



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

**State Narrative for
Indiana**

**Application for 2009
Annual Report for 2007**



Document Generation Date: Friday, September 19, 2008

Table of Contents

I. General Requirements	4
A. Letter of Transmittal.....	4
B. Face Sheet	4
C. Assurances and Certifications.....	4
D. Table of Contents	4
E. Public Input.....	4
II. Needs Assessment.....	6
C. Needs Assessment Summary	6
III. State Overview	8
A. Overview.....	8
B. Agency Capacity.....	20
C. Organizational Structure.....	29
D. Other MCH Capacity	33
E. State Agency Coordination.....	34
F. Health Systems Capacity Indicators	41
Health Systems Capacity Indicator 01:	41
Health Systems Capacity Indicator 02:	43
Health Systems Capacity Indicator 03:	44
Health Systems Capacity Indicator 04:	46
Health Systems Capacity Indicator 07A:	47
Health Systems Capacity Indicator 07B:	49
Health Systems Capacity Indicator 08:	50
Health Systems Capacity Indicator 05A:	52
Health Systems Capacity Indicator 05B:	53
Health Systems Capacity Indicator 05C:	54
Health Systems Capacity Indicator 05D:	55
Health Systems Capacity Indicator 06A:	56
Health Systems Capacity Indicator 06B:	57
Health Systems Capacity Indicator 06C:	58
Health Systems Capacity Indicator 09A:	59
Health Systems Capacity Indicator 09B:	60
IV. Priorities, Performance and Program Activities	62
A. Background and Overview	62
B. State Priorities	63
C. National Performance Measures.....	65
Performance Measure 01:	65
Performance Measure 02:	68
Performance Measure 03:	71
Performance Measure 04:	74
Performance Measure 05:	77
Performance Measure 06:	81
Performance Measure 07:	84
Performance Measure 08:	87
Performance Measure 09:	90
Performance Measure 10:	94
Performance Measure 11:	97
Performance Measure 12:	99
Performance Measure 13:	103
Performance Measure 14:	106
Performance Measure 15:	109
Performance Measure 16:	113
Performance Measure 17:	117
Performance Measure 18:	120

D. State Performance Measures.....	122
State Performance Measure 1:	122
State Performance Measure 2:	124
State Performance Measure 3:	127
State Performance Measure 4:	131
State Performance Measure 5:	134
State Performance Measure 6:	137
State Performance Measure 7:	139
State Performance Measure 8:	141
E. Health Status Indicators	145
F. Other Program Activities.....	148
G. Technical Assistance	150
V. Budget Narrative	152
A. Expenditures.....	152
B. Budget	155
VI. Reporting Forms-General Information	158
VII. Performance and Outcome Measure Detail Sheets	158
VIII. Glossary	158
IX. Technical Note	158
X. Appendices and State Supporting documents.....	158
A. Needs Assessment.....	158
B. All Reporting Forms.....	158
C. Organizational Charts and All Other State Supporting Documents	158
D. Annual Report Data.....	158

I. General Requirements

A. Letter of Transmittal

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

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and Certifications are kept on file at the Indiana State Department of Health both in the Finance Department and in the office of the MCSHC Grants Coordinator with the hard copy of the grant application. They are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

The State Title V program solicited public comments for this application by placing an Executive Summary of the FY 2006 application on the MCSHC web page. The web page provides the public an opportunity to review the Executive Summary and provide comments. After MCHB review, access to the entire application is also provided on the website. Copies of the Executive Summary were made available upon request and were also accessible in government document sections of thirteen public libraries across the state. A legal notice was placed in all major newspapers in the state alerting readers to the placement of the documents.

ISDH posted the 2007 application summary on the MCSHC web page and distributed the summary and the application electronically to the membership of the various MCSHC advisory committees and to all public libraries in the State. All public comments are recorded along with ISDH MCSHC response and all comments and responses are used during the preparation of the application for the following year. ISDH will announce the web location of the executive summary by legal notices placed in all major newspapers in the state.

Beginning with the FY 2007 application, MCSHC is making narrative sections of the application available to an advisory group and requesting input via e-mail.

/2008/The FY2008 application summary was sent electronically to the membership of the advisory committee to MCSHCS. MCSHCS received twenty two comments and several changes were made based on the suggestions. The application and an executive summary will be placed on the MCSHC website.//2008//

/2009/ For the FY2009 Title V Block Grant Application the State Title V program solicited public comments from their Advisory Panel. The Advisory Panel, made up of more than 100 members, reflects representation from the following types of organizations: Local Health Departments, Hospitals, Community Health Centers, the Department of Family and Children, Indiana Coalition Against Domestic Violence, Indiana Primary Health Care Association, Department of Education, Division of Mental Health and Addictions, Title X, the Bureau of Child Care, March of Dimes,

National Association of Social Workers, the Minority Health Council, Healthy Mothers Healthy Babies, and parental support groups and other groups representing the general public.

All panel members received an application summary electronically for their review and were encouraged to respond to any areas that fell under their field of expertise. Panel members from Title X's Indiana Family Health Council, the Health and Hospital Corporation-Marion County Health Department, MCH's Johnson Nichols's Health Clinic, Tri-Cap of Dubois/Pike/& Warrick counties Economic Opportunity Committee, 1st Steps, Clarion Hospital, Community Hospital East, and the Department of Education all responded with general comments. Their comments covered typos, suggestions for future inclusions, and overviews of what their specific projects were engaged in as related to the National and State Performance Measures. In response to this input, three changes were made to the Executive Summary section on National and State Performance Measures. Both the Application and Executive Summary will be placed on the MCSHC website as in past years.//2009/

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Summary of Needs Assessment for the Block Grant 2008

Since the submission of the FY 2006 Needs Assessment and the FY 2007 update, Maternal and Children's Special Health Care (MCSHC) Services has continued to focus on improving perinatal outcomes particularly those related to alcohol, tobacco, and other drug use statewide and by county. Assessments have been completed or are in progress which will assist MCSHC staff in educating local communities about problems and in developing local intervention plans to impact and improve national and state performance measures. (Please see the Needs Assessment Attachment to the grant application for specific highlights of the data and recommendations of the studies).

During FY 2007 additional statistical analyses were completed based on Vital Statistics data. Trends in Birth Outcomes in Indiana Counties--Statistics from Live Birth Data from 1990-2004 was published in March 2007 and Trends in Birth Outcomes in Indiana--Statistics from Live Birth Data from 1990-2005 was published in May 2007. Smoking During Pregnancy in Indiana, 1990-2004, Statistics from Live Birth Data was published in September 2006.

The first two studies present statistics on time trends in low birth weight, preterm birth, selected maternal characteristics and a variety of delivery methods (including cesarean delivery rates) by race and Hispanic origin of the mother over time as reported on birth certificates, according to the mother's Indiana residence at birth. The latter focuses on prenatal smoking statistics and includes the impact of urbanization on prenatal smoking.

Alcohol, Tobacco and Drug Use by Pregnant Women in Indiana was published September, 2006. This study was requested by the Indiana legislature. The purpose of this study was to collect information that would improve the understanding of the size of the problem of alcohol, tobacco, and drug (ATOD) use by pregnant women in Indiana; to determine the barriers, perceived or real, that keep pregnant ATOD users from getting needed treatment; and to suggest strategies that could be undertaken to improve the access to treatment services.

A Consensus Statement on Substance Use Disorders and Pregnancy was published in March, 2007. It was facilitated by the Indiana Perinatal Network, Inc., a Title V funded grantee which assist MCSHC in infrastructure building and policy development regarding perinatal health. These two external documents supported by the statistical trends provide recommendations for intervention.

With these statistics and assessments, the information gathered in the Community Forums and focus groups in the last two years, needs assessments, and recommendations, MCSHC has begun holding community disparity summits in five counties that focus on reducing disparity in perinatal health to engage and empower local groups to implement activities to impact ATOD use and other issues that inhibit access to care and impact poor outcomes of pregnancy. In addition, presentations for providers on tools to use to assess and intervene with pregnant smokers are being presented in five of the more rural focus counties and MCSHC is partnering with Indiana Rural Health Association to provide training in physicians' offices in five southern counties with the highest rates of smoking among pregnant women, as mentioned in the Title V grant application.

In recently published reports and state rankings related to access to care (insurance coverage and the state Medicaid program), Indiana was determined to be "mediocre" in number of uninsured and "poor" for Medicaid program qualities (eligibility, scope of services, quality of care and provider reimbursement). In the Robert Wood Johnson's Cover the Uninsured report distributed during the Cover the Uninsured Week, April, 2007, the State Profile for Indiana (based on 2003 data) reveals that 14.2% of Indiana's population and 9.0% of Indiana's children are uninsured. Based on 2004 and 2005 Medicaid data from Kaiser Family Foundation's Commission on Medicaid and the Uninsured and other data gathered and reported by Public Citizen, Indiana's state Medicaid program was ranked as one of the 10 worst programs in the nation. These rankings should change with recent legislation to expand Medicaid and health insurance coverage to families up to 200% of FPL and SCHIP coverage up to 300% of FPL. ***/2009/Indiana is in need of improvement in all the areas outlined in the FY09 Needs Assessment Update which is attached to the EHB. Indiana has a higher prevalence than the nation for children with asthma. Rates for SIDS and SUIDS have decreased in Indiana, but still need to continue the decline. Indiana has decreased in the percentage of short interpregnancy intervals over the past three years, but is still above the national average. Gestational weight gain and pre-pregnancy weight of women in Indiana will be analyzed in the next fiscal year.***

The Youth Risk Behavior Survey shows a few disturbing trends in Indiana. The rates of alcohol and drug use, self-inflicted injury and suicide, and students having sexual intercourse all increased. Smoking prevalence in students has decreased, but is still much higher than the national average. Physical activity and weight and nutrition have shown signs of improvement, but much more progress is needed in these areas.

The National Survey of Children with Special Health Care needs shows that Indiana is behind Region V and the nation in many areas. Indiana has a larger percent of children with special health care needs than every other state in Region V, and the nation. Indiana is consistent with the nation in most of the core outcomes, but still needs to improve in many areas of children with special health care needs. See the Attachment File//2009//

An attachment is included in this section.

III. State Overview

A. Overview

Section III. State Overview

A. Overview

Indiana elected a new Governor, Mitchell E. Daniels, Jr. in 2004. Governor Daniels appointed Dr. Judith Monroe as the State Health Commissioner and Medical Director for Medicaid, the first woman appointed to head the health department and the first person to hold both positions simultaneously. Dr. Monroe's background is Family Practice Residency Training and Primary Care.

PRINCIPLE CHARACTERISTICS of STATE HEALTH NEEDS

Population -- 6,195,643

Statewide, Indiana's population grew by about 3 percent between 2000 and 2002, with most of the growth coming from more births than deaths and people moving to the state from other countries. Indiana grew at a slightly faster pace than neighboring states from 2000 to 2003, but well below the fastest growing states such as Georgia, Nevada and Idaho, all above 7%. /2008/ Indiana's population in 2005 was 6,271,973. With the 24th highest population growth rate among the states in 2005, Indiana continued to grow at a slightly faster pace than neighboring states with the exception of Kentucky.//2008//

Source: <http://www.incontext.indiana.edu/2006/january/3.html>**/2009/Immigrants make up a much smaller share of Indiana's population than in the country as a whole. While 12% of the population of the United States (US) was born elsewhere, only four percent of Indiana's population is foreign-born, ranking the state 35th among the 50 states and the District of Columbia. On the other hand, the state ranks 12th in the percent change of its foreign-born population since 2000: this population grew almost 30 percent from 2000-2005, compared to a growth of the foreign-born population for the US as a whole of 16 percent during this period. Source: [www.sipr.org/PDF/Indiana Immigration and Workforce Patterns.pdf](http://www.sipr.org/PDF/Indiana%20Immigration%20and%20Workforce%20Patterns.pdf)//2009//**

Hundreds moved out of Madison County between 2000 and 2004. Between 2001 and 2004, manufacturing jobs in Madison County dropped from 9,781 to 7,180. Henry, Grant, Wayne, Randolph and Rush counties in east-central Indiana also experienced population declines after the loss of manufacturing jobs. Widespread population loss also occurred in Newton, Vermillion, Knox and Posey counties along the Illinois border. The drops in Vermillion and Knox are attributed to deaths outnumbering births./2007/Madison and Grant Counties lead the state for manufacturing job losses from 2001 - 2005. These counties industries are very reliant on General Motors. Other counties with high manufacturing job losses include White, Fayette, Johnson and Wabash Counties.//2007///2008/ Honda announced plans and began building a new automotive facility in Decatur County. Population growth in Indiana continued to move out to areas surrounding the metropolitan centers of Indianapolis, Chicago, and Louisville while the major cities in Indiana did not experience significant population growth. //2008// **/2009/According to the U.S. Bureau of Labor Statistics, Indiana's estimated unemployment rate in May 2008 had grown to 5.3 percent, compared to a rate of 4.4 percent in May 2007. //2009//**

Whites make up 89% of Indiana's population. Approximately 8.5% of the state's population is Black. Marion County (Indianapolis) and Lake County (Chicago area) have the highest concentrations of African Americans, representing 24%-25% of each county's population. Other counties with urban centers and manufacturing job concentrations also have significant numbers of African Americans, the next highest being St. Joseph, Allen and LaPorte Counties at 10%-12% of their population. /2008/African Americans are about 8.4% of Indiana's population. Roughly half of Indiana's African American high school graduates enrolled in college in 2005.//2008//

The Ku Klux Klan has resurfaced across Lake, Porter and LaPorte Counties and was implicated in the burning of a house being built for a black family in Lake Station. The City of Gary has started community meetings to address recent racism. /2008/Indiana is one of 19 states identified by the Anti-Defamation League as having notable growth in KKK activity.//2008//

At 1.2% of Indiana's population, Asians are the fastest growing minority with the highest concentration at 4.5% in Tippecanoe County, home to Purdue University. Monroe and Hamilton Counties also have more than 2% Asian representation. Numerically, the greatest concentration of Asians is in Marion County (12,325 = 1.4%). /2008/Asians remain the fastest growing racial demographic in Indiana, experiencing a population growth of more than 19% from 2000 to 2005.//2008//

The largest increase among Indiana's population has been the Hispanic ethnic group. Hispanics make up 3.5% of the state's population with the greatest concentration in Lake County, representing 12.2% of the population. The next closest county is Elkhart at 8.9%. Other counties that show the largest growth in Hispanic population include Marion, Allen, Tippecanoe and Porter. The influx of Spanish speaking people has caused hospitals, clinics, public safety and educational institutions to train personnel in Spanish language and Hispanic culture. /2008/ Hispanics made up 4.5% of the population in 2005. The Hispanic population in Indianapolis more than tripled from 1998 to 2004, making them the fastest growing demographic in the city. This increase is a product of an influx of Hispanic residents and a baby boom among this population. //2008// ***/2009/According to the Center for Urban Policy and the Environment at IUPUI (Indiana University Purdue University at Indianapolis), Latino births in Indianapolis increased 422 percent between 1997 and 2004 (from 468 to 1,977 births), a change that affects child-care providers and schools. In school year 2004-2005, an estimated 9,900 Latino children were enrolled in Marion County schools, 7 percent of the total enrollment.//2009//***

The second fastest growing minority population in Indiana is the Amish, with populations expected to double in 20 years. Concentrated in the northeast corner of the state, Indiana's Amish face unique challenges. The Elkhart-LaGrange settlement is the 3rd largest in the U.S. and while the U.S. Census does not track Amish populations, local estimates show about 3,300 school age (1st-8th grade) Amish children in the Elkhart-LaGrange settlement. According to estimates developed by Indiana University of Fort Wayne through the Amish Youth Vision Project, the total Amish population could be as high as 45,000 in this part of the state. An unusually high percentage of this population works in local factories -- more than 40% of Amish men.

During late teen years through their early twenties, Amish youth are not required to join the church and are not bound by its teachings. This tradition, known as Rumspringa, grows from the belief that Amish must join the church of their own free will. However, as documented in "The Devil's Playground," a video documentary prepared for the Public Broadcasting System, this population, particularly young Amish men are extremely vulnerable to drug use and other illegal and occasionally violent behavior -- particularly for factory workers who, unlike the Amish working in farming and small business, have free time, low cost of living and significant disposable income. Population increases and limited land availability put additional pressures on the Amish as their larger communities grow to several times the traditional settlement size./2007/The Amish population referred to is the Old Order Amish. The estimates of population were developed by Steven M. Nolt Ph.d. and Thomas J. Meyers Ph.d. of Goshen College. The Amish Youth Vision Project funded primarily through ISDH, focuses on drug and alcohol education in hopes to reduce usage among Amish youth. One conference for law enforcement dealing with responding to Amish youth has been held, and a second conference to include mental health/social service providers is planned for the fall of 2006. A counseling group is providing drug and alcohol classes exclusively to Amish youth led by Amish leaders. Other Amish communities are now requesting

assistance to implement their own programs.//2007//
/2008/Due to budget constraints, ISDH ended support for the Amish Youth Vision project in FY 2007, one year earlier than anticipated. Fortunately, the program has been funded by the Dekko Foundation. The project has now trained hundreds of police officers in ways to work more effectively with the Amish population to curb drug crimes among Amish youth. The project has also been very effective with involving and facilitating leadership within the Amish community. The bishops and elders now take the lead role in organizing the education for parents in more effective ways to help their adolescent and adult children through Rumspringa.//2008//
Source: Amish Youth Vision Project 2006 annual report to ISDH and Dekko Foundation

American Indians are one of the smallest minority groups in Indiana, making up 0.6% of the state's population, trailed only by Pacific Islanders at 0.1%. This population is scattered across the state. Only three counties, Marion, Lake and Allen have total American Indian populations of more than 1,000. Most counties have fewer than 100.

/2008/ Indiana's American Indian & Alaskan Native population grew by 6.4% while the population of Native Hawaiians & Pacific Islanders experienced a growth rate of 18.7% between 2000 and 2005. This population is so small, that the actual change in population during that period was an additional 539 persons.//2008//

Source:

http://www.stats.indiana.edu/stats_dp/dpage.asp?id=72&view_number=2&menu_level=&panel_number=Select Indiana, 2005, Overview Race

While Indiana's labor force grew, employment levels steadily decreased from 1999 to 2003, causing a jump in the unemployment rate from 3% to 5.1%. This current unemployment rate is below average for the Midwest region. Kentucky has the lowest regional unemployment rate at 4.5%; Michigan has the highest at 6%.//2007/Indiana's current unemployment rate is 5.0%, slightly above the 4.88% average for the Midwest. Minnesota had the lowest rate at 3.7% and Michigan the highest at 6.0%. The national average is 4.6%//2007//

/2008/Indiana's unemployment rate in November 2006 was 4.8% equal to the Midwest regional rate but above the national rate of 4.5%.//2008// Source: <http://www.bls.gov/lau/home.htm> Target = Unemployment Rates, seasonally adjusted. ***/2009/ Between the third quarter of 2001 and 2005, Indiana added 26,688 health care and social assistance jobs--a gain of 8.3 percent. This was the largest growth on a numeric basis and the second largest from a percent basis (trailing the administrative, support and waste management sector, whose growth exceeded 16 percent). Of the state's 92 counties, 73 experienced growth in the number of jobs in health and social assistance. Focusing on percentages, the largest increases occurred in Newton, Owen and Hamilton counties, and the largest declines were found in Jennings, Union and Rush counties.//2009//***

Source www.incontext.indiana.edu

Between 1999 and 2002, Indiana's poverty rate increased from 8.7% to 9.6% - still below the national average of 12.1%. The U.S. Census estimated in 2002 that 11.9% of Indiana's children live in poverty, with a higher rate of 14.5% for children under age 5. In Indianapolis, approximately 15,000 people are homeless in any given year, and an additional 45,000 people are in a housing crisis.//2007/The 2004 single year poverty rate estimate for Indiana is 11.6%. For children, the poverty rate in 2004 was 18.5%, higher than the national average of 17.8%.//2007///2008/The Kids Count Data Book by the Annie E. Casey Foundation shows 12% of the population in poverty with 20% of children under age 6 in poverty in 2005.//2008//

Indiana requires impoverished families to pay income tax. Currently, families begin paying state income tax when they earn 76% of the federal poverty level. This tax threshold could be lowered to 36% if the state Earned Income Tax Credit is not upheld for 2005. Specifics can be found at the Center on Budget and Policy Priorities - <http://www.cbpp.org/4-12-05sfp-in.pdf> /2007/Indiana's threshold for families paying the state income tax remained the same in 2005, but the poverty

level was increased, with the effect that families now begin paying state income tax when they earn 74% of the federal poverty level.//2007//

The Robert Wood Johnson Foundation (RWJF) used data collected by the Centers for Disease Control and Prevention to estimate that in 2003, there were more than 600,000 (16.3%) uninsured adults ages 18 to 64 in Indiana. The U.S. Census estimates the national uninsured rate at 13.9%. In 2003, 161,815 (9.6%) children in Indiana under age 19 were uninsured./2007/RWJF estimated that in 2004 14.2% of all Indiana residents did not have any insurance. For children under the age of 18, the uninsured rate is 8.9%. //2007///2008/U.S. Census data shows that in 2005 14.2% of all Indiana residents did not have any insurance and 9.7% of children under the age 18 were uninsured. In April the Indiana Legislature approved House Enrollment Act 1678 on health coverage for uninsured Hoosiers. The Act would raise the state's cigarette tax by 44 cents to help fund health coverage for 132,000 uninsured Hoosiers. The governor signed this legislation. //2008//

Indiana ranks 46th for the percent age 25+ with BS, BA or graduate degrees at 21.1%. The state's economy still is based heavily on manufacturing. College graduates tend to leave the state for better pay. Indiana University is proposing a 4.9% tuition increase for undergraduate courses. The increase would cost undergraduates as much as \$335 more in tuition and mandatory fees per semester. Purdue University is considering a 6% hike that would cost undergrads \$366 more./2007/Latest estimates show a marked improvement in college graduation rates for Hoosiers age 25 and older. With a rate of 26.3% in 2002, Indiana ranked 34th. Indiana University approved the 4.9% tuition fee increase in 2005. Purdue University adopted the proposed 6% hike.//2007//

/2008/The Indiana Department of Education revised the formula for determining high school graduation rates which show only 75.5% of high school students graduate statewide. The educational attainment rate for a Bachelors Degree or higher for Hoosiers age 25 and older was 21.1% in 2004.//2008//

In 2004, State Police alone arrested more than 1,200 people as a result of methamphetamine lab busts -- which affected the lives of at least 219 children, most of them related to the arrested adults and subsequently, thrust into the state's child protection system. Last year, state officials estimated, more than 30 percent of neglect and abuse cases they handled were in some way connected to methamphetamine abuse or manufacture. New legislation requires cold medications containing components used in methamphetamine manufacture to be controlled by pharmacists from behind the counter./2007/Methamphetamine lab seizures in Indiana decreased from 1549 in 2004 to 1300 labs seized in 2005.//2007//

/2008/ Heroin use is increasing in Indiana, State Police will have investigated about 700 cases in 2006, about 3 times the total in 2004.//2008//

/2009/Indiana is an active drug transportation and distribution area. The northern part of Indiana lies on Lake Michigan, which is a major waterway within the St. Lawrence Seaway system, providing international shipping for all sections of the Midwest. Seven interstate highway systems and 20 U.S. highways provide interstate and intrastate links for drug trafficking, especially with the southwest border and California. Highway (automobile and trucking) and airline trafficking are the primary means of drug importation, with busing systems as a secondary means. Mexican criminal groups are the primary wholesale distributors of marijuana, powdered cocaine, and methamphetamine within Indiana. 2007 Federal Drug Seizure In Indiana: Cocaine: 90.9 kgs., Heroin: 1.6 kgs., Methamphetamine: 13.1 kgs., Marijuana: 271.0 kgs., Meth Lab Incidents: 564 (DEA, state, and local) State Facts: Population: 6,271,973, State Prison Population: 24,008, Probation Population: 116,431, Violent Crime Rate: National Ranking: 29th //2009// Source: U.S. Drug Enforcement Administration- www.dea.gov.

The Environmental Integrity Project named 12 Indiana coal-burning power plants, including one on the Southside of Indianapolis, among the 50 "dirtiest" in the country for producing health-damaging pollutants. The report underscores the potential health threat from power company

smokestacks throughout Indiana. With one exception, the Indiana companies did not challenge the group's findings. The report, "Dirty Kilowatts: America's Most Polluting Power Plants," compiled data from the U.S. Environmental Protection Agency and the Department of Energy's Energy Information Administration for sulfur dioxide, nitrogen oxides, mercury and carbon dioxide. The mercury data were from 2002, and the rest of the information came from 2004. See <http://www.environmentalintegrity.org/pub315.cfm> /2008/In 2006, Indiana was identified as having 5 of the "dirtiest" coal-burning power plants in the nation -- more than any other state.//2008// Source: <http://www.environmentalintegrity.org/pub385.cfm> Target = Indiana (5);

According to the Indianapolis Star, April 15, 2005, Marion County's child welfare program faces a \$20 million deficit and will likely have to borrow money this year to feed and clothe more than 3,000 children. An increase in the number of children needing care has driven costs up. New children sent into the system by the juvenile court in 2004 had increased to more than 2,000, up from a figure of 540 in 1996. The Office of Family and Children is largely paid for by county taxes but is managed by the state, leaving county elected officials holding the purse strings with no oversight on spending and little incentive to increase funding. Similar structural problems statewide played a role in the development of a separate Department of Child Services at the state level distinct from the rest of state social services.

Planned Parenthood of Indiana sued Attorney General Steve Carter to stop his office from seizing the medical records of 73 low-income Medicaid patients who have sought reproductive services. None of the records involves abortions. The Attorney General's Medicaid Fraud Control Unit was investigating an incident report or complaint alleging failure to report statutory rape. The eight records already turned over are of 12- and 13-year-old patients. In Indiana, anyone under age 14 who is sexually active is considered to be a victim of rape. Planned Parenthood maintains its personnel follow the law and report those patients to child protective services for further review. The Indiana Civil Liberties Union filed the lawsuit on behalf of Planned Parenthood. The record seizure has been postponed by court injunction.//2007/A decision is pending in the Indiana Court of Appeals.//2007// /2008/The Attorney General has decided not to appeal the case further, with the result that the records in question will not be turned over to the Attorney General.//2008// Source: <http://www.ppin.org/news.aspx?NewsID=44> Target = Sept. 22 decision

Signed by Governor Daniels, new 2005 State Laws:

*Create a new cabinet level Department of Child Services to provide child welfare and protective services. This department takes over these duties from the Family and Social Services Administration (FSSA)

*Require all counties of Indiana to observe Daylight Savings Time beginning 2006. Since 1971, most of Indiana has not observed DST, while the counties nearest Chicago synchronized with Chicago

*Require FSSA Department of Mental Health, Indiana Department of Child Services and Indiana Department of Education to develop a plan for children's emotional and developmental health

*Require FSSA Office of Medicaid Policy and Planning to seek a family planning waiver for Medicaid

*Create a state Department of Homeland Security to take over duties from several state agencies that will be abolished or re-assigned

*Provide health coverage for the surviving spouse and dependent children of active Indiana State Police officers killed in the line of duty

*Increase the penalty for voyeurism from a misdemeanor to a felony if the offender has a previous conviction for voyeurism

*Start a "Code Adam" program to help find missing children in certain state buildings. The system would notify state employees about a missing child in the building, and employees could then stop normal work to help search for the child and monitor exits

*Make it a misdemeanor for someone to intentionally provide dental hygienist services without a license

*Require most voters to show State issued or military ID to cast a valid vote (Indiana's ACLU has

filed suit to contest this law on behalf of homeless and low-income residents)

*Create the Office of Inspector General, reporting to the Governor, to investigate fraud and abuse in state government and tighten State ethics rules

*Restrict the sale of cold medicines that contain chemicals that can be used to create methamphetamines

*Raise speed limits on most state highways to 60mph and Interstate highways to 70mph

*Require child care homes that receive a voucher payment and licensed child care homes to receive training concerning safe sleeping practices for children and require the Division of Family and Children to provide or approve training concerning safe sleeping practices for children

*Require ISDH to adopt rules for the case management of children with lead poisoning and allow ISDH to coordinate lead poisoning outreach programs with social service organizations and require OMPP to develop measures to evaluate Medicaid managed care organizations in screening children for lead poisoning, a system to maintain the results and a performance incentive program

*Require ISDH to develop storm safety guidelines to schools and make them available to child care centers, day care centers and public parks and require Department of Education to distribute the guidelines to all public and non-public schools in Indiana.

/2007/New state laws signed by Governor Daniels effective July 1, 2006:

*Require injuries resulting from fireworks or pyrotechnics be reported to ISDH

*Create sexual assault standards and a certification board to certify sexual assault victim advocates, transfer control of the new sexual assault victim's account from ISDH to the new board, and repeal the sexual assault victim's assistance fund

*Require ISDH to study the use of drugs, alcohol, and tobacco by pregnant women and submit a report to the legislative council and health finance commission by Oct. 1, 2006

*Allow employers to implement financial incentives related to employer provided health benefits to reduce employee tobacco use

*Require each school board to establish a coordinated school health advisory council to develop a local wellness policy that complies with certain federal requirements

*Specify a physician's duty to monitor bariatric surgery patients for 5 years, establish topics that must be discussed prior to surgery, specify the information that must be reported to the ISDH, and require 6 months of supervised nonsurgical treatment before health insurance, state health care plan or health maintenance organization are required to cover surgical treatment

*Establish the ISDH as the lead agency for the development and implementation of a statewide trauma system and adopt rules regarding the system

*Allow the Office of Medicaid Policy and Planning to apply for federal approval to amend the state Medicaid plan to include a pay-in option

*Require certain licensed professionals to provide the professional licensing agency or the ISDH with their Social Security numbers

*Create a water shortage task force to develop and implement an updated water shortage plan and address other surface and ground water issues.//2007//

/2008/New state laws passed by the legislature that the Governor is expected to sign for 2007:

*House Enrolled Act 1001 which provides funding for K-12 education, Medicaid, transportation and other state services. This Act will devote \$92 million to help school districts launch full-day kindergarten.

* House Enrolled Act 1678 would raise the state's cigarette tax by 44 cents to help fund health coverage for 132,000 uninsured Hoosiers. It also provides for a tax credit related to small employer qualified wellness programs, increase Medicaid coverage for pregnant women to 200% FPL allows for presumptive eligibility for ambulatory pregnant women and raises eligibility for children to 300% FPL.

*House Enrolled Act 1033 will require all new mobile homes to come equipped with emergency weather radios.

*House Enrolled Act 1548 would require ISDH to coordinate the donation, collection, and storage of umbilical cord blood from newborns

*Senate Enrolled Act 327 requires written notice for the parents of sixth grade girls, informing them about the connection between cervical cancer and the human papillomavirus. Also informs about vaccinations

*House Enrolled Act 1237 will require nearly all motorists in the state to wear seat belts, including those riding in back seats, pickup trucks and SUVs

*Senate Enrolled Act 9 will let local governments restrict or ban the use of fireworks except on New Year's Eve, New Year's Day and an 11 day period around July 4

*House Enrollment Act 1027 will tie Indiana's minimum wage to the federal minimum wage

*House Bill 1116 which requires emergency procedures training for teachers. Teachers will have training in cardiopulmonary resuscitation (CPR), removing obstructions to a person's airway, and the Heimlich maneuver before obtaining an initial license as a teacher

*Senate Bill 0207 Requires the state department of health, in regards to Medical adverse events reporting, to enter into an agreement with an agency to collect, analyze, interpret, and disseminate findings on a statewide basis until June 30, 2010, regarding patient safety

*House Bill 1457 reauthorizes the Indiana Birth Defects and Problem registry for 10 more years and establishes the prenatal substance use commission to develop and recommend a coordinated plan to improve early intervention and treatment for pregnant women who abuse alcohol or drugs or use tobacco. It also requires the first meeting of the commission shall be convened before October 15, 2007.//2008//

/2009/ New state laws signed by Governor Daniels

****HB1113 - Birth certificate fraud. Digest: Increases from a Class A misdemeanor to a Class D felony the penalty for: (1) making a false or fraudulent statement when applying for a birth certificate or when applying for permission to inspect birth records; (2) altering, counterfeiting, or mutilating a certified copy of a birth certificate; or (3) using an altered, counterfeit, or mutilated copy of a birth certificate.***

****HB1171 - Autism training for EMS personnel. Digest: Requires certified emergency medical services (EMS) personnel to successfully complete a course of education and training on autism beginning January 1, 2009. (The introduced version of this bill was prepared by the Indiana commission on autism.)***

****HB1172 - Various professions and occupations. Digest: Codifies the uniform emergency volunteer health practitioners act to provide a procedure for recognizing other states' licenses for health practitioners who volunteer to provide assistance during an emergency requiring significant health care assistance. Requires the office of the secretary of family and social services to form a nonprofit corporation to establish and operate an umbilical cord blood bank. Requires the nonprofit corporation to establish an umbilical cord blood donation initiative to promote public awareness concerning the medical benefits of umbilical cord blood. Amends the locations in which a dental hygienist may practice under direct supervision, prescriptive supervision, and without supervision of a dentist. Establishes requirements for a dental hygienist to administer local dental anesthesia. Requires a dental assistant to work under the direct supervision of a dentist. Specifies certain procedures that may and may not be delegated to a dental assistant. Establishes licensing and continuing education requirements for marriage and family therapist associates, and requires emergency rules for the implementation of the licensure. Requires the office of Medicaid policy and planning to receive approval to cover umbilical cord transplants under the Medicaid program. Makes conforming changes. Requires the health finance commission to address domestic violence programs. Repeals a provision that abolishes and transfers the rights, powers, and duties of the state board of examination and registration of nurses.***

****HB1266 - Priority for receiving services under Medicaid waivers. Digest: Requires the office of Medicaid policy and planning to apply to the United States Department of Health and Human Services to amend certain waivers to allow specified individuals to be given priority in receiving services under the waiver.***

****SB0026 - Smoke detectors in rental properties. Digest: Makes it a Class B infraction if a landlord fails to: (1) properly install a smoke detector at the time a tenant moves in; or (2) repair an inoperative hard wired smoke detector within seven days of receiving notice of the need for repair. Increases the penalty to a Class A infraction for a subsequent offense. Provides that a landlord and a tenant may not waive the requirement that a smoke detector be installed in each rental unit. Requires a tenant to replace batteries as needed in a battery operated smoke detector and to provide written notice of any malfunctions of a***

hard wired smoke detector to the landlord. Permits a fire department to inspect a private dwelling upon the request of the owner or primary lessee who resides in the dwelling.

**SB0028 - Fire safe cigarettes. Digest: Establishes reduced ignition propensity standards for cigarettes. Authorizes the state fire marshal, the department of state revenue, and the alcohol and tobacco commission to monitor and enforce the standards. Provides for certification fees and penalties. Establishes: (1) the reduced ignition propensity standards for cigarettes fund; and (2) the fire prevention and public safety fund.*

**SB0042 - Human services. Digest: Adds the determination of whether a managed care organization that has contracted with the state to provide Medicaid services has performed the terms of the contract to the duties of the select joint commission on Medicaid oversight (commission). Extends the expiration of the office of the secretary of family and social services (office), certain divisions within the office, and the office of Medicaid policy and planning until January 1, 2010, and provides that actions taken after December 31, 2007, by the office, certain divisions within the office, and the office of Medicaid policy and planning are legalized and validated to the same extent that the actions would have been legal and valid if they had been taken before January 1, 2008. Requires certain managed care organizations participating in the Medicaid program to: (1) be accredited by the National Committee for Quality Assurance within certain timeframes; and (2) accept electronic claims for payment.*

**SB0143 - Childhood lead poisoning prevention. Digest: Specifies certain requirements for laboratories, the state department of health, local health departments, and retail establishments related to childhood lead poisoning prevention. Provides for certain actions by the state department of health for noncompliance with certain provisions. Establishes the childhood lead poisoning prevention fund for outreach and prevention activities. Establishes a lead-safe housing advisory council to make recommendations related to lead poisoning prevention. Requires an interim committee to study issues related to childhood lead poisoning prevention. (The introduced version of this bill was prepared by the health finance commission).*

**SB0156 - Communicable disease rules. Digest: Specifies that the state department of health may adopt emergency rules concerning communicable diseases. (The introduced version of this bill was prepared by the health finance commission).*

**SB0157 - Opioid treatment programs. Digest: Changes the term "methadone treatment" to "opioid treatment" for purposes of the law concerning certification of opiate addiction treatment facilities. Requires approval and certification for each location that an opioid treatment program is operated. Requires an opioid treatment program to: (1) periodically and randomly test a patient for the use of specified drugs; and (2) take certain actions if the drug test is positive for an illegal drug other than the drug being used for the patient's treatment. Requires the division of mental health and addiction to adopt rules on: (1) standards for operation of an opioid treatment program; (2) a requirement that the opioid treatment facilities submit a current diversion control plan; and (3) fees to be paid by an opioid treatment facility. Requires the division to create a central registry and prepare a biennial report. Specifies violations and penalties. Repeals the expiration of current law requiring a methadone diversion control and oversight program.*

**SB0164 - Human services matters. Digest: Specifies that eligibility for the children's health insurance program is limited to a child whose family annual income is not more than 300% of the federal income poverty level or the maximum percentage approved by the federal government if the approved percentage is less than 300%. Requires the health finance commission to study during the 2008 interim the feasibility and costs of allowing individuals who meet certain requirements to participate in the Indiana check-up plan without state funding for the coverage.*

**SB0249 - Emergency medical services commission. Digest: Requires the emergency medical services commission to adopt rules concerning the triage and transportation protocols for the transportation of trauma patients.*

**SB0315 - Aging and long term care services. Digest: Provides that a person who has made certain asset transfers is not eligible for residential care assistance. Requires the adoption of rules to implement: (1) a screening and counseling program for individuals*

***seeking long term care services; (2) a process of prior approval for certain individuals seeking admission to a nursing facility; and (3) the annual review of Medicaid rates.
//2009//***

Governor Daniels formed a Hoosier Health Care Cabinet, a group of state employees with backgrounds in health care delivery and financing. Cabinet members include Family and Social Services Administration (FSSA) Secretary Mitch Roob, State Health Deputy Commissioner Mary Hill, FSSA CFO Dick Rhoad, FSSA Director of Health Policy for Medicaid Jeanne LaBrecque and FSSA Chief of Staff Anne Murphy. The direction for this group is not yet available./2007/ The Health Cabinet has overseen several projects such as: integration of public health principles into the delivery of quality healthcare to Medicaid recipients; systems evaluation to improve lead screening rates; rebuilding the service delivery model for children with developmental disabilities through coordination of education, public health, and human services resources; statewide leadership on the development of interactive electronic health information capabilities, with emphasis on security and privacy issues, as well as clinical messaging; and Removing regulatory impediments to the development of local traumatic brain injury facilities, as well as respite care facilities for families with disabled children./2007//

Gov. Daniels announced a new statewide program to help Hoosiers find and apply for programs providing free or lower cost prescription drugs. The program will expand on a privately run program in southern Indiana. The Evansville program allows people to access low-cost prescription drug programs by inputting basic information into a computer web site. The system searches for the best discount program and provides the application. Concerned that only one in 10 people who are eligible for such programs take advantage of them, the governor hopes "Rx for Indiana" will bolster those numbers. "Rx for Indiana" will offer information on more than 2,400 drugs and more than 300 discount programs, including those run by pharmaceutical companies and the state. The site, www.rxforindiana.org, includes a Spanish-language version and a toll-free number, (877) 793-0765, which has Spanish-speaking operators to help guide the individual through the application process./2007/ Over 98,000 Indiana residents accessed the Rx for Indiana website with 74% initially qualifying for assistance./2007//

ISDH CURRENT PRIORITIES and INITIATIVES

Indiana State Department of Health (ISDH) is charged with central planning and regulatory development and administration for all health care delivery in Indiana and with improving the overall health of the population through education, advocacy and program support. Indiana's 94 local health departments operate independently from ISDH as arms of local or county government. Many local health departments receive grants from ISDH Maternal and Children's Special Health Care (MCSHC), the division charged with carrying out the goals of Title V of the Social Security Act.

Indiana has a mix of for-profit and not-for-profit hospitals and a broad array of local clinics, many of which are also ISDH MCSHC grantees. Additionally, MCSHC contracts with a number of consulting groups, media services organizations and universities to provide planning, educational and public information programs to advance maternal and child health in the state.

STATE HEALTH PERFORMANCE PLAN

Indiana State Department of Health (ISDH) issued the 2005 State Health Performance Plan (SHPP) that set priorities in two areas: Health Status and Health Systems. Health Status Goals: Chronic Disease (heart disease, cancer, diabetes, asthma, hypertension), Infant mortality and prematurity, Minority health disparities, and Obesity. Health Systems Goals: Access to primary care (particularly for underserved populations), Health care quality (Regulation, Promoting evidenced-based medicine and best practices) and Public health infrastructure (Staffing {number, skills/training, age}, Budgets, Communication and Information Technology).

The following sections from the SHPP outline priorities for which MCSHC is partly or primarily responsible.

The SHPP identifies baseline chronic disease levels in Indiana and sets goals for 2010 in relation to the Healthy People 2010 goals. These goals include both total disease indicators and weighted indicators for Black and Hispanic populations. SHPP notes a 2002 baseline of 1.3 asthma-related deaths per 100,000 among children age 0-14 and a goal of 1/100,000 by 2010. For Black children, the 2000 baseline is 6.3 deaths per 100,000 with a 2010 goal of 3.8/100,000. ISDH Priority Goal: Reduce asthma morbidity and mortality rates in Indiana.

SHPP shows a 2002 baseline of 7.6 infant deaths in 1,000 (6.5 white, 15.6 black), 9.4% prematurity (9% white, 12.5% black) and 7.6% low birth weight (6.9% white, 12.9% black). ISDH Priority Goal: Decrease Indiana's infant mortality and prematurity rates.
/2008/ 2003 infant mortality rate was 7.3 per 1,000 (6.5% white, 14.2% black) //2008//

Obesity in Indiana is epidemic. SHPP notes 61.3% of adults are overweight and 26% obese (2003). Among high school students, those rates are 25.7% and 14.2%. ISDH Priority Goal: Decrease the percentage of overweight and obese persons in Indiana.

/2007/ In July of 2005, Governor Daniels initiated INShape Indiana, a statewide web-based health initiative. INShape Indiana is designed to help Hoosiers make healthy lifestyle choices. The INShape Indiana website includes a clearinghouse of information on programs, activities, and events from all over the state related to nutrition, physical activity, and tobacco cessation, a bi-weekly tracking mechanism that allows individuals to monitor their progress towards a healthier lifestyle, and the opportunity to celebrate individual and group success stories and serve as healthy role models for other Hoosiers. INShape Indiana promotes personal responsibility for health behaviors while promoting good nutrition, smoking cessation and increased physical activity. All MCSHC grantees are required to incorporate activities and information about INShape Indiana into their project activities.//2007//

Agency Priority Goals are to: Increase the number of minorities entering the field of public health; develop a more culturally competent workforce; enhance access to primary care; promote and improve the quality of health care provided by Indiana health care providers; and improve Indiana's public health care infrastructure./2007/New ISDH agency priority goals which all grantees must include are: Data driven efforts for both health conditions and health systems initiatives that are effective, efficient, provide timely data collection, and ensure evidence based results; Promote INShape Indiana -- this includes agency wide participation and engagement of all components of communities and collaborative partners; Integration of medical care with public health: Preparedness -- Planning and training for poised and effective response to threats that cannot be prevented.//2007//***2009/In 2007, the Indiana State Department of Health initiated a Public Health System Quality Improvement Project. The overarching goal of this program is to educate the public health workforce on the 10 Essential Public Health Services, and to begin preparing public health agencies for voluntary national accreditation, which is scheduled to be available beginning in 2011. This accreditation will be largely based on the 10 Essential Services. A State Accreditation Task Force has been established and other individual work teams have also been formed to address various issues that were identified in assessments that took place in 2007.//2009//***

TITLE V PRIORITY SELECTION

The MCSHC statewide needs assessment is the first step in determining priorities, identifying emerging issues and planning the development and delivery of Title V services.

ISDH MCSHC contracted with an epidemiologist to pull together information from 10 regional epidemiologists in the State's Public Health Preparedness program, along with other statistical information and data generated by other consultant contractors to create the 2006-2010 MCSHC

Needs Assessment. Below is an overview of those findings not previously detailed in the SHPP above.

Rates of overweight and obesity increased in Indiana from 1999 to 2002, mirroring national trends. Currently, more than 60% of Indiana's population is overweight, with more than 25% obese. These rates are slightly higher than national averages.

Only 42.8% of Indiana women were normal weight before pregnancy in 2001. According to the CDC Pregnancy Nutrition Surveillance System of pregnant women participating in WIC, 13.4% were overweight, 29.2% were very overweight, 9.7% were underweight and 4.9% were very underweight.

Pregnancy rates among Indiana women age 20 and less decreased from 3.2% in 1999 to 2.6% in 2002. Black teenagers are 2.5 times more likely to become pregnant than white teenagers. /2008/ The percent of births to women less than age 20 was 11% in 2003.//2008//

Between 1999 and 2001, the number of induced pregnancy terminations in Indiana decreased by 1.94% to a total number of 11,281 pregnancy terminations in 2001. /2008/ There were 10,036 induced pregnancy terminations in Indiana in 2004.//2008//

Indiana's 2002 birth rate was 1.38%, below the national average of 1.39%. /2007/ Indiana's 2003 birth rate was 1.40%, below the national average of 1.41%.//2007//

In 2002, there were 40 infant deaths due to SIDS in Indiana resulting in a SIDS age specific death rate of 47 per 100,000 live births. The Healthy People 2010 goal is to reduce the SIDS mortality rate to 30 per 100,000 live births. In whites SIDS is the third leading cause of death with age specific death rate of 45.3 per 100,000 live births (n=33) where as in blacks SIDS deaths ranked 5th (n=14) after short gestation/low birth weight disorders, congenital defects, accidents, and maternal pregnancy complications. /2008/ In 2004, there were 42 infant deaths due to SIDS, resulting in a rate of .48 per 1000 live births. Of the 42 infants, 32 were white infants and 8 were black infants. //2008// ***2009/Trend analysis in yearly infant mortality rates due to SIDS in Indiana between 1990 and 2006 reveals a consistent decline between 1993 and 2002 whereas mortality rates due to combined SIDS, other SUIDs, and unknown cause ceased to decline past 1998. It was concluded that the more recent decline in SIDS rate and increase in Accidental Suffocation and Strangulation in Bed (ASSB) rates (after 1998) were likely not a true decline in SIDS or increase in ASSB, but due to changes in the ways these infant deaths were being reported and classified. Percent distribution of infant deaths due to sudden infant death syndrome (SIDS), other sudden unexpected infant deaths (SUIDs), and unknown cause in selected counties during 1999-2006 shows that Allen County had the highest infant mortality rate due to SIDS (104.4) compared to Marion County with the lowest infant mortality rate due to SIDS deaths (38.5). Indiana, Washington State, and Washington D.C. were chosen to be a part of the collaboration with the Gates Foundations and First Candle to provide baby cribs to at risk families to decrease Postneonatal deaths due to unsafe sleeping arrangements. This five year program will include provider and consumer education, distribution of cribs to at risk families through county coalitions, and an evaluation component on the efficacy of the program in reducing SUIDS due to unsafe sleep environments. //2009//***

At 19.1% in 2002, Indiana had the 6th highest maternal smoking rate among 49 reporting states. This rate is higher among whites than blacks. While Indiana has seen a steady decrease in this rate, it is unlikely the state will reach the HP2010 goal of no more than 1%. /2007/ In 2003 the maternal smoking rate decreased to 18.5%.//2007//

However, results from the 2004 Indiana Youth Tobacco Survey show that the percentage of

children who smoked in grades 6 through 8 dropped to 7.8% from 9.8% in 2000. In grades 9 through 12, the percentage of smokers dropped to 21% from 32% in 2000. Nationally, 22.3% of high school students and 8.1% of middle school students said they had smoked cigarettes last year, according to CDC.

Indiana's infant mortality rate of 0.76% (7.6/1000 live births) in 2002 was higher than the national average of 7/1000. Of the total 649 infant deaths in Indiana in 2002, 68% occurred during the first 28 days of life. The remaining 32% were between 28 and 365 days. White infant mortality was 6.5 while black infant mortality was 15.6 (2.4 times the rate for white infants)./2007/In 2003 the infant mortality rate was 7.3/1000 live births, higher than the national average of 6.85. White infant mortality remained at 6.5, while black infant mortality decreased to 14.2./2007//

Racial and income-based disparities exist in nearly all health statistics with low-income women and women with less than high school diploma or GED experiencing higher rates of asthma, obesity, diabetes and heart disease and experiencing these problems at earlier ages. Despite concerted efforts, the black infant mortality rate remained about 2.5 times higher than the white in Indiana. The vast majority - 89% of Indiana's population is white. However, minority populations are growing faster than the white population with the highest growth rate (62%) among Asians

According to the 2003 US National Immunization Survey, Indiana has remained above the national average for percentage of children vaccinated for most individual antigens and all vaccination series.

In 2002, 15.7% of Indiana households had at least one child with asthma. According to the Office of Medicaid Policy and Planning (OMPP), of 23,161 children, age 0-17, enrolled in Medicaid in 2003, 10% had an emergency room visit with principal diagnosis of asthma and 4% were hospitalized for asthma. Asthma is the most common diagnosis among children enrolled in CSHCS.

Between 1999 and 2003, Allen, Clinton, Elkhart, Lake, Marion, St Joseph and Wayne Counties had the highest number of children with elevated blood lead levels. Except Elkhart, these counties have percentages of children living below poverty well above the state average of 14.4%. In 2003, the Childhood Lead Poisoning Program indicated that 2.9% of 31,413 children screened had elevated blood levels./2007/Currently only Marion County requires the testing of a home where a child has been lead poisoned. No county in Indiana requires testing of housing units built before 1950 prior to being rented./2007//

Indiana Attorney General, Stephen Carter, has provided a letter of support to all local health departments and cities applying for lead poisoning prevention and abatement grants indicating an aggressive stance to require landlords to reduce lead paint hazards and pursuing legal expenses in cases requiring court action.

Use of protective dental sealants among Indiana children increased by 13.5% from 1999-2003. Further data indicates sealants are increasing among all races. At 47.2% in 2002, Indiana was very close to the HP 2010 goal of 50% of children receiving protective dental sealants./2007/ 46% of third grade children had at least one permanent molar tooth treated with a protective sealant in 2005./2007//

The leading causes in Indiana's 2002 adolescent death rate of 83.2/100,000 were unintentional injury 43.9%, homicide 14.5% and suicide, 13%. Homicide was the leading cause of death for black adolescents in Indiana, accounting for more of the 147.65/100,000 death rate than all other causes combined.

/2008/ In 2004, Homicide claimed 91 Indiana citizens ages 15-24; of those, 59 were black individuals and 32 were white. Suicide claimed another 89, with blacks accounting for 8 deaths and whites for 77./2008//

From 1999 - 2003, reported cases of child abuse fluctuate between 3,620 and 4,415. Neglect cases rose to 15,634 in 2000 and tapered to 12,308 in 2003. However, a number of high profile cases during the election of 2004 have placed attention on this issue. Governor Daniels campaigned with a promise to separate child protective services from FSSA./2007/In 2004 there were 24,995 reports of abuse and/or neglect with 57 substantiated fatalities. The Department of Child Services (DCS) was established in January 2005 by an executive order of the Governor to better care for children by providing more direct attention and oversight in two critical areas: protection of children and child support enforcement. The DCS protects children and strengthens families through services that focus on family support and preservation. The department administers child support, child protection, adoption and foster care throughout the state of Indiana./2007//

Self-reported monthly alcohol use among high school seniors has dropped from 51.7% to 46.1% from 1999-2003, mirroring national averages. Marijuana and psychedelic consumption has also dropped. Cocaine use remained at 2.5% among Indiana adolescents in 2003, above the national average. Inhalant use also increased among younger adolescents./2007/The 2005 Youth Risk Behavior Surveillance System showed an increase from 12.9% in 2003 to 14.1% in 2005 for inhalant use. Teen age alcohol consumption within the past 30 days decreased to 41.4% in 2005 from 44.9% in 2003./2007//

DEVELOPMENT OF PRIORITIES

ISDH MCSHC determines priorities based on the following considerations: health and capacity data; priority survey data; state health plan; MCH objectives; and what other organizations are doing statewide. Priorities must meet the following criteria: ISDH must be able to address the problem; solutions must be feasible; resources must be available; and the problem must fit with purposes of Title V, Healthy People 2010, and the Governor's priorities. ISDH MCSHC addresses priorities through commitment of funding, staff time and working to focus the efforts of ISDH and other agencies on those priorities. MCSHC continuously evaluates programs and monitors emerging issues through staff effort and contracts with consultants to conduct needs assessment, project evaluation, public hearings, focus groups, surveys and analysis. /2007/MCSHC has developed a Priority Health Need for the MCH population for 2006-2011 to increase the rate of maternal smoking cessation and reduce the rates of domestic violence to women and children, child abuse and injury in Indiana. In 2003, domestic violence, caregiving stress and poverty were the top 3 challenges Central Indiana women faced. MCHSC will contract with the Indiana Coalition Against Domestic Violence to conduct a series of workshops entitled "Improving the Healthcare Response to Domestic Violence in Indiana". Indiana's infant death rate has ranked near the top nationally over the 1999-2003 period, with an infant injury related death rate nearly twice the national average. During 2003 Indiana ranked first in the nation in unintentional suffocation deaths of infants less than 1 year of age with a rate of 46.47 per 100,000. //2007//

B. Agency Capacity

B. Agency Capacity

In the State of Indiana, the Title V program is administered through the Maternal & Children's Special Health Care Services division (MCSHC) of the Indiana State Department of Health (ISDH) Human Health Services Commission. MCSHC manages a number of funds from federal and state sources including Title V for an estimated total allocation of \$35,832,070 for FY 2005. Additionally, most MCSHC grantees leverage local resources to provide a required 30% match to grant funds. MCSHC extends the capacity by outsourcing services to local entities.

MCSHC provides funding for projects in all levels of the MCH Pyramid. MCSHC staff is directly involved in infrastructure building within ISDH, among other state agencies, and among non-state agencies. Through the Title V Block Grant Federal/State Partnership, MCSHC funds agencies to provide direct medical services for women of childbearing age, pregnant women, infants, and children and acts as payer of last resort for primary and specialty care for children with special

health care needs (CSHCN). These grantees/contractors also provide enabling services (such as care coordination) to prenatal clients and to families of CSHCN. MCSHC also creates and implements population-based education on topics like adolescent pregnancy prevention. See Narrative Part C for a detailed list.

MCSHC staff interface with state physician and dental organizations, Office of Medicaid Policy and Planning (OMPP) and other managed care insurers (especially those working with low-income populations), laboratories that run the newborn screens and meconium screens, not-for-profit groups that are working toward the same improved health outcomes as ISDH MCSHC and other state agencies to coordinate and assure that quality health care is available. MCSHC also monitors statistics for Indiana's Health Status Indicators (HSI) and health outcomes and shares this information with the public.

ISDH is the statutory authority for Maternal and Child Health (Title V) programs, receiving state funds to match Title V funding. By statute, ISDH also operates through MCSHC the following state programs: Children's Special Health Care Services (CSHCS), Newborn Screening and Follow-up, which includes Sickle Cell Education, Screening for Drug Afflicted Babies, Adolescent Pregnancy Prevention, follow-up and education, Universal Newborn Hearing Screening, and the Indiana Birth Defects and Problems Registry.

MCSHC provides information, referral and assistance to Indiana citizens statewide through the Indiana Family Helpline (IFHL). The IFHL helps families and individuals access social and health services for mothers, children and families through telephone and e-mail contact. The IFHL has bilingual employees, uses the ATT Language Line, as well as a TTY line to better serve the hearing impaired. The IFHL is obtaining Alliance of Information & Referral Services accreditation to qualify to become a 211 Information and Referral (I&R) call center for some Indiana counties.

Genomics / Newborn Screening Program goals include increasing public and professional awareness of genetics, assuring access to services, enhancing genetic data collection statewide and improving the quality of the birth defects surveillance system. MCSHC funded projects offer genetic testing, evaluation and counseling, and prenatal diagnosis through support of five regional genetics projects that sponsor clinics in thirteen sites. The Genomics Program Director offers consultation to these and nine (seven non-funded and two state funded) additional Genetics Centers/Programs in Indiana. Genomics also facilitates the Folic Acid Initiative, sponsored by Title V and WIC, a population-based education effort and "Genetics and Your Practice," sponsored by MCSHC and March of Dimes, a professional training opportunity. ***/2009/ Beside the five state funded Genetic Centers, there are now ten additional Genetic Centers/Programs in Indiana that do not receive state funding. The Folic Acid Initiative Campaign concluded in 2007 after the Genetics Implementation Grant was completed, but members of the Folic Acid Task force constructed a new educational module entitled "Working to Prevent FASDs Through High School and Middle School Curricula". The "Genetics and Your Practice," training opportunity is no longer sponsored by the Genomics program. On October 1, 2007 Cystic Fibrosis (CF) was included in the state newborn screen. With the addition of CF, Indiana became the 15th state to screen for all 29 target newborn screening conditions recommended by the March of Dimes. Every newborn in Indiana will now be screened for a total of 45 conditions. //2009//***

MCSHC capacity to expand data integration and ISDH program integration was enhanced with receipt of the Genetics Implementation Grant (GIG) in September 2002. Through this grant, the MCSHC Genomics program assists with newborn screening, birth defect and other chronic disease data integration, as well as establishment of medical home, folic acid and genetics education for professionals and consumers. The scope of MCSHC Genomics includes adult chronic diseases and general genetics education and bridges the perinatal and child health services. The Genomics program strives to increase the awareness and understanding of genetic conditions and ensure that all of the approximate 5,000 infants born in Indiana each year with birth defects or genetic conditions have access to genetic services./2007/GIG funding has

concluded, but most of the programs initiated with GIG funds have been continued with other resources under the MCSHC Genomics and Newborn Screening Program. A one year extension at no additional cost has been requested to continue Medical Home training and to complete the Indiana Birth Defects and Problems Registry (IBDPR).*//2007// /2009/ The GIG grant has been completed for two years. IBDPR is supported through a dedicated birth certificate fee & medical home training is now a focus of the MCSHC Integrated Service Manager.//2009//*

Genomics collaborates and coordinates with regional genetic centers (both state sponsored and private providers of genetic services), as well as local agencies, individual providers, hospitals, health departments, the Indiana Perinatal Network (IPN), and the Indiana Chapter of the March of Dimes and builds public health genetics capacity within ISDH. Genomics also houses the Indiana Birth Defects and Problems Registry (IBDPR).

1. Pregnant Women, Mothers and Infants

MCSHC provides the Free Pregnancy Test program, a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The goals of the program include: (1) helping pregnant women obtain early prenatal care, Hoosier Healthwise, and WIC; (2) encouraging women to obtain a high school diploma or GED; (3) decreasing infant mortality and morbidity and the incidence of low birthweight; (4) assisting local communities and grantees to assess for service gaps for planning of future programs; and (5) assisting non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Through this program, MCSHC has developed an infrastructure of agencies that focus on women of childbearing women age and has created an ongoing database for assessment and evaluation of services offered and needed by sexually active, low-income women. Currently, the Free Pregnancy Test program is available in 63 counties. *//2009/The Title V funded Free Pregnancy Test program (FPT) is available in agencies in 58 counties. Agencies that participate must submit demographic data to MCSHC in exchange for receiving the free test and they may not charge the client. Many family planning and other agencies also provide pregnancy tests at low or no cost to the client. Some have chosen not to participate in the FPT program because of the data submission and the low cost of pregnancy tests in general. This program is being evaluated to determine its success.//2009//*

MCSHC provides preventive, primary care, and enabling services for pregnant women, mothers and infants including prenatal health care services through grants to 13 agencies to promote direct prenatal medical services, as well as funding 23 prenatal care coordination projects. The primary objective of these grants is to decrease infant mortality and low birthweight by providing quality, comprehensive, holistic health care to low-income pregnant women in community settings. MCSHC funded prenatal care coordination programs to develop and coordinate access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients. The direct medical and enabling services target pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCSHC staff also trains and certifies community health workers to assist prenatal care coordinators. MCSHC collects, analyzes and disseminates perinatal outcomes to communities to ensure that the planning and delivery of perinatal health care services meet the needs of the population.

MCSHC develops and enhances capacity to promote and protect the health of all mothers, children and families through Thirteen family care coordination projects that provide enabling services to facilitate a seamless delivery of services for mother and children through outreach, assessment, care planning, advocacy, referral, education and counseling on health behavior risk reduction during both clinic and home visits with the family. Goals are to improve utilization of EPSDT services, immunization service, and primary care providers, and to empower families with

education and support to access health, education, and social services they need.

MCSHC provides Family Planning and Women's Health Services through 11 local grantee agencies. The Indiana Family Health Council (Indiana's Title X agency) is contracted to provide clinic monitoring and standards of care for these grantees. /2007/Beginning in 2007, if approved, MCHSC will provide all Title V Family Planning through IFHC, blending Title V and Title X Family Planning programs. //2007//**2009/ All Title X and Title V Family Planning funds are provided through a contract with the Indiana Family Health Council (IFHC). //2009//**

The Prenatal Substance Use Prevention Program (PSUPP) is funded through a grant from FSSA Division of Mental Health and Addiction (DMHA) and supplemented with Title V Federal -- State Block Grant Partnership and funds from Indiana Tobacco Prevention and Cessation (ITPC). PSUPP works to prevent birth defects, low birthweight, premature births, and other problems associated with prenatal substance use. There are three primary objectives: (1) identify high risk, chemically dependent pregnant women, provide perinatal addiction prevention education, promote abstinence, provide referrals for treatment, and follow-up; (2) facilitate training and education for professionals and paraprofessionals who do not provide substance abuse treatment, but do work with women of childbearing age, on how to identify high risk, chemically dependent women; and (3) provide public education on the possible hazards to a fetus when alcohol, tobacco, and other drugs are used during pregnancy. Free posters, brochures, and other materials are available upon request through the Indiana Family Helpline. MCSHC supports enabling services for drug use cessation through 15 grantees. In addition, the PSUPP Director builds professional capacity through professional training. This program also interfaces with smoking cessation efforts with prenatal services and ISDH by providing public education. /2009/**MCSHC continues to support enabling services for alcohol, tobacco and drug (ATOD) use cessation. In addition, the PSUPP Director builds professional capacity through professional training. This program interfaces with smoking cessation efforts with prenatal services and ISDH by providing public education. During FY2008 MCSHCS screened 4,540 women. //2009//**

MCSHC Newborn Screening facilitates newborn screening and follow-up programs including metabolic screening, sickle cell follow-up, hearing screening programs, and meconium screening to test for drug-afflicted babies. Newborn screening is performed on every infant born in Indiana. The program is funded by a \$62.50 fee for each infant screened collected from each birthing facility by the central testing lab under contract with ISDH MCSHC. The contractor remits \$30.00 of each fee to ISDH and retains the balance to pay for laboratory and collection services. Indiana University Medical Center Newborn Screening Laboratory (IU NBS Lab) is the laboratory designated by the Indiana State Department (ISDH) for processing specimens. /2009/**In October 2007, Cystic Fibrosis (CF) was added to the list of disorders that Indiana screens for in the newborn screen. An ISDH CF follow-up program, headed by a professional program director, was developed to ensure that all children that screen positive for CF receive the appropriate follow-up care. The addition of CF to the NBS, led to an increase in lab costs. The central testing lab now collects \$82.50 for each infant screened. According to the new contract with the lab, which goes into place July 1, 2008, the fee will increase to \$85.00 for each infant screened. ISDH will still receive \$30.00 for each infant screened. //2009//**

A blood test (by heel-stick) is done on all infants shortly after birth to test for 39 metabolic or genetic disorders. Follow-up is done to obtain repeat screens on all abnormal and unsatisfactory screens. If further follow-up is needed, the Newborn Screening Section requests assistance from the local Public Health Nurse. Infants that have a positive screen for one of the designated genetic disorders are referred to the Metabolic Specialist or the Endocrinologist at the Indiana University Medical Center. The ISDH NBS Section works collaboratively with IU NBS Lab, Sickle Cell Program, and the Genomics Program to ensure follow-up and treatment for all infants diagnosed with one of the designated disorders. /2009/**The blood test performed shortly after birth now screens for 45 metabolic and/or genetic disorders. //2009//**

The MCSHC Early Hearing Detection and Intervention (EHDI) program screens all infants born in Indiana for possible hearing impairments. Those found with hearing impairments receive early intervention and follow-up services. UNHS coordinates with Indiana First Steps Early Intervention Services, hospitals, providers, and other agencies to provide statewide implementation. The goals for infants that do not pass the hearing screening are to receive audiology evaluations by three months of age and to be enrolled in an appropriate intervention program by six months of age. MCSHC EHDI collects comprehensive monthly data via Monthly Summary Reports (MSR) from each of the 108 birthing facilities throughout the state of Indiana and is developing a web-based electronic reporting system to enhance hospitals, audiologists and early intervention coordinators in ensuring timely and accurate evaluation and follow up treatment. The program educates the public, including parents and primary care physicians of the importance of early detection and intervention and works in conjunction with the Indiana School for the Deaf to promote awareness and parent participation in the program./2009/ ***There are now 102 birthing facilities throughout the state of Indiana./2009//***

MCSHC funds programs for Sickle Cell and Other Hemoglobinopathies. This program provides penicillin, education, care coordination, and counseling for sickle cell clients in the state. There are four regional sites for the care coordination. The Indiana Hemophilia and Thrombosis Center, Inc. (IHTC) also provides sickle cell education to families statewide. This program provides education and consultation to primary and hospital emergency room providers about current therapy for sickle cell disease complications and educational materials to health care providers and patients' families. MCSHC supports the Parents Empowering Parents (PEP) program to assist families living with children with Sickle Cell Disease with parenting./2007/There are 5 regional sites for the care coordination./2007//

MCSHC also contracts with IHTC to provide outreach to Amish persons with bleeding disorders. The program provides home visiting, health care services, an annual health clinic and factor concentrate to those affected.

Indiana Birth Defects and Problems Registry (IBDPR) is a population-based surveillance system that seeks to promote fetal, infant, and child health, in order to prevent birth defects and childhood developmental disabilities, and to enhance the quality of life of affected Indiana residents. IBDPR collects data on all children in Indiana from birth to age three with congenital anomalies or disabling conditions and up to age five for children with fetal alcohol syndrome and autism. The information provided by the registry has the potential to uncover the environmental causes of defects, thus preventing future cases./2007/IBDPR sent 2003 data to Birth Defects Research, Part A, Clinical and Molecular Teratology, 2006 Congenital Malformation Surveillance Report, showing increased IBDPR capability. IBDPR is a separate program under the Genomics and Newborn Screening Program./2007//2009/***IBDPR continues to submit data annually to the Birth Defects Research Report./2009//***

The data collected for IBDPR is used to (1) detect trends in birth defects and suggest areas for further study, (2) address community concerns about the environmental effects on birth outcomes, (3) evaluate education, screening, and prevention programs and (4) establish efficient referral systems that provide special services for the children with identified birth defects and their families.

Indiana State Law requires a screening test for possible drug affliction in certain newborns. Hospitals and physicians are required to submit a meconium specimen for every infant who meets the selection criteria to test for Amphetamines, Cannabinoids, Cocaine and Opiates. MCSHC contracts with a central lab to provide this screening for the state. MCSHC keeps the data from this program but does not do tracking. Local hospitals and the physicians are responsible to refer the mothers and infants for appropriate treatment, social services and early intervention./2007/Due to newly enacted legislation, MCSHC is conducting a study of the impact of alcohol, drugs, and tobacco use among pregnant women, and available services and making

recommendations for improved services. The report will have input from other partners and is due to legislators by October 1, 2006.//2007// ***/2009/ The October 2006 report resulted in the formation of the Alcohol, Tobacco, and Other Drug (ATOD) Use During Pregnancy task force. This task force is currently in the process of developing a needs assessment.//2009//***

2. Children

MCSHC provides preventive and primary care for children through 15 grants to agencies that provide direct medical services and enabling services to children and 6 adolescent health care programs. Many of these grantees are community health centers or are a part of a larger health care facility. They provide direct health care services and health and safety education. Using AAP guidelines and Bright Futures, MCSHC has developed Standards of Care for children 0-21 years of age.

MCSHC administers the Indiana Child Care Health Consultant Program (ICCHCP) through funding provided by FSSA from the Child Care Development Block Grant. MCSHC contracts with an outside entity to provide health education and technical assistance to licensed and unlicensed child care providers serving children 0-8 years of age. ICCHCP is contracted to hire and/or subcontract, educate and supervise qualified community based child care health consultants, identify out-of-home child care providers and develop an infrastructure linking them with child care health consultants in their local community and to identify, recruit, educate, certify, and provide oversight to professional child care health consultants and health advocates. ICCHCP collaborates with other health and safety providers in the state and with injury prevention efforts within ISDH.//2008/In October 2007 the FSS Bureau of Child Care will integrate the Child Care Health Consultant Program into it's Quality Rating System. A Chief Nurse Consultant from MCSHC will continue to act as liaison with ISDH programs//2008//

/2009/ Paths to Quality is promoting high quality child care by providing training and resources to promote children's health and wellness in Indiana Child Care Centers. These educational services are provided statewide by five health professionals on topics such as immunization, communicable disease, sanitation, nutrition, physical activity, and medication administration.//2009//

MCSHC is developing Early Childhood Comprehensive Services (ECCS) through a grant from MCHB to plan a coordinated, comprehensive, community-based system of services for young children from birth through age five and their families. ECCS is a collaborative process across public and private organizations. Core Partners include ISDH, FSSA, Indiana Department of Education (IDOE), Indiana Department of Corrections (IDOC), Indiana Department of Environmental Management (IDEM), the About Special Kids (ASK) program, formally known as Indiana Parent Information Network (IPIN), Indiana Association for the Education of Young Children, Indiana Head Start Association, and Riley Hospital for Children/Child Development Center. Additionally, five Subcommittees were formed and met to address the project's five focus areas which include: access to health insurance and a primary medical provider; mental health and socio-emotional development; early care and education; parent education; and family support. An application for implementation funding with a strategic plan has been submitted to MCHB.//2007/The ECCS program is now known as Sunny Start: Healthy Bodies, Healthy Minds.//2007// /2008/ Social and emotional development in young children continues to be a focus of Sunny Start. After receiving final approval from the Sunny Start Core Partners, the Social and Emotional Consensus Statement described above was finalized. Currently, Sunny Start committee members are developing a tool to be used in conjunction with the Consensus Statement that will help individuals assess the social and emotional competencies that their training addresses. Finally, Sunny Start is sponsoring a comprehensive one week Summer Institute in July, 2007 which will help mental health professionals in Indiana build skills in the area of social and emotional development in young children, infants and toddlers. //2008//***/2009/ Work on Sunny Start this year included marketing the expansion of the Early Childhood Meeting Place(ECMP) website to pediatricians, family practice physicians, and their***

patients.//2009//

The Oral Health Director (OHD) which is now located in MCSHC Division and funded by Title V, focuses on education and prevention with a special emphasis on fluoridation. Oral Health staff provide technical assistance and surveillance to communities and schools with fluoridated water supplies. MCSHC supports the Oral Health community-based pit and fissure sealant program. This program's objectives include (1) promoting the use of sealants throughout Indiana and working toward the national health objective to have 50% of children with sealants by Year 2010, and (2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in community dental health programs. MCSHC continues to provide partial funding for the Indiana SEAL program, providing a mobile unit to bring these services to children across the state. ***//2009/ In May 2007, the Oral Health Program was relocated under the MCSHC Title V umbrella. The new Dental Director, M. Kent Smith DDS, RPh, was hired in December 2007, after serving 8 years as the Dental Director for Indiana's largest local health department in Marion County. In May of 2007, Rita Hope, RDH, MS, LCSW was transferred from the Office of Primary Care to the Oral Health Program (OHP) bringing community health center partnership experience and a background from a variety of dental settings. With input from oral health partners they are finalizing the draft of the Indiana State Oral Health Plan, which emphasizes increasing access to dental care for the underserved and working poor. Oral Health Program Staff (OHPS) is restructuring the ISDH Oral Health Task Force (OHTF) and the Dental Advisory Workgroup (DAW) from the Office of Medicaid Policy and Planning (OMPP) with more community representatives to facilitate quicker results in achieving goals of recruiting more dental professionals to be Medicaid providers and enhancing dental programs to those in need. //2009//***

In addition to their fluoridation efforts, Oral Health is the investigative authority regarding universal precautions and infectious waste management issues as they pertain to delivery of oral health services; legislatively mandated to annually survey a percentage of Indiana licensed dentists as to the effectiveness of the routine biological testing of their autoclaves; promotes the P.A.N.D.A. program (Prevent Abuse and Neglect through Dental Awareness) by providing educational presentations to local dental societies and organizations throughout the state; and provides educational materials relative to Oro-facial Injury Prevention, as requested. Additionally, MCSHC funds a grantee to provide a dental clinic for Amish children in northern Indiana to provide dental care, achieve optimal fluoridation, & increase awareness of oral health and disease. ***//2008/ In Spring 2007 the Oral Health Program was moved under the purview of MCSHC. The Fluoridation Program was moved to the Division of Consumer Protection at ISDH. A state Oral Health Plan will be developed in December 07//2008// //2009/Indiana has long been honored for its proactive fluoride program and even though the program has moved to the Consumer Protection Department, the OHPS continues to provide technical support especially for the 30 schools which receive supplements in their water systems. MCSHC continues to partially finance the IUSD SEAL Indiana program which also has a fluoride varnish component and OHPS also monitors and shares in the data from three other sealant-fluoride programs in the state. MCSHC funds and OHPS consult grant recipients on an Amish dental clinic, a craniofacial cleft lip/palate project, and a donated dental services program for the disabled. OHPS are collaborating with Indiana University School of Dentistry Tobacco Cessation Initiative to educate on best practices and bring dental professionals up to date in their approach to pregnant women and to youth who use tobacco. ISDH and OHPS were instrumental in state rule changes bringing Indiana up to CDC recommended spore testing guidelines from every 30 days to every 7 days which began January 2008.//2009//***

MCSHC Medical Director, Dr. Judith Ganser, coordinates Addressing Asthma from a Public Health Perspective in conjunction with Indiana Department of Environmental Management. The Asthma Program organized the Indiana Joint Asthma Coalition and developed a state Asthma

Plan. OMPP and ISDH provide an Asthma case management program for Medicaid clients./2007/The State Asthma Program is now fully staffed and beginning implementation of the state Asthma Plan. The Asthma Program resides in the Chronic Disease Division of ISDH./2007//**2009/ The Asthma Program is in it's 3rd year of implementation. The updated Burden Report is available, and the Indiana Joint Astma Coalition is developing it's own website. Projects are continuing with communities, health care providers, schools, and child care providers. //2009//**

The MCSHC Adolescent Health Program works to improve Indiana adolescent health status regarding six major health risks (see YRBS below) & to increase Indiana adolescent access to primary health care services. The State Adolescent Health Coordinator manages the Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT) program that includes sexual abstinence education and adolescent pregnancy prevention programming as well as providing programmatic consultation to five Title V funded school-based adolescent health centers. MCSHC works in collaboration with other public and private entities (including the American Legacy Foundation Statewide Youth Movement Against Tobacco Use) to design, develop, and implement statewide initiatives to improve adolescent health, and coordinates the collection of the Indiana Youth Risk Behavior Survey.

Indiana RESPECT uses State Adolescent Pregnancy Prevention funds and Federal Sexual Abstinence Education Block Grant funds to fund three components: (1) community grant program, (2) community grant program evaluation, and (3) a statewide media campaign. Specific grant applications solicit proposals for the distinct State and Federal funding programs. Grantees provide these programs in a variety of youth-serving organizations including schools, faith based organizations, and community organizations. Montgomery, Zukerman, and Davis, an Indianapolis advertising agency, will implement and measure the effectiveness of Indiana's statewide sexual abstinence and adolescent pregnancy prevention media campaign. Free broadcast-quality copies of the media materials are provided to local communities for local campaign initiatives and local media scheduling. Awareness and recall of the media campaign will be assessed by telephone surveys completed with Indiana teens and parents after each broadcast flight of the TV and radio spots./2008/Federal funding through the Abstinence Education Block Grant (AEBG) was discontinued on June 30, 2007./2008// **/2009/ The Federal Abstinence Education Block Grant was reauthorized for the fourth quarter of FY07 and on a quarterly basis for FY08 with funding currently set to terminate after the end of the third quarter, June 30, 2008. Authorization has yet to be determined for the fourth quarter of FY08. During FY08, Indiana RESPECT has partnered with the Department of Adolescent Medicine at the Indiana University School of Medicine to do an evaluation of the program specifically looking at the capacity of community-based grantees, curriculum being implemented for programming, and knowledge of participants in grantee programs through a survey./2009//**

MCSHC Youth Risk Behavior Surveillance System (YRBS) is part of a national survey effort by CDC to monitor student health risks and behaviors in six categories identified as most likely to result in negative outcomes. YRBS was designed to determine the prevalence of health risk behaviors among youth; to assess whether health risk behaviors increase, decrease, or stay the same over time; and to examine the co-occurrence of health risk behaviors. The categories in the survey include: Tobacco Use, Alcohol and Other Drug Use, Unintentional Injuries and Violence, Adolescent Sexual Behavior, Weight and Nutrition, and Adolescent Physical Activity. The survey provides comparable state, and national data, as well as comparable data among subpopulations of youth. Health officials can use the data to monitor progress towards achieving the U.S. Department of Health and Human Services' Healthy People 2010 objectives, as well as to guide health programs. The sample collected for 2003 and 2005 was large enough for a weighted analysis of the data./2009/ **The YRBS was successfully administered for 2007, giving a large enough sample for weighted data analysis. Indiana now has weighted data for years 2003, 2005, and 2007. The six categories of health behaviors of the YRBS were the focus of Indiana's first youth summit held in March 2008. The summit was attended by nearly 600**

students from throughout the state. The summit was sponsored in part by the Indiana Coalition to Improve Adolescent Health, which the State Adolescent Health Coordinator oversees. This coalition is comprised of individuals and representatives from organizations (schools, healthcare, youth-serving organizations, etc.) across the state who share the common goal of improving the health of Hoosier adolescents. The coalition is currently working to author the state's first adolescent health plan. This plan will make Indiana a leader in the field of adolescent health, as only a handful of other states have such a plan. The plan will identify 10 priority health issues in the areas of access to care and prevention that need to be addressed for the adolescent population in Indiana.//2009//

3. CSHCN

Within MCSHC, the Children's Special Health Care Services (CSHCS) program provides financial support for primary, preventive and specialty care, including physician and hospitalization for services due to the eligible diagnosis for CSHCN statewide. The Authorization Unit completes prior authorization for services from providers. Program staff assists clients with programmatic questions and facilitates the program's services and using the Indiana Family Helpline (IFHL) for referrals to other services. CSHCS and IFHL provide access to hearing impaired and non-English speaking clients through a TTY number and translation services available within IFHL. CSHCS provides regular training to County Offices of Family and Children (OFC) staff throughout Indiana regarding the use of CSHCS services and the Enrollment Form -- a common intake for CSHCS, First Steps and Medicaid used by OFC and First Steps. This training emphasizes identification of outreach to eligible children. The CSHCS Program reimburses Family & Social Services Administration (FSSA) for local OFC staff to take CSHCS applications, gather verifications, & send applications to ISDH for eligibility determination.//2007//CSHCS is beginning to implement in 2006, efforts to integrate service systems for CYSHCN. A new staff position will be created & a strategic plan developed.//2007///2008//The county OFC offices have been redesignated as county Division of Family Resources (DFR) offices. CSHCS reimburses FSSA for services involved in First Steps taking CSHCS applications, not for applications processed through DFR offices. //2008//**2009//In May 2007, a manager was hired for The Integrated Community Services Program (I.G.S.) to focus on efforts around integrating service systems for CYSHCN. In February 2008, the Community Integrated Systems of Services (C.I.S.S.) Advisory Committee was developed. The committee is a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs & 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 objectives of the C.I.S.S. Advisory Committee are to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve community-based service systems as defined by the following goals:1. Family/professional partnerships 2.Comprehensive health care through a Medical Home 3. Access to adequate health insurance 4. Early and continuous screening 5. Organization of community services for easy use by families 6. Transition to different life stages including adult health care, work & independence.//2009//**

The Hemophilia Program pays premiums for a state insurance program, the Indiana Comprehensive Health Insurance Association (ICHIA), for children and adults diagnosed with hemophilia or von Willebrand disease who meet the program criteria. As applicable, premiums are paid by CSHCS or Chronic Disease.

a. Rehabilitation

CSHCS coordinates with the Supplemental Security Income (SSI) program to inform SSI recipients & applicants about CSHCS. CSHCS receives referrals from SSI to provide services for blind and disabled individuals under age 16 and sends information about CSHCS to those SSI recipients not already enrolled. SSI enrollment data is collected by Systems Points of Entry (SPOE) data system in First Steps & by the CSHCS HIPAA compliant data collection system,

Agency Claims Administration Processing System (ACAPS), which tracks participation in SSI.

b. Community-Based Care

CSHCS customer service staff are trained insurance experts, assisting families through insurance procedures to maximize coverage and eliminate gaps in service. CSHCS works to link clients to local primary care providers and specialty providers, where possible. CSHCS works through the ASK program, formally known as the Indiana Parent Information Network, to provide assistance to families of children with special health care needs as well as to professionals to disseminate information on community resources and systems of care. ***2009/CSHCS customer service staff are trained insurance experts, assisting families through insurance procedures to maximize coverage and eliminate gaps in service. The CSHCS Care Coordination nurses work to link clients to local primary care medical homes and specialty care providers. They also assess the client and their family's strengths and needs and make community-based referrals to meet the needs./2009//***

CSHCS works with its community partner, About Special Kids (ASK), the place for families and professionals in Indiana to go to "ASK" questions about children with special needs and to access information and resources about a variety of topics such as health insurance, special education, community resources and medical homes.

4. Culturally Competent Care

MCSHC encourages all grantees (especially those in areas with large or growing minority populations) to work with local Minority Health Coalitions to develop culturally competent staff and materials. The ISDH Office of Cultural Diversity and Enrichment addresses the public health needs of minorities in Indiana by offering once a month two-day training session in cultural competency to all employees of ISDH and to local health professionals and grantee staff twice per month as well as a monthly advanced workshop. This office also distributes and analyzes a minority health disparity survey ISDH requires for all contractors. If contractors do not meet ISDH cultural competency goals, ISDH seeks alternate contractors. ***2009/ MCSHC will partner with Indiana Perinatal Network to provide three regional trainings on the "Matters of the Heart" cultural competency tool kit, and the "Learner Stance" program developed as a result of focus groups and town meetings./2009//***

The ISDH Office of Minority Health (OMH) works with state groups working with minority populations. These include Indiana Minority Health Coalition, IPN, and Indiana Latino Institute. ISDH OMH works with the Indiana Minority Health Coalition, Indiana University School of Medicine, Eli Lilly & Co., & others to increase the number of minorities drawn to health careers through scholarships, mentoring, early introduction of the health sciences, & additional preparation support. ***2009/MCSHC & the State Office of Minority Health have partnered to address disparities in the MCH populations, thru summits, presentations, Ind. Black Expo, & collaboration on state conferences./2009//***

C. Organizational Structure

Section III. State Overview

C. Organizational Structure

The Honorable Mitchell E. Daniels, Jr. (R) was sworn in Jan. 10, 2005 as Indiana's 49th Governor. Daniels replaces Joseph Kernan (D) after a hard-fought gubernatorial campaign. State Health Commissioner Gregory Wilson, M.D., resigned in January. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head the Indiana State Health Department. Monroe was director of the Primary Care Center and Family Medicine Residency Program at St. Vincent Hospitals in Indianapolis since 1992. She earned her medical degree from the University of Maryland and formerly worked as director of clinics with the Indiana

University School of Medicine's Department of Family Medicine. Commissioner Monroe will also serve as medical director for the state's Medicaid program. This marks the first time the two agencies responsible for regulating and paying for the health care of the state's residents have had a direct connection.

The Indiana State Department of Health (ISDH) is one of several major departments in state government. ISDH has four commissions overseen by the State Health Commissioner and Deputy Health Commissioner Sue Uhl, J.D., also appointed in February 2005./2008/Mary Hill R.N. Esq. was appointed Deputy Health Commissioner effective November 15, 2006./2008//

The Operational Services Commission oversees three special institutions: Indiana's Soldier and Sailor's Children's Home, Indiana Veterans' Home, and Silvercrest Children's Developmental Center. Operational Services also provides Finance, Facilities Coordination and other administration for ISDH. The new Senior Director of Finance, Lance V. Rhodes, manages this commission under the authority of the Deputy Commissioner./2007//ISDH closed the Silvercrest Children's Developmental Center in May 2006. Residents have been transitioned to rejoin their families or communities. A collaborative group of parents, advocates and state agency representatives has been meeting to develop a comprehensive community-based system of services for children with developmental disabilities./2007///2008/ This commission has taken on oversight of the WIC Program, Legal Affairs Office, Public Affairs, Utility Services, and Vital Records./2008//**2009/ In April 2008, MCSHC was realigned from the Human Health Services Commission, which was reorganized and renamed as the Public Health & Preparedness Commission on June 1, 2008, to the Operational Services Commission (OPS), along with the Offices of Minority Health, Women Infants and Children program, and Legislative Affairs. The Information Services and Policy Commission was also renamed and reorganized to the Public Health Systems & Development & Data Commission, which houses the Epidemiology Resource Center Data Analysis Unit, Public Health Systems Development & Data Program and the Policy & Grants Management Program. //2009//**

The Information Services and Policy Commission lead by Assistant Commissioner: Joe Hunt, M.P.H., houses Information Technology Services (ITS), Epidemiology Resource Center (ERC), ISDH Laboratories, External Information Services (EIS), Public Health Preparedness, Utility Services, Vital Records, Office of Policy, and Quality Improvement/Statistics./2008/ He is being assisted by Dr. Ted Bailey who has had much experience in laboratory medicine, public health, and preparedness./2008// **2009/In April 2008, Loren Robertson, M.S., R.E.H.S., Assistant Commissioner of Human Health Services, assumed the oversight responsibility of the Public Health Preparedness & Emergency Response Program, now renamed as mentioned in the preceding paragraph. Dr Ted Bailey changed responsibilities to head the Response Operations Commission which provides direct oversight of the LRC Microbiology Lab.//2009//**

The Health Care Regulatory Commission under Assistant Commissioner Terry Whitson, J.D., regulates Acute Care Facilities, Long Term Care Facilities, Consumer Protection, Medical Radiology Services, Sanitary Engineering, and Weights and Measures.

The Community & Family Health Services Commission houses MCSHC, WIC, Community Nutrition, Local Liaison Office with local health departments, Chronic/Communicable Disease, Immunization, Human Immunodeficiency Virus/Sexual Transmitted Disease (HIV/STD), Quality Improvement, Oral Health, and Primary Health Clinics. The new Assistant Commissioner is Loren Robertson, M.S., R.E.H.S., formerly Administrator of the Fort Wayne/Allen County Health Department./2008/ The name of the commission was changed to the Human Health Services Commission and WIC was moved to the Operational Services Commission./2008//**2009/ The MCSHC, as stated above was also realigned under OPS.//2009//**

MCSHC is responsible for administering and coordinating all parts of the Title V Block Grant for Indiana. The MCSHC Administrative Director position is vacant. MCSHC Medical Director, Judith A. Ganser, M.D., M.P.H., serves as interim director along with Assistant Director Edward M. Bloom. /2007/Edward Bloom has been promoted to Director of MCSHC. The new Assistant Director is Robert K. Martin. //2007//

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

MCSHC Health Systems Development (HSD) includes subject matter experts who coordinate several MCSHC programs. HSD works closely with MCSHC Business Management to implement parts of these programs through grants and contracts. HSD consultants provide training and technical assistance to MCSHC grantee agencies and individually facilitate programs such as Indiana Family Helpline (IFHL), Prenatal Substance Use Prevention Program (PSUPP), Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens (RESPECT), and the Free Pregnancy Test Program (See Section B). HSD consultants build health services infrastructure with community organizations within their assigned counties. See attached HSD consultant county assignment schedule and map. One HSD team leader also serves as MCSHC Training Manager to facilitate training opportunities for MCSHC staff, other ISDH employees and grantee staff. One HSD consultant oversees the ICCHCP and another oversees PSUPP and IFHL.

Grant programs funded by MCSHC using Title V funds include: Indiana Women's Prison Families Project, Statewide Healthy Families Abuse Prevention, Statewide Family Planning Monitoring and Data Collection, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 13 Prenatal Medical Care Clinics, 13 Infant Health Care Clinics, 15 Child Health Care Clinics, 5 School Based Adolescent Health Clinics, 4 Women's Health Care Clinics, 4 Children and Families Dental Services Programs, 23 Prenatal Care Coordination Programs, 13 Family Care Coordination Programs, 11 Family Planning Programs, 4 Childhood Obesity Programs, 5 Genetics Clinics, 3 Prenatal Genetics Programs, 2 Lead Poisoning Prevention Programs, 7 Community Needs Assessment Projects, 3 Fetal Infant Mortality Review Projects, and a number of pilot projects designed to test new approaches to health service delivery and infrastructure building. MCSHC also uses Title V to provide partial funding for several PSUPP clinics, the Indiana Poison Control Center, some RESPECT projects, prophylactic penicillin for children with Sickle Cell disease, an outreach program for Amish families with bleeding disorders, and the production of technical manuals and training programs for MCSHC staff and grantees.

/2008/MCH now supports : Indiana Women's Prison Families Project, Statewide Healthy Families Abuse Prevention, Statewide Family Planning Monitoring and Data Collection, Statewide Perinatal Health Care Planning, Statewide Suicide Prevention, 14 Prenatal Medical Care Clinics, 12 Infant Health Care Clinics, 12 Child Health Care Clinics, 6 School Based Adolescent Health Clinics, 3 Women's Health Care Clinics, 3 Children and Families Dental Services Programs, 26 Prenatal Care Coordination Programs, 14 Family Care Coordination Programs, 11 Family Planning Programs through a contract with the Indiana Family Health council, 1 Childhood Obesity Program, 5 Genetics Clinics, and 4 Fetal Infant Mortality Review Projects. Most special projects started in FY 2005 are now no longer receiving funds from MCH, although several of them remain active with local funds. All Title V Family Planning services are now provided through a statewide grant //2008//

Some programs including the Newborn Screening Program, Meconium Screening for Drug-Exposed Newborns Program, Newborn Hearing Screening Program, IFHL, Free Pregnancy Test and some population-based educational campaigns, including the Folic Acid Awareness Campaign, are directly administered by MCSHC. HSD and Newborn Screening are under the direction of Nancy Meade, R.D., M.P.H., MCSHC Health Planner/Programs Manager, who also co-chairs the needs assessment process. **/2009/ The Genetics Services and Newborn Screening Programs have merged into Genomics and Newborn Screening Program. //2009//**

MCSHC Data Analysis section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies ranging from Indiana State Police (demographic data regarding truancy and arrests of minors) to the Department of Education (school attendance and enrollment information) to all MCSHC projects and clinics (clients served in various programs) and more in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section also maintains the MCSHC portion of the ISDH web page.

MCSHC Business Management staff manages all contracts and grants, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures. This section makes Title V budget planning recommendations and coordinates all applications for funding, including primary responsibility for preparing the Title V grant application and annual report narrative. MCSHC Business Management staff coordinates all contracting, procurement and programmatic financial tracking, as well as providing a clerical support pool for the division. /2008/The Business Management section has been reorganized. Clerical support and financial tracking functions are now directly under the Asst Director. The Grant Coordinator now supervises only the Asst Grants Coordinator. The Grants Coordinator position is currently vacant.//2008// **/2009/The Grants Coordinator, also known as the Business Management Manager, was filled in July 2007 by Vanessa Daniels who supervises the Assistant Grants Manager and the MCH Administrative Support Section.//2009//**

The MCSHC management team consists of the Administrative Director (vacant), Medical Director (a pediatrician with a Masters of Public Health), Assistant Director, MCH Health Planner/Programs Director, Cultural Diversity & Enrichment Director, CSHCS Claims Director and CSHCS Eligibility Director. See attached organizational chart./2007/The Assistant Director has now been promoted to MCSHC Administrative Director. The new Assistant Director is Robert K. Martin, Colonel, U.S. Army, Retired. The Assistant Director directly manages the Data Analysis and Business Management sections and also supervises a Health Planner. The Assistant Director also works with CSHCS to develop the Integrated Services initiative.//2007//

The Assistant Director (BS Health & Physical Education, CGSC military science graduate) w/business & automation skills coordinates personnel/facility issues & supervises the Data Analysis & Business Management team leaders.

The Data Analysis Section headed by a Public Health Administrator with a BS in Education and 20 years data analysis experience, provides data entry & analysis for MCSHC. This section includes 2 data analysis clerks & a technical consultant/web designer, as well as a data mgmt Coordinator. **/2009/ An Epidemiologist for all of MCSHC is contracted fulltime and is housed at ISDH. //2009//**

The Business Management Section, under a Grants Coordinator with a BS (general education) and 12 years grant management experience, coordinates contracting, financial tracking, grant application and provides a clerical pool. This section includes a Program Coordinator & Admin. Asst, w/more than 15 years exp. w/State government and three clerical/data entry staff. /2008/The Grants Coordinator position is currently vacant. The Program Coordinator position duties have been revised to serve as Assistant Grants Coordinator. The Administrative assistant position is also currently vacant. On an interim basis, clerical and administrative support staff, as well as the Assistant Grants Coordinator report directly to the Assistant Director.//2008// **/2009/ As stated up above, a new Grants Coordinator, Vanessa Daniels assumed the oversight of the Assistant Grants Coordinator and Administrative staff, no longer requiring the**

***Assistant Director to provide direct oversight of the Business Management Section.
//2009//***

The MCH Health Planner/Programs Director, an RD and MPH w/more the 30 years experience in maternal and child health, supervises the MCH Health Systems Development and Genomics in Public Health / Newborn Screening section team leaders.

Three HSD Teams Leaders (one with a PhD & MSW, 1 with BS in English & Psychology & 1 w/BS Public Admin) coordinate the HSD team of 3 Chief Nurse Consultants (1 RN, MSN for prenatal health, 1 RN, MS for early childhood & 1 vacant position), a MSW/LCSW HSD Consultant, the State Adolescent Health Coordinator (MPH) and the Indiana Family Helpline Program Coordinator (BA, MS, CIRS) who leads a team of 5 state and 6 contract data and clerical staff./2007/The State Adolescent Health Coordinator accepted a promotion outside of the division, and was replaced by another MPH./2007// ***/2009/ The vacant Chief Nurse Consultant position has been filled. //2009//***

The Genomics/Newborn Screening Director (MS, CGC) supervises two RN Chief Nurse Consultants, a Public Health Administrator, Social Services Specialist, Secretary and 2 clerical staff as well as a contracted State Audiologist. In addition she oversees, a Public Health Administrator who coordinates IBDPR & the vacant State Genetics Specialist position and 2 contracted Genomics Program Consultants - 1 RD & 1 Genetics Counselor (MS, ABGC eligible). MCSHC is in process of transitioning these 2 contractors into state positions. ***/2009/ A new Genetics Specialist was hired in May 2007, and a contracted Cystic Fibrosis (CF) Coordinator was hired in July 2007 to facilitate the follow-up and tracking of CF positive screen infants. //2009//***

The CSHCS management team includes the Eligibility Manager (RN), a Claims Manager (MA), and one RN/MSN who coordinates Prior Authorization and the cultural diversity and enrichment program, and a RN who manages the Provider Relations Section. /2008/CSHCS was reorganized to incorporate an Integrated Services Program and a separate Provider Relations Sections to implement new Indiana requirements for CSHCS providers to register to allow payment via electronic funds transfer. The revised organization of CSHCS is: MCSHC Dir. (also serving as CSHCS Dir.), MCSHC Med. Dir. (also serving as CSHCS Med. Dir.) CSHCS Program Dir. supervising the CSHCS Claims Mgr & CSHCS Systems Mgr., Integrated Services Dir., an Eligibility section, & a Prior Auth. Section./2008//

D. Other MCH Capacity

CSHCN Eligibility has 2 RN Public Health Nurse Consultants, 2 RN Welfare Nurse Consultants, 2 Welfare Consultants, 8 secretaries and 2 clerical staff. Prior Authorization has 3 RN Public Health Nurse Consultants, 2 Welfare Consultants, a Social Services Specialist, Environmental Scientist and an Administrative Assistant. Claims has a Program Director (vacant), a Health Planner, 2 Social Services Consultants, 2 Program Coordinators, 2 account clerks, a Social Services Specialist, 5 clerical staff and 2 secretaries./2007/CSHCS Eligibility has 1 Program Director, 2 RN Public Health Nurse Consultants, 2 RN Welfare Nurse Consultants, 2 Welfare Consultants, 8 secretaries and 4 clerical staff. Prior Authorization has 1 Program Director, 2 RN Public Health Nurse Consultants, 6 Nurse Consultants, and an Administrative Assistant. Claims has 1 Program Manager, 1 Program Director, a Health Planner, 7 account clerks, and 1 secretary. Provider relations has 1 Program Director, 1 Social Services Specialist (vacant), 1 Program Coordinator, 1 Account Clerk and 1 Secretary (vacant)./2007//
/2008/CSHCS re-aligned positions internally. Eligibility now has 1 RN Public Health Nurse Consultant, 2 RN Welfare Nurse Consultants, 1 Welfare Consultant, 8 eligibility clerks, and 4 clerical assistants. The Director of Claims also serves as director of Systems with 1 health planner and 1 program coordinator, and Director of Administration section with 1 administrative assistant. There are 6 clerical assistants./2008//

MCSHC staff includes approximately seven parents or grandparents of children with special health care needs. Two are in NBS and four are part of the IFHL, including the IFHL coordinator. MCSHC, through a contract with the Indiana Perinatal Network, Inc., supports a SIDS parent who runs the SIDS program in Indiana. A contract with Indiana Parent Information Network also supports parent involvement. /2008/ Indiana Parent Information Network has changed their name to About Special Kids (ASK) //2008// ***2009/The About Special Kids (ASK) contract supports parent involvement by using trained and experienced Parent Liaisons to provide peer support, information and referral and education and training for families of children with special health care needs. Activities include sending a monthly e-newsletter, developing and sending out educational materials, operating an information "hotline" and a system of follow-up contact with families, conducting training sessions, and assessing the ongoing and changing needs of families with special health needs. ASK, utilizes family input to develop strategies to address issues such as childcare, community resources, early intervention, health care financing, relocation and children's rights. //2009//***

MCSHC also supports one dentist, a dental hygienist, four fluoridation staff and two secretaries in the Oral Health Program; one lawyer in ISDH legal department; two Information Technology Services staff plus three contractual positions in ITS; and one Epidemiology Resource Center professional. /2007/ In FY 2007, MCSHC supports the following staff outside of the division: two clerical and five professional Oral Health Services staff, three Information Technology staff and four IT contractors, an epidemiologist (vacant) and two contracted epidemiologists, the director of Community Nutrition and Obesity Prevention (a MPH), two laboratory staff (a microbiologist and a chemist) one clerical staff and four professional/administrative staff for the Lead Poisoning Prevention Program as well as the Lead Poisoning Prevention Director. //2007///2008/ The Director of Oral Health position, which is currently vacant, now reports to the MCSHC Director. See section D. //2008// ***2009/ New Oral Health Program Director, Dr. Kent Smith, was hired in December 2007. Dr. Smith has 12 years experience in community health most recently as Director of the Marion County (Indianapolis) Health Department Dental Program. //2009//***

E. State Agency Coordination

Public Health Relationships

The public health system in Indiana includes ISDH and 94 autonomous local health departments (LHD) that are functions of county or municipal government. MCSHC coordinates with the ISDH LHD liaison office and local health departments to facilitate development of health systems in counties of need. MCSHC provides Title V funding to Marion, Lake, St. Joseph, and Madison counties for FIMR projects. Title V funding to other LHD MCH programs promotes direct services clinics, enabling case management services, infrastructure building services and population based services through free pregnancy testing programs and media campaigns.

ISDH MCSHC works with other parts of ISDH through informal and formal staff assignments, collaborative initiatives, technical assistance, development of policy, state plans and funding of programs. These include coordination with the Lead Prevention Program to develop policy & programs and Title V funding of a prenatal lead testing program, sitting on the State Immunization Program Committee, funding of the statewide Dental Sealant Program, & population based surveys through the Oral Health Department and the IU School of Dentistry, sharing of educational materials, & providing technical assistance to the Division of HIV/STD, Office of Cultural Diversity and Enrichment to provide mandatory cultural competence trainings for all Title V funded projects, Newborn Screening, co-location of clinics & shared funding with the Office of Primary Care and work to integrate MCSHC programs with FQHC & CHC programs, and WIC and Community Nutrition programs to develop a state breast feeding plan, chronic disease asthma program, & a state obesity prevention program. All of these ISDH divisions are housed alongside MCSHC within ISDH Community & Family Health Services Commission. /2007/ MCSHC provides funds to support several initiatives under the Community Nutrition and Obesity Prevention division. //2007// /2008/ Oral Health Director position is currently vacant and the

MCSHCS Medical Director is acting State Oral Health Director. A state breastfeeding plan was developed.//2008// ***/2009/ MCSHC Services through an Indiana Perinatal Network contract supports the State Breastfeeding Coordinator who is to facilitate the implementation of the State Breastfeeding Plan and staff the Indiana Breastfeeding Alliance. //2009//***

MCSHC also works with ISDH departments outside of the Community and Family Health Services Commission including collaboration with Epidemiology staff to develop the Operational Data Store (ODS) to create a common health status database to collect health status and services information across several program areas and provide for more comprehensive data analysis, Vital Records, the Office of Minority Health to address disparity issues, and the Office of Women's Health education and planning./2008/Commission name is Human Health Services.//2008//

MCSHC has an ongoing relationship with the Bioterrorism Preparedness Program within ISDH. MCSHC collaborated with the ten public health preparedness district epidemiologists to collect assessment data on each county and Systems Development consultants were reassigned counties to correspond with ten public health preparedness districts./2007/The FY 2007-2008 MCH Grant Application Procedure requires applicants to coordinate activities with local and regional health emergency preparedness coordinators.//2007///2008/The MCSHC Medical Director has discussed the issue of preparedness for pregnant women, infants and CSHCN with the ISDH Preparedness Program. They will be setting up plans for vulnerable populations this year. The MCSHC Medical Director will also be working with Indiana Chapter of March of Dimes to raise awareness about preparedness for pregnant women around the state in Fall 2007. //2008//***/2009/ MCSHC Medical Director gave five talks around the state regarding disaster preparation for pregnant women, infants, children, & children with special health care needs. //2009//***

MCSHC provides partial funding for the Indiana Poison Control Center (IPC), operated by Clarian Health Partners. IPC provides statistical data to MCSHC and also by contract provides epidemiological surveillance for potential bioterrorism or chemical disaster clusters by region, nature and frequency of incident reports./2008/State Department of Health is paying for the Indiana Poison Control Center with tobacco funds for 2008.//2008//

Relationships with Social Services

The Indiana Family and Social Services Administration houses the Division of Family Resources which encompasses Temporary Assistance to Needy Families (TANF), food stamps, child care, foster care, adoption, homeless services, and job programs; the Division of Disability and Rehabilitative Services which encompasses in-home services, deaf and hard-of-hearing services, blind and visually impaired services, and social security disability eligibility; the Division of Mental Health and Addiction, and the Office of Medicaid Policy and Planning.

ISDH and FSSA share data through a Memorandum of Understanding (MOU) that addresses general areas of collaboration and data interchange as well as specific issues like reimbursement for lead lab tests and IFHL outreach for FSSA services for children with special health care needs who are eligible for both Hoosier Healthwise and CSHCS. This includes eligibility for SSI through the FSSA Disability Determination Bureau and services through the FSSA Vocational Rehabilitation Services.

MCSHC coordinates with Indiana Family and Social Services Agency (FSSA) to expand Hoosier Healthwise (Medicaid) coverage, develop comprehensive early child care systems including the Early Childhood Comprehensive Systems Program (ECCS) & the Indiana Child Care Health Consultant Program (ICCHCP), provide partial funding for the Healthy Families program & receive funding for the PSUPP./2007/The ECCS program was renamed "Sunny Start: Healthy Bodies, Healthy Minds".//2007///2008/The Sunny Start project manager serves on the Head Start Collaboration Office Advisory Council. //2008//

The MCSHC Medical Director serves on the First Steps Interagency Coordinating Council and the Board for the Coordination of Child Care with FSSA staff and other state agencies and consumers./2007/The Board for Coordination of Child Care has been replaced by an advisory board made up primarily of child care providers./2007//

ISDH and FSSA coordinate with WIC, CSHCS and First Steps to reduce duplication and ensure coverage for all eligible infants and children. CSHCS & FSSA provide joint planning, outreach and training for county systems points of entry to determine Medicaid and/or CSHCS eligibility. MCSHC standards of care for prenatal care coordination & child health programs require developmental screening and referral to First Steps for children age 0-3.

MCSHC staff serves on FSSA's Indiana Head Start Partnership Project Advisory Council. Federal funding from DHHS, Administration for Children and Families has enabled Head Start programs to provide comprehensive services for low-income Hoosier children and their families for over 35 years./2007/The Indiana Head Start Partnership has been renamed the Indiana Head Start Collaboration Office./2007//

MCSHC requires all grantees to provide EPSDT & accept funding from Medicaid as payment in full. Medicaid provides reimbursement for EPSDT.

MCSHC houses the Prenatal Substance Use Prevention Program (PSUPP) with partial funding from Title V, FSSA Division of Mental Health and Addiction, and Indiana Tobacco Prevention and Cessation (ITPC). PSUPP works to prevent poor birth outcomes by helping women to decrease or cease alcohol, tobacco and other drug use during pregnancy. PSUPP is implemented statewide through the efforts of a MCSHC state program director, twenty local directors and an evaluation team. The local directors collectively serve, but are not limited to, constituents from twenty-two Indiana counties that include: Allen, Clark, Dearborn, Dubois, Delaware, Elkhart, Franklin, Jennings, Lake, LaPorte, Madison, Marion, Ohio, Owen, Putnam, Ripley, Spencer, Switzerland, Tippecanoe, Vanderburgh, Vigo, and Warrick./2007/Pike, Grant, and St. Joseph counties have been added for a total of 25./2007///2008/House Enrollment Act 1457, effective July 1, 2007, establishes the Prenatal Substance Abuse Commission to develop a plan to improve early intervention and treatment for pregnant women who abuse alcohol, tobacco, or drugs. This commission is to convene before October 15, 2007./2008///**2009/Substance Abuse Commission convened on October 7, 2007, has met two additional times and has three working committees to develop the plan./2009//**

MCSHC supports efforts to promote education and screening for perinatal depression. The Indiana Perinatal Network received a three-year continuation grant from HRSA to develop a perinatal depression state plan, including provider training and protocols./2007/Indiana Perinatal Network will be facilitating the second regional perinatal depression summit and certificate of completion course in Bloomington , in August 2006. The "Decision Tree for Depression During the Childbearing Years", a tool to assist professionals in identifying, treating, and referring women for post partum depression has been added to the IPN website and can be downloaded for use by professionals. For consumers, "Something Isn't Right: Do You Have Depression" has been added to the IPN website and includes the Edinburgh Screening Test that is taken and scored online. Women with a high score placing them at risk for suicide are referred to their ER./2007//

MCSHC provides partial funding for Healthy Families Indiana (HFI), a voluntary home visitation program designed to promote healthy families and healthy children through a variety of services, including child development, access to health care and parent education available in all 92 counties. Part of Healthy Families America, HFI provides support to families with their first newborn whose hospital or prenatal screens indicate that they are at risk for child abuse. HFI is also funded by FSSA and the Indiana Criminal Justice Institute and receives additional support through TANF funds, a specialized license plate, Kids First, and other sources.

MCSHC receives funds from FSSA to coordinate the ICCHCP that provides consultation on

health and safety issues to child care providers by site visit and phone and provide health and safety information, educational materials and contact information via the internet, access to resources, reports and data on the website./2007/Pilot projects in Lake (Gary) Dubois and Lawrence counties provide a greater concentration of services for providers of child care. The pilot will also focus on involving medical and health service providers in the support for child care./2007///2008/The program will transition in September 30, 2007 when FSSA resumes responsibility for child care health consultation in conjunction with the newly developed Quality Rating Systems program to be rolled out in January 2008./2008//

The new State Health Commissioner also serves as Medical Director for the State Medicaid program--appointed to that position by the Governor to better coordinate ISDH and Medicaid policy. MCSHC coordinates with FSSA Office of Medicaid Policy and Planning (OMPP) to expand Hoosier Healthwise (Medicaid) coverage. Many Title V grantees became Medicaid enrollment centers for Hoosier Healthwise when the State expanded the program for SCHIP. ***/2009/ MCSHC staff are working with several Office of Medicaid Policy and Planning Committees. The MCSHC Medical Director participates in the Medicaid Quality Strategy Committee (QSC). The Perinatal Nurse Consultant is a member of the Neonatal Workgroup of the QSC. ISDH and OMPP are working on a procedure to match birth certificate data with Medicaid perinatal outcome data. The State Health Commissioner is a member of the Medicaid Policy Advisory Committee (PAC) and the MCSHC Medical Director serves on the PAC working group. /2009//***

As of July of 2005 all Indiana Medicaid participants, except those with disabilities in the Medicaid Select program will be enrolled in mandatory Medicaid Managed Care Organizations (MCOs). OMPP has contracted with five MCOs to cover the state. MCSHC has been working with OMPP and the MCOs to ensure that targeted case management services remain available to meet the needs of pregnant women, infants and families.

Indiana Prenatal Care Coordination (PNCC) identifies pregnant women who are eligible for Title XIX and Title XXI and helps them apply for services. PNCC has been a Medicaid reimbursable service in Indiana since 1990. Services include outreach and case finding, home visit assessments per trimester, care plan monitoring, education, and referral to needed services. MCSHC funds local agencies and hospitals to provide prenatal care coordination in areas where mothers are at high risk for poor pregnancy outcomes. MCSHC provides technical assistance, training and oversight to funded and non-funded prenatal care coordination programs in Indiana. MCSHC works closely with the federally funded Healthy Start Programs outreach and case management initiatives in Indianapolis and Lake County./2007/Evaluation of 3 models of outreach and care coordination by the Indiana University School of Nursing's Institute for Action Research in Community Health (IARCH) was completed in April, 2006. Successful models will be replicated throughout the state including the faith based mentoring project out of South Bend that will be replicated in Indianapolis./2007///2008/House Enrolled Act 1678 signed into law on 6/7/07 increases coverage of pregnant women from 150% FPL to 200% FPL and allows presumptive eligibility for pregnant women limited to ambulatory prenatal care. In 2007 Indianapolis has modified the South Bend faith based model and uses pastor's wives or "First Ladies" to provide health education to the congregation./2008//

MCSHC collaborates with the Indiana Chapter of the National Association of Social Workers to provide certification training to nurses and social workers applying to become prenatal care coordinators.

With the entrance of Medicaid Managed Care in Indiana MCSHC found the PNCC program in jeopardy as MCOs wanted to provide care coordination services over the phone. MCSHC staff met with OMPP and the MCOs to assure that the Medicaid PNCC continued to be utilized and continued to receive reimbursement for services as stated in Indiana Code 405 IAC 1-7-24./2007/Ongoing meetings with all MCOs continue. MCO PNCC Operational Guidelines were finalized April 19, 2006 and will be a part of MCO contracts with prenatal care

coordinators.//2007//

MCSHC staff collaborated with OMPP and the MCOs to revise the State Prenatal Risk Assessment Tool, and works to standardize assessment and report tools, revise training of prenatal care coordinators, program evaluation, and also participates in the revision of the Medicaid Code on prenatal care coordination reimbursement. At least three training events, directed to local prenatal care coordination providers, are planned in cooperation with OMPP and the MCOs to educate providers on new tools, how to contract with MCOs, billing and reimbursement under MCOs.//2007//Standardization of assessment forms developed in collaboration with MCSHC, MCOs and prenatal care coordinators were completed and released in a Medicaid Bulletin in March, 2006. 3 regional trainings on use of the standardized forms were provided by MCSHC in May, 2006. 4 of the 5 MCOs attended one or more of the trainings to share their programs with Prenatal Care Coordinators and to facilitate initiation of contracts.//2007//

Relationship With Other State Agencies

MCSHC funds Indiana School for the Deaf (ISD) to support EHDl programs by providing training materials, a video project and regional audiologists to outreach to hospitals, audiologists and First Steps programs statewide to identify, promote, support and educate families with infants newly diagnosed with hearing loss in language development.//2007//ISDH now contracts directly with regional audiologists, but continues to support other ISD initiatives.//2007//

MCSHC receives funds from Indiana Department of Education (IDOE) to perform the Youth Risk Behavior Study (YRBS) to identify and reduce high-risk behaviors among school age children. ISDH partners with IDOE to improve the health of Indiana children through the schools. IDOE has received a 5-year grant from the Centers for Disease Control and Prevention to bring the Coordinated School Health Program model to Indiana. The grant includes staff members in both state agencies.//2008//In 2007, ISDH collected data for the YRBS which has been sent to CDC for analysis. It is unknown at this time whether Indiana will have weighted data again.//2008//**//2009// The YRBS was successfully administered for 2007, giving a large enough sample for weighted data analysis. Indiana now has weighted data for years 2003, 2005, and 2007. The MCSHC will assist with the administration of the 2009 YRBS which will be organized by the Indiana Department of Education.//2009//**

MCSHC provides technical assistance for school programs, policy and environmental change, educational strategies based on CDC guidelines and coordination of resources. This program has eight interactive components: Health Education, Physical Education, Health Services, Nutrition Services, Counseling, Psychological, & Social Services, Healthy School Environment, Health Promotion for Staff, & Family/Community Involvement. The key focus areas are obesity, nutrition, physical activity, chronic disease, & alcohol, tobacco, & other drugs.//2007//The office for the Coordinated School Health Program is under the Deputy Health Commissioner, but MCSHC is part of the internal steering committee.//2007//**//2009// Indiana was not refunded for the next five year Coordinated School Health Program grant from the CDC. This has been a collaborative effort between the Indiana State Department of Health, MCSHC, and the Indiana Department of Education.//2009//**

MCSHC has developed a coalition that includes IDOE, to implement the Early Childhood Comprehensive Systems program to create an integrated, coordinated, comprehensive system of services for children from birth to five. This initiative will help to ensure that a holistic system of care supports young children so they arrive at school ready to learn.//2007//The Sunny Start: Healthy Bodies, Healthy Minds Program (formerly the ECCS) Grant was funded by the Maternal and Child Health Bureau for 2 years of planning activities that began in 2003. In June 2005, a strategic plan was developed to support a coordinated system of resources and support for young children from birth to age 6 and their families.//2007//

MCSHC works with the Indiana Department of Corrections through coalitions, and programs that

provide services to prevent child abuse such as IHF, and the ICCHCP. MCSHC funds the Indiana Women's Prison's Responsible Mothers/Healthy Babies program to build and preserve the mother/child/family bonds while women are in prison.

/2009/ This year, the Women's Prison program expanded to include the Wee Ones Nursery, which allows carefully selected offenders to return to the prison with their newborns. Indiana is only the 7th state in the country to establish such a program./2009//

Relationships With Universities

Over the years MCSHC has developed a relationship with the Indiana University Schools of Medicine and Nursing, and the new Department of Public Health. MCSHC collaborates with the Indiana Perinatal Network (IPN) and with these educational institutions to develop, sponsor, and coordinate training events for health care professionals in public and private health settings./2008/The Marion County Health Department, ISDH MCSHC and IPN sponsored a one day conference on Prenatal Substance Abuse with speakers from Indiana University School of Medicine in Fall 2006. There will be an Unintended Pregnancy Summit sponsored by IPN and ISDH in September 2007. The Sunny Start (ECCS) Program is sponsoring a week long Institute on Infant and Toddler Mental Health in collaboration with Faculty from IUSM Department of Behavioral Pediatrics on July 9-13, 2007./2008//

MCSHC contracts with IU professors to evaluate pilot programs and conduct focus groups and town meetings around the issue of perinatal disparities. MCSHC has a long relationship with the IU Bowen Center to provide statistical evaluation of the PSUPP program and other funded initiatives. This year the Director of Adolescent Medicine will evaluate Indiana's RESPECT programs./2007/The evaluation is on hold due to funding constraints./2007//

MCSHC links with state universities through the Masters of Public Health Program at Indiana University (IU) and the Center for Public Health Leadership and Education. Medical students from the IU Medical School are provided with preceptors for a public health rotation. Riley Infant and Childhood Nutrition Fellows at Clarian's Riley Hospital for Children are provided Title V background information. The MCSHC Medical Director serves on the advisory board for the MCHB funded Adolescent Health Training Program, Riley Child Development Program, and Behavioral Pediatrics Program./2007/MCSHC works closely with Purdue University in regards to the Folic Acid Program and Indiana Suicide Prevention Coalition./2007// ***/2009/ ISDH has developed a month long rotation in Public Health for physicians in primary care residency training programs./2009//***

MCSHC works with IU School of Dentistry (IUSD) to provide the statewide Dental Sealant Program. Title V and Children's Oral Healthcare Access Program (COHAP) funds support a mobile dental unit to provide school-based dental sealants in rural areas, particularly those near community health centers. Student dentists & hygienists staff the unit. MCSHC also provides funds to IUSD to support the craniofacial reconstructive surgery unit for children born with dental deformities including cleft palate.

Indiana Minority Health Coalition

MCSHC collaborates with the Indiana Minority Health Coalition (IMHC) to provide consultation for MCSHC grantees. MCSHC funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Through 15 local Minority Health Coalitions, IMHC provides an immunization outreach program that works with local health departments and MCSHC projects to provide immunizations and health care. The IMHC Director also serves on the Steering Committee of Core Partners for ECCS.

MCSHC collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meetings, work with faith based organizations to provide culturally

competent services to African American families.

Helpline

MCSHC Indiana Family Helpline (IFHL) is a partner in IN211, Inc. IFHL and MCSHC staff have participated in the development of IN211 because IFHL is the only statewide I&R service. IFHL also assists the IMHC hotline by providing the database software & data./2007/IFHL no longer provides the database software for IMCH./2007///2008/The IFHL will work to become a 211 call center by December 2008./2008//**2009/ Because of staff turnover IFHL may not become a call center until early 2009./2009//**

Indiana Perinatal Network

MCSHC implements several programs through the Indiana Perinatal Network, Inc (IPN). These include the Indiana Perinatal Systems Strategic Plan for the 21st Century, developed through a series of regional town meetings and state task force groups. IPN builds infrastructure, provides professional and public education on perinatal health issues and quality assurance standards of care for perinatal services in Indiana. IPN houses the Sudden Infant Death (SIDS) program and the MCSHC Breastfeeding Program and provides a statewide Advisory Board for program planning, Regional Perinatal Advisory Boards, a speaker bureau, and a multi-media public education campaign. IPN also publishes Indiana Perinatal News (IPN newsletter), the Indiana Prenatal Online Magazine <http://www.indianaperinatal.org>, consumer information, clinical practice alerts, critical reports, and consensus documents like the Indiana Prenatal Guide. MCSHC also funds IPN to operate a pilot project to provide and evaluate Doula services in Marion County and the Indiana Friendly Access program to identify best practices to increase satisfaction with and utilization of health care services for low income pregnant women and children and to more clearly identify and address barriers to health care for pregnant women and families with young children./2009/ **IPN will complete the hospital survey regarding regional perinatal care in FY2008 & begin the training necessary to develop a regional perinatal system in FY2009./2009//**

Tertiary Care Centers

MCSHC funds a CSHCS satellite office at Riley Hospital to provide CSHCN and their families easily accessible and expedited entry to the CSHCS program. MCSHC funds the Riley Hospital Comprehensive High-Risk Newborn Follow-up Program to provide follow-up to children and their families who are at the highest risk, medically & developmentally, of morbidity or mortality and build community-based infrastructure for these fragile children./2009/**MCSHC funds a Care Coordination nurse practitioner (NP) for the Spina Bifida (SB) Program at Riley Children's Hospital. The SB Clinic serves over 500 children & adolescents with SB or related spinal problems from all areas of the state. MCSHC funds The Center for Youth and Adults with Conditions of Childhood (CYACC), a Transition Clinic that assists youth with chronic conditions of childhood integrate into the adult world. The clinic's Bridging Team links Youth with Special Health Care Needs (YSHCN) to a primary care Medical Home using an identified model of practice-based care coordination, community outreach & interagency collaboration to meet the youth & family's needs. The Bridging Team has the expertise and accessibility to be a resource for families and health care providers throughout the state. Social Workers at Lutheran Hospital, Ft. Wayne-IN, Clarian North Hospital, Carmel-IN, St. Joseph Memorial Hospital, South Bend-IN and Cincinnati Memorial Hospital for Children in Cincinnati, Ohio take CSHCN applications & are also kept up to date on changes to the application process. St. Vincents Hospital opened the Peyton Manning Children's Hospital that provides some tertiary care. //2009//**

IPN in collaboration with ISDH, ACOG (American College of Obstetricians and Gynecologists), the State Perinatal Advisory Board and Indiana hospitals that provide perinatal health care, developed a consensus statement on Levels of Hospital Perinatal Care in Indiana to establish criteria for risk-appropriate levels of hospital obstetric and neonatal care and provide recommendations for appropriate consultation, referral and transport. There are a total of five full Level III Obstetric Hospitals in Indiana: IU Hospital, Methodist Hospital, St. Vincent Hospital, &

Wishard Hospital in Indianapolis, and Memorial Hospital in South Bend. Riley Children's Hospital and St. Vincent Hospital in Indianapolis have the only two Level III/D Neonatal Intensive Care Units in the state. However, a total of six other hospitals are considered Level III/Subspecialty B-C. These are located in Indianapolis, South Bend, Evansville, Newburgh, Muncie and Fort Wayne. The Level I and II hospitals are encouraged to create a MOU with the tertiary hospital to stabilize and transport high-risk pregnant women and neonate.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	38.7	29.6	28.9	25.0	25
Numerator	1664	1276	1243	1076	
Denominator	430166	430557	430439	431089	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

FY2007 data not yet available. Estimate provided based on trend analysis.

Source of data will be ISDH Chronic Disease Program

Notes - 2006

Source of data: ISDH Chronic Disease Program

Notes - 2005

Source of data: ISDH Chronic Disease Program

Narrative:

Notes - 2007

Data unavailable; estimate given based on previous years' data and trend analysis.

Notes - 2006

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2005

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2004

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Notes - 2003

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates.

Source of data: Dr. Elizabeth Hamilton-Bird, Epidemiologist, ISDH Chronic Disease

Narrative:

#01 HEALTH SYSTEMS CAPACITY INDICATOR The rate of children hospitalized for asthma (10,000 children less than five years of age)

Since 1990, the prevalence of asthma for children 18 and under has doubled in Indiana, and currently 8% of all Hoosiers have asthma, placing Indiana 14th in the nation in asthma prevalence. (L. Stemnock and J. Lewis, "Asthma Prevalence in Indiana," Indiana State Department of Health (ISDH) Epidemiology Resource Center/Data Analysis Unit, 2001). However, the rate of Indiana children less than five years of age hospitalized with asthma has decreased from 38.7/10,000 in 2003 to 29.6/10,000 in 2004. This data was obtained from Indiana Hospital Discharge Data through the ISDH Epidemiology Resource Center. The reason for such a major reported decrease is greatly improved data from the Health and Hospital Corporation of Marion County, whose discharge data was until 2003 based on projections that were overstated. Now that we have established a reliable means of getting accurate data, we will use 2003 as a baseline.

In October 2002, the ISDH and the Indiana Department of Environmental Management (IDEM) were awarded interagency funding by the Centers of Disease Control and Prevention's (CDC) National Asthma Program for capacity building and asthma plan implementation.

In December 2004 the Indiana Joint Asthma Coalition, ISDH and IDEM published A Strategic Plan for Addressing Asthma in Indiana, a five-year strategy to begin addressing the burden of asthma in Indiana that includes a data surveillance plan. Currently, Indiana asthma surveillance involves the collection of prevalence, severity, and cost data using the Behavioral Risk Factor Surveillance Survey (BRFSS), Medicaid claims data, hospital discharge data, and mortality statistics. Each of these data sets has inherent limitations. For example, the BRFSS gives us data on adults only, patterns of health care are limited to Medicaid recipients, and hospital discharge data prior to 2002 was not individually identifiable which prevents trend analysis of hospitalizations.

The Data and Surveillance Workgroup of the Indiana Joint Asthma Coalition (IJAC) will work toward identifying gaps in present data sources describing the asthma burden and accessing additional data sources. Strategies of the workgroup include: 1) Solicit, inventory, and review the data needs, 2) Identify key users of asthma data in Indiana and review their data needs, 3) Identify gaps in present data collection and identify potential data sources to fill these gaps, and 4) Establish standardized data definitions, data analysis methods, and surveillance standards, utilizing nationally recognized definitions as applicable. In addition the workgroup will include geostatistical (GIS) analysis, the linkage of asthma prevalence with environmental data, and schools response in preventing and responding to asthma among students.

In 2005 and 2006 the IJAC continued to work on identifying gaps in data sources. Using the

same strategies formulated in 2005 (above), the Data and Surveillance Workgroup was able to provide ever more accurate data.

//2009/ In 2007 this has continued, while additional techniques and strategies discussed earlier have begun to be explored more more fully (e.g., exploring more uses for GIS analysis, linkage of asthma prevalence with environmental data). It is hoped that information gathered using these strategies will decrease data gaps and continue to increase accuracy in 2008. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	72.1	65.6	61.4	35.5	35.5
Numerator	58251	53875	52964	30614	
Denominator	80791	82169	86298	86282	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Provisional projection based on baseline data and calculation information from Medicaid (see note from 2006).

Notes - 2006

Data provided By OMPP using their new data system.

Note: This should be considered accurate, as Medicaid has now reportedly improved the accuracy of their new data system. Previous figures were, per Medicaid, overstated by approximately 50%.

New baseline: 35.5%

Last year's adjusted would have been 30.7%

Notes - 2005

Data provided By OMPP using their new data system. This should be treated as base year data.

Narrative:

Notes - 2007

OMPP were unable to provide this data; the indicator is calculated based on maintaining base year data.

Notes - 2006

After further revisions of the new data system at OMPP, a far more accurate numerator was submitted to ISDH. Therefore, rather than 2005, it will be 2006 data that will be used as base year data.

Notes - 2005

Data provided By OMPP using their new data system. This should be treated as base year data.

Notes - 2003

Source of Numerator & Denominator: Office of Medicaid Policy & Planning.

Narrative:

The percent of Medicaid enrollees whose age is less than one year during the reporting year who received one initial periodic screen.

The percent of Medicaid enrollees whose age is less than one year during the reporting year that received one initial periodic screen was reported by Medicaid as 65.6% for 2004. Medicaid's modifications to their computer system eliminated some unintentional duplication present in 2003's figures. Indiana mandatory Managed Care for the MCH Medicaid population began phase-in transition in 2002. Managed Care prenatal care providers have been encouraged to assist the mother with enrollment of the baby with a managed care provider prior to delivery.

In July 2005, five Medicaid Managed Care Organizations (MCOs) will cover all 92 counties in Indiana and will provide services for all Medicaid participants except those in Medicaid Select. The Indiana Prenatal Care Coordination program, and Healthy Families work closely with the MCOs and also assist in getting the infant into primary care. Performance data specific to each of the Hoosier Healthwise risk-based managed care plans will be published yearly by the Office of Medicaid Policy and Planning (OMPP).

In 2006, OMPP made significant changes to their data system. This enabled them to provide ISDH with what they concluded were far more accurate figures in many areas, including HSCI2.

//2009/ In 2007, after a further major change to OMPP's data system, eliminating duplicates and using more accurate techniques, OMPP provided new and significantly different figures for the numerator which thus affected the annual indicator greatly. This should be treated as new base year data. This is projected to remain the same for the next year //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	59.0	14.2	12.1	40.4	
Numerator	1662	225	186		
Denominator	2817	1581	1531		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2007

Provisional figure based on maintaining baseline rate.

Source of previous year's figures: ISDH EPSDT/S-CHIP program.

Notes - 2006

As expected, the new computer system generated significantly different figures than previously provided to us, increasing greatly the percentage of enrollees who received at least one periodic screen through EPSDT/S-CHIP.

These figures should be considered the baseline figures for the EPSDT/S-CHIP program.

Source of Data: ISDH EPSDT/S-CHIP Program

Notes - 2005

S-CHIP EPSDT Figures have undergone changes due to upgrade in computer software, leading to more accurate non-duplicative counts of total children eligible at all ages.

However, this information is provisional and should be treated as an estimate. The system is still undergoing modifications and next year (2006) will generate more accurate baseline data.

Narrative:

Notes - 2006

OMPP's new computer system has resulted in base year data that has been consistently very low. 2006 indicator is provisional and represents further clarification received from OMPP without the actual data being supplied by OMPP at this point. Unless OMPP's 2004 and 2005 figures were significantly in error, the provisional figure provided is an outlier. This will be flagged as being necessary to revisit when new data from OMPP is received. It may at that time need to be lowered. An estimate based on trend and base year would be 13.1 for 2006, which is what the figure is expected by data analysis to eventually be verified as being. However, it must be stressed that there is a great deal of fluctuation in figures of this nature as they are very low.

Notes - 2005

OMPP's new computer system had some necessary corrections which have now been made. 2003/2004 data will be changed by OMPP.

SFY 2005 data should be considered as base line and is the most accurate data available.

Notes - 2004

OMPP's new computer system is giving ISDH more accurate data than in prior years. 2004 figures should be used as baseline figures.

Source of data: Indiana Medicaid

Notes - 2003

Source of Numerator & Denominator: Office of Medicaid Policy & Planning. Figures for 2003 are being checked for accuracy by OMPP. Figure reported was incorrect due to computer error at OMPP. Actual figures for 2003 to be supplied by Medicaid before end of FY04.

Narrative:

The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

In Indiana, there were 618 SCHIP enrollees whose age was less than one year at the end of the fiscal year. There were a total of 1,531 unduplicated SCHIP enrollees during the fiscal year who had at least one initial or periodic screen. From this data, it is not possible to determine the total number of unduplicated SCHIP infants <1 year of age who had at least one periodic screen, as the figure available contains duplicates.

Additionally, this information was only provided by Medicaid in estimate form prior to the installation of Medicaid's new computer system. Medicaid reported making corrections to their new computer system. Thus, 2005 data rather than 2004 data will be used as baseline data.

This measure has been subject to high variability in the past due to small numbers. SCHIP and Medicaid enrollment appears to have an inverse relationship. All of our funded MCH Projects are encouraged to become Medicaid/SCHIP enrollment centers to facilitate easy enrollment for eligible family members.

/2009/ As of 2007, OMPP is still reporting fluctuating indicators provided by their upgraded computer system. It is hoped that when the actual figures from OMPP come in for 2006-2007 they will be more in line with the expected base year figures. However, as has been previously noted, there is a high variability in figures of this nature due to small numbers. This has continued to be the case. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	72.9	72.3	71.1	69.4	69.4
Numerator	62972	62991	61767	61027	
Denominator	86382	87124	86887	87936	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Figure projected to be maintained at current level. Source of Data will be ISDH ERC.

Notes - 2006

Source of data: ISDH ERC. Numerator calculated.

Notes - 2005

Source of data: ISDH ERC. Numerator calculated from percentage.

Narrative:

Notes - 2007

Data unavailable; estimate calculated based on trend analysis.

Notes - 2006

Numerator is calculated from the denominator and the percentage.

Source of data: ISDH ERC

Notes - 2005

Numerator is calculated from the denominator and the percentage.

Source of data: ISDH ERC

Notes - 2003

Numerator is calculated from the denominator and the percentage.

Source of data: ISDH ERC

Narrative:

The percent of women (15-44) with a live birth whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

Early and continuous prenatal care is promoted through the Indiana Perinatal Network "Baby First Right From the Start" Media Campaign, which promotes early prenatal care through billboards, free consumer videos, and print materials, the State Prenatal Care Coordination program which promotes early and continuous prenatal care utilization through outreach, education, and case management, and the MCH Free Pregnancy Test Programs which provides free tests to county agencies throughout the state.

In return for free pregnancy tests, agencies agree to assist all women with a positive pregnancy test into early prenatal care. There has been an increase in the use of community health workers and Baby First advocates providing outreach to pregnant women in targeted high-risk areas of the state with special project funding during FY 2005.

In 2004, 72.3% of all women in Indiana had adequate or adequate plus prenatal visits according to the Kotelchuck Index. The rate and the denominator for this figure are provided annually by the ISDH Epidemiology Resource Center; the numerator is then calculated. The OMPP has made the percent of women entering prenatal care in the first trimester a State Medicaid performance measure for State Medicaid MCOs.

//2009/ In 2006, 69.4% of all women in Indiana had adequate or adequate plus prenatal visits according to the Kotelchuck Index. The rate and the denominator for this figure are provided annually by the ISDH Epidemiology Resource Center; the numerator is then calculated. The OMPP has made the percent of women entering prenatal care in the first trimester a State Medicaid performance measure for State Medicaid MCOs. The small decline in percentage is due to fluctuation over time; the rate has 3.5% over the past several years, never in a straight line projection. While this is the lowest in a 4-year period, it has been the case that there has been a rebound after each lower percentage; that is hoped for in 2007 as well. //2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	86.0	85.0	89.7	89.7	90
Numerator	422501	417252	442210		
Denominator	491218	490996	492835		
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

Projection based on previous OMPP data.

Notes - 2006

Projection based on previous OMPP data.

Notes - 2005

Source of numerator OMPP

Denominator is calculated via trend analysis of previous OMPP data.

Narrative:

Notes - 2006

No information was available from OMPP for this HSCI from their revised computer system for this time period. There will be, presumably, a patch to once again allow OMPP to provide this information as they had in the past. For 2006-2007, indicators have been estimated based on trend analysis and approved by OMPP as reasonable projections.

Notes - 2005

Source of numerator OMPP

Denominator is calculated via trend analysis of previous OMPP data.

Notes - 2004

In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transitional period. Numerator available for 2004. Denominator for FY2004 provided by Medicaid as an estimate of number who meet eligibility requirements as of end of FY2004.

Source of data: IOMPP

Notes - 2003

In FY2003 the Indiana Office of Medicaid Policy and Planning improved their data reporting capabilities via a new computer system, increasing accuracy of their data and estimates. Percentage provided for 2003 during transition period between computer systems.

Source of data: IOMPP

Narrative:

Percent of potentially Medicaid-eligible children who have received a service paid for by the Medicaid program.

This percentage increased from 85% to 89.7% based on information from Medicaid's new computer program.

/2009/ In 2006 the OMPP computer system which had been able to give us the information for this HSCI was unable to provide this to us. The problem is being worked on at OMPP

and hopefully they will be able to give us the accurate data they have given us in the past, at which point we will keep it on hand for entry into next year's Title V Block Grant Application. For now, indicators for 2006 and 2007 were calculated based on trend analysis and submitted to OMPP who approved them as reasonable projections. //2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	46.1	47.1	47.7	55.1	58.1
Numerator	66880	70321	73219	68753	
Denominator	145088	149170	153452	124716	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

Proejction based on trend analysis. Source of data will be OMPP.

Notes - 2006

Source of Data: OMPP

Notes - 2005

Indiana Medicaid has made some corrections to its new computer system which is providing more accurate data than in the past. 2005 rather than 2004 data should be used as baseline.

Narrative:

Notes - 2007

Projection based on trend analysis from continuing accurate figures provided by OMPP for this measure.

Notes - 2006

Increase from 47.7 to 55.1. Source of data: OMPP

Notes - 2005

Indiana Medicaid has made some corrections to its new computer system which is providing more accurate data than in the past. 2005 rather than 2004 data should be used as baseline.

Notes - 2004

Indiana Medicaid has installed a new computer system which is providing more accurate data than in the past. However, Medicaid is still making some system corrections. 2005 should be used as baseline data.

Source of data: OMPP

Notes - 2003

Source of Numerator & Denominator: Office of Medicaid Policy & Planning.

Narrative:

The State slashed Medicaid dental reimbursements in 1994, which led to a mass exodus of dentists from the Medicaid program, and a decrease in dental health services to Medicaid eligible children. Reforms in Indiana's Medicaid Dental Program in 2001 led to an increase in the number of dentists providing dental health services to Medicaid enrollees.

Dental initiatives undertaken to promote utilization of dental services include Hoosier Healthwise educational brochures, referrals and advocacy from the MCSHC Indiana Family Helpline, MCSHC funding of the SEAL Mobile Unit to travel throughout the state and provide sealants to third grade students in school, requiring funded child health projects to report on the number of enrolled children receiving dental sealants, MCSHC funding of two dental health clinics within local health departments, and requirement of state funded community health centers to provide dental health.

Medicaid's new computer system has undergone some revisions in 2005; 2004's figure has been corrected following information received from those revisions. At 47.1% it still represents an increase over 2003's 46.1% and is now a reasonable and correct reported rate. The rate continued to increase in 2005 to 47.7%.

/2009/ Medicaid continues to provide accurate figures which show a definite trend toward improvement in this area. For 2006 the rate went from 47.7 to 55.1, the highest increase in the past several years. Based on this upward trend, a projection has been made for 2007 to continue the positive direction of the program. There is also, finally, after the serious decrease in reimbursement rates for years, the possibility of increasing Medicaid dental reimbursement, which could happen as early as the current year. //2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	16.4	8.4	2.0	2	2
Numerator	2409	1662	401		
Denominator	14690	19823	19823		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

Projected figure. Source of data will be SSA/SSI web page.

Notes - 2006

Source of data: ISDH CSHCS estimate. FY2006 data not yet available. Estimate provided based on baseline data.

Notes - 2005

We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated. Efforts are underway to determine a means to break out the appropriate age-range to ensure a direct comparison.

The CSHCS program provided the numerator for 2005, representing a 75% drop in number of children receiving rehabilitative services. This has been attributed by CSHCS to previous years' significant backlog of cases processed being virtually eliminated over the past two years after having been maintained at an overinflated level in years past. However, the extremely low number may be an aberration and thus is only preliminarily a baseline.

Source of data: SSI, CSHCS program.

Narrative:

Notes - 2007

Still no update from SSA. Again, the figures represented are so small that it is projected when that information becomes available it will remain the same (2%). However, with such small figures involved, it is possible for there to be considerable fluctuation in this indicator.

Notes - 2006

SSA no longer updates its website as they had begun doing; thus the figures cannot be accurately obtained for this measure using that method. The projection is that the figure will remain the same as the last accurate information from SSA and due to the small size of the sample involved.

Notes - 2005

We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated. Efforts are underway to determine a means to break out the appropriate age-range to ensure a direct comparison.

The CSHCS program provided the numerator for 2005, representing a 75% drop in number of children receiving rehabilitative services. This has been attributed by CSHCS to previous years' significant backlog of cases processed being virtually eliminated over the past two years after having been maintained at an overinflated level in years past. However, the extremely low number may be an aberration and thus is only preliminarily a baseline.

Source of data: SSI, CSHCS program.

Notes - 2004

We are able to use real data for this measure as of 2005. Previous estimated data was overinflated due to lack of updates from SSA for the denominator and projections for the numerator based on anticipated trends.

FY 2004 will thus be used as baseline data.

As of 2005, SSA provides an estimate on its web page of the number of SSDI recipients by state; however, there is no age breakdown for under 16. The under 18 age figure is therefore used. This means that the percentage is understated, as the denominator is somewhat inflated.

Numerator is defined as CSHCS clients in FY 2004 whose service was Therapy or outpatient and who had a revenue code of 420 through 449 on a claim and whose age was less than 16 years.

To give an accurate comparative figure, the same numerator but for children age less than 18 years is 1787, so the percentage comparing under 18's in both the numerator and denominator would be 9%.

Source of data: SSI, CSHCS program.

Notes - 2003

Source of denominator: Estimate provided by Social Security Administration.

Source of numerator: Provisional data, CSHCN Program.

Due to changes in both SSA's and CSHCN's databases, the figures as provided will be maintained for another year to better ensure accuracy.

Provisional FY2003 indicator is a projection based on multi-year data.

Narrative:

Indiana CSHCN Program provides rehabilitation services to children under the age of 16 receiving benefits under the Special Supplemental Insurance (SSI) Program to the extent medical assistance for such services are not provided through Medicaid. The CSHCS office provides Care Coordination, Eligibility, Prior Authorization (PA), Claims Processing, Provider Relations, and Travel Reimbursement support services for providers and participants or their families.

Until 2005, a significant backlog in case processing inflated the numerator reported by the CSHCS program, and also thus artificially inflated the percentage. This backlog has been virtually eliminated, bringing the number of children and the percentage much lower. At the same time, SSA has begun providing some data through their web site, although it has not been updated for 2005.

Therefore, while 2004 shows a marked reduction in percentage over 2003, that figure is being observed as to potentially being baseline. CSHCS is continuing to check into the computer report for the numerator, which represents a 75% reduction over 2004, but this is the best figure they can provide at this time. It is provisional and is expected to change, and is expected to bring the percentage in line with 2004's baseline data. Per SSA, their web site data should be updated for 2005 as well, hopefully by the end of the year.

//2009/ Unfortunately, SSA no longer updates this section of their website and has not since 2005. However, after contact with SSA it is believed that they will be able to provide that information once again in accurate form beginning possibly next year. While with such small figures there is a possible for significant fluctuation, it is projected that the general low figure will remain consistent. //2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-	ALL

system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State				MEDICAID	
Percent of low birth weight (< 2,500 grams)	2006	other	9.5	7.4	8.1

Notes - 2009

Percentage information based on previous reported figures; update pending from OMPP.

Actual total number lbw babies: 7280

Narrative:

Notes - 2007

For HSCI 05 a breakdown between Medicaid and Non-Medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:

Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

//2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	other	8	7	7.4

Notes - 2009

Percentage information based on previous reported figures; update pending from OMPP.

Actual rate of infant deaths per 1,000 live births: 7.85

Narrative:

Notes - 2007

For HSCI 05 a breakdown between medicaid and non-medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January, 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

//2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	other	73.2	89.9	80.6

Notes - 2009

Percentage information based on previous reported figures; update pending from OMPP.

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester = 77.57%

Narrative:

Notes - 2007

For HSCI 05 a breakdown between medicaid and non-medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January, 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:

Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	other	69.9	74.5	71.3

Notes - 2009

Percentage information based on previous reported figures; update pending from OMPP.

Percent of pregnant women with adequate prenatal care (80% Kotelchuck Index): 69.4%

Narrative:

Notes - 2007

For HSCI 05 a breakdown between Medicaid and Non-Medicaid is not possible at this time. Figures used are estimates which have been confirmed by medicaid as reasonable.

With implementation of the new Electronic Birth Certificate scheduled for January 2007, this information should be obtainable, which will allow the establishment of the baseline data.

Narrative:

Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State.

Until such time as Medicaid records are linked to Birth Certificate/Death Certificate records, the data on this form will be impossible to collect. Linkage of Medicaid records with Birth Certificate/Death Certificate records is in process, with a Memorandum of Understanding (MOU) in place and the Operational Data Store (ODS) in development. With the new Health Commissioner also now serving as Medicaid Medical Director, we anticipate receiving actual data from Medicaid. It is the intention of the ODS developers to design the ODS to be able to link between Medicaid and the ODS. This part of the ODS development is a key objective for the near future.

In FY 2005, the new Medicaid system underwent some revisions. FY 2005 data should be treated as baseline data.

2009/ While in 2006-2007 the Office of Medicaid Policy and Procedure continued to upgrade their computer and data systems, they were still unable to give us precise figures for this HSCI. However, Medicaid confirmed the projected figures calculated based on previous trend analysis as being reasonable figures to report. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2006	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2006	200

Notes - 2009

Information based on previous reported figures; update pending from OMPP.

Notes - 2009

Information based on previous reported figures; update pending from OMPP.

Narrative:

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in

Indiana. Indiana's Medicaid program covers pregnant women and children ages one and under, with family incomes up to 150 percent of poverty. Infants of mothers on Medicaid during the pregnancy are automatically eligible for Medicaid at time of birth.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program.

Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

//2009/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to uninsured infants age 0 to 1 with family incomes up to 150 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured infants age 0 to 1 with family incomes between 150 percent and 200 percent of poverty are also covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistent. //2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 21) (Age range to) (Age range to)	2006	133
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 21) (Age range to) (Age range to)	2006	200

Notes - 2009

Information based on previous reported figures; update pending from OMPP.

Notes - 2009

Information based on previous reported figures; update pending from OMPP.

Narrative:

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program. Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

/2009/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to uninsured children below the age of 21 with family incomes up to 133 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured children below the age of 21 with family incomes between 133 percent and 200 percent of poverty are covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistent. //2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2006	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2006	200

Notes - 2009

Information based on previous reported figures; update pending from OMPP.

Notes - 2009

Information based on previous reported figures; update pending from OMPP.

Narrative:

Notes - 2007

Pregnant women younger than 19 years of age are covered through SCHIP up to 200% of poverty level.

Narrative:

The percent of poverty level for eligibility in the State's Medicaid and State Children's Health Insurance Program (SCHIP) programs for infants (0-1), children, and pregnant women.

The OMPP under the Indiana Family and Social Services Administration administers Medicaid in Indiana. Indiana's Medicaid program covers pregnant women and children ages one and under, with family incomes up to 150 percent of poverty. Infants of mothers on Medicaid during the pregnancy are automatically eligible for Medicaid at time of birth.

Indiana's SCHIP was implemented in two phases. Phase I began on July 1, 1998 and expanded Medicaid eligibility. Phase II began January 1, 2000 and is a non-Medicaid program. Indiana's SCHIP is comprised of: Phase I SCHIP - Uninsured children below the age of nineteen with

family incomes up to 150 percent of poverty. There are no monthly premiums for this category of recipients. Phase II SCHIP - Uninsured children with family incomes between 150 percent and 200 percent of poverty. Recipients in this category are required to pay a small monthly premium for coverage.

//2009/ This information is provided by Medicaid on an annual basis. The coverage has remained the same with regard to pregnant women with family incomes up to 150 percent of poverty. There are still no monthly premiums for this category of recipients.

For phase II SCHIP, uninsured pregnant women with family incomes between 150 percent and 200 percent of poverty are also covered. Recipients in this category are required to pay a small monthly premium for coverage. This also has remained consistent. //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth certificates and WIC eligibility files	2	No
Annual linkage of birth certificates and newborn screening files	2	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	2	No

Notes - 2009

Narrative:

Notes - 2007

The reason for the "No" in Direct access, as explained during our review, is due to the interpretation of the word "Direct" which, being capitalized, we took to mean specifically direct access the the original database, not mirrored, extracted, or copied versions of the database. In almost every case we have access to a version of the database in question. At the same time, in almost every case this is not what we believe was meant by "Direct access to the electronic database." We will discuss and change this next year if it is determined that "Direct" access can encompass more than the limited perspective we interpret it as meaning.

Narrative:

Indiana continues to work on linkages as specified in the following seven areas: annual linkage of infant birth and infant death certificates, annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files, annual linkage of birth certificates and WIC eligibility files, annual linkage of birth certificates and newborn screening files, a hospital discharge survey for at least 90% of in-State discharges, an annual birth defects surveillance system, and a survey of recent mothers at least every two years similar to the Prenatal Risk Assessment Monitoring Surveillance (PRAMS) survey.

The State Systems Development Initiative (SSDI) grant provides for oversight of the Data Integration and linkage projects through the Data Integration Steering Committee (DISC), the main output being the Operational Data Store (ODS). The ODS is the agency's main linkage mechanism. Progress has been made to such an extent that Indiana can now report successful linkage at least some of the time in all seven areas. MCSHC now has the ability to obtain data for program planning or policy purposes in a timely manner for all seven areas, and for birth certificate/death certificate information and the annual birth defects surveillance system MCSHC has that ability all of the time. Access to the electronic databases for analysis has also been achieved with regard to the Newborn Screening link, the birth defects surveillance system link, and the survey of recent mothers (PRAMS like survey). The plan is to continue work on the ODS including both input links and output via specific Data Marts in 2006.

The attached document for 09a is the narrative for Indiana Health System Capacity Indicator 09c, a new measure dealing with obesity.

//2009/ The reason for the "No" in Direct access, as explained during our review, is due to the interpretation of the word "Direct" which, being capitalized, we took to mean specifically direct access the the original database, not mirrored, extracted, or copied versions of the database. In almost every case we have access to a version of the database in question. At the same time, in almost every case this is not what we believe was meant by "Direct access to the electronic database." We will discuss and change this next year if it is determined that "Direct" access can encompass more than the limited perspective we interpret it as meaning. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2009

Narrative:

Notes - 2007

Narrative:

Indiana high-school students are marginally more likely than their national counterparts to smoke cigarettes, according to the findings of the 2003 Indiana Youth Risk Behavior Survey conducted by the Indiana State Department of Health, MCSHC. Forty-eight high schools in the state and 1,674 students in grades 9 through 12 participated in the survey, which is part of a national study initiated by the Centers for Disease Control and Prevention to monitor student's health risks and behaviors.

2003 was the first time enough high schools in the state responded to the survey to allow the data collected to be weighted, that is, to be generalized for all Indiana high-school students. The Indiana Youth Risk Behavior Survey has been completed for 2005 with enough completed surveys to produce a weighted sample. Fewer Indiana teens are smoking.

The 2004 Indiana Youth Tobacco Survey (IYTS) shows that 21 percent of Hoosiers in grades 9-12 are smokers compared to 32 percent in 2000. This represents a 32 percent decline in smoking prevalence over the four-year period bringing Indiana's high school smoking rate below the national average. The Indiana Youth Tobacco Survey was conducted from November 2004 to January 2005 surveying more than 5,400 Indiana youth in grades 6-12 at 92 schools statewide. The survey included an over sample of African American and Hispanic youth.

Indiana Tobacco Prevention and Cessation (ITPC) programs adapted the Youth Tobacco Survey, developed by the Centers for Disease Control and Prevention, by adding questions designed for Indiana to serve as a surveillance measure for statewide tobacco use prevalence among youth. The full 2004 Indiana Youth Tobacco Survey Report is available at www.itpc.in.gov.

***//2009/ 2005 YRBS Information: 53 High Schools, 1528 students grades 9-12 surveyed.
//2009//***

IV. Priorities, Performance and Program Activities

A. Background and Overview

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to: promote integration of public health and health care policy; strengthen partnerships with local health departments; collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities; support locally-based responsibility for the health of the community. 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.

In order to fulfill our mission, ISDH Maternal and Children's Special Health Care Services (MCSHC) continues to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as state initiatives, based on the latest needs assessment. The needs assessment results focused on the following health status indicators: Asthma Hospital Discharges, Medicaid/CHIP Screening, Prenatal Care Adequacy, Low/Very Low Birthweight, MCSHC Access to Data Sources, Fatal/Non-Fatal Injuries, Chlamydia Rates, Dental Screening, and Adolescent Tobacco Use.

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

Direct Health Care is being evaluated with performance measures (PM) for Newborn Screening, CSHCS Family Participation, and Asthma Hospitalization. Enabling Services PM include the CSHCS Medical/Health Home and decreasing tobacco use in prenatal smokers. Population-based PM address CSHCS Insurance, CSHCS Community Systems, CSHCS Transition Issues, Immunization Rates, Teen Birth Rates, Dental Sealants, Child Motor Vehicle Accidents, and Lead Screening. Infrastructure Building PM include Breastfeeding Improvements, Newborn Hearing Screening, Child Health Insurance, Medicaid Usage, Very Low Birth Weight, Teen Suicide, High Risk Deliveries, Prenatal Care, Data Integration, Prenatal Care for Black Women, Birth Spacing, and Overweight Rates among High School Students. State and National Performance Measures have been established and hold ISDH MCSHC accountable for the success (or failure) of each of these initiatives.

Outcome Measure data for Infant Mortality, Black/White Infant Mortality Disparity, Neonatal Mortality, Postneonatal Mortality, Perinatal Mortality, and the Child Death Rate are also monitored and reported annually.

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

Population- Based Services that are provided by ISDH MCSHC or funded by MCSHC include the

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

Progress toward the achievement of our National and State performance goals is reported in Sections C and D, following. ISDH MCSHC continues to build on previous year's successes. This year's Annual Report reflects that for 2004, ISDH MCHSC met eight of the thirteen National performance measures for which FY 2004 data is available, and six of the seven previous State-Negotiated performance measures have been met. Progress could not be reported on the five performance measures that are reported through the CSHCN survey, as current data is not available. Of the five national performance measures and the state-negotiated performance measure that were not actually met, most were close.

MCSHC is proposing a new set of State Negotiated Performance Measures (SP) based on the results of the needs assessment. Several of the new SP are identical to the previous SP, only the number has been changed. Others are similar in the need addressed, but the measure has been changed to keep up with MCSHC progress in addressing that need. There are three entirely new proposed SP and some of the previous SP are being discontinued. These are enumerated in Sections B and D. /2007/ Final FY 2005 activities for the SP that are being discontinued are in section D, at the beginning of related (for the most part) new SP. In 2006, ISDH MCSHC met or exceeded 9 performance measures, did not meet but came close to meeting 8 performance measures and recorded progress on another 9 performance measures that were in transition. /2007// /2008/ Final FY2006, ISDH MCSHC met or exceeded 14 performance measures, did not meet but came close to meeting 9 performance measures and recorded progress on another 3 performance measures. /2008//

B. State Priorities

Indiana experiences high rates of low birthweight, infant mortality, and inadequate prenatal care with greater disparity among minority populations. Childhood immunizations, while significantly improving, are still below HP2010 targets and environmental hazards, such as lead and second hand smoke, threaten the health of tens of thousands of children and adults.

Risky behaviors among adolescents lead to teen pregnancy and childbearing, and high rates of tobacco use. Obesity among children and adults contributes to higher incidences of chronic diseases like diabetes and cardiovascular diseases that contribute to escalating health care costs.

A high priority must be given to expanding the availability of care for isolated rural residents and underserved urban and suburban persons and to assisting the MCH populations' access to needed services, including the continued need to identify early and link children with special health care needs to appropriate services. At the same time, broad based education and outreach is needed to improve knowledge of healthy practices among the entire population.

The top priority needs identified in Indiana are:

1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality.
2. To reduce both qualitative and quantitative 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.

ISDH MCSHC Now reports on 8 State Negotiated Performance Measures (SP):

- SP 01 The number of data sets, including the NBS, UNHS, Lead, Indiana Birth Defects and Problems Registry, Immunizations, CSHCS, and First Step Data, that are completely integrated into the Indiana Child Health Data Set. (Similar to previous SP 09)
- SP 02 The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old. (Previously SP 10)
- SP 03 The percent of live births to mothers who smoke. (Previously SP 11)
- SP 04 The percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate. (Previously SP 12)
- SP 05 The percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter. (Similar to previous SP 14)
- SP 06 The proportion of births occurring within 18 months of a previous birth. (New)
- SP 07 The number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities so that appropriate responses can be implemented at the local level to lessen these differences. (New)
- SP 08 The percentage of high school students who are overweight. (New)

The identified priority needs will be impacted by activities in the listed Performance Measures as follow:

- Priority 1 is addressed in PM 01, PM 08, PM 15, PM 17 & PM 18 and SP 01, SP 03, SP 04, SP 06 & SP 07
- Priority 2 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06, PM 07, PM 09, PM 13, PM 14 & PM 19 and SP 04 & SP 07
- Priority 3 is addressed in PM 02, PM 03, PM 04, PM 05, PM 06 & PM 11 and SP 04, SP 05, SP 06, SP 07 & SP 08
- Priority 4 is addressed in PM 01, PM 12, PM 17 & PM 18 and SP 01, SP 02, SP 03 & SP 05
- Priority 5 is addressed in SP 03
- Priority 6 is addressed in SP 01
- Priority 7 is addressed in PM 08, PM 10 & PM 16
- Priority 8 is addressed in SP 08
- Priority 9 is addressed in PM 08 & PM 16
- Priority 10 is addressed in PM 01 - 18 and SP 01 - 05 (All of them)

NOTE: In 2007 the definitions for Federal PM 14 and 15 changed significantly. These two PM now address different priorities:

- PM 14 -- Priorities 1, 2, 3, 6, 7, and 8
- PM 15 -- Priorities 1, 2, 3, 4, 5, and 10

MCSHC grants approximately \$7.5 million to fund more than 50 local and statewide projects that build infrastructure and provide population-based, enabling and direct services to meet these

objectives. Additionally, beginning in FY 2005, MCSHC has provided approximately \$1 million in one-time infrastructure grant funds to more than 30 local and statewide projects to conduct community needs assessment, operate pilot projects or otherwise address the priority needs and performance measures above.

//2007/ Because of reductions in Title V allocations and increased costs, MCSHC is reducing grant funding from \$8.5 million in FY 2006 to \$6.5 million in FY 2007. This requires early termination of most of the one-time Special Projects initiated in FY 2005 and reductions of 6% to 11% for existing service providers. Special Projects being cut include obesity prevention and lead poisoning prevention. However, MCSHC has added obesity prevention performance measures to service provision requirements for most currently funded service providers and is also providing information about lead screening requirements and medical management recommendations for children ages 6 to 84 months to all currently funded service providers.

Additionally, MCSHC projects some cost savings for Family Planning provision by combining Title V and Title X Family Planning services. MCSHC will provide all Title V Family Planning services through a grant to the Indiana Family Health Council, the delegate for all Title X funding for Indiana. //2007//2008/ MCSHCS is working toward distributing the Title XX and TANF family planning funding in FY 2009//2008//**2009/ Beginning of Title XX and TANF Family Planning funding will not begin until at least October 1, 2009 //2009//**

Activities of MCSHC staff and grantees to meet these performance measures are discussed in sections C and D below.

C. National Performance Measures

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	99	99	99.2	100	100
Annual Indicator	100	100	100.0	100.0	100.0
Numerator			111	126	132
Denominator			111	126	132
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

Provisional based on calculations now used (see 2006 note for details).

Notes - 2006

Note: All tests except for Sick Cell TRAIT are included in the 2006 total.

Due to the new system in place for determining appropriate need for follow up, 100% of our confirmed positives will now always receive appropriate follow-up.

Source of data: ISDH NBS program.

Notes - 2005

When this performance measure changed, we had, and maintained, a 100% rate of follow-up in all screen positives. We were using this to report percentage of children screened, which this measure formerly had been.

a. Last Year's Accomplishments

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.

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.

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

a. FY 2007 Accomplishments

Activities that impacted this performance objective included:

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 eight in-service trainings to Public Health Nurses, midwives, hospitals, and birthing centers.

The Genomics/NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 100 % newborns whose screens were invalid, abnormal, or positive received follow-up.	X			
2. 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.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Performance Objective: Maintain at 100 %, the percent of screen positive newborns who received timely follow up to definitive diagnosis & 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 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 beginning 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 1/1/08.

The Genomics/NBS Director participated in the Region IV Genetics Collaborative & on the screening committee of the Indiana Genetics Advisory Committee.

c. Plan for the Coming Year

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.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	61.1	63	63	63	64
Annual Indicator	61.1	61.1	61.1	61.1	59.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	60	60	61	61	62

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Application Program will not allow change in objectives for current or previous years.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments

PERFORMANCE MEASURE # 2 The percent of children with special health care needs age 0 to 18 years whose families 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.

Status: 59.3 % per 2005/2006 CSHCN Chart book.

a. FY 2007 Accomplishments

Activities that impacted this performance objective included:

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. Twenty eight percent 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.

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, mailed Developmental Calendars to all participants age 0-5 years of age, and 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 four 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCS continues to grant 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 & building partnerships with professionals.				X
2. Medical Director will be working with ISDH Disaster Preparedness to assure needs of CSHCN are included.				X
3. CSHCS staff participated in 9 statewide "Roadshows" with members of the Indiana State Transition Team and presented information about the CSHCS program.		X		
4. CSHCS will continue to participate in statewide conferences and exhibitions to promote the CSHCS program.		X		

5.				
6.				
7.				
8.				
9.				
10.				

b. 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 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 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/Prof. 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.

c. Plan for the Coming Year

FY 2009 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 Service Systems 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 by 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, ensuring 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 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	55.7	56	56	56	56
Annual Indicator	55.7	55.7	55.7	55.7	54.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	55	55	56	56	57

Notes - 2007

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

Application Program will not allow change in objectives for current or previous years.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments

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 that impacted 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.

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 communities based medical practices to begin teaching about community resources and the medical home. A total of 28 medical staff was trained through these efforts.

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.				X
2. 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		X		

participants.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. 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.

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 (C.I.S.S.) 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 homes.

MCSHC will select or develop a brochure for physicians about the medical home concept.

MCSHC convened The Community Integrated Service Systems Advisory Committee (C.I.S.S.) in February 2008, to create a statewide Advisory Committee of governmental & 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.

c. Plan for the Coming Year

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.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	63.3	65	65	67	67
Annual Indicator	63.3	63.3	63.3	63.3	61.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	62	62	63	63	64

Notes - 2007

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

Application Program will not allow change in objectives for current or previous years.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments

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: Not Met at 61.8%.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.		X		

2. 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.				X
3. ASK currently has representation on the C.I.S.S. subcommittee addressing uninsured and underinsured children in our state.				X
4. ASK is currently revising its public health insurance training.		X		
5. 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.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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. For 2007, 91 % of participants had other insurance or Medicaid.

Activities to impact this Performance Objective Include:

CSHCS will be updating ACAPS to utilize insurance information for processing electronic pharmacy claims. Electronic Coordination of Benefits (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 the Provider Manual and will be issuing this revised manual later in this year. This manual is 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.

c. Plan for the Coming Year

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.

Activities to impact this Performance Objective include:

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	79.5	80	80	80	80
Annual Indicator	79.5	79.5	79.5	79.5	94.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	95	95	96	96	97

Notes - 2007

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

Application Program will not allow change in objectives for current or previous years.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments

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.

Status: Met at 94.3 %.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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. There were over 34,000 hits on this site.
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. There were 5100 families. (These were new families and follow ups with previously identified 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 continued 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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 various health care settings.		X		
2. 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, CYSHN, & families.		X		
3. 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 easy to use community-based service systems.		X		
4. MCSHC maintains an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.		X		
5. CSHCS provides current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, & to improve the organization & delivery of services to children with special health care nee		X		
6. CSHCS continues to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.		X		
7. CSHCS provides outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.		X		
8. CSHCS promotes Single Points of Entry (SPOE) early intervention sites, and use local Offices of Family Resources to take CSHCS applications.		X		
9. 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.).		X		
10. 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.		X		

b. Current Activities

FY 2008 Performance Objective: 95 % 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 2008.

c. Plan for the Coming Year

FY 2009 Performance Objective: 95 % 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 will continue to develop 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.

Indiana WINS, an internet based application system will be implemented statewide. Consumers can apply for CSHCS, Medicaid and MCH clinic services through this application.

CSHCS will continue to reimburse families for in-state and out-of-state transportation to medical facilities.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	6	6	6	6
Annual Indicator	5.8	5.8	5.8	5.8	41.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	41.5	41.5	42	42	42

Notes - 2007

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

Application Program will not allow change in objectives for current or previous years.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure. This is from SLAITS.

Application Program will not allow change in objectives for current or previous years.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Application Program will not allow change in objectives for current or previous years.

a. Last Year's Accomplishments

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: 6 % of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life (CSHCN Survey).

Status: Met at 41.1 %

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 with Special Health Care Services (CSHCS) 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.		X		
2. Materials and tools developed at the CYSHCN transition clinic continue to be distributed to other providers.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				

b. Current Activities

FY 2008 Performance Objective: 41.5 % 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 ages 14 years and older. 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 (CYSHCN) 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.

CSHCS work 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. Plan for the Coming Year

FY 2009 Performance Objective: 41.5 % 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 ages 14 years and older.

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 (CYSHCN) 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.

CSHCS 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.

The Community Integrated Systems of Services (C.I.S.S.) Transition Sub-Committee focuses on youth with special health needs making successful transitions to adult life by ensuring that community services are coordinated to help youth move from the pediatric to the adult health care systems, from secondary to post-secondary education, and toward employment and self-sufficiency.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	83	80	81	81	84
Annual Indicator	79.5	79.0	81	83.2	84
Numerator	203559	200692			
Denominator	256084	254041			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	84	85	85	86	86

Notes - 2007

See 2006 note; provisional data calculated based on trend analysis.

Source of data: ISDH Immunization program.

Notes - 2006

Source of data: ISDH Immunization Program.

Figure used is the lowest of the figures provided by the ISDH Immunization program for this group of immunizations and this age range. Individual numerator and denominator figures were not provided; however, we expect to receive those later in the year.

Objectives for 2007 and forward have been revised upwards due to FY2006 success.

Notes - 2005

2005 data not yet available. Estimate provided based on trend analysis.
 Future objectives have been revised incase estimate is not met.

a. Last Year's Accomplishments

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 84 % 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 84 %, which is an increase over 2006.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

The ISDH Immunization Program provided the Advisory Committee on Immunization Practices (ACIP) recommended vaccines for 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.				X
2. The legislature increased cigarette tax by 44 cents of which a portion will be used to buy vaccines.				X
3. The ISDH Immunization Program worked with MCSHC to increase the number of sites using reminder/recall systems of needed immunizations to 75%.		X		

4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. 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 84% in 2008.

Activities to impact this Performance Objective include:

The ISDH Immunization Program continues to provide the Advisory Committee on Immunization Practices (ACIP) recommended vaccine for MCSHC sites enrolled in the Vaccines for Children (VFC) program.

The ISDH Immunization Program continues to 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 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 enroll able 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. Plan for the Coming Year

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 85% in 2009.

Activities to impact this Performance Objective include:

The ISDH Immunization Program will continue to provide the Advisory Committee on Immunization Practices (ACIP) recommended vaccine for 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 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	23	22	20	19.5	19
Annual Indicator	21.5	20.9	20.5	20.8	20.2
Numerator	2817	2749	2757	2808	
Denominator	130897	131532	134457	134753	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	20.1	19.8	19.5	19.2	18.9

Notes - 2007

Provisional based on trend analysis.

Source of data will be ISDH ERC.

Notes - 2006

No data available for FY2006 at this time. We are in process of acquiring FY2006 data and hope to have that data later in the year.

Notes - 2005

Objective changed 19.9, but web program would not allow change.

Source: U.S. Census Bureau, ISDH ERC

a. Last Year's Accomplishments

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 20.2 for 2007.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 application. A grant was awarded and MCSHC was able to support a statewide media campaign that reinforces the consequences of sexual activity, including teen pregnancy, and advocates for teens to 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 above mentioned 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 website. Interactive elements were also 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

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 youth summit held in September 2007 which focused on unintended pregnancies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The SAHC continued 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.				X
2. 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 & on their terms, using methods that connect with and involve youth in their communities.				X
3. 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.		X		
4. The SAHC was part of the planning committee for the first ISDH youth summit held in the state. The event attracted nearly 600 students statewide. The summit offered breakout sessions to students on healthy relationships.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 20.1 in FY 2008.

Activities to impact this Performance Objective include:

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 provide the program an opportunity to spread the message of abstinence and delaying parenting and pregnancy among teens.

The 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.

c. Plan for the Coming Year

FY 2009 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 19.8 in FY 2009.

Activities to impact this Performance Objective include:

The State Adolescent Health Coordinator (SAHC) will author and submit the fiscal year 2009 Section 510 Abstinence Education Program grant application if this program is reauthorized.

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 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.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	35	42.7	46	47	48
Annual Indicator	47.3	45.1	44.5	47.1	48.7
Numerator					

Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	49	50	51	52	53

Notes - 2007

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

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This means that, based on our revised projection, we met out goal for 2007.

Notes - 2006

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

Note: This survey has not been done since 2005. It will not be done again until 2010. However, our programs have been successful, decreasing the rate of decline from -2.2 to -.0.6 in one year. Based on that success, we can predict increasing success for the intervening years. This revises 2006's figure and actually means that, based on our final revised projection, we met out goal for 2006.

Notes - 2005

Note: In the past, multiple methods have been used to find this measure, including questions on the BRFSS and in-mouth surveys. Questionnaire surveys from 2000 and 2001 and in-mouth survey from Fall 2000 were conducted. Using these three surveys, an estimate of this measure has been calculated for the 2001 figure. If the questionnaire survey is continued, data from the questionnaire will be used for future reports.

2005: The questionnaire was continued.

Source of Percentage for 2003-2004: ISDH Oral Health program.

a. Last Year's Accomplishments

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 48 % in FY 2007.

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 Objective included:

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 Oral Health 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.

Oral Health Staff 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 drafting 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).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.		X		
2. OHS has collaborated with Indiana University School of Dentistry and Indiana University School of Public and Environmental Affairs, Center for Health Policy to apply for CDC and HRSA Oral Health opportunities.				X
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. 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 49% 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:

Oral Health Director Hired In Dec. 07.

OHS promotes community-based dental sealant programs, & collaborates with the IU School of Dentistry Community Dentistry's sealant placement program, St Mary's Mobile Unit, Smile Indiana Mobile Program & 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 & 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, & collaborated with these community experts on drafting the State Oral Health Plan, which will increase dental services to the underserved.

OHS consults regularly meet on a quarterly basis or as needed with the Office of Medicaid & Policy Planning and the Dental Advisory work group on oral health issues.

OHS promotes the use of pit & fissure sealants.

c. Plan for the Coming Year

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 50 % 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 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) and it's Dental Advisory work group 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, 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 Director 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.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	4	3	3	3.4	3.2
Annual Indicator	3.2	4.3	3.3	3.5	3.2
Numerator	43	57	44	46	
Denominator	1325771	1330543	1326607	1301093	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	3	2.8	2.6	2.5	2.4

Notes - 2007

Fluctuating figure; expected to decrease next year.

Source of data will be US Census Bureau; ISDH ERC.

Notes - 2006

Projection based on last year's data. 2006 data will not be complete per ISDH ERC until all figures are in to Vital Records and subsequently analyzed. VR does not get them from other states until September, so this will always be a provisional figure.

Notes - 2005

2005 data not yet available. Estimate provided based on trend analysis.
 Future objectives have been revised in case estimate is not met.

a. Last Year's Accomplishments

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 3.2 in 2007. (Baseline of 3.38 in 2005)

Status: In 2006 (provisional), the rate of motor vehicle accident deaths per 100,000 residents age 0 -14 was 3.5 (46/1,301,093).

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 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 which 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 MCSHC projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC began funding a part-time injury epidemiologist position to support the ISDH Injury Prevention Program.			X	
2. ISDH maintained a web-based Injury and Violence Prevention Resource Center as a resource for injury prevention information for Indiana.		X		
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. 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 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. Plan for the Coming Year

FY 2009 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will be 2.8 in 2009 (baseline of 3.38 in 2005).

Activities to impact this Performance Objective include:

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 with 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: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				35	31
Annual Indicator			29.2	30.2	34.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	35	36	37	38	39

Notes - 2007

Source of data: US CDC report.

Notes - 2006

Source of Data: ISDH WIC program.

Notes - 2005

Program director suggested a very aggressive goal of 35%. As this goal was defined as very aggressive, future objectives remain the same until baseline data is established.

a. Last Year's Accomplishments

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 31% in FY 2007.

Status: Met at 34.6 %

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

The Indiana Breastfeeding Alliance (IBFA) was formed from the members of the State Breastfeeding Task Force 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), 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, who will 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The IBFA has continued to collaborate with ISDH in pursuing funding to create a Breastfeeding Center for Excellence.				X
2. ISDH has maintained the breastfeeding website for consumers and professionals. Future updates to include coalition information are in the planning stages. In the interim, IPN created a blog to enhance communication between State Coordinators.			X	
3. Indiana Black Breastfeeding Coalition (IBBC) since early 2007 seeks to 'promote, empower, embrace, & encourage mothers, fathers, & family members in the African American community through outreach, education, & advocacy to breastfeed.			X	
4. 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.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

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 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, Aug. 1 -- 7. HRSA's, "The Business Case for Breastfeeding" also was presented and materials handed out for use by the coalitions in their communities.

The Indiana Breastfeeding Alliance has been working to formalize bylaws and update the Breastfeeding Consensus Statement. They will seek key partners and form standing committees in their effort to support breastfeeding statewide.

c. Plan for the Coming Year

FY2009 Performance Objective: The percentage of mothers who breastfeed their infants for six months of age will be 36 % in 2009.

Activities to impact this Performance Objective include:

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 that 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 before hospital discharge.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	99	99	98.4	98.6	99.6
Annual Indicator	99.7	97.9	99.6	99.6	99.6
Numerator	84490	86077	87371		
Denominator	84744	87927	87685		
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	99.7	99.7	99.7	99.8	99.8

Notes - 2007

Provisional based on trend analysis.

Source of data will be ISDH UNHS/EHDI Program(s)

Notes - 2006

Projection used, as ISDH ERC is in process of verifying questionable immunization data.

Notes - 2005

Final information received from ISDH Newborn Screening Program; figures updated.

a. Last Year's Accomplishments

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 99.6 % 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. 99.6 % of newborns were screened prior to hospital discharge in Calendar Year (CY) 2006. Preliminary data from CY 2007 suggests that at least 99.6 % of newborns were screened prior to leaving the birthing center.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 in March 2007.

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.

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 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. EHDI is continued the 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.		X		
2. 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.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Performance Objective: Improve universal newborn hearing screens to 99.7 % 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 for use 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.

c. Plan for the Coming Year

FY 2009 Performance Objective: Improve universal newborn hearing screens to 99.7 % in FY 2009.

Activities to impact this Performance Objective include:

EHDI (State EHDI Coordinator, the EARS Consultant, and Regional Consultants) will continue to train hospital staff 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 materials to all Public Health Departments to improve Public Health Nurse's (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: *Percent of children without health insurance.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	10	6	12	8.7	9.5
Annual Indicator	12.9	8.9	9.5	10.0	9.0
Numerator	206111	144000	161260	158000	141990
Denominator	1603970	1617977	1689985	1577629	1577667
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	8.5	8	7.5	7	6.5

Notes - 2007

Source of data: Kids Count book (Ann Casey/Robert Wood Johnson Foundation); US Census Bureau.

Note: This is children age 17 and below.

Notes - 2006

Provisional estimate from Robert Wood Johnson foundation figures and US Census Bureau figures.

Notes - 2005

Additional Note: Final figures used from Robert Wood Johnson Foundation for FY2005.

For FY2004, the data source is Annie E Casey foundation "Kids Count 2005" as the variability is no longer as large as the three year average previously used.

Because of this, the objective for 2005 should have been changed to maintain at 8.9. However, in 2004 we were unable to determine if the 2003 figure or the 2004 figure would be the correct one to use as a baseline. This has now been determined, so in future the 2005 objective should read 8.9; however the computer application does not allow us to change objective for current or past years to correct provisional data.

a. Last Year's Accomplishments

PERFORMANCE MEASURE # 13 Percent of children without health insurance.

Performance Objective: To decrease the percent of children without insurance to 9.5 % in FY 2007.

Status: Percentage: 9.0 % of children uninsured. Performance Objective achieved.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

The MCHB funded project, the Indiana Early Childhood Comprehensive System (ECCS) Program continued to include strategies to increase the percentage of children on child care voucher programs who have health insurance.

The MCSHC Sunny Start: Healthy Bodies, Healthy Minds program continued to provide service information to families via a website.

MCSHC grantees continued to serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.

The Indiana Family Helpline continued to provide referrals and screens clients for Hoosier Healthwise eligibility.

MCSHC continued to require all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees continued to facilitate children into Hoosier Healthwise.

The MCSHC Director continued to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.

MCSHC staff continued to participate in the Department of Family Resources Partnership subcommittee.

CSHCS program continued to provide for children enrolled in the program last payer reimbursement for primary care and specialty care and hospitalization for services related to the diagnosis that made them eligible for the program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC continued to require all grantees providing primary care to children to be Medicaid providers.		X		
2. The MCSHC Director continued to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.				X
3.				
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

Performance Objective: To decrease the percent of children without insurance to 8.5 % in FY 2008.

Activities to impact this Performance Objective include:

The MCHB funded project, the Indiana Early Childhood Comprehensive System Program continues to include strategies to increase the percentage of children on child care voucher programs who have health insurance.

The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program continues to provide service information to families via a website. The website will be expanded to include more information.

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

The Indiana Family Helpline continues to provide referrals and screens clients for Hoosier Healthwise eligibility.

MCSHC continues to require all grantees providing primary care to children to be Medicaid providers.

MCSHC Family Care Coordination grantees continue to facilitate children into Hoosier Healthwise.

The MCSHC Director continues to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.

MCSHC staff continue to participate in the Department of Family Resources Partnership subcommittee.

c. Plan for the Coming Year

FY 2009 Performance Objective: To decrease the percent of children without insurance to 8.0 % in FY 2009.

Activities to impact this Performance Objective include:

The MCHB funded project, the Indiana Early Childhood Comprehensive System Program will continue to include strategies to increase the percentage of children on child care voucher programs who have health insurance.

The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program will continue to provide service information to families via a website. The website will be expanded to include more information.

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

The Indiana Family Helpline will continue to provide referrals and screens clients for Hoosier Healthwise eligibility.

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

MCSHC Family Care Coordination grantees will continue to facilitate children into Hoosier Healthwise. Emphasis on doing so will be increased.

The MCSHC Director will continue to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.

MCSHC staff will continue to participate in the Department of Family Resources Partnership subcommittee.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				23	49
Annual Indicator			23.0	17.5	17.5
Numerator			18232	14862	
Denominator			79406	84925	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	17	16.5	16	15.5	15

Notes - 2007

Figures provided for CY 2005 by WIC program may have been in error. Actual figures for CY 2006 from the WIC program are 14862 (numerator) and 17.5% (denominator calculated from those to be 84975).

This would be much closer to the original WUC estimates for CY 2005 (18232/79406=23%) and show a marked decrease due to our effective programs.

The corrected but suspect figures for CY 2005 are being checked by WIC at this time. Final figures for CY 2005 will be entered into the historical notes when available.

Source of data: ISDH WIC program.

Application would not allow change of 2007 objective. Actual objective would be 17.5%.

Notes - 2006

Corrected information for this historical note (also see note for 2007):

Figures provided for CY 2005 by WIC program may have been in error. Actual figures for CY 2006 from the WIC program are 14862 (numerator) and 17.5% (denominator calculated from those to be 84975).

This would be much closer to the original WUC estimates for CY 2005 ($18232/79406=23\%$) and show a marked decrease due to our effective programs.

The corrected but suspect figures for CY 2005 are being checked by WIC at this time. Final figures for CY 2005 will be entered into the historical notes when available.

Source of data: ISDH WIC program (see original historical note below for further details).

=====

WIC information provided to us a correction for CY2005 for baseline figures. However, the TVIS application would not let us change CY2005's figures; here are the actuals:

CY2005 Numerator: 25320
CY2005 Denominator: 51472

Which equals 49.2%.

The previous figure of 23% did not include >95% numbers.

CY2006 figure estimated based on CY2005 actuals.

Source of data: ISDH WIC Program

Notes - 2005

Figures provided by WIC. These are CY 2005 figures. Adding risk factors 113 & 114 together gives the number of children at or above the 85th percentile.

Baseline has been established, as we have from WIC figures for CY 2003 and 2004 as follows:

CY 2003 - Total Children ages 2 to 5 receiving WIC services: 79484
CY 2003 - Total Children with risk factor 113: 7658
CY 2003 - Total Children with risk factor 114: 9635

CY 2004 - Total Children ages 2 to 5 receiving WIC services: 80374
CY 2004 - Total Children with risk factor 113: 8197
CY 2004 - Total Children with risk factor 114: 10171

a. Last Year's Accomplishments

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

FY 2007 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 49 %.

Status: 17.5 % For 2007

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.			X	
2. WIC provided or referred families of WIC eligible children for counseling that includes as appropriate, physical activity ideas, reduced sedentary activities, and healthy eating.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. 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 17 %.

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. MCSHC 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, MCSHC 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. MCSHC clinics are displaying posters and creating bulletin boards communicating information on physical activity, nutrition and healthy eating habits.

WIC is providing educational books, handouts, and videos on healthy eating and physical activity.

c. Plan for the Coming Year

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 16.5 %.

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%). MCSH health care professionals will also screen all participants for "Overweight" (BMI equal to or > 95%) and "At Risk for Overweight" (BMI85% 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. MCSHC 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, MCSHC 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. MCSHC 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. MCSHC 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.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				16.1	15.8
Annual Indicator			16.2	15.9	15.7
Numerator				15589	15450
Denominator				97788	98408
Check this box if you cannot report the numerator					

because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	15.6	15.5	15.4	15.3	15.2

Notes - 2007

Percentage and numerator provided by ISDH VR; denominator calculated.

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

Notes - 2006

Information estimated based on number of women who reported smoking on birth certificates. All of those who reported smoking on the birth certificate were definitely smoking during the final trimester. This is probably close to the actual percentage, as it only omits women who smoked through the end of their second trimester but quit prior to delivery.

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

Notes - 2005

Baseline information for 2004 is 15954 numerator, 97818 denominator with an indicator of 16.3.

Source of 2005 indicator: ISDH Epidemiology Resource Center.

a. Last Year's Accomplishments

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 15.8 % in FY 2007.

Status: Provisional data from the 2007 Electronic Birth Certificate shows 15.7% of pregnant women were smoking in third trimester.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

MCSHC contracted to have in-depth epidemiology analysis of maternal smoking and birth outcomes data. This was completed and posted on ISDH Website.

MCSHC completed the on-site training of OB providers and office staff in Crawford, Clark, Scott, Jefferson, and Perry Counties. Smokefree Indiana, in collaboration with the Indiana State Department of Health, 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC staff worked with Hoosier Healthwise & Contracted MCO's health care providers & outreach workers on smoking cessation. Training of physician representatives of all 3 MCO's on evidence based assessment tools, the 5A's, 5R's & the Quitline.			X	X
2. PSUPP will distribute 27,000 informational items about the impact of substance use among pregnant women to the public.			X	
3. All ITPC County Coalitions have been trained in the prenatal office training model and are replicating the in office training in 80 counties.				X
4. MCSHC will work with Indiana ACOG to disseminate information on prenatal smoking cessation and one IPN Newsletter will be dedicated to prenatal smoking.			X	
5. Baby First Packets will be sent to Prenatal IFHL callers that includes information on smoking cessation.			X	
6. Dr. Judith Monroe, Health Commissioner, implemented a collaboration with Indianapolis Women's Magazine to insert				X

health focus inserts in each magazine. The April 2008 edition was Power over Addiction including smoking.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.6 % 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 ITPC program in all 92 counties will be brought in for training 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 MCSHC 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 in three focus counties for prenatal clients.

MCSHC analyzes the rate of smoking in the third trimester quarterly to determine training needs.

c. Plan for the Coming Year

FY 2009 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.5% in FY 2009.

ISDH will continue with legislative commission on prenatal smoking, alcohol, and drug use to develop an 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, and 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 three clinics, 4) educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy, and 5) expand where and when possible.

MCSHC will continue as a partner in the Coalition to Promote Smokefree Pregnancies to assist Clarian 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 >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.

//2009/ Further training for prenatal projects on correct data entry into FRED with reference to tobacco usage is still postponed. MCH is currently reviewing whether to retain FRED as the primary data collection mechanism by the MCH projects.

In 2009 MCH is completing a two-year analysis of trends of smoking in the last three months of pregnancy with multiple cohorts related to both the birth mother and the child, including an emphasis on various demographics. This analysis will be used as one of the major parts of the upcoming 5-year Needs Assessment in relation to smoking in the last trimester. //2009//

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8	8	8	8	6.9
Annual Indicator	6.6	8.1	6.9	7.3	7.2
Numerator	29	36	31	33	
Denominator	442311	445489	450445	450758	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	7.1	6.9	6.7	6.5	6.3

Notes - 2007

Fluctuating rate; average based on trend analysis. Data from previous years is not final.

Source of data: US Census Bureau, ISDH ERC

Notes - 2006

Estimate provided based on previous year's figures which are now final. Despite this measure fluctuating considerably, it is hoped we can maintain at CY2005's level of 6.9.

TVIS application did not allow changing objective for 2006; projected objective would have been changed to 6.9.

Notes - 2005

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

Source of Data: ISDH ERC.

a. Last Year's Accomplishments

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 6.9 in FY 2007. (Baseline rates of 9.1 in 2002 and 6.6 in 2003).

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.

Status: Not Met 7.2 %

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborated with Indiana Department of Education to include prevention content in annual school conferences, specifically the Safety Specialist Academy.				X
2. Continued to establish local or regional prevention councils in underserved areas of the state, with Muncie and Jeffersonville being the newest additions.				X
3. Helped existing local/regional suicide prevention councils utilize the results from the statewide needs assessment in their planning efforts.				X
4. Continued to provide technical assistance to organizations and individuals throughout Indiana regarding suicide prevention.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.1 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.

c. Plan for the Coming Year

FY 2009 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 6.9 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 two 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 update 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.

ISDH was unable to finalize the draft of the State Injury Prevention and Control Plan last year (which includes youth suicide as one of five objectives) due to lack of personnel in the ISDH Injury Prevention Program. However, due to the importance of this issue, new personnel who are involved in Injury Prevention have been approached for the possibility of re-energizing the SIPCP, finalizing the draft, and including youth suicide as one of the objectives, of which all five are expected to be maintained when the draft is finished.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	58	58	77	80	81
Annual Indicator	76.4	78.5	77.4	70.3	77.4
Numerator	941	1002	947	893	
Denominator	1231	1277	1224	1271	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	78	80	82	84	86

Notes - 2007

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

Estimates provided based on CY2006 figures which are now final. CY2007 data is not yet available.

Source of data: ISDH MCH Consultant Program.

Because application did not allow changing the objective, the objective would actually be 77.

Notes - 2006

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

CY2006 figures used. Source of data: ISDH MCH Consultant Program.

This major drop is a suspected outlier. Further checking into the hospitals identifying themselves as level three, especially considering name-changes, mergers, hospitals that no longer do deliveries, etc. will be required to ensure that this is an accurate figure. At the moment it is the best using the data supplied.

Notes - 2005

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

Source of Numerator and Denominator: Indiana Birth Records, ISDH Epidemiology Resource Center.

The numerator is total number of occurrent births of Very Low Birth Weight at hospitals who have self-declared their status as a level 3 hospital. Although Indiana does not have a formal perinatal system in place, the Indiana Perinatal Network conducted a new survey in FY 2003 which requested that hospitals identify their level according to established standards. The denominator is the total occurrent births of Very Low Birth Weight.

a. Last Year's Accomplishments

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.

Status: Not Met 77.4% (based on preliminary data)

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 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 was reviewed by a MCH 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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Birth data by hospital was reviewed by a MCH consultant for appropriate deliveries and transport of high-risk deliveries and neonates. MCSHC will notify counties of any problems.				X
2. MCSHC participated in 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.		X		
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. 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 78 % in CY 2008.

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. This should 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 Clinton 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. Plan for the Coming Year

FY 2009 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 80% in CY 2007.

Activities to impact this Performance Objective include:

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 program to implement statewide in 2010.

MCSHC will work with Lake County hospitals to assess competency levels, how to do an equipment inventory, and how to build a perinatal network. A modified PCEP training program will be offered to all hospitals and implemented by at least one of them. Memorial Hospital in St. Joseph County, a level 3 hospital, will be encouraged to participate, as high risk women from Lake County may be transported to Memorial for delivery. The use of tele-medicine 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.

/2009/ Efforts will be made to update documentation of tertiary status using the

aforementioned survey rather than simply self-identification for birthing centers. Efforts will be made to follow up and document the follow up of the survey. Data from the survey will be used to guide the portion of the upcoming Needs Assessment related to VLBW. //2009//

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	80.2	80.4	81.1	81	78.5
Annual Indicator	80.6	78.5	78.2	77.6	76.6
Numerator	69605	69054	68723	69358	
Denominator	86382	87961	87864	89404	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	76.6	77.6	78.6	79.6	80.6

Notes - 2007

Provisional calculated based on trend analysis. Program will not allow us to change objective for 2007 or it would have been lowered. Future objectives have been adjusted based on trend analysis; however, we are hoping to reverse the downward trend in the near future based on our programs.

Source of data will be ISDH ERC

Notes - 2006

Actual data final.

Source of data: ISDH ERC.

Notes - 2005

Source of data: ISDH ERC. Data for 2005 is now final.

a. Last Year's Accomplishments

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 78.5 % in 2007.

Status: Not Met at 76.6 %

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 completed in 2008 because of the need for 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.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCSHC perinatal consultant worked with Office of Medicaid Policy & Planning (OMPP) and MCOs to expand Early Start projects in counties with poor access to prenatal care.				X
2. MCSHC funded 22 prenatal care coordination projects throughout the state that provided outreach, case finding, referral, advocacy, and education of at risk pregnant women.		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. 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 76.6 % 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.

The Early Start program is being implemented 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, casefinding, 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 23rd 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.

c. Plan for the Coming Year

FY 2009 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 77.6 % in 2009.

Activities to impact this Performance Objective include:

Target two emergency departments in two priority counties will implement the ER protocol to refer all pregnant women in the ER to PNCC and a MCH funded prenatal clinic or CHC. Stakeholders in the targeted counties must pull together 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 mid-level nurses to run early start clinics as a stop gap until pregnant women can get an appointment with a prenatal care provider.

D. State Performance Measures

State Performance Measure 1: *The number of data sets, including the NBS, UNHS, Lead, IBDPR, Immunizations, CSHCS, Vital Statistics, and First Steps Data, that are completely integrated into the Indiana Child Health Data Set.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1	1
Annual Indicator			1	2	1

Numerator			1	2	1
Denominator	1	1	1	1	1
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1	1	1	1	1

Notes - 2006

Source of Data: ISDH Data Integration Steering Committee

Notes - 2005

Application would not allow us to change the denominator nor the objective. We expect to fully integrate one additional data set per year.

a. Last Year's Accomplishments

STATE PERFORMANCE MEASURE # 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.

FY 2007 Performance Objective: At least one additional data set will be integrated into the Indiana Child Health Data Set. This was the objective under the old definition. Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data sets will be completely integrated into the Indiana Child Health Data Set along with at least two additional data sets well under way in final development and testing.

Status: Performance Objective Accomplished

Activities that impacted this Performance Objective included:

The Operations Data Store (ODS) development team, coordinated by the Data Integration Steering Committee (DISC), continued to develop and test input and output from various sources, most importantly, the new Vital Records Electronic Birth Certificate (EBC), which went live in January 2007. Implementation is being staged, with the birth module completed prior to the death module. The significant change in the data fields on the birth certificate enabled us to obtain verified data rather than estimates for the Health Status Indicator related to Medicaid versus non-Medicaid population.

Universal Newborn Hearing Screening, Lead, Indiana Birth Defects and Problems Registry, Immunizations, Children's Special Health Care Services, and First Steps Data continued development for integration into the ODS when completed.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Operations Data Store (ODS) development team, coordinated by the Data Integration Steering Committee (DISC), continued to develop and test input and output from various sources.				X
2. Universal Newborn Hearing Screening, Lead, Indiana Birth Defects and Problems Registry, Immunizations, Children's Special Health Care Services, and First Steps Data continued to				X

be developed for integration into the ODS when completed.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Performance Objective: Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data sets totals will be completely integrated into the Indiana Child Health Data Set, with at least two additional data sets well under way in final development and testing.

Activities to impact this Performance Objective include:

The integration of the EHDI portion of Newborn Screening, and the Indiana Birth Defects and Problems Registry into the Indiana Child Health Data Set for initial use was completed.

The integration work and testing of First Steps data began.

The use of verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations began.

c. Plan for the Coming Year

FY 2009 Performance Objective: At least one new data set will be completely integrated into the Indiana Child Health Data Set, with at least two additional data sets well under way in final development and testing.

Activities to impact this Performance Objective include:

The Newborn Heel Stick Screening datamart will be developed and implemented.

The Lead program integration will continue to be evaluated along with the CHIRP data.

The Children's Special Health Care Services, and the First Steps Data will continue development for integration into the Indiana Child Health Data Set when completed.

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.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	75.1	73.3	38	29	28
Annual Indicator	38.7	29.6	28.9	25.0	24
Numerator	1664	1276	1242	1076	
Denominator	430166	430557	430439	431089	

Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	23	22	21	20	19

Notes - 2007

Actual data for FY2007 not yet available. Estimate provided based on previous two years' actual data. Application did not allow for changing 2007 objectives.

Source of data will be ISDH Chronic Disease Program

Notes - 2006

Source of data: ISDH Chronic Disease Program

Notes - 2005

Actual data received beginning in 2003. Previous estimates and projections were inflated due to Health and Hospital Corporation providing counts which included duplicates. Source of data: ISDH Chronic Disease Program. Estimate provided based on previous year baseline.

a. Last Year's Accomplishments

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 24 in 2005. Source: The Burden of Asthma in Indiana: Second Edition, March 2008.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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.

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.

The Environmental Quality workgroup promoted Breathyeasyville 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.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The State Asthma Program promoted the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma.				X
2. The State Asthma Program provides evidence-based and data driven information on asthma management and care, through addressing indoor and outdoor environmental asthma triggers, at trainings, and conferences.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. 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 23.

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.

c. Plan for the Coming Year

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 22.

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's 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 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 into account 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.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	19.8	19.5	17.8	17.1	16.5
Annual Indicator	18.5	17.9	17.7	17.3	17.1
Numerator	15954	15707	15589	15450	
Denominator	86382	87961	87864	89404	

Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	16	15.5	15	14.5	14

Notes - 2007

Source of data will be ISDH Epidemiology Resource Center. Data for CY2007 based on trend analysis.

Application would not allow a change in 2007 objective. However, actual 2007 objective will be 17.1.

Notes - 2006

Source of data ISDH Epidemiology Resource Center. Data for CY2006.

Notes - 2005

Source of data ISDH Epidemiology Resource Center. Denominator = occurrent births CY2005.

a. Last Year's Accomplishments

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 16.5 % in CY 2007.

Status: Met 17.1 %

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 Quitline to all funded prenatal projects.

Quitline 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 the 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 for all three 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 five focus counties. The training took place in Newton, Starke, Grant, Knox, and Fayette, but invitees also attended from their contiguous counties.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.				X
2. MSCHC contracted with the American Lung Association to provide "Freedom from Smoking for You and Your Baby" Train-the-Trainer workshops training to health professionals in 3 additional fpcis counties.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. 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 Quitline 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.

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 Quitline by each project.

c. Plan for the Coming Year

FY 2009 Performance Objective: The percent of live births to mothers who smoke will decrease to 15.5 % in FY 2009.

Activities to impact this Performance Objective include:

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, and continue to provide support groups for pregnant women for smoking cessation in three counties (Vigo, Clark, Vanderburgh), they will also continue to distribute educational items about the impact of smoking on pregnancy, and participation 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 Quitline to all funded prenatal projects.

MCSHC will evaluate the success of the PSUPP projects on success of prenatal smoking cessation, and referrals to the Quitline 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 care visits were adequate.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	66	67	62	63	64
Annual Indicator	61.6	61.3	60	57.3	58
Numerator	5722			5957	
Denominator	9288			10396	
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	59	60	61	62	63

Notes - 2007

Indicator will be provided by Epidemiology Resource Center. Data provided for FY2007 based on trend analysis.

Application would not allow change of 2007 objective. Actual 2007 objective will be 58.

Notes - 2006

Indicator provided by Epidemiology Resource Center. Denominator provided by ERC also. Numerator calculated.

Notes - 2005

Indicator provided by Epidemiology Resource Center.

a. Last Year's Accomplishments

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

FY 2007 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 64% in FY 2007.

Status: Not Met 58 %

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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. 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 four counties with resulting recommendations to reduce disparities and improve local perinatal systems. A statewide report will be published. An interim one year report was done by all projects due to staff changes, the state report will be completed in 2008.

The number of black women age 15-44 with a live birth whose prenatal care visits were adequate actually increased by over 200 out of a small group of under 6,000 total. Clearly there is room for improvement but also there are some obstacles to persuading the population to attend the minimum number of prenatal care visits in order to ensure this is adequate, as the population (denominator) is over 10,000. However, given that the percentage has been relatively stable, ranging from 61.6 to 60 in the three years prior to 2006, it is possible that the much lower figure for 2006 is an outlier, statistically, and will show a bounce back to the normal curve when 2007's figures are available. This is very likely the case, as we are dealing with very small numbers in the numerator for this performance measure. It will continue to be watched closely.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.			X	
2. MCSHC is working to increase the number of certified nurse midwives providing care in high risk neighborhoods.		X		
3. 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.			X	
4. IPN and MCSHC addresses perinatal disparities by sponsoring a booth at the Indiana Black Expo Black and Minority Health Fair.			X	
5. IPN will provide ongoing evaluation of the community based Doula program. MCSHC will assess the feasibility of replication based on outcomes and cost.				X
6.				
7.				
8.				

9.				
10.				

b. 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 59 % 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 is 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 works 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.

c. Plan for the Coming Year

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 60 % in FY 2009.

Activities to impact this Performance Objective include:

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 1st 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 the Black and Minority Health Fair. 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.

There will be community presentations in the disparity counties and will have town meetings with training on FIMR .

The number of black women age 15-44 with a live birth whose prenatal care visits were adequate actually increased in 2006 by over 200 out of a small group (under 6,000 total). Clearly there is room for improvement but also significant difficulty in persuading the population to attend the minimum number of prenatal care visits in order to ensure this is adequate, as the population (denominator) is over 10,000. However, given that the percentage has been relatively stable, ranging from 61.6 to 60 in the three years prior to 2006, it is possible that the much lower figure for 2006 is an outlier, statistically, and will show a bounce back to the normal curve when 2007's figures are available. This is very likely the case, as we are dealing with very small numbers in the numerator for this performance measure. This Performance Measure will continue to be watched closely.

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.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2.4	2.4
Annual Indicator			2.5	1.0	0.9
Numerator				637	
Denominator				61650	
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	0.8	0.8	0.7	0.7	0.6

Notes - 2007

Source of data: ISDH LEAD Program. Now that the new software is completely installed and running, the improvement was dramatic. The application will not allow for changes to objectives in 2006-2007, but the actual figures were much smaller. This trend we hope to continue. 2007 figure is provisional based on the new baseline figure (2006's actual). Objectives revised to reflect this as well.

2007 objective will be .9.

Notes - 2006

Source of data: ISDH LEAD Program. Now that the new software is completely installed and running, the improvement was dramatic. The application will not allow for changes to objectives in 2006-2007, but the actual figures were much smaller. This trend we hope to continue. 2007 figure is provisional based on the new baseline figure (2006's actual). Objectives revised to reflect this as well. 2006 objective would have been 1.0.

Notes - 2005

New performance measure, baseline data will establish future objectives. Source of projection: Indiana LEAD Program.

a. Last Year's Accomplishments

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.

FY2007 Performance Measure Objective: During FY 2007, the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will decrease to 2.4 %.

Status: In FY 2007, 61,650 children were tested, resulting in 637 having 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 .09 %.

a. FY 2007 Accomplishments

Activities that 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)

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.		X		
2. Five major local health departments have become Medicaid providers ready to claim under the new codes being set up by Medicaid.		X		
3. 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.			X	
4. Comprehensive lead legislation, designed with the input of ILHHP and ISDH, was introduced in the 2008 General Assembly session.				X
5.				
6.				

7.				
8.				
9.				
10.				

b. 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 .8 % .

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 to impact 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.

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).

c. Plan for the Coming Year

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 .80 % of the total children tested. The projections for total tested is 70,400 with 634 elevated.

Activities to impact this Performance Objective 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 children with blood lead elevation 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, and 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.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				18	17
Annual Indicator			18.4	11.9	17
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	16	15	14	14	13

Notes - 2007

FY 2007 Data Unavailable. Indicator has been entered to reflect expected objective. Real objective will be maintained at 17, as 11.9 could be an outlier. Figure is inconsistent; no trend analysis possible yet. Source of Data will be ISDH HSC Program.

Notes - 2006

FY2006 data unavailable; baseline continued.

Notes - 2005

New Performance Measure. Baseline data will be used to establish future objectives.

a. Last Year's Accomplishments

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 2007.

Status: Met. 17 percent had a birth in 2007 that was within 18 months of previous birth. This was mostly caused by a reduction in teen births and an increase in the undocumented Hispanic population.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

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 2008 and will be placed on the web site.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A birth cohort data analysis to identify commonalities in the subpopulation of women who do not space births at least 18 months was begun.				X
2. A call to action document produced by the Unintended Pregnancy advisory group was shared throughout the state.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. 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. Plan for the Coming Year

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.

Activities to impact this Performance Objective include:

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 Group 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 to all 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 begun in 5 targeted counties to identify perinatal disparities.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1	1
Annual Indicator			1	1	1
Numerator			1	1	1
Denominator	1	1	1	1	1
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1	1	1	1	1

Notes - 2005

Application would not allow us to change the denominator nor the objective. We expect to begin one additional partnership per year.

a. Last Year's Accomplishments

STATE PERFORMANCE MEASURE # 7 Number of community/neighborhood partnerships established in five 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 three community partnerships established.

a. FY 2007 Accomplishments

Activities that impacted this Performance Objective included:

MCSHC continued to disseminate the "Baby First" educational campaign community digital toolkit statewide and provided technical assistance for expansion into Madison County.

By August 30, 2007, a brief guide of Model Programs for Prenatal Care was shared with Marion, St. Joseph, and Lake Counties' coalitions during post disparity meetings.

Two new trainers of community health workers were identified in Lake County and a class of ten new community health workers have been trained through IVY TECH Community College. At least three have been placed within the East Chicago REACH project to advocate for Hispanic families, two 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.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.		X		
2. 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.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Performance Objective: The number of targeted communities with such community/neighborhood partnerships will increase from two to three 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 three 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 being planned for

September 17 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.

c. Plan for the Coming Year

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

Activities to impact this Performance Objective include:

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 three of the five 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 and Minority Health Fair.

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 five perinatal trainings on at least six 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 breast feeding among minority employees of low paying businesses, 4) use of alcohol, tobacco and other drugs among women of child bearing age and during pregnancy, and 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's. 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.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				24.9	24.1

Annual Indicator			25.7	25.7	29.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	28	25	22	20	18

Notes - 2007

Source of Data: ISDH YRBS Program.

Future objectives adjusted based on 2007 information provided.

Notes - 2006

Source of data will be ISDH YRBS Program. FY2006 data unavailable at present. Data expected to be available prior to end of calendar year. Baseline figure used as projection for FY2006.

Notes - 2005

New Performance Measure. Baseline data will be used to establish future objectives.

a. Last Year's Accomplishments

State Performance Measure # 8: The percent of high school students who are overweight or at risk of overweight.

FY 2007 Performance Objective: The percentage of high school students who are overweight or at risk will decrease to 24.1 in 2007.

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:

Activities that impacted this Performance Objective included:

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.

During the FY2007, the Body and Soul collaborative oriented 12 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.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 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.			X	
2. School height and weight collection guidelines were distributed through the Indiana Department of Education in the Coordinated School Health newsletter called Healthy Connections.			X	
3. 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.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FY 2008 Objective: The percentage of high school students who are overweight or at risk will decrease to 28 (from the 2007 YRBS baseline of 13.8% overweight and 15.3% at risk of overweight) in 2008.

Activities to impact this Performance Objective include:

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 promote the development of community level obesity prevention programs.

NPA will continue to assist in promoting 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.

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 at ISDH.

c. Plan for the Coming Year

FY 2009 Performance Objective: The percentage of high school students who are overweight or at risk will decrease to 25 % (from the 2007 YRBS baseline of 13.8% overweight and 15.3% at risk of overweight) in 2009.

Activities to impact this Performance Objective include:

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![™] 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 that 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/>.

E. Health Status Indicators

Indiana has continued to submit the Health Status Indicators annually. Hoosiers or anyone else can access these statistics included in the grant from the ISDH website. Some of these same data are also found on the website in the statistics that the ISDH Epidemiology Research Center provides. Hoosiers may access whichever data is most user-friendly.

Several of the Health Status Indicators--like the population demographics and the injury and STD statistics--were used as issue benchmarks to determine which counties in Indiana were in highest need of attention both for benchmark issues and overall. From this analysis for all Indiana counties, 30 focus counties were identified along with the issues that needed addressing within those counties. This analysis was included in the criteria for local funding in the MCSHC FY 2007-08 Request for Proposals. ***//2009/ The 30 focus counties identified, along with the issues that needed addressing within those counties in 2007, continued to be monitored for analysis of progress on Health Status Indicators. //2009//***

These indicators will continue to be used as a monitoring tool, particularly for issues that others in ISDH or other agencies are taking the lead, (e.g. injury prevention and STDs). When appropriate, the statistics can also be used for evaluation.

Health Status Indicators 1A, 1B, 2A, and 2B -- low weight births, low weight singleton births, very low weight births, and very low weight singleton births -- directly provide information on that segment of Indiana's population. This supports a focus specifically on efforts to improve factors that contribute to low and very low birth weight babies, e.g., early entrance into prenatal care, nutritional education guidance, etc. By having several years' data on these measures it serves as a monitoring tool for our programs, and allows us to evaluate the success of the programs involved. At present, despite very small numbers, the multi-year trend is overall trending down or stabilized.

//2009/ In 2009 we will complete a detailed, year-long statistical analysis comparing various cohorts of the mother with various results of births. This will be used in a number of ways, but the one most corresponding to HSI's 1A-2B is specifically the group of cohorts statistically significantly affecting, positively or negatively, the birth weight of the babies. //2009//

Health Status Indicators 3A, 3B, and 3C -- the death rate per 100,000 from, respectively, unintentional injuries to children 14 and younger, unintentional injuries to children 14 and younger due to motor vehicle crashes, and unintentional injuries to children 15 - 24 due to motor vehicle crashes -- directly provide information related to child mortality, both in motor vehicle accidents,

and due to overall unintentional injuries in the youngest segment of the population through age 14. This supports a focus on addressing causes of those fatal injuries and allows for targeted educational programs to encourage preventive behaviours, e.g., proper car seat use, proper seat belt use. It serves as a monitoring tool for the success of those programs, and allows us to evaluate those programs in terms of effect on the target populations. At present, the data on motor vehicle fatalities due to unintentional injuries is too varied to do a trend analysis, but the overall death rate from unintentional injuries to children age 14 and younger is trending down, with an unexplained drop in 2003; 2004 data continues the downward trend from 2002.

/2009/ In 2009 we will be looking into and doing analysis of the data from the last several years of mortality reports. We will also be looking at death certificates which will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

Health Status Indicators 4A, 4B, and 4C -- identical to 3A, 3B, and 3C, except as applied to nonfatal injuries -- directly provide much of the same information, support much of the same programmatic approaches, and also serve as a monitoring and evaluation tool as to the success of these approaches. The difference from HSI's 3A, 3B, and 3C is that success of the programs and approaches can be more reliably measured as the numbers of nonfatal injuries are greater than the numbers of fatal injuries. However, there are not enough years of data to establish a specific trend for HSI's 4A, 4B, and 4C at present. A few more data points, which will be collected over the next few years, will allow more detailed analysis.

/2009/ In 2009 we will be able to finish the study of injuries which was delayed due to personnel challenges. This will include several parts (see Youth Suicide for details from that perspective), but will give us significant data to be able to direct our efforts into the most appropriate and effective areas of preventive cause. //2009//

Health Status Indicators 5A and 5B -- the rate per 1,000 women with a reported case of chlamydia among, respectively, women aged 15 through 19 and women aged 20 through 44 -- provides information related to one of the major sexually transmitted diseases in Indiana's women, both the teen-age and the young adult segment. This problem is growing among both populations. The upward trend supports the Indiana State Department of Health assigning a greater priority and more resources to combat this problem.

/2009/ In 2009 the prevalence of STDs in Indiana's population, and its continued growth, will be one of the major areas of focus for our Needs Assessment in order to discern the best strategies for being able to bring this down to the level of our sister states. While we will continue to run advertising, support programs based on abstinence education, and continue other items addressing this (see narrative section referencing Abstinence), we are studying this problem as it is one of our priority concerns. //2009//

Health Status Indicators 6A through 12 are the Demographic health status indicators and give overall breakdowns which can be used in multiple ways.

/2009/ See section below 6A through 8B for further details. //2009//

Health Status Indicators 6A and 6B give total population by race, ethnicity, and age. This shows what segments of our population are experiencing the most growth and thus must be given more weight in programmatic terms. For example, Indiana is one of several states with an increasing Hispanic population. This knowledge helps us develop more multi-cultural programs, cultural awareness training, etc.

/2009/ See section below 6A through 8B for further details. //2009//

Health Status Indicators 7A and 7B give us similar information, but specifically related to birth rates. This allows for us to specifically aim the multi-cultural programs and awareness toward pregnant women and newborn programs.

//2009/ See section below 6A through 8B for further details. //2009//

Health Status Indicators 8A and 8B give us similar information to 7A and 7B except that it is related to death data rather than birth data.

//2009/ See section below 6A through 8B for further details. //2009//

In all cases, HSI 6A through 8B, we are able to glean information regarding disparities among races and ethnic groups in terms of total population, births, and deaths, all broken into age groups. This allows a very specific program development and focus, as it identifies where the largest discrepancies lie. This also allows us to monitor and evaluate the programs developed to deal with these disparities.

//2009/ In 2009, we are beginning the Needs Assessment process to determine how best to serve the people of Indiana. This of course means the demographic information from 6A and 6B will point us toward segments of population experiencing more need. The figures from 7A, 7B, 8A, and 8B will also provide us, when correlated with 6A&B, more details on which populations should be priority focus populations. In turn, this will guide our efforts to collect information related to addressing those priorities that have the most increased need based on demographics. To that end, we are developing statistical analyses, including trend analyses and various cohort analyses (see 1A through 2B for further details on this area of focus). //2009//

Health Status Indicator 9 is the most diverse of the Health Status Indicators, encompassing racial and ethnic breakdowns among the following populations for children 0-19 years of age:

- Percent in households headed by single parent
- Percent in TANF (grant) families
- Number enrolled in Medicaid
- Number enrolled in SCHIP
- Number living in foster home care
- Number enrolled in food stamp program
- Number enrolled in WIC
- Rate per 100,000 of juvenile crime arrests
- Percentage of high school dropouts, grades 9 through 12

Each one of these involves specific programs, some internal to ISDH and some external. We have some programs and some targets for the disparities revealed by these data. This allows for monitoring results and evaluating what effect our programs have on these varying areas. Health Status Indicator 10 is the total of children ages 0 through 19 based on geographic living area. These areas are Metropolitan, Urban, Rural, and Frontier. Just over 2/3 of Indiana's children ages 0 through 19 live in urban areas, the vast majority of whom live in metropolitan areas. Just under 1/3 of Indiana's children ages 0 through 19 live in rural areas. Each living area represents unique challenges and benefits. For example, transportation to an adequate care facility may be more difficult in a rural area due to distance, whereas specific health problems (e.g., lead poisoning) may be more prevalent in a metropolitan setting due to a higher concentration of old housing with lead-based paint.

//2009/ It is impossible to address each of these components collectively, as they are completely separate and come from a wide range of sources including many from outside the agency's purview, and certainly outside agency control. Likewise, various of these items individually can only be impacted minimally by our efforts. However we can, and

will, be effective in all of these areas to some degree via educational programs geared toward the population making up those varying demographic pieces (e.g., addressing several items via educational programs, advertisement, and services aimed at High School youth could have an impact on dropouts, juvenile crime, grant families, and tangentially other areas as well). We will continue the programs we have in place in 2009 while using data analysis to determine additional areas where our focus may have positive impact. //2009//

Health Status Indicators 11 and 12 deal with the percentage of people living in poverty, 11 being for the entire state population percentage and 12 being the percentage of those 0 through 19 years of age in said condition. Again, as in Health Status Indicator 10, poverty reflects unique challenges, and the different conditions of poverty--50% of poverty level versus 100% of poverty level versus 200% of poverty level--call for different programmatic approaches. While the basic factor, money, is the core of what is involved, there is a significant difference in whether a mother or child can pay for a service at all, even on a sliding scale, or whether that service has to be provided with no direct charge to the person served. The intent is to lower the number of persons living in poverty, but more specifically to raise those in extreme poverty to at least some level higher. Indiana has succeeded in lowering the percentage in the worst poverty category, which has caused some growth in the higher poverty level groups. By continuing to address the issues of health needs for all women and children in the state, and adding an additional focus as to the income aspect, it is anticipated that in the future all levels of poverty, from 200% of poverty level and lower, will decrease.

//2009/ This Health Status Indicator is very much reflective of the success of a variety of programs and as such can only be preipherally tied to ISDH efforts, yet is reflective of the success of those efforts. It is, however, the most tenuous of indicators, especially in the current housing/financial crises which have the capacity to overwhelm the poverty numbers no matter how successful any or all MCH programs are at lifting people out of poverty. In 2009, a close eye will be kept on everything that could impact this situation from a political, financial, and world perspective. By closely monitoring the effect outside forces are having, it may be possible to develop programs to mitigate some of the worst of the circumstances, which is exactly what we hope to do. //2009//

In conclusion, Indiana's continual annual submission of the above Health Status Indicators, which Hoosiers or anyone can access from the ISDH website and from the ISDH Epidemiology Research Center, provides a great deal of data about many statistics that figure in to MCH program decisions. This helps to continually inform Indiana's residents, as well as those researching Indiana's statistics, to find information, compare data, and provide feedback through whatever means they wish including accessing the main ISDH web page or the MCH web page, submitting an e-mail, or sending a letter, or simply calling the agency and asking to speak with someone in any particular program. Also, in summary, several of the Health Status Indicators were used to assist in determining Indiana's counties in highest need of attention for single issues and overall, yielding 30 focus counties identified along with the issues that needed addressing within those counties. This was included in the criteria for local funding in the MCSHC FY 2007, 08 Request for Proposals, and these indicators will continue to be used to monitor and evaluate programs.

//2009/ In addition to the monitoring of each of the 30 focus counties identified and the main issues identified by those counties as being specifically in need of being addressed, the progress of the Health Status Indicators (see more detail in updates of narrative for each individual Healh Status Indicator later in the Narrative) is being monitored and taken as a whole is improving in general over previous years.//2009//

F. Other Program Activities

The Indiana Family Helpline (IFHL) is designed to assist in promoting Maternal and Child Health Services, WIC and other programs and services throughout the state. In August 1992, the CSHCS Helpline merged with the IFHL to improve services to all Indiana families. During FY 2004, the IFHL responded to 18,828 calls and made 1,781 advocacy calls, resulting in 58,765 referrals./2008/During FY2006, the IFHL responded to 23,045 calls and made 2,183 advocacy calls resulting in 64,089 referrals.//2008//**2009/ During FY2008, the IFHL responded to 26,550 calls and made 1,967 advocacy calls resulting in 65,824 referrals. Approval has been received from the Health Commissioner for the IFHL to begin the process of becoming an IN211 call center and certification with the Association of Information and Referral Services (AIRS). Indiana 211 is a nonprofit organization and the goal is to create a seamless network of information and referral (I & R) services that enables anyone in Indiana in need of human services to have quick referrals to those who provide them by dialing 2-1-1. //2009//**

The Office of Cultural Diversity and Enrichment was created in March 2001 to help address the public health needs of minorities in Indiana. It was recognized that there was a need to place a stronger emphasis on cultural competency for health care professionals throughout the state, as well as all health care professional employees in the ISDH. On a yearly basis, the Office has conducted the Minority Health Disparity survey. The fifth annual assessment of cultural competence for ISDH contractors described in this plan was designed to continue efforts to improve the ability of contractors to meet the needs of Indiana minority populations in an effective, culturally competent manner. The assessment serves as the basis for requiring contractors to receive training on cultural competence until they demonstrate acceptable levels of performance. If current ISDH contractors demonstrate a continued inability to meet ISDH goals regarding effective, efficient, culturally competent programs, ISDH will seek alternate culturally competent contractors. In order to address the public health needs of Indiana minority groups, the Office of Cultural Diversity and Enrichment began offering a two-day Cultural Competence Workshop twice a month and a one-day Advanced Cultural Competency Workshop that is also held twice a month. To date, 1,300 health care professionals have attended these workshops. The two-day workshops emphasize cultural knowledge and cultural differences, strategies for working with racial/ethnic populations, the principles of interpreter services, and discussion of four different cultures (African American, Hispanic/Latino, Asian, Native American). The Advanced Workshops focus on dissimilarities in areas such as values, communication patterns, religion, beliefs, and health care professionals limited knowledge of other cultural groups. **/2009/ This responsibility has now been moved to the Office of Minority Health. Workshops have been conducted at regional sites statewide //2009//**

The Indiana Child Care Health Consultant Program was established in FY 2003 with the Family Social Services Administration - Bureau of Child Development providing dollars from the Child Care Development Fund, and Quality Initiatives Fund, to the State Department of Health to fund the project. The goal of the program is to increase the level of health and safety in out-of-home child care settings across Indiana through technical assistance and training for child care providers. The project provides another portal to services to increase the level of health and wellness that child care providers provide and the children they serve and their families need. Program staff includes a contracted Project Director, six regional child care health consultants, and a part-time support person. The regional child care health consultants are located in the field and coordinate with the numerous individuals and agencies currently involved with child care providers. There are four programmatic functions of the program. They include:

- Identification of licensed, registered, and license-exempt child care settings;
- Collection of data such as the child care settings' programs, health and safety practices, the immunization status and health insurance coverage status of the enrollees, back-to-sleep practices, accident occurrences, and the smoke-free status of the setting;
- Creation or identification and distribution of appropriate health and safety educational materials for use by child care providers and parents;
- Provision of consultation for child care providers around health and safety issues in out-of-home child care settings.

Another major component of the program is data collection and report generation. Documentation of the activities of the regional child care health consultants and the resulting changes in health and safety practices in out-of-home child care settings, and the change in health status of the children enrolled in the programs are two of the major foci. This program is currently being re-designed./2008/ In FY2006-2007 the focus shifted from state wide to three focus areas, Gary Indiana, Lawrence, Dubois, Spencer, and Perry Counties in Indiana. The consultants focused intensively of system development in these specific areas. Three ICCHC's conducted research with willing child care providers in these specific regions using a Health and Safety Assessment survey adapted from one used in California. They provided consultation on how to improve and are currently following up to assess improvement. //2008// **/2009/ This program was transferred to the Bureau of Child Care in the Family and Social Services Administration. //2009//**

In July 2003, the ISDH/MCSHC received a two-year grant from MCHB to fund the Indiana Early Childhood Comprehensive Systems (ECCS) Program. The program will create an integrated, coordinated, comprehensive system of services for children from birth to five. The coordinated system will support ease of access to needed services, increase the utilization of appropriate services and support the role of the family as their child's first teacher. This initiative will help to ensure that a holistic system of care supports young children and they arrive at school healthy and ready to learn. A Core Partner (steering committee) group was created to establish the Vision, Mission and Values of the program that provided the focus for the planning process The ECCS program staff, with ISDH technical staff assistance, established a website to promote public participation and facilitate communication across all committees. The site can be found at <http://www.in.gov/isdh/programs/mch/eccs/eccsindex.htm>. The ECCS Project Director is working closely with other groups promoting healthy children and families that have been initiated by the Governor, Lt. Governor and federal grant opportunities to ensure the work is not being duplicated and that all the groups are communicating and moving forward together. The Implementation phase of the ECCS is scheduled to begin as the statewide strategic plan has been completed and submitted in May 2005 to the Maternal and Child Health Bureau./2007//The ECCS program has been renamed Sunny Start./2007//**/2009/ The initiative continues to impact the lives of children and families in the area of social emotional health with the development of a consensus statement regarding the content and core competencies for social-emotional training activities across all providers/caretakers of young children, birth to five. Sunny Start sponsored a comprehensive one week Summer Institute in July 2007.//2009//**

G. Technical Assistance

Title V 2005 Technical Assistance Request

Description of Technical Assistance Requested

Workshops are needed to address issues surrounding the fact that in Indiana the number of meth labs (Methamphetamine) found statewide has risen from 43 in 1998 to 1549 in 2004, with 15,994 meth labs found producing the drug nationally in 2004.

Reasons Why Assistance Needed

The greatest concentration of Meth Labs has been in the Midwest, and from 2003 to 2004, Indiana moved up the list of labs busted nationwide from sixth place to fourth place. As a result, children of families involved in Methamphetamine use and production in Indiana are disproportionately suffering from various forms of abuse and neglect.

What state, organization or Individual would you suggest providing the TA

Not known at this time

Description of Technical Assistance Requested

Domestic Violence is the leading cause of serious injury to women, more than rape, mugging and car crashes combined. Domestic Violence includes but is not limited to Physical, Sexual, Emotional, and Financial abuse.

Reasons Why Assistance Needed

The number one killer of pregnant women nationally is homicide. Technical assistance for MCH funded and Non-funded projects is desperately needed.

What state, organization or Individual would you suggest providing the TA

Indiana Coalition Against Domestic Violence

//2007/ Implementation of the Lung Associations Smoking and Pregnant Women cessation program training. Indiana ranks #1 among the 50 states as having the greatest number of women who smoke while pregnant. Training is available from the American Lung Association of Indiana which is a non-profit, dedicated to reducing the effects of Lung disease through education.

Prevention of child abuse. Indiana provides programs for professional, Medical staff, Families, and Adolescents. Statistically, Indiana ranks top five for child abuse. Training is available from Prevent Child Abuse Indiana, a non profit organization whose mission is to serve as a catalyst for preventing child abuse.//2007//

//2008/ Suicide is the 2nd leading cause of injury death in Indiana. In fact the state's rate has been higher than the national average for nearly a decade. The problem of suicide has an incredibly devastating effect on Hoosier families and communities--lost children, lost loved ones, lost employees, and lost resources. These losses are preventable. In 2001, US Surgeon General, David Satcher, released a report entitled, "National Strategy for Suicide Prevention: Goals and Objectives for Action." This report described suicide as a serious public health problem throughout the United States and introduced a blueprint for addressing suicide prevention through Awareness, Intervention, and Methodology (AIM). The Surgeon General also recommended that each state adopt a suicide prevention plan that would incorporate the national recommendations.

In response to the national call to action and the magnitude of the problem in the state, the Indiana Suicide Prevention Coalition (ISPC) formed in 2001 to address this issue. Statewide workshops are needed to ensure that the MCSHC funded and Nonfunded network becomes familiar with Suicide's devastating effects on Hoosiers and the strategy for Suicide Prevention as outlined by the Surgeon General and the Indiana Suicide Prevention Coalition. //2008//**2009/ Suicide remains as the second leading cause of death for Hoosiers ages 15 to 19, according to the Indiana Suicide Prevention Coalition. //2009//**

V. Budget Narrative

A. Expenditures

Annual Budget Expenditure Narrative
FY'05 Budget Expenditures

Indiana's FY 2003 cost-cutting measures included early retirement incentives, a personnel furlough program, and a statewide hire freeze. These programs were implemented for all state personnel positions, whether funded by state funds or other (Federal) funds. While these measures were not continued in FY 2004, the long-term impact still resulted in significant expenditure reductions for both state and Federal funds in FY 2005, as reflected on Form 3, Form 4, and Form 5.

As a result, ISDH MCSHC increased funding allocations to local projects. Additionally, MCSHC implemented a one-time program to fund infrastructure building and pilot projects at the local level. These projects were funded for one to three years.

In FY 2005, ISDH MCSHC began spending down the large carryover. By FY 2007, the remaining carryover will have been reduced from over 5 million to less than one million dollars./2008/For 2008, due to the movement of costs from Title V to the state CSHCN budget and the reduction of funding for grants, the MCH program was able to carry over \$1.216 million dollars.//2008//
//2009/The remaining carryover balance was reduced to \$775K for 2008 and is projected to be a zero carry over going into 2009. In accordance with Finance's understanding of guidance received from HRSA, the budget figures for FY 2009 used on this application, starting with line 1 on Form 2, reflect the projected expenditures if current expenditure rates could be maintained. This figure (\$14,210,461) exceeds the amount of the Federal allocation to Indiana actually anticipated (\$11,779,106). //2009//

Maintenance of State Effort

In FY'89, Indiana's MCH Block Grant award was \$10,527,556 and the State expended \$11,539,520 in support of MCH activities. In FY'04 the MCH Block Grant award was \$12,746,245 and the State expended \$19,245,364 in support. In FY 2007 the MCH award is expected to be \$11,890,921 and the State has available \$39,092,884. State support includes money provided by state and local funds that MCSHC is authorized to spend on behalf of children with special health care needs. In FY 2004, MCHSC began counting the 30% match required of local projects as part of the Maintenance of State Effort. Line item expenditures for FY'89, FY'05 and budgeted amounts for FY'07 and FY08 are listed below:/2009/***Additions to line item expenditures for 2007 and budgeted amount for 2009 are listed below.//2009//***

State Funds

Expenditures in 1989
Expenditures in 2005
Expenditures in 2006
Expenditures in 2007
Budget for 2007
Budget for 2008
Budget for 2009

MCH Supplement

\$193,223 expended in 1989
\$0 expended in 2005
\$0 expended in 2006
\$0 expended in 2007
\$176,700 expended for 2008
\$0 budgeted for 2007

\$0 budgeted for 2008

\$176,700 budgeted for 2009

(\$176,700 was appropriated in both FY 2005 and FY 2007, but these funds are administratively withheld as a cost-cutting measure to address state budget shortfalls.)/2008/The state appropriation continues to be withheld.//2008//**2009/The state appropriation was released and applied towards funding of two different grants.//2009//**

Newborn Screening

\$33,669 expended in 1989

\$1,819,011 expended in 2005

\$1,406,198 expended in 2006

\$1,204,134 expended in 2007

\$1,224,126 budgeted for 2007

\$1,360,958 budgeted for 2008

\$1,360,958 budgeted for 2009

(This program is funded by a provider fee for each newborn screened. This fee was increased from \$7.50 to \$30.00 in 2004.)

Children with Special Health Care Needs

\$11,312,628 expended in 1989

\$10,508,873 expended in 2005

\$13,812,256 expended in 2006

\$16,392,075 expended in 2007

\$31,675,974 budgeted for 2007

\$28,591,740 budgeted for 2008

\$16,760,542 budgeted for 2009

(ISDH has seen an increase in projected revenue for State Children's Special Health Services funds. These are partially funded by county revenue that increased as a result of an increase in assessed property values. The budgeted amount includes carryover funds and reflects the balance in the dedicated account. These funds are dedicated to the CSHCS program to pay for covered health care for CSHCN. Funds available for FY 2007 will not all be used.)/2008/Revenue for 2008 has been projected as a decrease based on a state appropriation reduction from an anticipated \$5.9 million to \$1.7 million.//2008// **2009/Additionally, in 2008 another \$850K was withheld from the State appropriation. Property Taxes were restructured, causing a delay in receipt of revenues for the year. Indiana is in a transition period of moving the source of State CSHCN funding from property taxes to a general appropriation. By State FY 2010, we expect to receive all State CSHCN funding from a general appropriation.//2009//**

TDAB Meconium Screening

\$0 expended in 1989

\$59,371 expended in 2005

\$55,840 expended in 2006

\$58,121 expended in 2007

\$62,496 budgeted for 2007

\$61,246 budgeted for 2008

\$62,496 budgeted for 2009

RESPECT (State sexual abstinence education)

\$0 expended in 1989

\$520,866 expended in 2005

\$509,809 expended in 2006

\$438,381 expended in 2007

\$596,280 budgeted for 2007

\$554,540 budgeted for 2008

\$554,500 budgeted for 2009

TPSUPP (Prenatal Substance Use Prevention - State Tobacco Settlement Funds)

\$0 expended in 1989
\$181,899 expended in 2005
\$120,270 expended in 2006
\$91,045 expended in 2007
\$153,333 budgeted for 2007
\$147,000 budgeted for 2008
\$150,000 budgeted for 2009

Local MCH Appropriations

(Municipal and County appropriations used by local MCH grantees as matching funds)

\$0 expended in 1989
\$674,567 expended in 2005
\$1,119,588 expended in 2006
\$1,568,926 expended in 2007
\$753,805 budgeted for 2007
\$1,172,528 budgeted for 2008
\$1,146,380 budgeted for 2009

Other Matching Funds

(Funds from sources other than local appropriations and income used by local MCH grantees as matching funds)

\$0 expended in 1989
\$3,050,850 expended in 2005
\$1,667,081 expended in 2006
\$1,572,421 expended in 2007
\$2,620,339 budgeted for 2007
\$2,874,550 budgeted for 2008
\$3,076,071 budgeted for 2009

Program Income

(Income from Medicaid, patient fees, insurance and donations used by local MCH grantees as matching funds)

\$0 expended in 1989
\$2,990,665 expended in 2005
\$3,050,389 expended in 2006
\$2,446,299 expended in 2007
\$2,006,531 budgeted for 2007
\$2,473,958 budgeted for 2008
\$2,586,655 budgeted for 2009

TOTAL

\$11,539,520 expended in 1989
\$19,806,102 expended in 2005
\$32,132,370 expended in 2006
\$40,084,803 expended in 2007
\$39,092,884 budgeted for 2007 (Funds available for FY 2007 will not all be used.)
\$44,902,793 budgeted for 2008
\$43,048,193 budgeted for 2009

FY'05 Unobligated Funds

Despite growing expenses and decreasing federal Title V awards, the large unobligated balance carried over from FY 2004 remained large coming into FY 2005.

In FY 2004, ISDH allowed ongoing MCH projects to apply for a 10% increase in requested funds to take into account previous flat-line allocations. Further, ISDH has implemented a one-time,

short-term grant program to build infrastructure throughout the state. Additionally, Title V funds are now called upon to support allowable programs previously supported by funds such as the Preventive Health and Health Services Block Grant that are no longer available. This significantly reduced carryover amounts for FY 2005 through FY 2007. The projected carryover into FY 2007 will be \$951,353./2008/The carry-over is \$1.216 million as a result of effective budgeting and controlling expenditures, most effectively.//2008//**2009/There is no projected carry-over of funds for FY09.//2009//**

Indiana operates its program on a first in first out basis; therefore the unobligated carryover will be expended first.

B. Budget

Annual Budget and Budget Justification

FY'08 Summary Budget

Component A: Services for Pregnant Women, Mothers, and Infants up to age one.

Component B: Preventive and Primary Care Services for Child and Adolescents.

Component C: Family-Centered, Community-Based, Coordinated Care and the development of Community-Based Systems of Care for Children with Special Health Care Needs and their Families.

Administrative Costs: Indirect Costs

Dollars | Percentages

Component A \$4,943,308 | 34.78 %

Component B \$4,314,498 | 30.37 %

Component C \$4,290,810 | 30.19%

Administrative Cost \$ 661,845 | 4.66%

Grant Total \$ 14,210,461 | 100.00%

I. Direct Medical Care Services

The \$19,530,717 budgeted at this level include all community grants that provide direct services and projected medical claims for CSHCN and hemophilia premiums./2008/FY2006 \$14,199,521 was expended for Direct Care; \$14,973,082 and \$16,340,115 for 2007 and 2008 are budgeted, respectively.//2008//**2009/ Actually expended \$13,019,914 for FY 2007; budgeted \$17,805,732 for FY 2009.//2009//**

II. Enabling Services

The \$24,050,864 budgeted at this level include all community grants that provide enabling services and all other CSHCS state funds not projected for direct medical care services./2008/FY2006, \$8,175,574 was expended for Enabling Services; \$25,791,692 and \$16,943,524 are budgeted for FY2007 and FY 2008 respectively.//2008//**2009/Actually expended \$13,702,289 for FY 2007 and budgeted \$10,676,564 for FY 2009.//2009//**

III. Population Based Services

The \$3,935,733 budgeted at this level include all community grants that will provide population based services, Newborn Screening funds, and Indiana RESPECT funds./2008/FY2006, \$4,017,739 was expended for Population Based Services; \$4,664,006 and \$4,237,716 are budgeted FY 2007 and FY2008 respectively.//2008//**2009/Actually expended \$3,008,030 for FY2007 and budgeted \$3,793,473 for FY 2009.//2009//**

IV. Infrastructure Building Services

The \$8,433,775 budgeted at this level include salaries of all staff and other operating expenses

(minus insurance premiums and community grant funds), the statewide needs assessment, data systems, and the Indiana Perinatal Network./2008/FY2006, \$5,739,536 was expended for Infrastructure Building Services./2008//**2009/Actually expended \$6,596,854 for FY2007 and budgeted \$7,809,034 for FY2009./2009//**

Total FY 2007 budget is \$55,190,207 and expended \$36,327,087.

3.3.1 Completion of Budget Forms

See forms 3, 4, and 5.

3.3.2 Other Requirements

Maintenance of State Effort -- See comparisons of FY 1989 and FY 2005 expenditures and FY 2007 budget in previous section.

FY'07 Unobligated Funds

The projected unobligated balance for FY 2007 is \$951,553, which reflects a significant decrease from the unobligated balance for FY 2006. ISDH structured costs for this program have grown while federal allocations have been reduced. As a result, ISDH MCSHC has had to reduce local MCH grants from a high of 8.5 million to less than 6.5 million dollars./2009/**For FY2009 there are no carryover funds and grants will be reduced to under 5 million dollars. The budget figures for FY2009 used on this application starting with line 1 on form 2 reflect the projected expenditures if current expenditure rates could be maintained. This figure (\$14,210,461) exceeds the amount of the Federal allocation to Indiana actually anticipated (\$11,779,106)./2009//**

Carryover grew from FY 2001 through FY 2005 as a result of tightened state spending during FY 2002 through FY 2004. ISDH MCSHC took a number of steps to use these savings to build infrastructure throughout the state. Ongoing MCH project allocations were increased by nearly a million dollars from FY 2003 to FY 2004 and an additional one-time, short-term grant program was developed that obligated an additional \$1,034,858 in FY 2005 and was designed to grant out up to an additional million dollars each year during FY 2006 and 2007. These short-term, one-time grants were primarily targeted to conducting Fetal Infant Mortality Reviews, community-based needs assessment and other infrastructure building projects.

Additionally Title V funds are being called upon to provide additional support for projects previously funded by funds no longer available such as the Preventive Health and Health Services Block Grant. This included a \$335,000 grant to the Indiana Poison Control Call Center. Alternative funding is being sought for these expenditures.

Due to reduced available funding, MCSHC has to go from approximately \$8.5 million in local grants down to less than \$6.5 million. In addition, the new Medicaid eligibility requirements may increase the non-paying clients prenatal and child health clients served by local MCH projects. As a result, MCSHC is reducing grants to most existing local MCH projects by 6% to 9% from FY 2006 funding levels. Additionally, MCHSC is reducing or terminating a number of Special Projects that were projected to be funded for FY 2007. Also, some new projects that have been approved will not be funded until funds become available. This will enable MCSHC to maintain as broad array of services to as large a population as possible and achieve the broadest healthy maternal, birth and child health outcomes with a minimal disruption in services.

To improve budget flexibility to provide maximum services to the MCH population, ISDH MCSHC is requesting a waiver for FY 2007 to allow Title V expenditures for CSHCN to be less than 30% of total Title V expenditures./2008/MCH took steps to request the waiver but clarification by MCHB pointed out that States had additional flexibility in allocating expenditures. With this additional flexibility MCH met the 30%./2008//

/2009/For FY2009, due to reduced available funding, MCH has projected a reduction in local grants down to approximately \$5 million. The budget figures for FY2009 used on this

application starting with line 1 on form 2 reflect the projected expenditures if current expenditure rates could be maintained. This figure (\$14,210,461) exceeds the amount of the Federal allocation to Indiana actually anticipated (\$11,779,106).//2009//

MCSHC has traditionally met the 30% requirement for expenditures related to CSHCN by using Title V funds to pay for staff who administer the State-funded CSHCN program and by funding local initiatives serving CSHCN. Indiana has a unique State-funded program to pay for services for CSHCN. This program expends more than \$10 million annually. The State CSHCN program has sufficient State funds to support the CHSCN initiatives currently funded by Title V while remaining self-supporting. By transferring a greater responsibility for these costs to the State CSHCN funds, MCSHC could make more funds available for programs to ensure healthy birth outcomes.

Indirect Cost Rate Agreement

The rates listed below and approved in the Rate Agreement between ISDH and DHHS are for use on grants, contracts, and other agreements with the Federal Government subject to the conditions in Section III. It should be noted that Indiana considers indirect costs to be the administrative costs of the programs.

SECTION I: INDIRECT COSTS RATES* RATETYPES FIXED FINAL PROV.(PROVISIONAL)

PRED.(PREDETERMINED)EFFECTIVEPERIOD
TYPES FROM TO RATES(%) LOCATIONS APPLICABLE
FIXED 07/01/05 06/30/06 7.0 All All Programs
PROV 07/01/06 until amended 11.5 All Programs

*Based:

Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations), sub-awards and flow-through funds. 11.5 is the maximum rate currently projected for FY'07.

/2009/The rate during FY2008 was 14.2, but has dropped to 11.8 on July 1, 2008.//2009//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.