

FY 2014 and FY 2015 NS Application for Funding Biochemical Genetics Services

ISDH Maternal and Child Health Division (MCH) makes funds available for specific programs using this Grant Application Procedure (GAP). This GAP has been specifically designed for the Biochemical Genetics program.

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

ISDH has also developed the following priority health initiatives:

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

Instructions

1. An application for Newborn Screening (NS) funds must be received **by ISDH MCH by Friday, March 15, 2013 at 4:30 pm EST.**
2. Mail application to: Indiana State Department of Health
ATTENTION: Vanessa Daniels
2 North Meridian Street, 2C
Indianapolis, IN 46204
3. Submit the original proposal and three copies. Do not bind or staple.
4. The application must be typed (no smaller than 12 pitch, printed on one side only) and double-spaced. Each page must be numbered sequentially beginning with Form A, the Applicant Information page.
5. The narrative sections of the application must not exceed 30 double-spaced, typed pages. Applications exceeding this limit will not be reviewed.
6. Appendices, excluding CVs, must not exceed 20 pages. Appendices that serve only to extend the narrative portion of the application will not be accepted.
7. The application must follow the format and order presented in this guidance. Applications that do not follow this format and order will not be reviewed.
8. The application will not be reviewed if all sections are not submitted.

Note: Questions about this application should be directed to Bob Bowman, Director of Genomics and Newborn Screening, at 317.233.1231 or BobBowman@isdh.in.gov.

CRITERIA FOR ELIGIBILITY

Prerequisites

Eligible applicants must have a board-certified metabolic geneticist on staff.

Purpose of Grant

Provide early intervention and follow-up services for children born in Indiana and originally referred by the Indiana University Newborn Screening (NBS) Laboratory for having a newborn screening result that is presumptive positive for any inborn error of metabolism (IEM). A single applicant will be selected to receive funding for this project.

NOTE: All patients, regardless of income, should receive necessary services.

Description of Required Services

Applicants must be able to provide the following services:

- 1) Ensure that all newborns born in Indiana and originally referred by the NBS Laboratory receive appropriate diagnoses, treatment, and follow-up services, including the following:
 - a. Provide early contact with the primary care providers (PCPs) and/or families of children with NBS results that are presumptive positive for an IEM, including ensuring that appropriate diagnostic and/or confirmatory testing is performed as necessary.
 - i. If the PCP cannot be identified, the grantee will contact the child's parent(s)/guardian(s) directly to identify the child's PCP.
 - ii. If the child does not have a PCP, the grantee will offer their services.
 - iii. **NOTE:** To ensure that all patients receive necessary services, grant money can be used to support staff who provide services to patients without other methods of reimbursement, provided that grant money is only utilized as payer of last resort **and** that all other methods of reimbursement (e.g. Hoosier Healthwise, Children's Special Health Care Services, sliding fee scale) have been exhausted.
 - b. Discuss transportation plans with families and provide assistance in resolving transportation issues as needed.
 - c. Disseminate appropriate educational materials to PCPs and/or families of newborns with IEMs (e.g. information on specific IEMs, brochures/applications/information on family resources).
 - d. Provide genetic counseling to families of newborns with IEMs.
 - e. Refer families of newborns with IEMs to appropriate resources (e.g. Children's Special Health Care Services, Women with Infants and Children, family support resources).
 - f. Provide families with assistance when applying to appropriate resources and/or programs.
 - g. Develop a protocol to ensure that each newborn with a diagnosed IEM receives appropriate treatment and medical foods.
- 2) Ensure that all children less than 5 years of age with a diagnosed IEM receive necessary medical foods. Grantee will be expected to serve as payer of last resort for medical foods.
- 3) Increase awareness regarding health behaviors that impact the patient population and birth outcomes.
 - a. Provide education regarding the negative effects of smoking and alcohol and the positive effects of taking folic acid.
 - b. Ensure that patients who admit to smoking, drinking alcohol, or using drugs are referred to appropriate community resources.
- 4) Provide educational presentations to health care professionals and college or graduate-level students.

Size of Population Being Served

The grantee will be expected to provide services for children born in Indiana, their families, and health care providers throughout the state of Indiana. Annually, there are approximately 120 newborns identified as being presumptive positive for an IEM.

Reporting Requirements

- 1) The grantee will be expected to maintain a log of follow-up services provided for all children receiving services funded by this grant.
- 2) The grantee will be required to attend quarterly meetings with the ISDH Director of Genomics and Newborn Screening and the ISDH Heelstick Program Director in order to clarify and resolve the status of any open cases.
- 3) The grantee will be expected to utilize the Indiana Newborn Screening Tracking & Education Program (INSTEP) web application, when available, in order to maintain complete records and track all children receiving services funded by this grant.

FORMS

Applicant Information (Form A)

NS Project Description (Forms B-1 and B-2) *NOTE: B-1 does not substitute for a project summary.*

Funding Currently Received by Your Agency from ISDH (Form C)

APPENDICES

Appendix A – Biochemical Genetics Services Providers Annual Performance Report

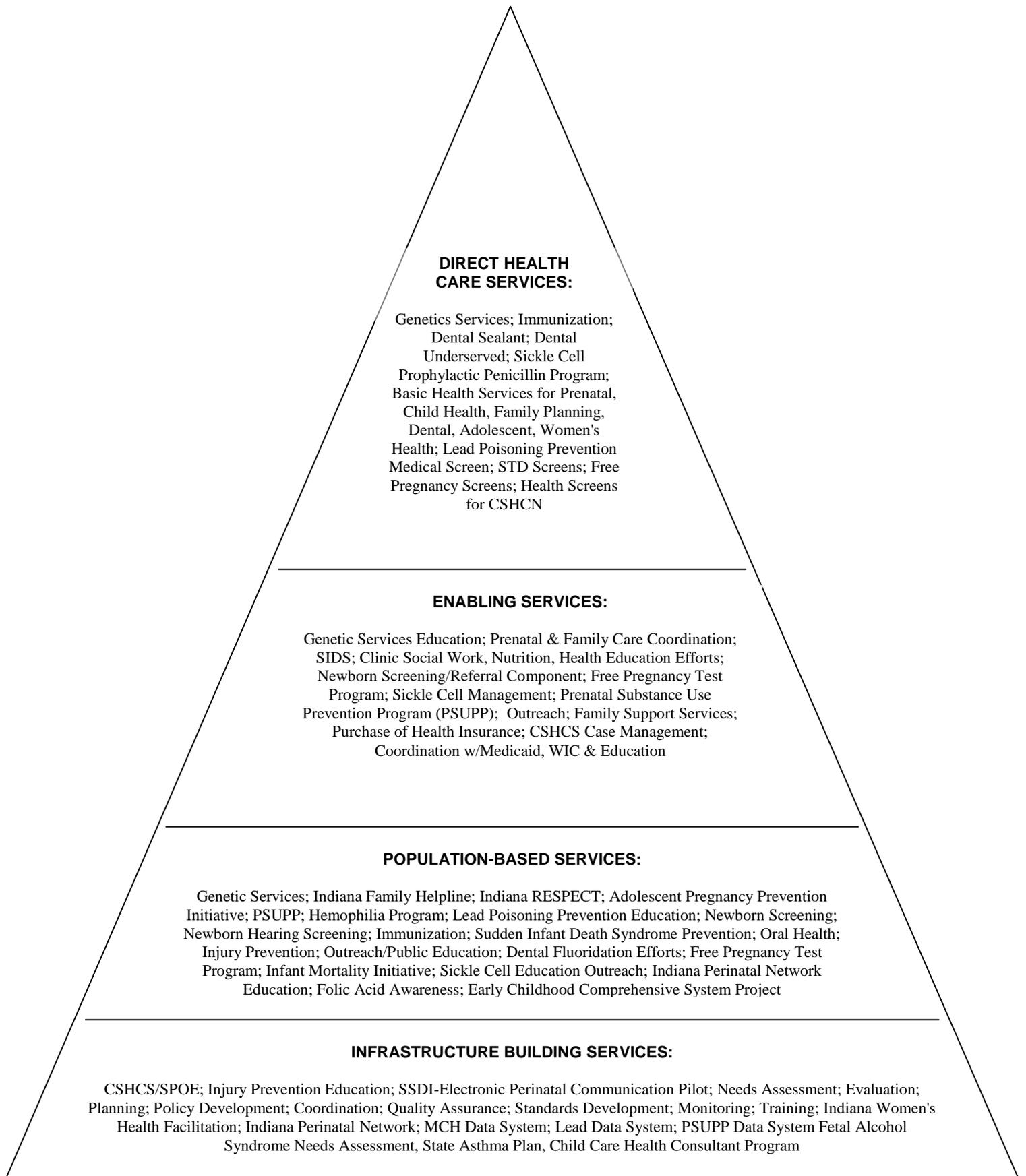
Appendix B – Definitions (NS Services)

Appendix C – Grant Application Scoring Tool

Priority Health Needs for the MCH population

1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality, and racial and ethnic disparities in pregnancy outcomes. (ISDH Priorities #1 & #3)
2. To reduce barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families. (ISDH Priorities #1, #3, & #4)
3. To build and strengthen systems of family support, education and involvement to empower families to improve health behaviors. (ISDH Priorities #1, #2, & #3)
4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects. (ISDH Priorities #1, #2, #3 & #4)
5. To decrease tobacco use in Indiana, particularly among pregnant women. (ISDH Priorities #1, #2, & #3)
6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs. (ISDH Priorities #1 & #3)
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. (ISDH Priorities #1, #2, & #3)
8. To reduce obesity in Indiana. (ISDH Priorities #1, #2, & #3)
9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana. (ISDH Priorities #1 & #3)
10. To improve racial and ethnic disparities in women of childbearing age, mothers, and children's health outcomes. (ISDH Priorities #1 & #3)

FIGURE 2: CORE PUBLIC HEALTH SERVICES



FY 2014 and FY 2015 Biochemical Genetics Services Grant Application Guidance

1. Applicant Information Page (Form A)

This is the first page of the proposal. **Complete all items on the page provided (Form A).** The project director, the person authorized to make legal and contractual agreements for the applicant agency, must sign and date this document.

2. Table of Contents (created by applicant)

The table of contents must indicate the page where each section begins, including appendices.

3. Biochemical Genetics Services Proposal Narrative

A. Summary (created by applicant)

Begin this page with the Title of Project as stated on the Applicant Information Page. The summary will provide the reviewer a succinct and clear overview of the proposal. The summary should:

- Relate to Biochemical Genetics program services only;
- Identify the problem(s) to be addressed;
- Succinctly state the objectives;
- Include an overview of solutions (methods);
- Emphasize accomplishments/progress made toward previously identified objectives and outcomes; and
- Indicate the percentage of the target population served by your project and the percentage of racial/ethnic minority clients among your clients served.

B. Forms B-1 and B-2

All information on the Project Description Forms (Forms B-1 and B-2) must be completed. Indicate how many clients will be served for FY 2014 and FY 2015. This summary form with its narrative will become part of the grant agreement and will also be used as a fact sheet on the project. Form B-2 requests specific information on each clinic site. The following information should be included:

FORM B-1

- **Project Description (created by applicant)**
 - The Project Description must include, at a minimum, a history of the project, problems to be addressed, and a summary of the objectives and work plan. Any other information relevant to the project may also be included, but this should be an abstract of the Project Summary described in section A. *Hint: If it runs to more than one page, you've written too much.*
 - May not be more than one page, but may be single-spaced.

FORM B-2

- The "Target population and estimated number to be served" on Form B-2 is for individual clinic site(s) and is the number to be served with Newborn Screening (NS) funds.

- The “NS Budget for Site” is the estimated NS funds budgeted for the individual clinic site.
- The “Services Provided in NS Budget Site” should include only those services provided with NS funds.
- The “Other Services Provided at Site” section should include all services offered at clinic site(s) other than NS funded services.

4. Applicant Agency Description (created by applicant)

Note: Large organizations should write this description for the unit directly responsible for administration of the project.

This description of the sponsoring agency should:

- Identify strengths and specific accomplishments pertinent to this proposal;
- Include a discussion of the administrative structure within which the project will function within the total organization (**NOTE: Applicants should attach an organization chart.**);
- Identify project locations and discuss how they will be an asset to the project; and
- Include a discussion on the collaboration that will occur between the project and other organizations and healthcare providers. The discussion should identify the role of other collaborative partners and specify how each collaborates with your organization. You may attach MOUs, MOAs, and letters of support.

5. Outcome and Performance Objectives and Activities

Biochemical Genetics Services projects have mandatory related Performance Measures (see pages 12 –20).

Pages 12 – 20 provide the format for applicants to indicate the goal (Annual Performance Objective) for each Performance Measure (PM), the baseline from which the project will improve or maintain the Performance Measures, and the activities on which the project will focus to impact the performance measure (Supporting Activities). Activities must reflect a comprehensive plan to achieve the objective. Some PM tables list required activities. Projects applying for these Performance Measures must list additional activities to accomplish the objective.

For each activity on the table, the applicant must indicate a clear and objective method to measure and document the activity, what documentation will be used, and what staff position is responsible for implementing, measuring, and documenting that activity.

Grantee is expected to fulfill the requirements of Indiana’s Newborn Screening Law and the ISDH Priority Health Initiatives as outlined in the Performance Measures for this funding opportunity. For a list of the ISDH Priority Health Initiatives, see pages 4 – 5 of this application.

Applicants are to complete the Biochemical Genetics Services Performance Measures on pages 12 – 20. There is an additional blank table for optional project-specific performance measures, objectives and activities that an applicant may add based on local needs. This blank table should be copied for each additional objective and

activities added by the project. Project-specific activities will be evaluated as part of the quality evaluation of the project. **Applicants are strongly encouraged to discuss development of project-specific performance measures with MCH consultants before submitting them with the grant application.**

Pages 12 – 20 are to be used by grantees to monitor progress on each activity and to submit in the Annual Performance Report for FY 2014 and FY 2015 after each year is completed. The columns on the Performance Measures forms labeled “Activity Status,” “Documentation Used,” “Staff Responsible,” and “Comments/Adjustments” are only to be completed and submitted with the FY 2014 and FY 2015 Annual Performance Reports. MCH consultants will contact projects quarterly to monitor progress on the activities and provide technical assistance. All applicants are required to collect data for monitoring purposes. See Appendix A (the Annual Performance Report) for required monitoring data elements. This information will be reported in the FY 2014 and FY 2015 Annual Performance Reports.

6. Evaluation Plan

NOTE: This should be a separate narrative section. Evaluation methods reflected on the Performance Measures Tables should be included in the overall Evaluation Plan.

A project evaluation plan should have two parts: 1) an evaluation plan to determine whether the evidence-based interventions/activities are working to impact both the specific objective goal and the priority/ies and 2) a quality assurance evaluation plan to ensure that services are performed well.

In the first part, discuss the methodology for measuring the achievement of activities. The plan should include intermediate (e.g. monthly, quarterly) measures of activities as well as assessment at the end of the funding period. An effective evaluation requires that:

- Project-specific activities to meet objectives are clear and measurable;
- Plan explains how evaluation methods reflected on the Performance Measure forms will be incorporated into the project evaluation;
- Staff member(s) responsible for the evaluation is/are identified;
- Plan includes explanation of what data will be collected and how it will be collected;
- Plan lists how and to whom data will be reported;
- Appropriate methods are used to determine whether measurable activities and objectives are on target for being met; and
- If activities and objectives are identified as off-target during an intermediate or year-end evaluation and improvement is necessary to meet goals, staff member(s) responsible for revisiting activities to make changes which may lead to improved outcomes is/are identified.

In the second part, discuss:

- Methods used to evaluate quality assurance (e.g. chart audits, patient surveys, presentation evaluations, observation); and
- Methods used to address identified quality assurance problems.

7. Staff

List all staff that will work on the project. Include name, job title, primary duties, and number of hours per week for each staff member. *Hint: Make sure the number of staff hours reflected in this list agrees with the staff hours total listed on the Budget Summary page.*

Describe the relevant education, training, and work experience of the staff that will enable them to successfully develop, implement, and evaluate the project. Submit job descriptions and curriculum vitae of key staff as an appendix. Copies of current professional licenses and certifications must be on file at the organization. In this section you must show that:

- Staff is qualified to operate proposed program;
- Staffing is adequate; and
- Job descriptions and curriculum vitae (CVs) of key staff are included as an appendix.

8. Facilities

Describe the facilities that will house project services. Address the adequacy, accessibility for individuals with disabilities in accordance with the Americans with Disabilities Act of 1990, and assure that project facilities will be smoke-free at all times. Hours of operation must be posted and visible from outside the facility. (Include evening and weekend hours to increase service accessibility and indicate hours of operation at each site on Form B-2.)

In this section you must demonstrate that:

- Facilities are adequate to house the proposed program;
- Facilities are accessible for individuals with disabilities;
- Facilities will be smoke-free at all times; and
- Hours of operation are posted and visible from outside the facility.

9. Budget and Budget Narrative

NOTE: Do not combine budget information for FY 2014 and FY2015. You must complete separate budget pages for each fiscal year.

In this section, be sure to demonstrate that:

- All expenses are directly related to project;
- The relationship between budget and project objectives is clear; and
- The time commitment to the project is identified for major staff categories and is adequate to accomplish project objectives.

Complete this entire section by providing budget information for FY 2014 and for FY 2015. The budget is an estimate of what the project will cost. Complete the provided standard budget form (NS Budget page 1) according to directions. Do not substitute a different format. Projects do not need to include matching funds. However, any additional source(s) of funds that support services should be reported under non-matching funds.

NOTE: A Budget Narrative form is provided. Do not substitute a different format.

The budget narrative must include a justification for every NS line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the NS budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. Please do not round any of your figures to whole dollars. They should be rounded to the penny.

In-state travel information must include miles, reimbursement, and reason for travel. Travel reimbursement may not exceed State rates. Currently, the in-state travel reimbursement is \$0.44 per mile.

Complete Form C – List all ISDH funding received by proposing organization in FY 2013.

Check for internal consistency among the budget forms:

- Budget page 1 is complete for each year
- Budget narratives include justification for each line item and are completed for each year
- Budget correlates with project duration
- Funding received for ISDH Form C is complete
- Information on each budget form is consistent with information on all other budget forms

10. Minority Participation

All applicants must include a statement regarding minority participation in the planning and operation of their MCH program. Minority individuals and/or organizations should be involved in planning and evaluating the project to ensure services are adequate for the minority community. Projects are also encouraged to seek to do business with Minority-Owned Business Enterprises to help provide services or operational support for the project. For a list of certified Minority-Owned Business Enterprises, see <http://www.in.gov/idoa/2352.htm>.

11. Endorsements

Submit letters of support and memoranda of understanding (MOU) that demonstrate a commitment to collaboration between the applicant agency and other relevant community organizations. Letters of support and MOUs must be current. Each application must include at least three letters of support from or MOUs with relevant agencies.

Applicants are not required to obtain the signature(s) of or send a support letter(s) to the local health officer(s) in each county where services are proposed. Applicants may enter “N/A” for this line on Form A.

Projects are also strongly encouraged to work with their Local Public Health Coordinators to enhance preparedness (ISDH Priority Health Initiative #4).

Checklist – Letters of Support and Memoranda of Understanding:

- Endorsements are from organizations able to effectively coordinate programs and services with applicant agency.
- Memoranda of Understanding (MOU) clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care.
- Endorsements and/or MOUs are current.
- MOUs with other genetic services serving the same geographic area, including MCH-funded and MCH non-funded services, clearly state how the services will work together.
- Letters and a summary of the proposed program have been sent to all health officers in jurisdictions within the proposed service area (unless health officer(s) has/have signed Form A).

Questions regarding this grant application may be directed to Vanessa Daniels (vdaniels@isdh.in.gov / 317-233-1241) or Bob Bowman (BobBowman@isdh.in.gov / 317-233-1231).

REQUIRED FORMS FOR BIOCHEMICAL GENETICS SERVICES PROVIDERS

- 1) Form A: Applicant Information**
- 2) Form B-1 and B-2: Biochemical Genetics Project Description**
- 3) Form C: Funding Currently Received by Your Agency from
ISDH**
- 4) Performance Measures 1 - 4**

Note: Providers serving counties with significant numbers of minority populations must identify activities for Performance Measures 1 and 3 related to outreach and marketing to the minority populations to provide culturally competent services to those populations.

Indiana State Department of Health
Biochemical Genetics Services Providers

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 1: Prevent mental retardation, developmental disabilities or severe, potentially lethal illness through early detection, diagnosis, medical and genetic counseling, and social intervention of patients with inborn errors of metabolism (IEM).

Directions for Completion

The ISDH Genomics/Newborn Screening (NBS) Program expects that **100%** of newborns that whose newborn screens (NBS) were positive for an inborn error of metabolism (IEM) will receive appropriate services within appropriate time limits. **Please complete the tables below. FY 2012 numbers should be the same as your FY 2012 annual report. FY 2013 numbers should be an estimate based on available FY 2013 data. FY 2014 and FY 2015 should be percentages that you have set as a goal in the Performance Objective.** Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time. Please see **Biochemical Genetics Services Definitions** on page 57 for more information concerning types of services.

Performance Objective 1a: Ensure that 100% of newborns with phenylketonuria (PKU), maple syrup urine disease (MSUD), and galactosemia (GAL) receive appropriate treatment by 2 weeks of age.

PO 1a: Newborns with PKU, MSUD, and GAL who received appropriate treatment by 2 weeks of age

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of newborn patients with PKU, MSUD, and GAL on treatment by 2 weeks of age				
(b) Total number of newborn patients with <u>confirmed</u> diagnoses of PKU, MSUD, and GAL				
Percentage of newborn patients with PKU, MSUD, and GAL on treatment by 2 weeks of age*			100%	100%
Total number of newborn patients with <u>possible, but unconfirmed</u> , diagnoses of PKU, MSUD, and GAL				

*Percentage = (a / b) x 100

Performance Objective 1b: Ensure that 100% of newborns with homocysteinuria (HCY), biotinidase deficiency (BD), fatty acid oxidation disorders (FAO), and organic acidemias (OA) receive appropriate treatment by 4 weeks of age.

PO 1b: Newborns with HCY, BD, FAO, and OA who received appropriate treatment by 4 weeks of age

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of newborn patients with HCY, BD, FAO, and OA on treatment by 4 weeks of age				
(b) Total number of newborn patients with <u>confirmed</u> diagnoses of HCY, BD, FAO, and OA				

Percentage of newborn patients with HCY, BD, FAO, and OA on treatment by 4 weeks of age*			100%	100%
Total number of newborn patients with <u>possible, but unconfirmed</u> , diagnoses of HCY, BD, FAO, and OA				

*Percentage = (a / b) x 100

Performance Objective 1c: Ensure that 100% of newborns with all other inborn errors of metabolism (IEM) diagnosed through newborn screening receive appropriate treatment by 4 weeks of age.

PO 1c: Newborns with all other inborn errors of metabolism (IEM) diagnosed through newborn screening who received appropriate treatment by 4 weeks of age

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of newborn patients with other IEM diagnosed through NBS on treatment by 4 weeks of age				
(b) Total number of newborn patients with <u>confirmed</u> diagnoses of other IEM (diagnosed through NBS)				
Percentage of newborn patients with other IEM diagnosed through NBS on treatment by 4 weeks of age*			100%	100%
Total number of newborn patients with <u>possible, but unconfirmed</u> , diagnoses of other IEM				

*Percentage = (a / b) x 100

Performance Objective 1d: Ensure that 100% of individuals with a designated inborn errors of metabolism (IEM) and seen by this practice within the past year have the necessary information entered into the Indiana Newborn Screening Tracking and Education Program (INSTEP) application.

PO 1d: Individuals with a designated inborn errors of metabolism (IEM) and seen by this practice within the past year have the necessary information entered into the Long-term Follow-up (LTFU) section of the Indiana Newborn Screening Tracking and Education Program (INSTEP) application.

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of individual patients seen by this practice within the past year whose information has been completely entered into the ISDH INSTEP application.				
(b) Number of individual patients with an IEM seen by this practice within the past year				
Percentage of individual patients whose information has been completely entered into the ISDH INSTEP application*			100%	100%

*Percentage = (a / b) x 100

Supporting Activities Table

Directions: State the planned activities to provide services to patients diagnosed with IEM and which staff members will be responsible for those activities.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Ensure that > 90% of families of children in the appropriate age range are informed about First Steps, Children's Special Health Care Services, WIC, SCHIP, and Hoosier Healthwise (Medicaid).			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that > 90% of patients/families receive assistance in utilizing local agencies and schools for care coordination; nutritional care; and financial, social, rehabilitative, developmental or educational assistance as needed.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that the results/outcomes of all visits are communicated to the primary care physician.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Indiana State Department of Health
Biochemical Genetics Services Providers

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 2: Prevent mental retardation, developmental disabilities or severe, potentially lethal illness by ensuring that all children less than 5 years of age, with a diagnosed inborn error of metabolism (IEM) receive necessary medical foods.

Directions for Completion

The ISDH Genomics/Newborn Screening (NBS) Program expects that at least **98%** of children (< 5 years of age) that have a diagnosed IEM will receive the necessary medical food to prevent mental retardation, developmental disabilities, or severe, potentially lethal illnesses. **Please complete the tables below. FY 2012 numbers should be the same as your FY 2012 annual report. FY 2013 numbers should be an estimate based on available FY 2013 data. FY 2014 and FY 2015 should be percentages that you have set as a goal in the Performance Objective.** Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time. Please see **Biochemical Genetics Services Definitions** on page 57 for more information concerning types of services.

Performance Objective 2: Ensure that at least ____% of children (< 5 years of age) that have a diagnosed IEM receive the necessary treatment (medical food) to prevent mental retardation, developmental disabilities or severe potentially lethal illnesses.

PO 2: Children < 5 years of age with an IEM

	FY 2012 (Baseline)		FY 2013		FY 2014		FY 2015	
	Total Number of Children ¹	Total Number of Months on Formula Provided by Each Payer ²	Total Number of Children	Total Number of Months on Formula Provided by Each Payer	Total Number of Children	Total Number of Months on Formula Provided by Each Payer	Total Number of Children	Total Number of Months on Formula Provided by Each Payer
SAMPLE	20	(10 children on formula x 3 months per child) + (10 children on formula x 6 months per child) = (30 months + 60 months) = 90 months total						
(a) Children < 5 years of age with a diagnosed IEM receiving medical food from private insurance								
(b) Children < 5 years of age with a diagnosed IEM receiving medical food through Hoosier Healthwise (Medicaid) & SCHIP								

(continued on next page)

(c) Children < 5 years of age with a diagnosed IEM receiving medical food through Children's Special Health Care Services								
(d) Children < 5 years of age with a diagnosed IEM receiving medical food through WIC								
(e) Children < 5 years of age with a diagnosed IEM receiving medical food from this grant ³								
(f) Total unduplicated children < 5 years of age with a diagnosed IEM <u>receiving</u> medical foods ⁴								
(g) Total unduplicated children < 5 years of age with a diagnosed IEM <u>requiring</u> medical foods								
Percentage of children < 5 years of age with a diagnosed IEM receiving medical foods ^{5,6}		FOR ISDH USE ONLY						

¹ This number represents the total number of children receiving medical food from each specific source of payment. **NOTE:** Children may be included in more than one row, if they received medical food from more than one payer (e.g. private insurance and WIC).

² This number represents the total number of months children received medical food from each specific source of payment. See the line labeled "SAMPLE" for an example of this calculation.

³ **NOTE:** Grant money should only be used as payer of last resort.

⁴ This value is the sum of the unduplicated children who received medical foods, regardless of payer.

⁵ Percentage of children receiving medical foods = (f / g) x 100

⁶ The percentages related to the total number of months children receive medical foods are for ISDH use only. Grantees will not be evaluated based on this value.

Supporting Activities Table

Directions: State the planned activities to provide services to patients diagnosed with IEM and which staff members will be responsible for those activities.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Ensure that > 90% of families of children in the appropriate age range are informed about First Steps, Children's Special Health Care Services, WIC, SCHIP, and Hoosier Healthwise (Medicaid).*			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that all patients/families obtain necessary prior authorizations for medications, formulas, and supplements.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that all patients lacking the resources to obtain necessary medical food receive the necessary food on a sliding fee scale based on income.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

*See Page 57 for contact information for family resources available through ISDH.

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 3: Increase individual awareness and personal responsibility of health behaviors that impact the patient population and birth outcomes.

Directions for Completion

The ISDH Genomics/Newborn Screening (NBS) Program expects that at least **90%** of new families seen in clinic will be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid. **Please complete the tables below. FY 2012 numbers should be the same as your FY 2012 annual report. FY 2013 numbers should be an estimate based on available FY 2013 data. FY 2014 and FY 2015 should be percentages that you have set as a goal in the Performance Objective.** Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Performance Objective 3a: _____% of new families seen in clinic will be educated to the **negative** effects of **smoking** during pregnancy.

PO 3a: New families seen in clinic and educated to the negative effects of smoking during pregnancy

	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of new families with members who smoke and were seen in clinic that received smoking cessation education				
(b) Number of new families with members who reportedly smoke and were seen in clinic				
Percentage of new families with members who smoke and were seen in clinic that received smoking cessation education*				

*Percentage = (a / b) x 100

Performance Objective 3b: _____% of new families seen in clinic will be educated to the **negative** effects of **consuming alcohol** during pregnancy.

PO 3b: New families who were seen in clinic and educated to the negative effects of alcohol consumption during pregnancy

	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of new families who were seen in clinic and received education on alcohol-related birth defects				
(b) Number of new families who were seen in clinic				
Percentage of new families who were seen in clinic and received education on alcohol-related birth				

defects*				
----------	--	--	--	--

*Percentage = (a / b) x 100

Performance Objective 3c: _____% of new families seen in clinic will be educated to the *positive* effects of taking *folic acid*.

PO 3c: New families seen in clinic and educated to the *positive* effects of taking *folic acid*

	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of new families who were seen in clinic and received folic acid education				
(b) Number of new families who were seen in clinic				
Percentage of new families who were seen in clinic and received folic acid education *				

*Percentage = (a / b) x 100

Supporting Activities Table

Directions: State which staff members will be responsible for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Develop and incorporate an intake protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol or other drugs during pregnancy.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that greater than 90% of patients who admit to smoking, drinking, or using drugs are referred to appropriate community cessation programs (e.g. Prenatal Substance Use Prevention Program (PSUPP), Indiana Tobacco QuitLine, Alcoholics Anonymous).*			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Indiana State Department of Health
Biochemical Genetics Services Providers

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 4: Provide educational presentations to health care professionals and college or graduate level students.

Directions for Completion

A **minimum** of **four (4)** presentations are to be given to health care professionals, college students, and/or graduate students. **Please complete the tables below. FY 2012 numbers should be the same as your FY 2012 annual report. FY 2013 numbers should be an estimate based on available FY 2013 data. FY 2014 and FY 2015 should be percentages that you have set as a goal in the Performance Objective.** Do not count one talk under two different audiences; each presentation should be included in the column that corresponds to the majority of the audience.

Performance Objective 4: Project staff will provide ____ presentations.

PO 4: Biochemical Genetics Presentations

Main Audience	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
Health care professionals and college or graduate level students				
Other presentations				
Total				

Supporting Activities Table

Directions: State which staff members will be responsible for the following activity. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Evaluation sheets will be collected for each talk; feedback from evaluation sheets will be used to modify and improve presentation.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Audience size will be counted at each talk. (Note: Attendance or evaluation sheets may be used to determine these numbers.)			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

Note: Application narrative should include a sample evaluation sheet and a description of how scores will be compiled.

Indiana State Department of Health
Biochemical Genetics Services Providers

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Project Specific Performance Measure:

Project Specific Performance Objective:

Service Projections

	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015

Supporting Activities Table

Directions: State which staff members will be responsible for the following activities, the current status of each activity, and provide a brief comment on how this activity is to be completed. Additional activities can be added at the bottom of this table. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

BUDGET INSTRUCTIONS

Materials Provided: The following materials are included in this packet:

Instructions
Chart of Account Codes
Non-allowable Expenditures
Budget Narrative Form (NS Budgets for FY 2014 & FY 2015)

INSTRUCTIONS

Review all materials and instructions before beginning to complete your budget. If you have any questions relative to completing your project's budget, contact:

Vanessa Daniels

vdaniels@isdh.in.gov

317/233-1241

In completing the packet, remember that all amounts should be rounded to the nearest penny.

Completing the Budget Narrative Form

NOTE: Create a separate budget for Fiscal Year (FY) 2014 and for FY 2015.

- FY 2014 runs from July 1, 2013 through June 30, 2014.
- FY 2015 runs from July 1, 2014 through June 30, 2015.

Schedule A

For each individual staff member, provide the name of the staff member and a brief description of his/her role in the project. If multiple staff members are entered in one row (for instance, 111.400 Nurses), a single description may be provided, if applicable. Each staff member must be listed by name. Calculations must be provided for each staff member in the Calculations column. This calculation should be in the form salary (\$) = \$/hour x hours/week x weeks/year. Fringe may be calculated for all staff. If different fringe rates are used for different categories of staff, fringe may be calculated by category.

Schedule B

List each contract, general categories of supplies (office supplies, medical supplies, etc.), travel by staff members, and significant categories in Other Expenditures in the appropriate column. Provide calculations as appropriate. Calculations are optional for Contractual Services. Travel must be calculated for each staff member who will be reimbursed and may not exceed \$0.44 per mile.

SCHEDULE A - CHART OF ACCOUNT CODES

111.000	<u>PHYSICIANS</u>	
	Clinical Geneticist	OB/GYN
	Family Practice Physician	Other Physician
	General Family Physician	Pediatrician
	Genetic Fellow	Resident/Intern
	Medical Geneticist	Substitute/Temporary
	Neonatologist	Volunteer
111.150	<u>DENTISTS/HYGIENISTS</u>	
	Dental Assistant	Substitute/Temporary
	Dental Hygienist	Volunteer
	Dentist	
111.200	<u>OTHER SERVICE PROVIDERS</u>	
	Audiologist	Outreach Worker
	Child Development Specialist	Physical Therapist
	Community Educator	Physician Assistant
	Community Health Worker	Psychologist
	Family Planning Counselor	Psychometrist
	Genetic Counselor (M.S.)	Speech Pathologist
	Health Educator/Teacher	Substitute/Temporary
	Occupational Therapist	Volunteer
111.350	<u>CARE COORDINATION</u>	
	Licensed Clinical Social Worker (L.C.S.W.)	Social Worker (B.S.W.)
	Licensed Social Worker (L.S.W.)	Social Worker (M.S.W.)
	Physician	Substitute/Temporary
	Registered Dietitian	Volunteer
	Registered Nurse	
111.400	<u>NURSES</u>	
	Clinic Coordinator	Other Nurse
	Community Health Nurse	Other Nurse Practitioner
	Family Planning Nurse Practitioner	Pediatric Nurse Practitioner
	Family Practice Nurse Practitioner	Registered Nurse
	Licensed Midwife	School Nurse Practitioner
	Licensed Practical Nurse	Substitute/Temporary
	OB/GYN Nurse Practitioner	Volunteer
111.600	<u>SOCIAL SERVICE PROVIDERS</u>	
	Caseworker	Social Worker (B.S.W.)
	Licensed Clinical Social Worker (L.C.S.W.)	Social Worker (M.S.W.)
	Licensed Social Worker (L.S.W.)	Substitute/Temporary
	Counselor	Volunteer
	Counselor (M.S.)	

111.700	<u>NUTRITIONISTS/DIETITIANS</u>	
	Dietitian (R.D. Eligible) Nutrition Educator Nutritionist (Master Degree)	Registered Dietitian Substitute/Temporary Volunteer
111.800	<u>MEDICAL/DENTAL/PROJECT DIRECTOR</u>	
	Dental Director Medical Director	Project Director
111.825	<u>PROJECT COORDINATOR</u>	
111.850	<u>OTHER ADMINISTRATION</u>	
	Accountant/Finance/Bookkeeper Administrator/General Manager Clinic Aide Clinic Coordinator (Administration) Communications Coordinator Data Entry Clerk Evaluator Genetic Associate/Assistant Laboratory Assistant	Laboratory Technician Maintenance/Housekeeping Nurse Aide Other Administration Programmer/Systems Analyst Secretary/Clerk/Medical Record Substitute/Temporary Volunteer
115.000	<u>FRINGE BENEFITS</u>	
200.700	<u>TRAVEL</u>	
	Conference Registrations In-State Staff Travel	Out-of-State Staff Travel (only available with non-matching funds)
200.800	<u>RENTAL AND UTILITIES</u>	
	Janitorial Services Other Rentals Rental of Equipment and Furniture	Rental of Space Utilities
200.850	<u>COMMUNICATIONS</u>	
	Postage (including UPS) Printing Costs Publications	Reports Subscriptions Telephone
200.900	<u>OTHER EXPENDITURES</u>	
	Insurance and Bonding Maintenance and Repair -- Other	Insurance premiums for fire, theft, liability, fidelity bonds, etc. Malpractice insurance premiums cannot be paid with grant funds. However, matching and nonmatching funds can be used. Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project. Approved items not otherwise classified above.

EXAMPLES OF EXPENDITURE ITEMS THAT WILL NOT BE ALLOWED

The following may not be claimed as project cost for NS projects and may not be paid for with NS Funds:

1. Construction of buildings, building renovations;
2. Depreciation of existing buildings or equipment;
3. Contributions, gifts, donations;
4. Entertainment, food;
5. Automobile purchase / rental;
6. Interest and other financial costs;
7. Costs for in-hospital patient care;
8. Fines and penalties;
9. Fees for health services;
10. Accounting expenses for government agencies;
11. Bad debts;
12. Contingency funds;
13. Executive expenses (car rental, car phone, entertainment);
14. Fundraising expenses;
15. Legal fees;
16. Legislative lobbying.
17. Equipment;
18. Out-of-state travel; and
19. Dues to societies, organizations, or federations.
20. Incentives

For further clarification on allowable expenditures, please contact:

Vanessa Daniels, MCH Business Manager, vdaniels@isdh.in.gov or 317/233-1241

FY 2014 Budget Narrative

The budget narrative must include a justification for every NS line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the NS budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement (\$0.44 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total NS
	<p>For each personnel entry, include name, title and brief description of his/her role in the project (i.e. provides direct services).</p> <p>List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.</p>	<p>Personnel = \$/hr X hrs per week X weeks per year</p> <p>Fringe = salary X fringe rate</p>	Total to be charged to NS
Schedule A			
111.000 Physicians			
111.150 Dentists / Hygienists			
111.200 Other Service Providers			
111.350 Care Coordination			
111.400 Nurses			
111.600 Social Service Providers			
111.700 Nutritionists / Dietitians			
111.800 Medical/Dental / Project Director			
111.825 Project Coordinator			
111.850 Other Administration			
115.000 Fringe Benefits			
Account Number and Item	Description and Justification	Calculations	Total NS
	<p>List each contract and explain its purpose. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.</p>	<p>Travel = \$0.44 X miles for each staff member being reimbursed for travel.</p>	Total to be charged to NS
Schedule B			
200.000 Contractual Services			
200.600 Consumable Supplies			
200.700 Travel			

200.800 Rental and Utilities			
200.850 Communications			
200.900 Other Expenditures			
		SUBTOTAL SCHEDULE A	
		SUBTOTAL SCHEDULE B	
		TOTAL SCHEDULES A&B	

FY 2015 Budget Narrative

The budget narrative must include a justification for every NS line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the NS budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement (\$0.44 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total NS
	<p>For each personnel entry, include name, title and brief description of his/her role in the project (i.e. provides direct services).</p> <p>List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.</p>	<p>Personnel = \$/hr X hrs per week X weeks per year</p> <p>Fringe = salary X fringe rate</p>	Total to be charged to NS
Schedule A			
111.000 Physicians			
111.150 Dentists / Hygienists			
111.200 Other Service Providers			
111.350 Care Coordination			
111.400 Nurses			
111.600 Social Service Providers			
111.700 Nutritionists / Dietitians			
111.800 Medical/Dental / Project Director			
111.825 Project Coordinator			
111.850 Other Administration			
115.000 Fringe Benefits			
Account Number and Item	Description and Justification	Calculations	Total NS
	<p>List each contract and explain its purpose. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.</p>	<p>Travel = \$0.44 X miles for each staff member being reimbursed for travel.</p>	Total to be charged to NS
Schedule B			
200.000 Contractual Services			
200.600 Consumable Supplies			
200.700 Travel			

200.800 Rental and Utilities			
200.850 Communications			
200.900 Other Expenditures			
		SUBTOTAL SCHEDULE A	
		SUBTOTAL SCHEDULE B	
		TOTAL SCHEDULES A&B	

BIOCHEMICAL GENETICS SERVICES PROVIDERS
GRANT APPLICATION
FY 2014 & FY 2015

Title of Project: _____ Federal I.D. #: _____

Medicaid Provider Number: _____ FY 2013 NS Contract Amount: \$ _____

FY 2014 NS Amount Requested: \$ _____

FY 2015 NS Amount Requested: \$ _____

Legal Agency / Organization Name: _____

Street _____ City _____ Zip Code _____

Phone _____ FAX _____ E-Mail Address _____

Project Director (type name) _____ Phone _____ E-Mail Address _____

Board President/Chairperson (type name) _____ Phone _____

Project Medical Director (type name) _____ Phone _____

Agency CEO or Official Custodian of Funds (type name) _____ Title _____ Phone _____

Signature of Project Director _____ Date _____

Signature of person authorized to make legal And contractual agreement for the applicant agency _____ Title _____ Date _____

Signature of County Health Officer (or date letter sent to County Health Officers) _____ County _____ Date _____

Are you registered with the Secretary of State? Yes No

Note: All arms of local and State government are registered with the Secretary of State. Applicants must be registered with the Secretary of State to be considered for funding.

FY 2014 & FY 2015
Project Description

Project Name:		Project Number:
Address:	City, State, Zip	
Telephone Number:	Fax Number:	E-Mail Address:
Counties Served:		
Type of Organization:	State <input type="checkbox"/>	Local <input type="checkbox"/> Private Non-Profit <input type="checkbox"/>
Requested Funds: \$_____ (Amounts above should reflect total for FY 2014 + total for FY 2015)		
Sponsoring Agency:		
Summarize identified needs from the needs assessment section. Include only those needs the Project will address.		
Summarize Performance Measures from Performance Measures Tables (Hint: Each identified need above should be addressed with a Performance Measure.)		

NS Project Name:		Project Number:	# Clinic Sites
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site:	
Counties Served:	Services Provided in NS Budget for site:		
Target Population and estimated number to be served with NS funds:	Other services provided at site (non-NS):		
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site:	
Counties Served:	Services Provided in NS Budget for site:		
Target Population and estimated number to be served with NSfunds:	Other services provided at site (non-NS):		
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site:	
Counties Served:	Services Provided in NS Budget for site:		
Target Population and estimated number to be served with NSfunds:	Other services provided at site (non-NS):		
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site:	
Counties Served:	Services Provided in NS Budget for site:		
Target Population and estimated number to be served with NSfunds:	Other services provided at site (non-NS):		
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site:	
Counties Served:	Services Provided in NS Budget for site:		
Target Population and estimated number to be served with NSfunds:	Other services provided at site (non-NS):		
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site:	
Counties Served:	Services Provided in NS Budget for site:		
Target Population and estimated number to be served with NS funds:	Other services provided at site (non-NS):		

Appendix A

INDIANA STATE DEPARTMENT OF HEALTH
NEWBORN SCREENING PROGRAM
BIOCHEMICAL GENETICS SERVICES PROVIDERS
ANNUAL PERFORMANCE REPORT FY 2014

PROJECT NAME: _____

PROJECT NUMBER: _____

APPLICANT AGENCY: _____

REPORTING PERIOD: FY 2014 (7/1/13 TO 6/30/14)

DATE SUBMITTED: _____ PREPARED BY: _____

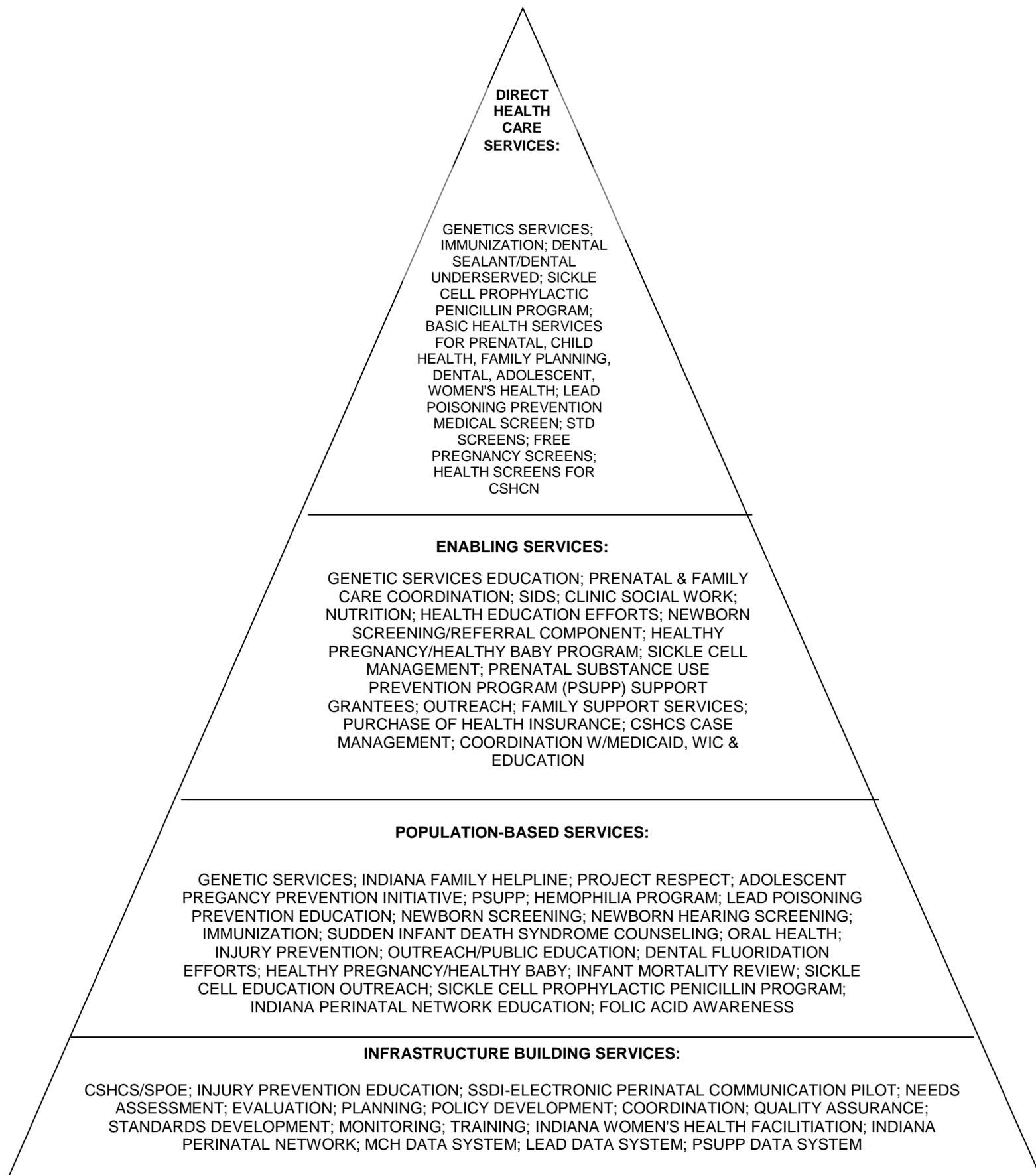
- I. Instructions.....(Page 37)
- II. Narrative.....(Page 37)
- III. Quality Assurance.....(Page 37)
- IV. Demographic Data.....(Pages 37 - 39)
- V. Program Monitoring Data.....(Pages 39 - 43)
- VI. Project Data.....(Pages 44 - 54)
- VII. Appendices.....(Pages 55 - 59)

Appendix 1 Performance Objective Summary

Appendix 2 Definitions

Appendix 3 Descriptions for Final or Best Working Diagnosis Table

**FIGURE 1: CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES**



I. Instructions

Instructions are included by section in the report form.

II. Narrative

Using the categories below, describe through narrative and statistics the services provided by NS funding to women and/or children in your project during the last fiscal year. Keep the discussion brief and address only the services and activities in which your project is engaged and which are funded by NS funds. The Narrative should be supported by the statistical report and completed work plan. It should provide a complete picture of your NS program, including where your services fit into the Core Public Health Services Pyramid. As part of the description of services provided, the discussion should include the following information for each service category:

- Explain the strengths and weaknesses of the project and project accomplishments during the funding year.
- Explain any significant discrepancies between projected number served and actual number served. Significant discrepancies exist if the number served fell below or exceeded projected service levels by more than 10%.
- Explain any change in clinical or administrative procedure, including staffing changes.
- Document activities to improve communications with, outreach to, and services for racial and ethnic minorities. Include plans to reduce disparities in access to services and health outcomes.
- Complete the hours of services form. Indicate any changes from the original application.
- List which agencies and organizations are cooperating with the project and explain their role. **All** indicated agencies and organizations should have current MOUs with the project.
- Elaborate on special events and initiatives undertaken by the project in the Work Plan Activities listed on the Performance Measure Tables Work Plans.

III. Quality Assurance

1. Chart audit. If the Project served less than 200 clients, review 50 charts or all charts of clients served (whichever # is less annually). If the Project served 200 or more clients, review 100 charts. **Summarize the findings and indicate changes or improvements to be made.** The project should conduct 25% of the annual chart reviews during each quarter during the funding year and describe the reviews in the quarterly reports, along with adaptations, changes, or adjustments made in the work plan or policies and procedures as a result of the chart review findings.
2. Review the NS data reports. Summarize the data problems – incomplete collection or program challenges – indicating the specific areas. Review the charts to determine if staff completion or errors are contributing to the problem.
3. Report appropriate individuals to the IBDPR. Document every child with a birth defect that was seen in the Project clinic and verify that the child is reported to the Indiana Birth Defects and Problems Registry, provided the patient is within the appropriate age range.
4. Send a copy of the chart audit tool format used for each service type.

IV. Demographic Data

Complete Tables 1-4. This information is essential for Maternal and Child Health Services to meet federal reporting requirements.

Table 1. Number of New Individuals Who Received Services, Fiscal Year 2014, by Race

Class of individual and type of service	# Est. to be Served*	Race						Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/Unknown	Total Served (All Races)	Non-Hispanic/Unknown	Hispanic
PREGNANT WOMEN										
INFANTS UNDER ONE YEAR OF AGE										
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)										
OTHER INDIVIDUALS										
OTHER INDIVIDUALS > 22 years										
OTHER SERVICES (SPECIFY):										
TOTAL (All Services):										

*As indicated in FY 2014/2015 proposal.

**If applicable

Totals Should Match

Table 2. Number of Return Visit Individuals Who Received Services, Fiscal Year 2014, by Race

Class of individual and type of service	# Est. to be Served*	Race						Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/Unknown	Total Served (All Races)	Non-Hispanic/Unknown	Hispanic
PREGNANT WOMEN										
INFANTS UNDER ONE YEAR OF AGE										
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)										
OTHER INDIVIDUALS										
OTHER INDIVIDUALS > 22 years										
OTHER SERVICES (SPECIFY):										
TOTAL (All Services):										

*As indicated in FY 2014/2015 proposal.

Totals Should Match

Table 3. Number of New Individuals Who Received Services Provided or Paid for in Whole or in Part by NS Funds in Fiscal Year 2014, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMEN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

Table 4. Number of Return Visit Individuals Who Received Services Provided or Paid for in Whole or in Part by NS Funds in Fiscal Year 2014, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMEN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

V. Program Monitoring Data

Tables 5 - 12 request program monitoring data.

Table 5: Types of Service Provided

Type of Service	Pregnant Women	Infants <1 Year of Age	Children Under 22 (Excluding Those < 1 yr)	Patients ≥ 22 years of age	Total
Pre-Diagnosis Counseling					
Post-Diagnosis Counseling					
Evaluation/Counseling for a known diagnosis					
Evaluation/Counseling for an unknown diagnosis					
Counseling Only					
Consultations					
Telephone Contacts					
Referrals To MCH Clinic					
Referrals To First Steps					
Referrals To NS					
Referrals To PSUPP					
Referrals To WIC Clinic					

See **Definitions** in Appendix 2 for clarification of the types of services.

Table 6: Educational Outreach Activities

	Number of Education Sessions Completed	Average Number of Participants per Session	Overall Score From Evaluation Sheets
Health care professionals and college or graduate level students			
Other presentations			
TOTAL			

NOTE: The number of educational sessions should match the number given in the grant application. Additional information required in the Performance Measures section.

Table 7: Patient Satisfaction Surveys

	Number of Surveys Given to Clients	Number of Surveys Completed and Returned	Survey Return Rate	Score for Scheduling and Location	Score for Interaction with Clinic Staff	Score for Expectations and Understanding	Score for Benefits of Genetics Clinic	Score for Overall Satisfaction
Prenatal Services								
Clinical Services								
TOTAL								

Table 8: Primary Indication for Reason for Referral to Clinical Services

	FY 13	FY 14	FY 15
1. Rule Out/Confirm or Make Specific Diagnosis	_____	_____	_____
2. Return Visit (returning to same project group)	_____	_____	_____
3. Follow-up Appointment for Diagnosis Made by an Unaffiliated Provider	_____	_____	_____
4. Unknown Reason for Referral	_____	_____	_____
TOTAL	_____	_____	_____

Table 9: Final or Best Working Diagnosis for Clinical Patients

	FY 13	FY 14	FY 15
1. No Evidence of Abnormality or Specific Disorder	_____	_____	_____
2. Chromosomal and Single Gene Disorders	_____	_____	_____
3. Metabolic/Endocrine Disorder	_____	_____	_____
4. Neuromuscular	_____	_____	_____
5. Skeletal/Connective Tissue/Neural Ectodermal (Excluding Chromosomal)	_____	_____	_____
6. Hematologic	_____	_____	_____
7. Functional Disorders	_____	_____	_____
8. Single Malformation	_____	_____	_____
9. Reproductive Risks (Use only when none of the above apply)	_____	_____	_____
10. Multiple Congenital Anomalies/Multiple Malformation Syndrome	_____	_____	_____
11. Unknown	_____	_____	_____
TOTAL	_____	_____	_____

Note: See Appendix 3 for examples of *Final or Best Working Diagnosis* for each option.

VI. Project Data

Specific directions are stated for each Performance Measure. Indicate if the Performance Objective was met by checking Yes or No. A Performance Objective Summary of all services is provided in Appendix 1. Please complete the summary for all services provided by the project.

FY 2014 objectives should be completed based upon the projections submitted in the FY 2014 – 2015 grant application.

The specific activities for each objective should be completed and the status of each indicated in the Comments/Adjustments section. If objectives were not met, indicate in this column why they were not met and what action will be taken to meet them this year. Your consultant will use this section to monitor project activities and provide technical assistance. Some forms have specific activities already listed. The status of each should be indicated as well as any additional comments. Any additional activities for your project should be listed. (See Appendix 2 for additional instructions and definitions).

Biochemical Genetics Services Providers should complete the following pages addressing NS performance measures.

A. Biochemical Genetics Services

Performance Measure 1: Prevent mental retardation, developmental disabilities or severe, potentially lethal illness through early detection, diagnosis, medical and genetic counseling, and social intervention of patients with inborn errors of metabolism (IEM).

Directions for Completion

Please complete the tables below. Report the total number of newborn patients with IEM seen in your project population. The ISDH Genomics/NBS Program expects that **100%** of newborns with IEM will receive appropriate services within correct time limits.

Performance Objective 1a: Ensure that 100% of newborns with phenylketonuria (PKU), maple syrup urine disease (MSUD), and galactosemia (GAL) receive appropriate treatment by 2 weeks of age.

PO 1a: Newborns with PKU, MSUD, and GAL who received appropriate treatment by 2 weeks of age

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of newborn patients with PKU, MSUD, and GAL on treatment by 2 weeks of age				
(b) Total number of newborn patients with confirmed diagnoses of PKU, MSUD, and GAL				
Percentage of newborn patients with PKU, MSUD, and GAL on treatment by 2 weeks of age*				100%
(c) Total number of newborn patients with possible, but unconfirmed, diagnoses of PKU, MSUD, and GAL				

* Percentage = (a / b) x 100

Performance Objective 1b: Ensure that 100% of newborns with homocystinuria (HCY), biotinidase deficiency (BD), fatty acid oxidation disorders (FAO), and organic acidemias (OA) receive appropriate treatment by 4 weeks of age.

PO 1b: Newborns with HCY, BD, FAO, and OA who received appropriate treatment by 4 weeks of age

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of newborn patients with HCY, BD, FAO, and OA on treatment by 4 weeks of age				
(b) Total number of newborn patients with confirmed diagnoses of HCY, BD, FAO, and OA				
Percentage of newborn patients with HCY, BD, FAO, and OA on treatment by 4 weeks of age*				100%
(c) Total number of newborn patients with possible, but unconfirmed, diagnoses of HCY, BD, FAO, and OA				

* Percentage = (a / b) x 100

Performance Objective 1c: Ensure that 100% of newborns with all other inborn errors of metabolism (IEM) diagnosed through newborn screening receive appropriate treatment by 4 weeks of age.

PO 1c: Newborns with all other inborn errors of metabolism diagnosed through newborn screening who received appropriate treatment by 4 weeks of age

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of newborn patients with other IEM diagnosed through NBS on treatment by 4 weeks of age				
(b) Total number of newborn patients with confirmed diagnoses of other IEM (diagnosed through NBS)				
Percentage of newborn patients with other IEM diagnosed through NBS on treatment by 4 weeks of age*				100%
(c) Total number of newborn patients with possible, but unconfirmed, diagnoses of other IEM				

* Percentage = (a / b) x 100

Performance Objective 1d: Ensure that 100% of individuals with a designated inborn errors of metabolism (IEM) and seen by this practice within the past year have the necessary information entered into the Indiana Newborn Screening Tracking and Education Program (INSTEP) application.

PO 1d: Individuals with a designated inborn errors of metabolism (IEM) and seen by this practice within the past year have the necessary information entered into the Long-term Follow-up (LTFU) section of the Indiana Newborn Screening Tracking and Education Program (INSTEP) application.

Annual Outcome Objective	FY 2012 (Baseline)	FY 2013	FY 2014	FY 2015
(a) Number of individual patients seen by this practice within the past year whose information has been completely entered into the ISDH INSTEP application.				
(b) Number of individual patients with an IEM seen by this practice within the past year				
Percentage of individual patients whose information has been completely entered into the ISDH INSTEP application*				100%

*Percentage = (a / b) x 100

PERFORMANCE OBJECTIVE MET: YES NO

Supporting Activities Table

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that aided in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Ensure that > 90% of families of children in the appropriate age range are informed about First Steps, Children's Special Health Care Services, WIC, SCHIP, and Hoosier Healthwise (Medicaid).			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that > 90% of patients/families receive assistance in utilizing local agencies and schools for care coordination; nutritional care; and financial, social, rehabilitative, developmental or educational assistance.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that the results/outcomes of all visits are communicated to the primary care physician.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

A. Biochemical Genetics Services

Performance Measure 2: Prevent mental retardation, developmental disabilities or severe, potentially lethal illness by ensuring that all children less than 5 years of age, with a diagnosed inborn error of metabolism (IEM) receive necessary medical foods.

Directions for Completion

The ISDH Genomics/NBS Program expects that at least **98%** of children (< 5 years of age) that have a diagnosed IEM will receive the necessary medical food to prevent mental retardation, developmental disabilities, or severe, potentially lethal illnesses.

Performance Objective 2: Ensure that at least ____% of children (< 5 years of age) that have a diagnosed IEM receive the necessary treatment (medical food) to prevent mental retardation, developmental disabilities or severe potentially lethal illnesses.

PO 2: Children < 5 years of age with an IEM

	FY 2012 (Baseline)		FY 2013		FY 2014		FY 2015	
	Total Number of Children ¹	Total Number of Months on Formula Provided by Each Payer ²	Total Number of Children	Total Number of Months on Formula Provided by Each Payer	Total Number of Children	Total Number of Months on Formula Provided by Each Payer	Total Number of Children	Total Number of Months on Formula Provided by Each Payer
SAMPLE	20	(10 children on formula x 3 months per child) + (10 children on formula x 6 months per child) = (30 months + 60 months) = 90 months total						
(a) Children < 5 years of age with a diagnosed IEM receiving medical food from private insurance								
(b) Children < 5 years of age with a diagnosed IEM receiving medical food through Hoosier Healthwise (Medicaid) & SCHIP								
(c) Children < 5 years of age with a diagnosed IEM receiving medical food through Children's Special Health Care Services								

(d) Children < 5 years of age with a diagnosed IEM receiving medical food through WIC								
(e) Children < 5 years of age with a diagnosed IEM receiving medical food from this grant ³								
(f) Total unduplicated children < 5 years of age with a diagnosed IEM receiving medical foods ⁴								
(g) Total unduplicated children < 5 years of age with a diagnosed IEM requiring medical foods								
Percentage of children < 5 years of age with a diagnosed IEM receiving medical foods ^{5,6}		FOR ISDH USE ONLY						

¹ This number represents the total number of children receiving medical food from each specific source of payment. **NOTE:** Children may be included in more than one row, if they received medical food from more than one payer (e.g. private insurance **and** WIC).

² This number represents the *total number of months* children received medical food from each specific source of payment. See the line labeled "SAMPLE" for an example of this calculation.

³ **NOTE: Grant money should only be used as payer of last resort.**

⁴ This value is the sum of the *unduplicated* children who received medical foods, regardless of payer.

⁵ **Percentage of children receiving medical foods = (f / g) x 100**

⁶ **The percentages related to the total number of months children receive medical foods are for ISDH use only. Grantees will not be evaluated based on this value.**

PERFORMANCE OBJECTIVE MET: YES NO

Supporting Activities Table

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Ensure that > 90% of families of children in the appropriate age range are informed about First Steps, Children's Special Health Care Services, WIC, SCHIP, and Hoosier Healthwise (Medicaid).*			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that all patients/families obtain necessary prior authorizations for medications, formulas, and supplements.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that all patients lacking the resources to obtain necessary medical food receive the necessary food on a sliding fee scale based on income.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

*See Page 57 for family resources available through ISDH.

A. Biochemical Genetics Services

Performance Measure 3: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Directions for Completion

Please complete the tables below. The ISDH Genomics/NBS Program expects that at least **90%** of new families seen in clinic should be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid.

Performance Objective 3a: _____% of new families seen in clinic and educated to the **negative** effects of **smoking** during pregnancy.

PO 3a: New families who were seen in clinic and educated to the negative effects of smoking during pregnancy

	FY 2012	FY 2013	FY 2014	FY 2015
(a) Number of new families who smoke and were seen in clinic that received smoking cessation education				
(b) Number of new families who reportedly smoke and were seen in clinic				
Percentage of new families who smoke and were seen in clinic, that received smoking cessation education *				

* Percentage = (a / b) x 100

Performance Objective 3b: _____% of new families seen in clinic and educated to the **negative** effects of **consuming alcohol** during pregnancy.

PO 3b: New families who were seen in clinic and educated to the negative effects of alcohol consumption during pregnancy

	FY 2012	FY 2013	FY 2014	FY 2015
(a) Number of new families who were seen in clinic and received education on alcohol related birth defects				
(b) Number of new families who were seen in clinic				
Percentage of new families who were seen in clinic and received education on alcohol related birth defects *				

* Percentage = (a / b) x 100

Performance Objective 3c: _____% of new families seen in clinic and educated to the **positive** effects of taking **folic acid**.

PO 3c: New families seen in clinic and educated to the positive effects of taking folic acid

	FY 2012	FY 2013	FY 2014	FY 2015
(a) Number of new families who were seen in clinic and received folic acid education				
(b) Number of new families who were seen in clinic				
Percentage of new families who were seen in clinic and received folic acid education*				

* Percentage = (a / b) x 100

PERFORMANCE OBJECTIVE MET: YES NO

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Develop and incorporate an intake protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol or other drugs during pregnancy.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Ensure that greater than 90% of patients who admit to smoking, drinking, or using drugs are referred to appropriate community cessation programs (e.g. Prenatal Substance Use Prevention Program (PSUPP), Indiana Tobacco QuitLine, Alcoholics Anonymous).*			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

* Please see Biochemical Genetics Services Definitions on page 57 for contact information for available ISDH family support resources.

A. Biochemical Genetics Services

Performance Measure 4: Provide educational presentations to health care professionals and college or graduate level students.

Directions for Completion

Report the total number of presentations given by your project staff. A **minimum of 4** presentations are to be given to health care professionals, college students, and/or graduate students. Calculate the Percent Completed only for the current year. In terms of estimating audience size, when the audience is mixed, count individuals under the group that makes up the majority of the audience. Do **not** count one talk under two different audiences; each presentation should be included in the column that corresponds to the majority of the audience.

Performance Objective 4: Project staff provided _____ presentations.

Main audience:	# of Talks						
	FY 2013 Actual	FY 2014 Actual	FY 2014 Estimated	FY 2014 % Completed	FY 2015 Actual	FY 2015 Estimated	FY 2015 % Completed
Health care professionals and college or graduate level students							
Other presentations							
Total							

Percent completed = [Number of talks given / Estimated number of talks] x 100

PERFORMANCE OBJECTIVE MET: YES NO

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Evaluation sheets will be collected for each talk; feedback from evaluation sheets will be used to modify and improve presentation.			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
Audience size will be counted at each talk. (Note: Attendance or evaluation sheets may be used to determine these numbers.)			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	
		53	<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Other <input type="checkbox"/> Does not apply	

A. Biochemical Genetics Services

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2013	FY 2014	Percent change from previous year

Percent change = [(2014 #s – 2013 #s) / 2013 #s] x 100

PERFORMANCE OBJECTIVE MET: YES NO

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	

A. Biochemical Genetics Services

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2014	FY 2015	Percent change from previous year

Percent change = [(2015 #s – 2014 #s) / 2014 #s] x 100

PERFORMANCE OBJECTIVE MET: YES NO

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	
			<input type="checkbox"/> Initiated <input type="checkbox"/> Ongoing <input type="checkbox"/> Completed <input type="checkbox"/> Other	

Appendix 1

**Biochemical Genetics Services Providers
Performance Objective Summary
FY 2014 & FY 2015**

FY 2014**MET**

<i>PERFORMANCE OBJECTIVE 1a:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 1b:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 1c:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 1d:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 2a:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 2b:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 2c:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 3:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<i>PERFORMANCE OBJECTIVE 4:</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Percent of NS Required Performance Objectives Met _____

Number of Project Chosen Objectives Met _____

Total Number of Project Chosen Objectives _____

Percent of Project Chosen Objectives Met _____

Appendix 2

**Biochemical Genetics Services
DEFINITIONS
FY 2014 & FY 2015**

Definitions are listed according to appearance in the application.

Tables 2 and 4

Return Visit Individuals – Individuals that have been previously seen in your project clinic and are returning for follow-up care.

Table 5

Clinical Patient – Any individual who had an appointment and was evaluated by or received counseling from the project.

Counseling Only – A communication which deals with the human problems associated with the occurrence or risk of occurrence of a disorder in a family. For reporting purposes, this **only** includes face-to-face interactions. No physical exam or prenatal procedure is performed during this type of encounter.

Consultation – A visit with a patient where the grantee is **not** the primary provider of services.

Telephone contact – A phone conversation where a limited amount of counseling and/or a referral is discussed.

Evaluation/Counseling – Some degree of assessment (e.g., a physical examination) is performed in addition to genetic counseling services.

Performance Measure 1d

Designated inborn errors of metabolism – are those conditions for which an interval and/or an initial reporting form has been created within the Indiana Newborn Screening Tracking and Education Program (INSTEP) application.

Performance Measure 3 – Contact Information for ISDH Family Support Resources

- **Children’s Special Health Care Services (CSHCS)**
 - 2 North Meridian Street, 7B, Indianapolis, IN 46204
 - (800) 475-1355 (phone)
 - Option 1 - Spanish Interpretation
 - Option 2 – Application Status or Eligibility/Reevaluation Information
 - Option 3 – Prior Authorization, Care Coordination or Insurance Updates
 - Option 4 – Travel Inquiries or Travel Reimbursement
 - Option 5 – Payment of Claims
 - Option 6 – Provider Relations & Provider Agreement

- **Indiana Family Helpline**
 - (800) 433-0746 (voice)
 - (866) 275-1274 (TTY / TDD)

- **Indiana Tobacco Quitline**
 - (800) QUIT-NOW

- **Prenatal Substance Use Prevention Program (PSUPP)**
 - PSUPP Director, Indiana State Department of Health
 - 2 North Meridian Street, Indianapolis, IN 46204
 - 317-233-1325 (phone)
 - 317-233-1300 (fax)
 - A list of PSUPP Program Clinics is available at <http://www.in.gov/isdh/22245.htm>.

Performance Measure 4

College or graduate level students – Includes nursing and medical students.

Appendix 3

Descriptions for Final or Best Working Diagnosis Table

(Five examples for each are listed.)

Chromosomal / Single gene

(includes cytogenetic and mutation analysis)

- 1) Trisomies
- 2) 45,X
- 3) 47,XXY
- 4) Fragile X
- 5) 22q11.2 deletion

Metabolic / Endocrine

- 1) PKU
- 2) Galactosemia
- 3) Hypothyroidism
- 4) Cystic Fibrosis
- 5) Tay-Sachs disease

Neuromuscular

- 1) Huntington disease
- 2) Muscular dystrophy
- 3) Mitochondrial disorders
- 4) Myasthenia gravis
- 5) Glycogen storage diseases

Skeletal / Connective Tissue

- 1) Marfan syndrome
- 2) Ehlers-Danlos syndrome
- 3) Tuberous sclerosis
- 4) Neurofibromatosis
- 5) Dysplasias

Hematologic

- 1) Hemophilia A
- 2) Other hemophilias
- 3) Alpha-thalassemia
- 4) Beta-thalassemia
- 5) Sickle cell anemia

Functional Disorders

- 1) Autism
- 2) Epilepsy
- 3) Cerebral palsy
- 4) Mental retardation
- 5) Failure to thrive / growth retardation

Single Malformation

- 1) Limb abnormalities
- 2) Anencephaly
- 3) Myelomeningocele
- 4) Cleft lip and/or palate
- 5) Heart defects

Reproductive Risk

- 1) Infertility
- 2) Consanguinity
- 3) Exposures
- 4) Known carrier
- 5) Increased empiric risk

Multiple Congenital Anomalies

- 1) CHARGE
- 2) VATER / VACTERL
- 3) MURCS
- 4) Pierre-Robin sequence
- 5) Potter sequence

Multiple Malformation

(More than one malformation is present and the overall gestalt does not match any known association or syndrome or sequence.)

NS DEFINITIONS FY 2014 & FY 2015

Client/Patient – A recipient of services that are supported by program expenses funded in whole or in part by Newborn Screening (NS) dollars

Program Expenses – any expense included in the budget that the NS project proposes to be funded by NS dollars (includes staff, supplies, space costs, etc.)

Types of Clients – Pregnant women, infants, children, adolescents, adult women and families

NS Supported Services

- Direct medical and dental care: Family Planning, Prenatal Care, Child Health (infant, child adolescent), Women's Health
- Enabling services: Prenatal Care Coordination, Family Care Coordination

These definitions will allow NS projects to include all clients seen that are funded by NS dollars in their client count. They will also allow projects to enroll all clients that are served by staff paid with NS funds.

Cultural Competence

Cultural competence requires that organizations:

- Have a defined set of values and principles and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve;
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (adapted from Cross et al., 1989)

**INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES
GRANT APPLICATION SCORING TOOL**

FY 2014 & FY 2015 NS Application Review Score: _____

Applicant Agency: _____
 Project Title: _____
 Reviewer: _____
 Date of Review _____

Content Assessment

1.0 Applicant Information – Form A is complete (3 points)

Includes *all* of the following elements

- _____ Title of Project
- _____ Federal I.D. #
- _____ Medicaid Provider #
- _____ FY 2013 NS contract amount
- _____ Funds requested FY 2014 & FY 2015
- _____ Complete sponsoring agency data
- _____ Project Director signature
- _____ Authorized legal signature
- _____ County Health Officer signature
- _____ Secretary of State registration

NOTE: Primary and Secondary Reviewers do not need to evaluate section 1.0. Business Management staff will evaluate this section.

1.0 Score: _____
(3 points maximum)

2.0 Table of Contents

Table indicates the pages where each Section begins including appendices. Yes No

NOTE: Primary and Secondary Reviewers do not need to evaluate section 2.0. Business Management staff will evaluate this section.

*This document is an adaptation of an instrument by Dr. Wendell F. McBurney, Dean, Research and Sponsored Programs, Indiana University-Purdue University at Indianapolis. Dr. McBurney has granted permission of use of this adaptation.

3.0 NS Proposal Narrative (15 points)

3.1 Project Summary includes *all* of the following elements (3.1 = 10 points max.)

- Relates to NS services only
- Identifies problem(s) to be addressed
- Objectives are stated
- Overview of solutions (methods) is provided

3.2 Form B (**5 points**) (3.2 = 5 points maximum)

- NS Project Description (B-1)
 - Brief history is included
 - Problems to be addressed are identified
 - Objectives and workplan are summarized
- Clinic Site information (B-2)
 - Project locations are identified
 - Target population and numbers to be served by site are identified
 - NS and Non-NS budget information per site is included

Comments:

3.0 Score: _____
(15 points maximum)

4.0 Applicant Agency Description

Flows from general to specific and includes *all* of the following elements:

4.1 Description of sponsoring agency

- Mission statement
- Brief history
- Description of administrative structure (organization chart is included)
- Project locations

4.2 Discussion of proposer’s role in community and local collaboration (MOUs and MOAs attached if not previously submitted)

Comments:

4.0 Score: _____
(5 points maximum)

5.0 Statement of Need

Must address MCH priorities for which applicant agency is requesting funding:

- Clearly relates to ISDH MCH Priorities
- At least one problem statement addresses either MCH Priority #1 or Priority #2
- Specifically addresses one or more of MCH priority needs #3 - #10
- Relates to purpose of applicant agency
- Problem(s)/need(s) identified are ones that applicant can impact
- Client/consumer focused
- Supported by statistical data available on ISDH website and local sources. Data indicates the problem(s) or need(s) exist in the community
- Target populations/catchment areas are identified
- Describes systems of care
- Barriers to care are described
- Racial/ethnic disparities that impact access to care are described

Comments:

5.0 Score: _____
(25 points maximum)

6.0 Tables

- NS service forms and tables are completed for one or more of the proposed services.
 - Pregnant women
 - Child health
 - Family planning
 - School-based adolescent health
 - Family care coordination
 - Women's health
- Performance objectives are included
- Appropriate activities are included
- Appropriate measures, documentation, and staff responsible for measuring activities are included
- Project identifies how ISDH priority health initiatives will be incorporated into service delivery (activities on PM tables)

NOTE: Projects do not need to apply for every service (or even more than one) to receive full points for this section. Evaluators should verify that the application contains all required Performance Measure Tables for each service proposed and evaluate the quality of those tables.

Comments:

6.0 Score: _____
(15 points maximum)

7.0 Evaluation Plan Narrative

- Project-specific objectives are measurable and related to improving health outcomes
- Plan explains how evaluation methods reflected on the Performance Measures tables will be incorporated into the project evaluation
- Staff responsible for the evaluation is identified
- What data will be collected and how it will be collected are identified

- ___ How and to whom data will be reported are identified
- ___ Appropriate methods are used to determine whether measurable activities and objectives are on target for being met
- ___ If activities and objectives are identified as not on-target during an intermediate or year-end evaluation and improvement is necessary to meet goals, who is responsible for revisiting activities to make changes which may lead to improved outcomes
- ___ Methods used to evaluate quality assurance (e.g. chart audits, client surveys, presentation evaluations, observation) are described
- ___ Methods used to address identified quality assurance problems

Comments:

7.0 Score:_____
(10 points maximum)

8.0 Staff

- ___ Staff is qualified to operate proposed program
- ___ Staffing is adequate
- ___ Job description and curriculum vitae of key staff are included as an appendix

Comments:

8.0 Score:_____
(4 points maximum)

9.0 Facilities

- ___ Facilities are adequate to house the proposed program
- ___ Facilities are accessible for individuals with disabilities
- ___ Facilities will be smoke-free at all times
- ___ Hours of operation are posted and visible from outside the facility

Comments:

9.0 Score:_____
(4 points maximum)

10.0 Budget and Budget Narrative

- ___ Relationship between budget and project objectives is clear
- ___ All expenses are directly related to project
- ___ Time commitment to project is identified for major staff categories and is adequate to accomplish project objectives

Comments:

10.0 Score: _____
(8 points maximum)

10.1 Budget and Budget Narrative Forms

- ___ Budget page 1 is complete for each year
- ___ Budget narratives include justification for each line item and are completed for each year
- ___ Budget correlates with project duration
- ___ Funding received from ISDH (Form C) is complete
- ___ Information on each budget form is consistent with information on all other budget forms

NOTE: Primary and Secondary Reviewers do not need to evaluate section 10.1. Business Management staff will evaluate this section.

10.1 Score: _____
(4 points maximum)

11.0 Minority Participation

- ___ Statement regarding minority participation in program design and evaluation

Comments:

11.0 Score: _____
(2 points maximum)

12.0 Endorsements

- _____ Endorsements are from organizations able to effectively coordinate programs and services with applicant agency
- _____ Memoranda of Understanding (MOU) clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care
- _____ Endorsements and/or MOUs are current
- _____ Endorsement or MOU with Local Public Health Coordinator
- _____ Letters and a summary of the proposed program have been sent to all health officers in jurisdictions within the proposed service area (unless health officer(s) has signed Form A)

Comments:

11.0 Score: _____
(5 points maximum)

TOTAL SCORE (To be calculated by Business Management staff): _____
(100 points maximum)

CHECKLIST To be completed by Business Management Staff

The following forms are completed:

Application Information – **Form A** Yes No

NS Project Description – **Form B** (B-1, B-2) Yes No

Funding Received thru ISDH – **Form C** Yes No

Informing Local Health Officers of Proposed Submission

- Includes letters to all health officers in jurisdictions included in proposed service area(s) or signature(s) of health officer(s) on Form A Yes No

Project Performance During FY 2012 & FY 2013

The Regional Health Systems Development Consultant (primary reviewer) should describe below performance achievements and/or problems/concerns identified in review of the FY 2012 & FY 2013 Annual Performance Reports that are relevant to this proposal.

(The rest of this page left blank intentionally)