state GIS map showing county perinatal status with number of hospitals, level of care, and number of Medicaid prenatal providers was completed and shared with the State Perinatal Advisory Board and Anthem Health.
- MCSHC is participating on the Office of Medicaid Policy and Planning Quality Strategy Prenatal Workgroup. The CMS 7 point initiative to improve neonatal outcomes will be incorporated into developed performance measures for MCOs. The workgroup meets monthly and is addressing access to care and prenatal smoking

**b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 82% in CY 2007.

Activities to impact this performance objective include:

- A PCEP (Prenatal Continuing Education Program) training for coordinators (Train-the Trainers) will be hosted by St. Vincent hospital in Marion County. All tertiary hospitals will be trained to teach PCEP to surrounding feeder hospitals. It is hoped this will lead to a natural perinatal system of care and will improve appropriate transfer rates of high risk mothers. St. Vincent in Marion County, Vigo County and Franklin County will complete the PCEP training in June, 08.
- A more in depth analysis of birth data by hospitals, to include updated level of care, number of NICU beds, birthweight, gestation, race/ethnicity, maternal characteristics, c-section rates and type of provider, will be initiated by a MCH epidemiologist and consultant for appropriate deliveries and transport of high-risk deliveries and neonates. After the state report is completed, a working group of state maternal-fetal specialists will be formed to develop a performance measures report that will be shared with all hospitals.
- A state PPOR review will be conducted to identify areas of excess deaths to guide future activities and resources.

#### c. Planned Activities FY 2009

FY 2009 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 83% in CY 2007.

- IPN will develop and implement an MOU with a sub-specialty hospital will be obtained to provide a PCEP train-the trainer program with the sub-specialty hospital being trained to train feeder hospitals on appropriate assessment, care and transport. This will serve as a pilot to implementing this program statewide in 2010.
- MCSHC will work with Lake County hospitals to assess competency levels, how to do an equipment inventory, how to build a perinatal network. A modified PCEP training program for internal hospital training will be offered to all hospitals and implemented by at least one. Memorial Hospital in St. Joseph County, a level 1 Hospital will be encouraged to participate as high risk women from Lake County may be transported to Memorial for delivery. The use of telemedicine support in Lake county will be explored.
- An updated assessment of the state's perinatal system and status will be completed with assistance from IPN, regional perinatal networks, and others.
- Efforts are underway to expand the state perinatal network membership and reach out to all regions of the state to share education and allow for greater participation in quarterly State Perinatal Advisory Board meetings. Video conferencing for board meetings will be explored.

**PERFORMANCE MEASURE # 18** Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

FY 2007 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.2% in 2007.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC funded 22 prenatal care coordination projects throughout the state that provided outreach, case finding, referral, advocacy, and education of at risk pregnant women.
- MCSHC developed a brief guide of the Model Programs for Prenatal Care including Centering Pregnancy and Parenting, Maternity Outreach Mobilization Services (MOMS) and Baby First Advocates outreach programs. MCSHC presented the guide to coalitions and agencies in Marion, Elkhart, Lake, LaPorte, and St. Joseph Counties.
- The MCSHC collaboration with the Indiana Perinatal Network (IPN) and Indiana ACOG updated and expanded the IPN Prenatal Care Guide (standards) to include preconception/interconception care. This was put on hold and is in the process of being competed in 2008 because we waited for the updated guidelines for ACOG/AAP.
- In FY 2007 each Prenatal Care Coordinator was sent 15 Baby First packets and nearly 800 were sent to agencies and individuals by Indiana Family Helpline and IPN.
- Collaboration was begun with the Office of Medicaid Policy and Planning, and state managed care organizations as part of the Office of Medicaid Policy and Planning Quality Strategy Prenatal Workgroup. Individual ERs will be targeted as pilots.

**b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.3% in 2007.

Activities to impact this performance objective include:

- County data books, including entrance into prenatal care **were** published on the ISDH website and shared with local communities in counties with significant access problems.
- Counties with access to care problems **received** technical assistance from MCSHC to identify barriers and plans to improve access.
- Implement the Early Start program in at least one of the counties with poor access to prenatal care due to systems barriers.
- Funding of prenatal care coordination projects throughout the state and the ISDH Free Pregnancy Testing program continues to provide outreach, case finding, referral, advocacy and education of high risk pregnant women to facilitate early entrance into prenatal care.
- MCSHC is disseminating information about model programs that impact early entrance into prenatal care in all communities with access problems.
- OMPP informed MCSHC on April 23<sup>rd</sup> that the Office of Medicaid Policy and Planning have made the decision to not adopt Presumptive Eligibility at this time. Much consideration and analysis went into this decision and we would like to express that our dedication to improving our neonatal outcomes is a continued priority. The data available to date does not demonstrate that PE itself will lead to the improved outcomes we are targeting for our Medicaid population.
- MCSHC perinatal consultant will work with Office of Medicaid Policy & Planning (OMPP) and MCOs to expand Early Start projects in counties with poor access to prenatal care.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.5% in 2009. Due to Indiana's declining percent of pregnant women initiating prenatal care in the first trimester, MCSHC will assess the state of the state's perinatal system, barriers to access and publish a report with recommendations.

Activities to impact this performance objective include:

- Target 2 emergency departments in 2 priority counties to implement the ER protocol to refer all pregnant women in the ER to PNCC and a MCH funded prenatal clinic or CHC. Pull together all stakeholders in the targeted counties to develop a system of referral and follow-up and an MOU among partners.
- Title V funded prenatal and PNCC projects are mandated in 2009 and 2010 to provide neighborhood outreach through the MCH free pregnancy test program,

enroll women with positive pregnancy tests, identify another project specific outreach activity, and identify another project activity to increase enrollment in the first trimester. Projects will report results quarterly.

- Explore incorporating community based doulas into Healthy Families Indiana to facilitate early identification of repeat pregnancies and assistance and follow-up of mothers through the pregnancy.
- Collaborate with Office of Medicaid Policy and Planning and the Medicaid Managed Care organizations to fund midlevel nurse run early start clinics as a stop gap until pregnant women can get an appointment with a prenatal care provider.

## STATE PERFORMANCE MEASURES

### State Performance Measure # 1 (Joel) In Process of Completion.

**STATE PERFORMANCE MEASURE # 2** The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old.

FY 2007 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will drop to 28.0.

Status: Met – The rate per 10,000 for diagnosed asthma hospitalizations among children less than five years old was 25.1 in 2005. Source: The Burden of Asthma in Indiana: Second Edition, March 2008.

#### a. FY 2007 Accomplishments

Activities to impact this performance objective include:

- The Asthma Burden Report was updated and made available to the public in March 2008. The report is available online at <http://www.in.gov/isdh/programs/asthma/pdfs/IndianaBurden.pdf>. The report provides data from the Behavioral Risk Factor and Surveillance System (BRFSS), as well as data on hospitalizations, emergency department (ED) visits, and mortality due to asthma. Medicaid data is also available. Indiana has met Healthy People 2010 (HP 2010) Objective 1-9a for asthma hospitalizations among children under 18 (target HP 2010 objective = 17.3 per 10,000). The Indiana hospitalization rate due to asthma for children under 18 was 13.2 per 10,000 in 2005.
- The State Asthma Program, with the Indiana Joint Asthma Coalition (InJAC), localized the Ad Council's and U.S. Environmental Protection Agency's National

Asthma Campaign. The localized campaign included radio and TV public service announcements (PSA) and billboard sheets. Media kits of the PSAs were sent to all radio and TV stations in Indiana, including counties that had the highest hospitalization rates for asthma (Lake, Marion, Blackford, Delaware, Fulton, Grant, Huntington, Jay, Jefferson, Lawrence, Switzerland, Vigo, Wabash, and Wells).

- The State Asthma Program, with InJAC's Children and Youth Workgroup, has analyzed data collected from a survey of school personnel and child care providers. Reports on the data are available online at [www.in.gov/isdh/programs/asthma/InJAC/index.htm](http://www.in.gov/isdh/programs/asthma/InJAC/index.htm).
- The State Asthma Program highlighted data on influenza and asthma, as well as smoking and asthma in the Breathe In, Breathe Out newsletter. The newsletter is available online at [www.in.gov/isdh/programs/asthma/publications.htm](http://www.in.gov/isdh/programs/asthma/publications.htm).
- The Environmental Quality workgroup promoted Breatheeasyville and its online materials to help patients, parents, caregivers, school personnel, and others identify environmental asthma triggers.
- The State Asthma Program planned and sponsored an asthma session for the Indiana School Nurse conference 2007. The Asthma Program and the American Lung Association of Indiana invited members of InJAC (i.e. a respiratory therapist, nurse practitioner, indoor air specialist, and the Asthma Program health educator) to present on numerous topics related to asthma. Also, the Asthma Program health educator developed and distributed a toolkit for nurses at the conference. Approximately 75 nurses were present at the asthma session. The State Asthma Program attended the Indiana Association for the Education of Young Children, April 12-14, 2007. Educational materials were provided at this conference.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will drop to 27.0.

Activities to impact this performance objective include:

- Plan and promote asthma outreach activities and events in 25% of Indiana counties to assist in providing the latest information on key educational messages. The State Asthma Program is using the Ad Council and the Indiana State Department of Health's Office of Public Affairs to encourage all radio and TV stations throughout Indiana to play the localized National Asthma Campaign PSA's during Asthma Awareness Month (May). The Asthma Program and InJAC have also printed educational materials and delivered to libraries, community

health centers, Head Start programs and rural health clinics in at least 15% of the state's counties. An email was sent in March to school administrators and other school personnel (statewide) to consider planning an activity for Asthma Awareness Month.

- Support the asthma activities of local asthma and health coalitions to reduce the asthma burden in Indiana schools and regulated early child care settings.
- By August 2008, the State Asthma Program and InJAC will launch a continuing medical education (CME) online training specific to understanding the key points and key differences of the updated Expert Panel Report:3 (EPR:3) Guidelines for the Diagnosis and Management of Asthma.
- The State Asthma Program is promoting the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma. The State Asthma Program will also dedicate one staff to participate on the review committee for the 5-Star Recognition Program.
- The State Asthma Program is providing evidence-based and data driven information on asthma management and care, through addressing indoor and outdoor environmental asthma triggers, at trainings, conferences, and meetings that are for regulated early care settings, public health professionals, health care providers, and environmentalists.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective 1: The rate per 10,000 of hospitalizations due to asthma among children less than five years old will drop to 23.0.

Activities to impact this performance objective include:

- Provide regulated early care settings, including Early Head Start and Head Start, with information to implement policies and practices that meet or exceed best practices for asthma management and are coordinated to support the educational, physical, emotional and social well-being of children. Information will be provided according to available resources for dissemination (i.e. trainings, conferences, online, etc.).
- The State Asthma Program will promote the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma. The State Asthma Program will also dedicate one staff to participate on the review committee for the 5-Star Recognition Program.

- The State Asthma Program and InJAC will work with the Indiana State Department of Health Maternal and Child Health Services Program to review the medical guidelines for asthma for the Children's Special Health Care Services (CSHCS). Additionally, the State Asthma Program and InJAC will provide information to participating providers in the CSHCS program to ensure their awareness of the key points and key differences in Expert Panel Report:3 (EPR:3) Guidelines for the Diagnosis and Management of Asthma.
- Train local health department, health, building code staff, and construction plan reviewers on environmental hazards for asthma and ways to reduce environmental hazards.
- Work in collaboration with the Indiana Tobacco and Prevention and Cessation Agency to reduce smoking and exposure to environmental tobacco smoke (ETS), especially as it relates to smoking and pregnancy and exposure of children under the age of five.
- Educate health care providers on appropriate ETS history taking and the importance of smoking cessation as it relates to preventing asthma development in young children and decreasing asthma symptoms and attacks in children with asthma.

**STATE PERFORMANCE MEASURE # 3** The percent of live births to mothers who smoke.

FY 2007 Performance Objective: The percent of live births to mothers who smoke will decrease to 17.3% in CY 2007.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- The ISDH Prenatal Substance Use Prevention Program (PSUPP) identified and provided educational and support services to 4540 high risk, chemically dependent pregnant women.
- Smokefree Indiana, in collaboration with the Indiana State Department of Health (ISDH), Indiana Tobacco Prevention and Cessation and the Indiana Rural Health Association (IRHA), on March 23, 2007, launched a Prenatal Cessation Pilot Project, designed to educate rural prenatal healthcare providers in counties with high maternal smoking rates about the Indiana Tobacco Quitline and the fax-referral system. Counties included in the pilot were Clark, Jefferson, Scott, Crawford, and Perry. The project was designed to overcome two common problems: many healthcare providers can not attend trainings away from their office; and pregnant smokers are not seeking cessation services. This project was loosely modeled after a pharmaceutical representative's position. Three

consultants/ reps were hired and trained to visit healthcare provider offices in the five pilot rural counties, through a collaborative contract between the ISDH and IRHA. Reps received training on basic prenatal cessation, ACOG in office prenatal cessation training, and the Indiana Tobacco Quitline fax-referral system, which is designed to assist healthcare providers in implementing the 5A's of cessation support. A series of three (3) office contacts were made to assess provider current cessation practices, determine if the entire staff needed additional training in smoking cessation for pregnant women, and to educate providers about the Indiana Tobacco Quitline fax referral system and how to incorporate this into their office practice. The pilot project ended 8/07. A full pilot evaluation report was completed 10/07 and is available for review.

- MCSHC continued providing brochures on "You and Me Smoke-Free" program and on the "ASK" Protocol to agencies that requested them.
- MCSHC informed all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and provided materials promoting the Quit Line to all funded prenatal projects. Quit Line materials were provided to all funded prenatal projects.
- MCSHC provided training on Federal Resource Enabling Data (FRED) to all funded prenatal projects on correct data entry on smoking usage per trimester as part of routine training of new data entry staff.
- MCSHC analyzed the percent of live births of mothers who smoke on a yearly basis to determine training needs. MCSHC provided technical assistance as needed when quarterly reports were received by Title 5 funded projects.
- The report, Smoking During Pregnancy in Indiana 1990-2004, Statistics from the Live Birth Data was completed the end of FY 2007 and was placed on the ISDH website in early 2008. Data maps of prenatal smoking rates by county were completed and shared with individual counties and to local Health Officers during ISDH monthly conference call.
- MCSHC staff worked with Hoosier Healthwise quality improvement committee and contracted MCO's to educate physicians and outreach workers on smoking cessation. Training was completed for MCO physician outreach representatives of all 3 MCO's on the 5 A's, 5 R's and the Indiana Tobacco Quitline.
- MCSHC collaborated with Indiana Lung Association and provided the smoking cessation train the trainer training "Freedom From Smoking For You and Your Baby" to Health Professionals who work with pregnant women in 5 focus counties. The training took place in Newton, Starke, Grant, Knox, and Fayette, but invitees also attended from their contiguous counties.

**b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of live births to mothers who smoke will decrease to 16.0% in CY 2008.

Activities to impact this performance objective include:

- The ISDH Prenatal Substance Use Prevention Program (PSUPP) is identifying and providing educational and support services for high risk, chemically dependent pregnant women.
- MCSHC continues to provide brochures on "You and Me Smoke-Free" program and on the "ASK" Protocol to providers requesting them.
- MCSHC continues to expect all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and will provide materials promoting the Quit Line to all funded prenatal projects. A massive mailing of educational materials was sent to all prenatal programs and community health centers on October 23, 2007.
- MCSHC provides training on Federal Resource Enabling Database (FRED) to all funded prenatal projects on correct data entry on smoking usage per trimester as new staff were sent for training.
- PSUPP continues to participate in 170 community events, health fairs, conferences, and other public forums.
- PSUPP distributes 1,000 educational items to providers, including physician's offices, indicating the importance of identifying at-risk clients.
- PSUPP will distribute 27,000 information items about the impact of substance use among pregnant women to the public.
- PSUPP clinics (3) Terre Haute, Evansville and Jeffersonville continue to provide support groups for women in substance use cessation.
- MCSHC will evaluate the success of the PSUPP projects through prenatal smoking cessation rates, and referrals to the Quit Line by each project. Data from the new birth certificate on the number of women self reporting smoking in the third trimester of pregnancy will be evaluated. ISDH will compare data on Medicaid clients with statewide data.
- MSCHC is contracting with the American Lung Association to provide "Freedom from Smoking for You and Your Baby" Train-the-Trainer workshops training to health professionals in an additional 3 counties identified with significantly high

prenatal smoking rates. The counties include Marion, Clark, and St. Joseph counties.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The percent of live births to mothers who smoke will decrease to 15.9% in FY 2009.

- MCSHC will continue to contract with the Prenatal Substance Use Prevention Programs (PSUPP) to identify high risk, chemically dependent pregnant women. Quarterly reports will be received to monitor progress.
- PSUPP clinics will continue to educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs, will continue to provide support groups for pregnant women for smoking cessation in three counties (Vigo, Clark, Vanderburgh), will continue to distribute educational items about the impact of smoking on pregnancy, and will continue to participate in community events, health fairs, conferences and other public forums to educate the public about the impact of smoking on pregnancy and infants.
- MCSHC will continue to participate on the OMPP Neonatal Quality committee to promote prenatal smoking cessation among Medicaid patients to decrease NICU use due to complications from prenatal smoking.
- MCSHC will continue to expect all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and will provide materials promoting the Quit Line to all funded prenatal projects.
- MCSHC will evaluate the success of the PSUPP projects on success of prenatal smoking cessation, and referrals to the Quit Line by each project. Data from the new birth certificate on the number of women self reporting smoking in the third trimester of pregnancy will be evaluated. ISDH will compare data on Medicaid clients with statewide data.
- MCSHC will continue to facilitate the Prenatal Substance Abuse Commission to develop a plan to improve early intervention and treatment for pregnant women who abuse alcohol or drugs or use tobacco.

**STATE PERFORMANCE MEASURE # 4** The percent of black women (15 through 44) with a live birth whose prenatal visits were adequate

#### **a. FY 2007 Accomplishments**

FY 2007 Performance Measure: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 64% in FY 2007.

Activities to impact this performance objective include:

- MCSHC completed a ten year birth cohort of county and state birth outcomes by race and ethnicity. The report was published in June and placed on the website in October.
- MCSHC disseminated these data through presentations in the six targeted counties to ensure that the planning and delivery of perinatal health care services meet the needs of the at-risk population.
- MCSHC conducted perinatal disparity summits in the three targeted disparity counties of , Lake, Marion, and St. Joseph counties. In each county several pre-summit and post summit meetings were held around the summit.
- MCSHC shared state and local statistics on perinatal health issues in summit and post summit meetings. Statistics were also shared on weekly conference calls with all local Health Officers.
- MCSHC helped counties identify specific barriers to prenatal care for black women in their county through the summit and post summit meetings.
- MCSHC facilitated counties in developing a plan to improve access to prenatal care for black women in summit and post summit meetings
- MCSHC developed performance measures regarding disparities for all funded grantees. MCSHC began working with local Minority Health Associations.
- FIMRs with focus on perinatal disparities will continue in 4 counties with resulting recommendations to reduce disparities and improve local perinatal systems. A statewide report will be published. An interim 1 year report was done by all projects due to staff changes, the state report will be completed in 2008.

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 65% in FY 2008.

Activities to impact this performance objective include:

- MCSHC is providing ongoing technical assistance to Allen, Elkhart, Lake, LaPorte, Marion, and St. Joseph counties to strengthen community partnerships between policymakers, health care providers, families, the general public, and others to form county coalitions to identify and solve perinatal disparity issues.

- MCSHC staff is partnering with the state office of Minority Health to decrease black infant and disparity in birth outcomes. A Statewide summit will be held in Lake County in September 2008.
- ISDH are providing at least yearly training to county perinatal disparity coalitions on cultural competency, social determinants in perinatal disparities, life course perspective, impact on perinatal care, how to use tools to create and implement local action plans, and exploring promising approaches for effective action in the disparity counties listed above.
- MCSHC continues to be a part of the Hoosier Healthwise Quality Improvement Committee, and work with OMPP through the Quality Strategy Prenatal Workgroup to reduce disparity issues in prenatal care.
- MCSHC is publishing best practice models of care to improve access to prenatal care and reduce disparity outcomes on the ISDH website. Pilot projects will be encouraged in the disparity counties.
- The Centering pregnancy model of care is being encouraged as a best practice model in all disparity counties. A Centering pregnancy training is being offered in September 2008.
- MCSHC is working to increase the number of certified nurse midwives providing care in high risk neighborhoods.
- The National Office of Minority Health media campaign "A Healthy Baby Begins with You " is being initiated in all five of the disparity counties plus Vanderburgh county. September is National Black Infant Mortality Month and there will be a training and presentation in each disparity county.
- IPN and MCSHC addresses perinatal disparities by sponsoring a booth at the Indiana Black Expo Black and Minority Health Fair.
- IPN will provide ongoing evaluation of the community based Doula program. MCSHC will assess the feasibility of replication based on outcomes and cost.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 66% in FY 2009.

- To increase the percent of black women with adequate prenatal care in 2009, prenatal projects applying for Title V funding for 2009 and 2010 were mandated to: 1) increase the number of black women entering prenatal care in the 1<sup>st</sup> trimester through a community/neighborhood outreach plan to include African

American churches, 2) provide reminder/recalls for all scheduled appointments for black pregnant women, 3) identify and refer all high risk pregnant women to an appropriate high-risk provider and to prenatal care coordination. Projects will be monitored and technical assistance will be given those projects in need. In addition, all of the disparity counties will facilitate “Baby Showers”, and “Grandmothers Teas” that will include outreach, and education to the African American community.

- The Office of Minority Health media campaign *A Healthy Baby Begins with You* will continue to be implemented in the disparity counties as well as at Black Expo. Five regional trainings on “Matters of Heart” from Indiana Access will be implemented to encourage providers in the disparity counties to take a learners stance when working with minority patients and will encourage providers to ask at the beginning of the visit what are your concerns today rather than waiting until the end of the visit and asking do you have any other concerns? Follow-up with cultural competency training will be available for providers that express an interest in further training.
- FIMR will continue in two Indiana Counties with a focus on disparity deaths.
- Community presentations in the disparity counties will have town meetings with training and resentations.

**STATE PERFORMANCE MEASURE # 5** The percentage of children age 0 to 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter.

Status : During FY 2007, the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will decrease to 2.3%. In FY 2007, 61,650 children were tested. Of the children tested, 637 had a confirmed elevated blood lead level equal to or greater than ten (10) micrograms per deciliter of blood. The percentage of confirmed elevated children was 1.03%.

**a. FY 2007 Accomplishments**

Activities in SFY 2007 which impacted this performance objective included:

- Administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING was drafted from legislation passed in 2005. Public hearings were held throughout the year and the rule was signed by the Governor to become effective February 1, 2007.
- ICLPPP\* held its annual training to assist local entities in applying for HUD lead hazard control grant funds. Forty-seven individuals representing communities from all over the State attended.

- Three new HUD grants totaling nearly five million dollars were awarded in the state in the fall of 2006; two to local health departments for lead hazard control and one to a statewide not-for-profit for a lead outreach campaign targeted at minority populations.
- ICLPPP was awarded funds by the Indiana Department of Environmental Management for the establishment of a centralized database for risk assessment and lead hazard remediation information to improve the environmental follow up on lead poisoning among the children.
- The ISDH Commissioner committed to pursue comprehensive new lead legislation for the next year's legislative session.

\* Now changed to the Indiana Lead and Healthy Homes program (ILHHP)

#### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: During FY 2008 the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will be maintained at 1.6% .

Status: By the end of FY 2008, a currently projected 64,000 children will be tested. Of children tested, ILHHP projects a total of 608 will be confirmed as having an elevated blood lead level equal to or greater than ten (10) micrograms per deciliter of blood. The percentage of confirmed elevated children is projected at .95%.

Activities which are impacting this performance objective include:

- Training is being conducted on the administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING. Already, nine training opportunities have been attended by over 200 persons. Training has been provided in regional settings, to individual LHDs, in statewide training and at the Lead and Healthy Homes Conference.
- In October 2007, ILHHP established a Memorandum of Understanding with the Indiana Department of Environmental Management (IDEM) to administer the Lead-Based Paint regulations (326 IAC 29), including: abatement notification, training provider accreditation, monitoring and lead professional licensing. Concurrently, IHLLP was awarded EPA grant funds for the purpose of the program which is assisting in efforts in the primary prevention of lead poisoning among children.
- To reflect an expanded mission, the program name was changed from the Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) to the Indiana Lead and Healthy Homes program (ILHHP).

- ILHHP has increased efforts to improve the screening rate of Medicaid recipient children. Information on MCO screening rates is made available in a formal data exchange between ILHHP and Medicaid. Contract incentives were added for MCOs to improve screening rates. MCOs implemented contracts for filter paper testing.
- Five major local health departments have become Medicaid providers ready to claim under the new codes being set up by Medicaid.
- ILHHP turned over awareness campaign materials it had developed to Indiana Black Expo to be used in the statewide outreach grant that was received from HUD. ILHHP continues to assist in the IBE campaign training.
- Comprehensive lead legislation, designed with the input of ILHHP and ISDH, was introduced in the 2008 General Assembly session. Though stripped of some of its provisions the legislation passed and was signed into law.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: During FY 2009 the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will be decreased to .90% of the total children tested. The projections for total tested is 70,400 with 634 elevated.

Activities which will impact this performance objective will include:

- ILHHP will work to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.
- ILHHP will continue to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.
- ILHHP will decrease the percent of elevated children through increased primary prevention activities including: increasing the overall number of environmental inspections and investigations, increasing the number of housing units becoming lead safe by increasing follow-up and enforcement of existing regulations, helping to increase the lead hazard remediation grants in the state, improving training and increasing the number of licensed lead professionals, improving enforcement of existing abatement regulations, and an expanded mission to include an overall healthy homes approach to environmental case management.
- ILHHP will continue in efforts to affect an increase in the percent of Medicaid screened children by encouraging Medicaid reimbursement for testing, case management, and environmental inspection.

- ILHHP will improve lead program data collection and analysis including: data collections and comparisons with other programs such as Medicaid and WIC, use of the I-LEAD web application to produce consistent and effective risk assessments and environmental follow-up, development of an enhanced database of medical and case management information.
- ILHHP will increase awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.
- ILHHP will continue to develop additional lead poisoning prevention legislation by working with the child care summer study committee and the new lead program advisory committee.

**STATE PERFORMANCE MEASURE # 6** The proportion of births occurring within 18 months of a previous birth to the same birth mother.

FY 2007 Performance Measure: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 17% in 2006.

**a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC Adolescent Coordinator, began working with DOE to add sexuality and pregnancy prevention to the curriculum of junior high school students.
- A call to action document produced by the Unintended Pregnancy advisory group was shared throughout the state. County or regional coalitions developed action plans during a 2 day state summit Wed-Thurs, September 12-13, 2007.
- A birth cohort data analysis to identify commonalities in the subpopulation of women who do not space births at least 18 months was begun. It was completed in January of 2008 and will be placed on the web site.

**b. FY 2008 Current Activities**

FY 2008 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 16% in 2008.

Activities to impact this performance objective include:

- Agencies interested in impacting unintended pregnancy were encouraged to apply for funding for interconception projects through the FY 2009-2010 competitive RFP completed in February this year. Technical assistance was provided to

Wishard Hospital in Marion County. PNCC projects in Lake County, St. Joseph County and Allen County will begin to implement some interconception follow-up of mothers giving birth to preterm/LBW babies until at least 1 year of age.

- Consultants from Title X have met with coalitions in disparity counties about developing a county level program including a media campaign.
- The perinatal consultant is providing training to Family Practice residents taking their public health rotation on the life course perspective fetal origins of chronic disease and why they need to “ask every woman every time” about a life plan, interconception health, etc, regardless of whether they are seeing the child or the mother for a routine preventative exam.
- Interconception messages will be published in one Perinatal Perspectives newsletter, and placed on the web.
- Begin to work with the Department of Education to develop a curriculum on Life Planning that would include pregnancy delay.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 15% in 2009.

- A state task force will implement two (2) of the recommendations in the consensus document, *Best Intentions: unplanned pregnancy*.
- MCSHC and the State Perinatal Advisory will explore the best way to operationalize the concept of interconception care for health care providers and will implement at least one strategy (vitamins for the whole family- all family members take a Flintstone vitamin together – to promote healthy families and folic acid for women., Rx pads for physicians to give all to women of childbearing age in their practice with “Every Woman Every Time messages.)
- Work with Title X to implement media campaign. MCSHC will continue to work with disparity counties to implement *A Healthy Baby Begins with You* campaign and healthy interpregnancy intervals.

**STATE PERFORMANCE MEASURE # 7** Number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities

FY 2007 Performance Measure Objective: The number of targeted communities with such community/ neighborhood partnerships will increase from 1 to 2 in 2007.

Status: In 2007 there were 3 community partnerships established.

### **a. FY 2007 Accomplishments**

Activities to impact this performance objective include:

- MCSHC continued to disseminate the Baby First educational campaign community digital tool-kit statewide and provided technical assistance for expansion into Madison County.
- By August 30, 2007 a brief guide of Model Programs for Prenatal Care were shared with Marion County, St. Joseph County and Lake County coalitions during post disparity meetings.
- Two new trainers of community health workers were identified in Lake County and a class of 10 new community health workers has been trained through IVY TECH Community College. At least 3 have been placed within the East Chicago REACH project to advocate for Hispanic families, 2 newly trained community health workers are working within Northshore Community Health Center as family advocates to help families navigate the system and follow-up on referrals.

### **b. FY 2008 Current Activities**

FY 2008 Performance Objective: The number of targeted communities with such community/neighborhood partnerships will increase from 2 to 3 in 2008.

Activities to impact this performance objective include:

- MCSHC is continuing to provide technical assistance and follow-up to the five targeted disparity counties to help county coalitions address disparity issues. The 3 disparity summits are being followed up with a series of workshops on coalition building, cultural competence, and best practice models.
- A perinatal health disparity consensus statement with best practices for provider patient interactions will be completed and published on the IPN website by September 30, 2008.
- The Indiana State Plan on Perinatal Disparities will be published. County disparity plans will be included. This is still in progress. All counties have not completed a disparity plan.
- A statewide summit on the Life Course Perspective and perinatal disparities is planned for September 17<sup>th</sup>, 2008.
- MCSHC will work with the Office of Medicaid Policy and Planning, Office Of Women's Health, Indiana Perinatal Network, Indiana Minority Health Coalition, Governor's Office Of Faith Based Initiatives, state legislators, local county coalitions, and others to develop a preconception and interconception health

program. MCSHC began working OMPP and others on a presumptive eligibility plan to be implemented in early 2008, and on a state family planning waiver. The family planning waiver was postponed so the state HIP waiver could be implemented and is now progressing. Presumptive eligibility plan was pulled by OMPP.

### **c. Planned Activities FY 2009**

FY 2009 Performance Objective: The number of targeted communities with such community/neighborhood partnerships will increase from 3 to 4 in 2009.

- MCSHC and Office of Minority Health (OMH) will work collaboratively to bring the national office of Minority Health media campaign “A Healthy Baby Begins with You” in 3 of the 5 disparity counties (Allen, Lake, Marion, St. Joseph, and Vanderburgh) in Indiana as part of the National Partnership for Action to End Health Disparities.
- Include infant mortality disparity issues as a part of the Indiana Black Expo.
- Include required disparity outreach activities for all applicants of the Title V 2009-2010 MCSHC RFP. Promote collaboration with local minority health coalitions and churches.
- MCSHC will continue to provide technical assistance and follow-up to the five targeted disparity counties to help county coalitions address disparity issues. Continue to assist disparity counties in completion and implementation of a county plan.
- Provide 5 perinatal trainings on at least 6 topics for a total of 25 trainings in disparity and focus counties. Topics will include: 1) Indiana Access Habits of the Heart – Cultural Awareness, 2) Screening and treatment for PMD, 3) relevant breastfeeding topics, including “Business Case for Breastfeeding” to promote breastfeeding among minority employees of low paying businesses, 4) Use of alcohol, tobacco and other drugs among women of child bearing age and during pregnancy, 5) a how to menu / tool kit of community-based model programs designed to decrease perinatal disparities and increase access to care. At a minimum, the following programs will be described: Centering, Baby First Advocates / MOM, Baby First Digital Tool Kit, Crib Program, community based Doula. CEU contact hours will be provided as well as CME approved hours when possible.
- Increase outreach among priority counties to bring in new IPN members, form/expand local perinatal networks/coalitions to utilize current infrastructure in improving perinatal outcomes.

- Explore use of videoconferencing to include more members in quarterly State Perinatal Advisory Board Meetings.

**State Performance Measure # 8:** The percentage of high school students who are overweight or at risk will decrease by 3% over the next five years.

Status: Youth Risk Behavioral Survey (YRBS) Data: According to 2007 YRBS data, 15.3% of Indiana students reported being “at risk for overweight,” a slight increase from 2005 YRBS results which reported 14.3% of Indiana students as “at risk for becoming overweight.”

According to the 2007 YRBS data, 13.8% of students in 2007 reported being “overweight,” a decrease from the 2005 YRBS survey results in which 15% of students reported being “overweight.” This represents a total decrease in reported overweight of 1.2% between YRBS 2005 and YRBS 2007.

#### **a. FY 2007 Accomplishments**

- Five school-based adolescent health clinics that are funded (FY07-08) by MCH Block Grant funds have been monitoring Body Mass Index (BMI). For FY07, 679 unduplicated adolescents served by the clinics were identified with a BMI that placed them at risk for overweight or obesity. Of the 679 adolescents, 411 (60.5%) received healthy weight counseling and/or other related interventions or treatment.
- In FY-2007, CNOP formed a Gestational Weight Management Steering committee to coordinate efforts in this program area. Representatives from several ISDH offices, including MCH and CNOP, were included in the steering committee. The steering committee developed and submitted a proposal to recruit a Public Health Prevention Specialist (PHPS) from the Centers for Disease Control and Prevention (CDC) to coordinate the Gestational Weight Gain (GWG) Program Initiative in Indiana. Melissa Kimball, MPH, a PHPS was assigned to the Indiana State Department of Health and started in October (2007).
- By July 2007, the former CNOP division had seven half-time AmeriCorps members placed in seven different MCH clinics. The members worked in varying capacities to promote pre and post natal care as well as encourage patients and visitors to adopt healthy lifestyles. Members were placed at the following sites or with the following individuals: Fetal Infant Mortality Review; Marion County Health Department; Health Visions Midwest; MCH Network Lake; Indianapolis Healthy Start; Minority Health Coalition and Angela Goode.
- CNOP staff participated in approximately 17 health fairs and/or informational sessions through community level, faith-based, worksite, or coordinated senior healthy living programs. Each year the ISDH Office of Minority Health sponsors the Indiana Black Expo Minority Health Fair. As an exhibitor at this event, the

CNOP program provided nutrition and physical activity information along with Body Mass Index (BMI) screenings to a large number of the approximately 37,000 attendees.

- By July 2007, Healthy Vending/Snack Bar and Food Handling and Demo Policies/Procedures had been published and made available on the CNOP website.
  - Due to staff changes it is unknown how many presentations and workshops were conducted in FY 2007 by the CNOP.
  - NPA will continue to assist in promoting of the Body and Soul program within Minority congregations in collaboration with American Cancer Society and Indiana Minority Health Coalition. The collaborative worked to develop and distribute data tracking and monitoring tools for participating congregations.

#### **FY 2008 Report of Current Activities**

- MCSHC funded Bowen Research Center to develop two resource guides to assist with statewide obesity prevention efforts. The first guide identified existing data from several different sources such as the Behavioral Risk Factor Surveillance System (BRFSS) and the YRBS. This guide is featured on the ISDH website and is available to the public. The second guide featured needs assessment methods that could be implemented by communities to inform the development of community level obesity prevention programs.
- During the 2007 fiscal year, the Body and Soul collaborative oriented twelve churches on the program and successfully implemented the curriculum in two congregations. In one congregation, a policy was implemented to encourage church members to provide at least one healthy meal alternative at all congregation functions where a meal would be served.
- On October 3, 2007, Public Health Prevention Specialist (PHPS) Fellow, Melissa Kimball, MPH, started working as the Gestational Weight Program Manager. This position is currently housed in the Division of Nutrition of Physical Activity (NPA) however, the program manager works closely with staff in Maternal and Child Health (MCH) as well as other chronic disease offices within the ISDH. The initial timeline proposed for the development of a strategic plan for the program has been re-evaluated and extended. However, significant progress has been made. Activities conducted by the Gestational Weight Management program during FY 2008 include: Meeting of existing Gestational Weight Management Task Force (12/7/08); Development of short-term strategic plan to cover 1/1/08-6/1/08; Completion of Gestational Weight data analysis document identifying strengths and weaknesses of currently available surveillance data related to GWG

in Indiana; Comprehensive analysis of *Provisional* Indiana Birth Certificate Data for 2007 and development of educational presentation on incident of excessive GWG.

- Presentations on this material have been made on the following dates: 12/7/08, 2/1/08, 3/19/08, 4/1/08 and 4/9/08. In addition to MCH management staff and other high level ISDH program directors; this information has been shared with Medical residents and key partners and stakeholders at the Indiana Perinatal Network Annual meeting.
- A registered dietitian for the CNOP division was hired in September 2007 to lead the state in its efforts to promote fruit and vegetable consumption. Indiana became licensed to use the Fruit & Veggies—More Matters logo in February 2008. Due to a focus on compiling a draft obesity prevention plan and the subsequent transition in the division, outlined activities such as providing training the trainer sessions, developing an educational tool kit and releasing an email campaign to all MCH clinics were not completed. New direction for the program will be developed for the 2008-2009 FY.
- School height and weight collection guidelines were distributed through the Indiana Department of Education in the Coordinated School Health newsletter called *Healthy Connections*. Modifications to the original guidelines will be made for FY 2009. This information has not been finalized at this time. Food demonstrations through the INDY COOKS program will not be held. Proposal plans for the BMI4kidz program is being further investigated.
- MCSHC funded the Body Talk program developed and implemented by the Ruth Lilly Health Education Center. The program is designed to increase middle school student's awareness of nutrition, physical activity and body image. Results from the 2007-2008 school-year have not been compiled at this time.
- In January 2008, the AmeriCorps program was moved from the CNOP division to a different division in the ISDH. Although the AmeriCorps program has been relocated in the agency, the NPA division continues to fund some of the AmeriCorps activities which focus on obesity prevention.
- Of the activities listed by the former program, a health worksite program and emergency food supplies will not be provided to MCH clinics by the NPA Division.

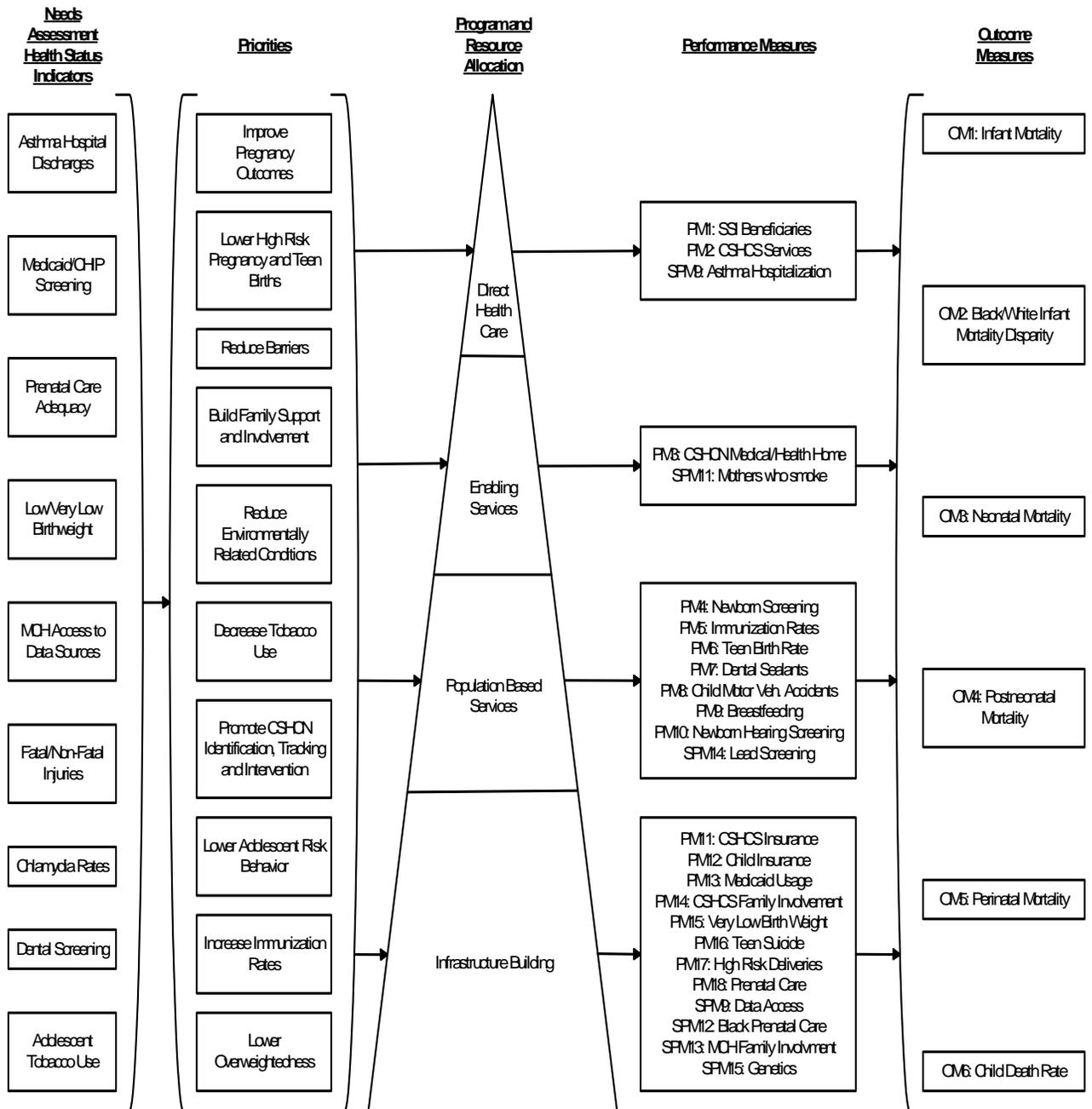
#### **Planned activities FY 2009**

- NPA will Collaborate with the Indiana Department of Education (IDOE). Monthly meetings will be held between the NPA and IDOE staff to discuss potential strategies to assist with continued development of the Coordinated School Health (CSH) program. The NPA Division will provide support and

assistance as needed in the implementation of the second round of CSH programs (known as MICHIANA II).

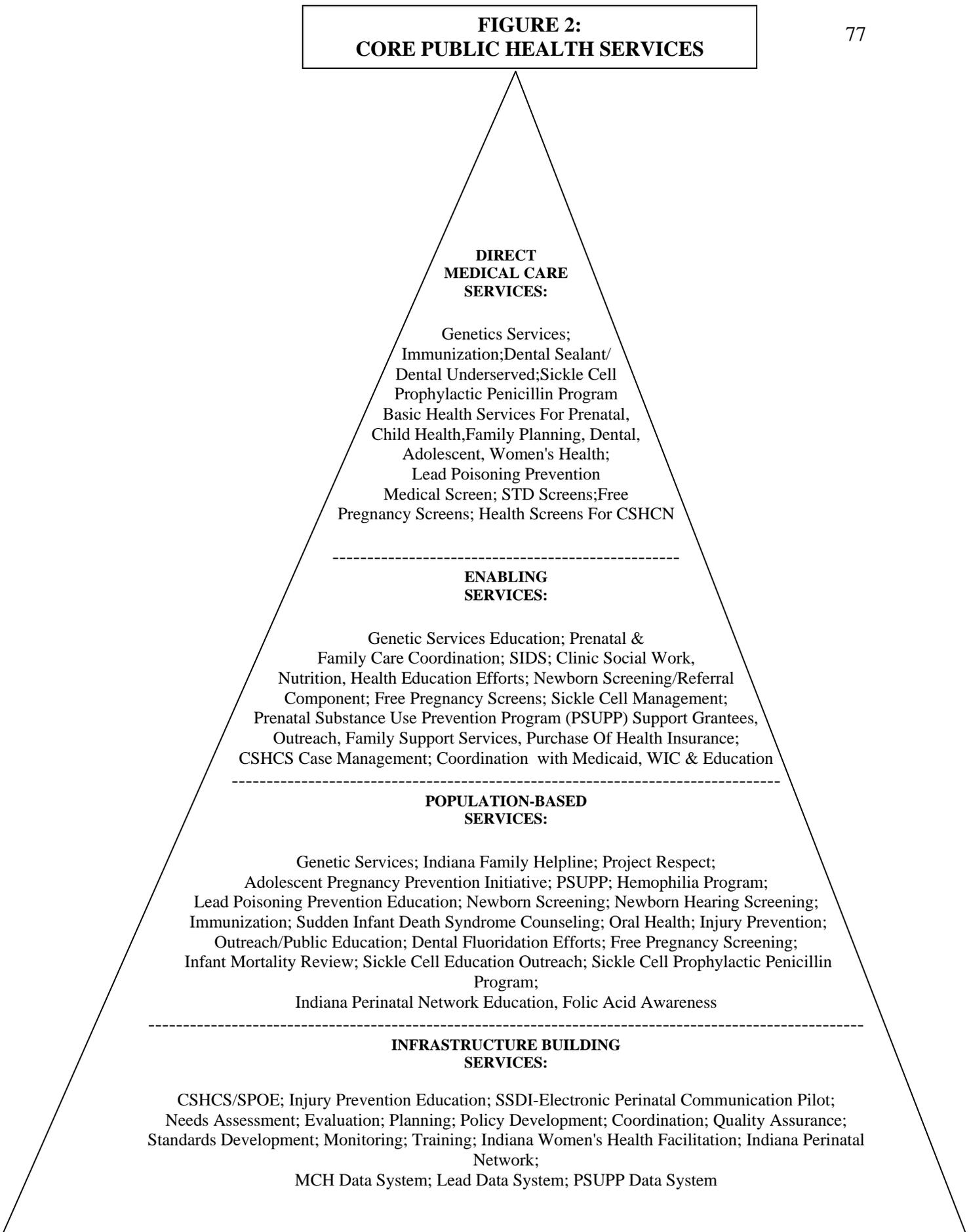
- An incentive program and implementation plan will be developed by the NPA Division (with the assistance of IDOE) to encourage High Schools to complete the School Health Index (SHI) developed by the CDC. The SHI is a self-assessment and planning tool that schools can use to improve their health and safety policies and programs. The School Health Index is an important aspect of the Coordinated School Health program and is essential to ensure program effectiveness and sustainability.
- The NPA Division will develop a more in-depth analysis of available YRBS data to provide additional information to schools and other stakeholders. All information will be provided online for easy access and review. This report will provide additional data to school officials and parents regarding the nutrition and physical activity behaviors of adolescents and provide important evidence to support the need for programs and policies to promote healthy eating and physical activity in schools.
- With the assistance of a statewide task force representing many different levels of influence and settings, a statewide obesity prevention plan titled the Indiana Health Weight Initiative will be developed and published in FY 2009. Included in this plan will be goals, objectives and strategies targeting settings such as schools and communities and special populations such as adolescents and parents.
- The NPA Division will encourage and disseminate information to communities to implement the We Can! program. **We Can!**<sup>™</sup> or "Ways to Enhance Children's Activity & Nutrition" is a national program designed for families and communities to help children maintain a healthy weight. The program focuses on *three* important behaviors: *improved* food choices, *increased* physical activity and *reduced* screen time. Additional information about this program can be found at <http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan/>.

**Figure 3: TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM**



As part of this system, all services provided by MCHS are organized in pyramidal structure as shown in Figure 2.

**FIGURE 2:  
CORE PUBLIC HEALTH SERVICES**



**DIRECT  
MEDICAL CARE  
SERVICES:**

Genetics Services;  
Immunization; Dental Sealant/  
Dental Underserved; Sickle Cell  
Prophylactic Penicillin Program  
Basic Health Services For Prenatal,  
Child Health, Family Planning, Dental,  
Adolescent, Women's Health;  
Lead Poisoning Prevention  
Medical Screen; STD Screens; Free  
Pregnancy Screens; Health Screens For CSHCN

**ENABLING  
SERVICES:**

Genetic Services Education; Prenatal &  
Family Care Coordination; SIDS; Clinic Social Work,  
Nutrition, Health Education Efforts; Newborn Screening/Referral  
Component; Free Pregnancy Screens; Sickle Cell Management;  
Prenatal Substance Use Prevention Program (PSUPP) Support Grantees,  
Outreach, Family Support Services, Purchase Of Health Insurance;  
CSHCS Case Management; Coordination with Medicaid, WIC & Education

**POPULATION-BASED  
SERVICES:**

Genetic Services; Indiana Family Helpline; Project Respect;  
Adolescent Pregnancy Prevention Initiative; PSUPP; Hemophilia Program;  
Lead Poisoning Prevention Education; Newborn Screening; Newborn Hearing Screening;  
Immunization; Sudden Infant Death Syndrome Counseling; Oral Health; Injury Prevention;  
Outreach/Public Education; Dental Fluoridation Efforts; Free Pregnancy Screening;  
Infant Mortality Review; Sickle Cell Education Outreach; Sickle Cell Prophylactic Penicillin  
Program;  
Indiana Perinatal Network Education, Folic Acid Awareness

**INFRASTRUCTURE BUILDING  
SERVICES:**

CSHCS/SPOE; Injury Prevention Education; SSDI-Electronic Perinatal Communication Pilot;  
Needs Assessment; Evaluation; Planning; Policy Development; Coordination; Quality Assurance;  
Standards Development; Monitoring; Training; Indiana Women's Health Facilitation; Indiana Perinatal  
Network;  
MCH Data System; Lead Data System; PSUPP Data System

### Selected Health Status Indicators

	1999	2000	2001	2002	2003	2004	2005
The Percent of Women (15 through 44) with a live birth during the reporting year whose prenatal visits are considered adequate.	75.2%	72.4%	74.1%	73.5%	72.9%	72.3%	71.1%
The Percent of Live Births weighing less than 2,500 grams.	7.8%	7.4%	7.6%	7.3%	7.9%	6.6%	6.9%
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.	10.0	11.4	11.5	9.0	9.6	11.6	11.3
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.	18.5	21.7	23.8	23.8	23.7	26.6	26.2
The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.	4.6	5.7	7.1	7.1	7.0	8.2	8.4

### Selected Performance Measures

	1999	2000	2001	2002	2003	2004	2005
Percent of newborns in IN with a confirmed case of selected genetic condition/s who received appropriate follow-up.*	99.3%	99.9%	99.4%	99.6%	99.8%	100%	100%
Percent of children through age 2 who have completed immunizations.	78.9	79.3%	78.5%	78.5%	79.3%	79%	81.4% +/- 6.5
The Rate of Births (per 1,000) for teenagers aged 15 through 17 years.	27.4	26.6	23.7	22.5	21.5	20.9	20.5
Percentage of mothers who breastfed their infants 6 months after hospital discharge.**	56.3%	59.8%	62.6%	64.9%	63.2%	66.4%	30.2 +/-5
Percent of newborns screened for hearing impairment before hospital discharge.	56.6%	95%	98%	99.6%	99.8%	97.9%	98.5%
Percent of children without health insurance.	11.8%	7.8%	7.8%	7.6%	7.6%	8.9%	9.1%
The rate (per 100,000) of suicide deaths among youths aged 15-19.	8.1	8.7	9.0	9.1	6.6	8.1	6.9
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	79.5%	79.4%	78.8%	80.5%	80.6%	78.5%	78.9%
Percent of live births to mothers who smoke.***	20.9%	20.2%	20.2%	19.1%	18.5%	17.9%	17.3% ^
The percent of black women (15 through 44) with a live birth whose prenatal care visits were adequate.	63.5%	60.2%	63.2%	61.6%	61.6%	61.3%	60.0%

### Selected Outcome Measures

	1999	2000	2001	2002	2003	2004	2005
The infant mortality rate per 1,000 live births.	7.8	7.7	7.5	7.6	7.4	8.1	8.1
The ratio of the black infant mortality rate to the white infant mortality rate.	2.5	2.4	1.9	2.4	2.5	2.5	2.4
The perinatal mortality rate per 1,000 live births + fetal deaths.	6.9	7.4	7.1	11.4	10.6	6.9	10.8
The child death rate per 100,000 children aged 1-14.	27.5	25.5	21.8	22.6	19.3	23.5	24.5

\* This performance measure was changed in FY 2004.

\*\* This performance measure was changed in FY 2005; the figure is normally approximately 50% of those who breastfeed at birth (which was the former performance measure).

\*\*\* This performance measure will be changed in FY 2006 to “smoked during last trimester”, as the new Electronic Birth Certificate contain that information.

^ Preliminary data

+/- means within that variance for 95% confidence

Revised 2008-05-23