FY 2014 & FY 2015 Application for Maternal and Child Health
Grant Application Procedure (GAP)

The Indiana State Department of Health (ISDH) Maternal and Child Health Division (MCH) is requesting applications from local and statewide service providers and planning organizations to provide services and planning for Maternal and Child Health and Children with Special Health Care Needs.

In spring 2005, MCH identified ten health priorities (listed in the GAP) through a data-driven needs assessment process with statewide citizen input. The primary MCH health priority is to improve infant health outcomes. MCH is currently emphasizing initiatives to significantly decrease the percentage of Indiana women who smoke during pregnancy.

This grant application will be open to all projects proposing to address the four ISDH Public Health Initiatives and two or more of the ten identified Maternal and Child Health priorities. Applicants will be required to identify at least one measurable deliverable related to each of these priorities and initiatives.

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
    - Promote prevention and individual responsibility, especially in the area of obesity prevention, through good nutrition, 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 target access to care for underserved Hoosiers.
    - Provide pportunities 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 responses to threats that cannot be prevented.
    - Coordinate with the Local Public Health Coordinator.

REQUIREMENTS

All MCHSC applicants must address either MCH Priority #1 and one or more of Priorities #3 - #10 **or** MCH Priority #2 and one or more of Priorities #3 - # 10 (see page 4). All MCH applicants are also required to incorporate each of the four ISDH priority health initiatives (above) into their local project efforts. For example, applicants must submit evidence-based interventions for which data will be collected that can show results-oriented outcome improvements based on MCH Priority #1 or #2 and one or more of the other MCH priorities. Projects must participate in community collaborations to promote INShape Indiana and promote individual responsibility within their project clientele, particularly for smoking cessation and obesity prevention and weight management efforts. Projects must work within their community in establishing preparedness responses to emergencies and determining their appropriate role in emergency response.

Benchmark Needs Assessment data were also used to determine focus counties (see Appendix E) in which to target resources. MCH will assign additional evaluation weight to projects providing services in focus counties that impact the MCH priorities that need to be addressed.

Instructions

1. An application for funds must be received by Maternal and Child Health Services by the close of business on **Friday, March 15, 2013 at 4:30 pm EST**.

2. Mail application to: Indiana State Department of Health

   ATTENTION: Vdaniels@isdh.in.gov
   2 North Meridian Street, Section 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 point, 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 Vdaniels@isdh.in.gov, MCH Business Manager, at Vdaniels@isdh.in.gov or 317-233-1241, or Malorie Hensley, Genomics and Cystic Fibrosis Program Director, at MHensley@isdh.IN.gov or 317-233-7019.

Informing Local Health Officers of Proposal Submission

Funded projects are expected to collaborate with local health departments. If you are unable to submit a letter of support from the local health officer, at a minimum, submit copies of letters sent to the local health officers from all jurisdictions in the proposed service area, informing them of your application. These letters should include requests for support and collaboration and indicate that the proposal was included for review by the health officer(s).

FORMS

Applicant Information (Form A)

MCH 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 – Genetic Services Annual Performance Report

Appendix B –Definitions (MCH and Genetic Services)

Appendix C – MCH Consultant Assignments and Map

Appendix D – Hoosier Healthwise Pediatric Provider Participation

Appendix E – Focus Counties

Appendix F – Health Professional Shortage Areas (HPSA)

Appendix G – Medically Underserved Areas (MUA)

Appendix H – Grant Application Scoring Tool

WEBSITES

- FY 2014 & FY 2015 MCH GAP: http://www.in.gov/isdh/22430.htm
- Direct data sites for:
  - MUA/HPSA data: http://bhpr.hrsa.gov/shortage/
  - Health data: http://www.in.gov/isdh/dataandstats/data_and_statistics.htm (page not found)
  - Poverty data: http://www.stats.indiana.edu/welfare_topic_page.html (page not found)
- "Best Practice" guidelines for pregnant women: http://www.indianaperinatal.org
- County Fact Sheets with MCH Priority Counties:
  http://www.in.gov/isdh/programs/mch/countydatasheet.htm (page not found)
- Title V FY 2010 – 2015 Needs Assessment:
  http://www.in.gov/isdh/programs/mch/NAwithactivitiesattachmentfinal.pdf (page not found)
- National Center for Cultural Competence: http://gucchd.georgetown.edu/nccc/index.html
- Indiana Department of Administration list of Minority and Women's Business Enterprises:
  http://www.in.gov/idoa/2352.htm

Priority Health Needs for the MCH population, FY 2011-2015

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)

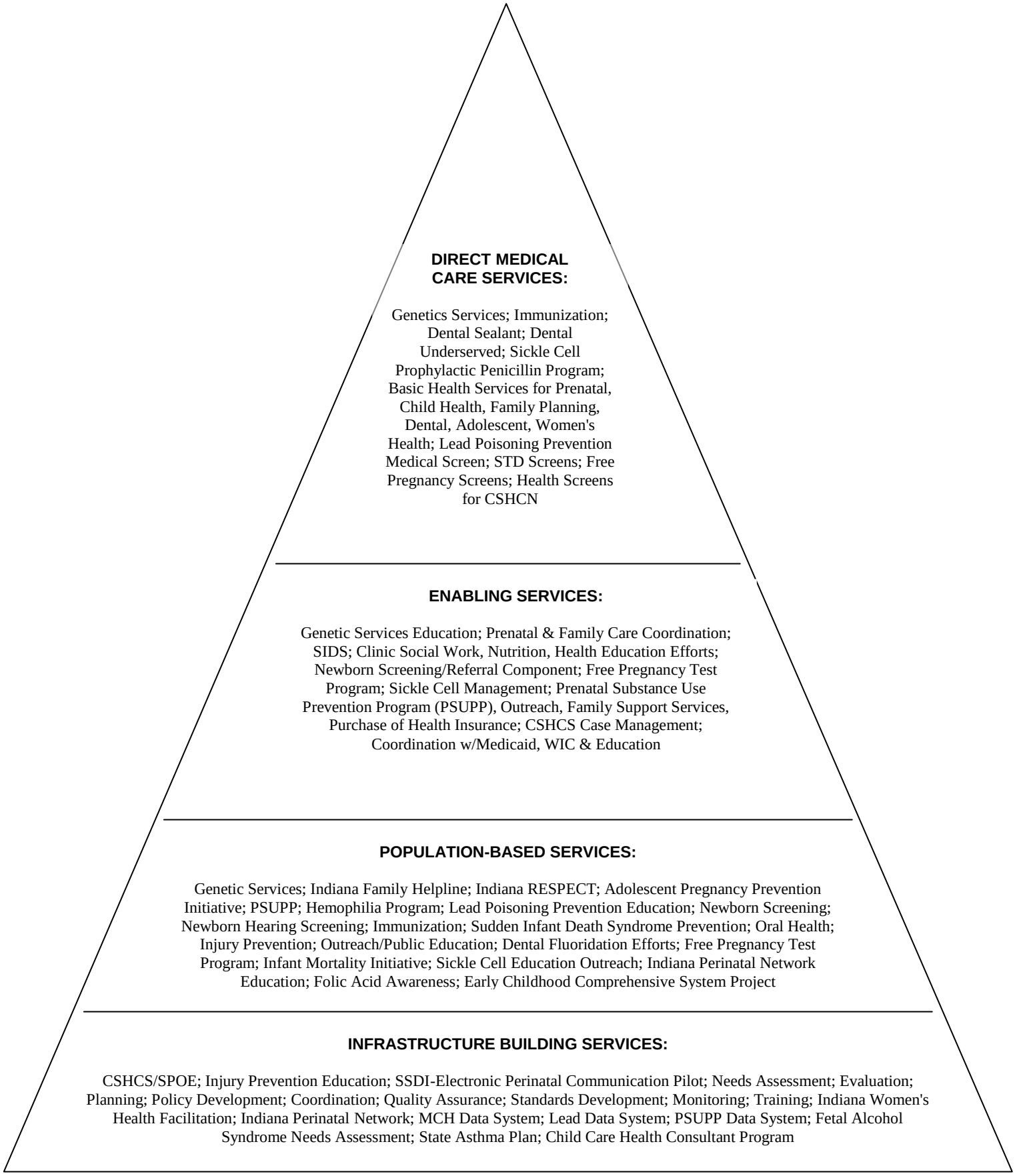
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior (including teen pregnancy), unhealthy dietary behaviors, and physical inactivity. (ISDH Priorities #1, #2, & #3)

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 & FY 2015 Genetic Services 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 and the person authorized to make legal and contractual agreements for the applicant agency must sign and date this document. If the project will not require a medical and/or dental director, write "not applicable" on the appropriate line(s). All appropriate lines must be signed and dated. While the signature of the County Health Officer is not mandatory, if there is no signature, this space should be used to note the date that letters were sent to all affected County Health Officers.

2. Table of Contents

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

3. Genetic Services Proposal Narrative

A. Project Summary

NOTE: This is a separate narrative section. The abstract on form B-1 will be taken from this summary.

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 MCH proposal. The summary will be the last section written and should:

- Relate to program services only;
- Identify the problem(s) to be addressed;
- Succinctly state the objectives; and
- Include an overview of solutions (methods).
- Currently funded programs should also emphasize accomplishments/progress made toward previously identified MCH objectives and outcomes.
- Currently functioning services should indicate the percentage of the target population served by your project and the percentage of minority clients among your population.

B. Form Completion

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

FORM B-1

- Project Description section 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

- Target population and estimated number to be served on page B-2 is for the individual clinic site(s) and is the number to be served with MCH and local matching funds.
- Total MCH budget for site is the estimated MCH funds budgeted for the individual clinic site.
- Services provided in MCH budget site should include only those services provided with MCH funds.
- Other services provided at site should include all services offered at clinic site other than MCH funded services.

4. Applicant Agency Description

This description of the sponsoring agency should:

- Include a statement of purpose (mission statement);
- Include a brief history;
- 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 (attach an organizational 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 local agencies and specify how each collaborates with your organization. Attach Memoranda of Understanding (MOU), Memoranda of Agreement (MOA) and Letters of Support (LOS).

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

5. Statement of Need

Describe and document the specific problem(s) or need(s) to be addressed by the project. This section must address those MCH priorities that you intend to impact. Documentation may be provided by reference – do not include copies of source material. Documentation may include current data, research, local surveys, reports from the local Health Department or United Way, and must include data available from the ISDH website. Proposals to address problems that are not adequately supported with such data will not be considered.
The problems identified should:

- Clearly relate to ISDH MCH Priorities (see Page 4);
- At least one problem must relate to either MCH Priority #1 or Priority #2;
- Specifically address one or more of MCH priority needs #3 - #10;
- Clearly relate to the purpose of the applicant agency;
- Include only those problems that the applicant can impact;
- Be client/consumer focused;

- Be supported by data available on the ISDH website and/or from local sources (this evidence must show that the problem(s) or need(s) exist(s) in *your* community);
- Describe the target population(s) and numbers to be served and identify catchment areas;
- Describe the system of care and how successfully the project fits into the system (identify the public service providers and the number of private providers in the area serving the same population with the same services and indicate a need for the project);
- Describe barriers to access to care;
- Address disparities if the county has significant minority populations; and
- Indicate whether the program provides services in a focus county (Appendix E), Health Professional Shortage Area (HPSA – Appendix F), Medically Underserved Area (MUA – Appendix G), and/or an at-risk lead concentration area (Appendix H), or provides child health services in a county with inadequate child health providers (Appendix D).

6. Performance Objectives and Activities

MCH requires that grantees be accountable for some of the 18 MCHB and 8 State Negotiated Performance Measures that relate to their service category and some related Performance Measures that require direct or enabling services to make an impact. Genetic Services projects have mandatory related Performance Measures (see pages 14-21).

Pages 14-21 provide the format for applicants to indicate the goal (Annual Performance Objective) for each Performance Measure, 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 (Work Plan Measurable 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.

All applicants are required to incorporate each of the four ISDH priority health initiatives into their service delivery (see page 1 for a list). Issues such as data collection, emphasis on prevention and individual responsibility, integration of INShape Indiana, targeting access to care, and scanning for public health threats should be addressed in the activities on the Performance Measure tables. Emphasis should be on health outcomes (e.g. smoking cessation or weight control).

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.

Applicants are to complete the Genetic Services Performance Measures on pages 14-21. 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 14 – 21 are to be used by grantees to monitor progress on each activity and to submit in the Annual Performance Reports for FY 2014 and FY 2015 after each year is completed. The columns

on the Performance Measures forms for Quarterly Results, Adjustment in Work Plan, and Problems are also 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.

7. 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: 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 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.

8. 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 totals 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.

9. 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.

10. Budget and Budget Narrative

NOTE: Do not combine budget information for FY 2014 and 2015. 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;
- Relationship between budget and project objectives is clear; and
- Time commitment to 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.

NOTE: A Budget Narrative form is provided. Do not substitute a different format.
The budget narrative must include a justification for every MCH 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 MCH budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. Please round all numbers to the nearest 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 2014 and FY2015.

Check for internal consistency among the budget forms:

- 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

11. 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.

12. 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.

The local health department should be involved in planning the project. At a minimum, the local health officer in each county where services are proposed must be notified that the organization is proposing services. Signature of the local health officer on Form A is sufficient; if a signature cannot be obtained, include a copy of the organization's letter to the health officer in each service county advising of proposal submission to ISDH. If a signature is not feasible, be sure to indicate in the signature space on Form A the date that the letter was sent to all affected health officers.

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
- Collaborate with Local Public Health Coordinator
- 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)

GENETIC SERVICES REQUIRED FORMS

1) Form A: Applicant Information

2) Form B-1 and B-2: MCH 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
Genetic Services

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 1: Provide genetic evaluation and counseling services in designated area(s).

Performance Objective 1:
☐ ***Increase*** the number of patients receiving genetic services by _____%.
☐ ***Maintain*** the number of patients receiving genetic services.

Service Projections

Directions: Give estimates for current and upcoming years for the total number of patients. For FY 2013, state the number of patients seen for each of the types of services listed below. ***FY 2012 & 2013 numbers should be the same as your FY 2012 – 2013 application. FY 2014 and FY 2015 should be numbers that reflect the percentage increase 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 **Genetic Services Definitions** on page 54 for more information concerning types of services.

Prenatal Genetics Patients

	# of Pregnant Women			
Type of Service	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Pre-Diagnosis Counseling				
Post-Diagnosis Counseling				
Genetic Counseling Only (no prenatal procedures)				
Consultations				
Telephone Contacts				
Teratogens Call Line[1]				
Total				

[1]*Only if applicable*

Clinical Genetics Patients

	# of Patients			
Type of Service	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Evaluation/Counseling: Patient is an infant < 1 year of age				
Evaluation/Counseling: Patient is a child > 1 year of age, but < 22 years of age				
Evaluation/Counseling: Patient is ≥ 22 years of age				
Genetic Counseling Only				
Consultations				
Telephone Contacts				
Total				

Supporting Activities Table

Directions: State the planned activities to increase the number of patients receiving genetic services and which staff members will be responsible for those activities. The Activity Status and Comments/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Greater than 90% of families of children under 3 years of age are informed about First Steps.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families are informed about Children's Special Health Care Services (CSHCS)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families with children < 5 years of age are informed about Women, Infants, and Children (WIC) clinic		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Indiana State Department of Health
Genetic Services

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 2: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

(Please report the following percentages in the subsequent tables.)

Performance Objective 2a: _____% women of childbearing age seen in clinic will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

Performance Objective 2b: _____% women of childbearing age seen in clinic will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

Performance Objective 2c: _____% women of childbearing age seen in clinic will be educated to the ***positive*** effects of taking ***folic acid***.

Service Projections

Directions: We expect that at least **90%** of women of childbearing age 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. Give estimates for current and upcoming years for each of the types of services listed below. Please give actual numbers and percentages for 2012 & 2013. Only complete for patients in your project population. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

PO 2a: Women of childbearing age seen in clinic and educated to the *negative* effects of *smoking* during pregnancy

	FY 2012	FY 2013	FY 2014	FY 2015
Number of women of childbearing age who smoke and were seen in clinic that received **smoking cessation education**				
Number of women of childbearing age who reportedly smoke and were seen in clinic				
Percentage of women of childbearing age who smoke and were seen in clinic that received **smoking cessation education**				

PO 2b: Women of childbearing age who were seen in clinic and educated to the *negative* effects of *alcohol consumption* during pregnancy

	FY 2012	FY 2013	FY 2014	FY 2015
Number of women of childbearing age who were seen in clinic and received education on **alcohol-related birth defects**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received education on **alcohol-related birth defects**				

PO 2c: Women of childbearing age seen in clinic and educated to the *positive* effects of taking *folic acid*

	FY 2012	FY 2013	FY 2014	FY 2015
Number of women of childbearing age who were seen in clinic and received **folic acid education**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received **folic acid education**				

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/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comments/TA plans
Develop and incorporate into your patient intake a protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol during pregnancy.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients who admit to smoking, drinking, or using drugs, and live in an area in which a Prenatal Substance Use Prevention Program (PSUPP) exist, are informed about PSUPP.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Indiana State Department of Health
Genetic Services

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 3: Provide educational genetics presentations to the general public and health professionals **not** in the field of genetics.

Performance Objective 3: *(Please report the following numbers in the subsequent table.)*

Project staff will provide _____ presentations, with at least _____ presentations being given to the general public and at least _____ presentations being given to health care providers **not** in the field of genetics.

Service Projections

Directions: A ***minimum of 4*** presentations are to be given, with at least 2 given to the general public and 2 being given to health care professionals **not** in the field of genetics. Give estimates for current and upcoming years for each of the types of presentations listed below. Please give actual numbers for 2012 and 2013. While a **minimum** of 4 talks is required, please try to give accurate estimates. For upcoming years, please honestly project how many talks you might be providing. 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. Please see **Genetic Services Definitions** on page 54 for more information concerning types of audiences.

Genetics Presentations

	# of Talks			
Main audience:	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
General public *(e.g. high school students, support groups, etc.)*				
Health care professionals and college or graduate-level students ***not*** in the field of genetics				
Other presentations				
Total				

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/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Evaluation sheets will be collected for each talk.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Audience size will be counted at each talk. (**Note**: attendance or evaluation sheets may be used to determine these numbers)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

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

Indiana State Department of Health
Genetic Services

FY 2014 – 2015 OBJECTIVES and ACTIVITIES

Performance Measure 4: Provide confirmation of birth defects to the Indiana Birth Defects and Problems Registry (IBDPR).

Performance Objective 4: 100% of children in the appropriate age group with a confirmed diagnosis are reported to the IBDPR.

Service Projections

Directions: For current and upcoming years, estimate the **total** number of children < 3 years old with a reportable birth defect that you will see in your clinic. **If you have not already submitted a report for these children, please do so in the near future**. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time. A list of reportable conditions and PDF version of the reporting form can be found at http://www.birthdefects.in.gov.

Reporting to the IBDPR

	# of Patients			
	FY 2012 (Baseline)	**FY 2013**	**FY 2014**	**FY 2015**
Number of children < 3 years of age* with at least 1 reportable birth defect that **were** reported to the IBDPR				
Total number of children < 3 years of age* with at least 1 reportable birth defect				
Percentage of observed birth defects reported to IBDPR				

*up to 5 years of age for autism or FAS

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/TA plans will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
Complete a reporting form for each patient < 3 years of age (5 years for autism or FAS) that is born with a reportable condition and then fax the form to ISDH.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Indiana State Department of Health
Genetic Services

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/TA plans will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Activity	Staff Responsible	Activity Status	Comment/TA Plans
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ 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 (MCH 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:

Vdaniels@isdh.in.gov **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 July 1, 2013 through June 30, 2014. FY 2015 runs 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 PHYSICIANS

Clinical Geneticist
Family Practice Physician
General Family Physician
Genetic Fellow
Medical Geneticist
Neonatologist
OB/GYN
Other Physician
Pediatrician
Resident/Intern
Substitutes/Temporaries
Volunteers

111.150 DENTISTS/HYGIENISTS

Dental Assistant
Dental Hygienist
Dentist
Substitutes/Temporaries
Volunteers

111.200 OTHER SERVICE PROVIDERS

Audiologist
Child Development Specialist
Community Educator
Community Health Worker
Family Planning Counselor
Genetic Counselor (M.S.)
Health Educator/Teacher
Occupational Therapist
Outreach Worker
Physical Therapist
Physician Assistant
Psychologist
Psychometrist
Speech Pathologist
Substitutes/Temporaries
Volunteers

111.350 CARE COORDINATION

Licensed Clinical Social Worker (L.C.S.W.)
Licensed Social Worker (L.S.W.)
Physician
Registered Dietitian
Registered Nurse
Social Worker (B.S.W.)
Social Worker (M.S.W.)
Substitutes/Temporaries
Volunteers

111.400 NURSES

Clinic Coordinator
Community Health Nurse
Family Planning Nurse Practitioner
Family Practice Nurse Practitioner
Licensed Midwife
Licensed Practical Nurse
OB/GYN Nurse Practitioner
Other Nurse
Other Nurse Practitioner
Pediatric Nurse Practitioner
Registered Nurse
School Nurse Practitioner
Substitutes/Temporaries
Volunteers

111.600 SOCIAL SERVICE PROVIDERS

Caseworker
Licensed Clinical Social Worker (L.C.S.W.)
Licensed Social Worker (L.S.W.)
Counselor
Counselor (M.S.)
Social Worker (B.S.W.)
Social Worker (M.S.W.)
Substitutes/Temporaries
Volunteers

111.700 NUTRITIONISTS/DIETITIANS

Dietitian (R.D. Eligible)	Registered Dietitian
Nutrition Educator	Substitutes/Temporaries
Nutritionist (Master Degree)	Volunteers

111.800 MEDICAL/DENTAL/PROJECT DIRECTOR

Dental Director	Project Director
Medical Director	

111.825 PROJECT COORDINATOR

111.850 OTHER ADMINISTRATION

Accountant/Finance/Bookkeeper	Laboratory Technician
Administrator/General Manager	Maintenance/Housekeeping
Clinic Aide	Nurse Aide
Clinic Coordinator (Administration)	Other Administration
Communications Coordinator	Programmer/Systems Analyst
Data Entry Clerk	Secretary/Clerk/Medical Record
Evaluator	Substitutes/Temporaries
Genetic Associate/Assistant	Volunteers
Laboratory Assistant	

115.000 FRINGE BENEFITS

200.700 TRAVEL

Conference Registrations	Out-of-State Staff Travel (only available with non-matching funds)
In-State Staff Travel	

200.800 RENTAL AND UTILITIES

Janitorial Services	Rental of Space
Other Rentals	Utilities
Rental of Equipment and Furniture	

200.850 COMMUNICATIONS

Postage (including UPS)	Reports
Printing Costs	Subscriptions
Publications	Telephone

200.900 OTHER EXPENDITURES

Insurance and Bonding	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 --	Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project.
Other	Approved items not otherwise classified above.

EXAMPLES OF EXPENDITURE ITEMS THAT WILL NOT BE ALLOWED

The following may not be claimed as project costs for Maternal and Child Health projects and may not be paid for with MCH Funds:

1. Construction of buildings or 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:

Vdaniels@isdh.in.gov, MCH Business Manager, Vdaniels@isdh.in.gov or 317-233-1241

FY 2014 Budget Narrative

The budget narrative must include a justification for every MCH 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 MCH 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 ($.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 MCH
	For each personnel entry, include name, title and brief description of their role in the project (i.e. Provides direct services) List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to MCH
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 MCH
	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.	Travel = $0.44 X miles for each staff being reimbursed for travel.	Total to be charged to MCH
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 MCH 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 MCH 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 ($.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 MCH
	For each personnel entry, include name, title and brief description of their role in the project (i.e. Provides direct services) List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to MCH
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 MCH
	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.	Travel = $0.44 X miles for each staff being reimbursed for travel.	Total to be charged to MCH
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	

FORM A

MATERNAL AND CHILD HEALTH
APPLICATION
FY 2014 & FY 2015

Title of Project _____ Federal I.D. # _____

Medicaid Provider Number: _____ FY 2013 MCH Contract Amount $_____

FY 2014 MCH Amount Requested: $_____

FY 2015 MCH 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.

FORM B-1

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 ☐	Local ☐	Private Non-Profit ☐	
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.)			

FY 2014 & FY 2015

FORM B-2

MCH Project Name:	Project Number:	# Clinic Sites

Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site:
Counties Served:	Services Provided in MCH Budget for site:	
Target Population and estimated number to be served with MCH funds:	Other services provided at site (non-MCH):	
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site:
Counties Served:	Services Provided in MCH Budget for site:	
Target Population and estimated number to be served with MCH funds:	Other services provided at site (non-MCH):	
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site:
Counties Served:	Services Provided in MCH Budget for site:	
Target Population and estimated number to be served with MCH funds:	Other services provided at site (non-MCH):	
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site :
Counties Served:	Services Provided in MCH Budget for site:	
Target Population and estimated number to be served with MCH funds:	Other services provided at site (non-MCH):	
Clinic Site Address:	Clinic Schedule (days & times):	Total MCH Budget for site:
Counties Served:	Services Provided in MCH Budget for site:	
Target Population and estimated number to be served with MCH funds:	Other services provided at site (non-MCH):	

FORM C

FUNDING **CURRENTLY** RECEIVED BY YOUR AGENCY
FROM THE INDIANA STATE DEPARTMENT OF HEALTH

LIST ALL SOURCES OF ISDH FUNDING

SOURCE	FISCAL YEAR	AMOUNT

TOTAL $_____

COMMENTS:

_____

_____

_____

Appendix A

INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES
GENETIC SERVICES
ANNUAL PERFORMANCE REPORT FY 2014

PROJECT NAME: _____

PROJECT NUMBER: _____

APPLICANT AGENCY: _____

REPORTING PERIOD: FY 2014 (07/01/13 TO 06/30/14)

DATE SUBMITTED: _____ PREPARED BY: _____

I. Instructions……(Page 35)

II. Narrative……(Page 35)

III. Quality Assurance……(Page 35)

IV. Demographic Data……(Pages 35- 37)

V. Program Monitoring Data……(Pages 37 - 43)

VI. Project Data……(Pages 44 - 52)

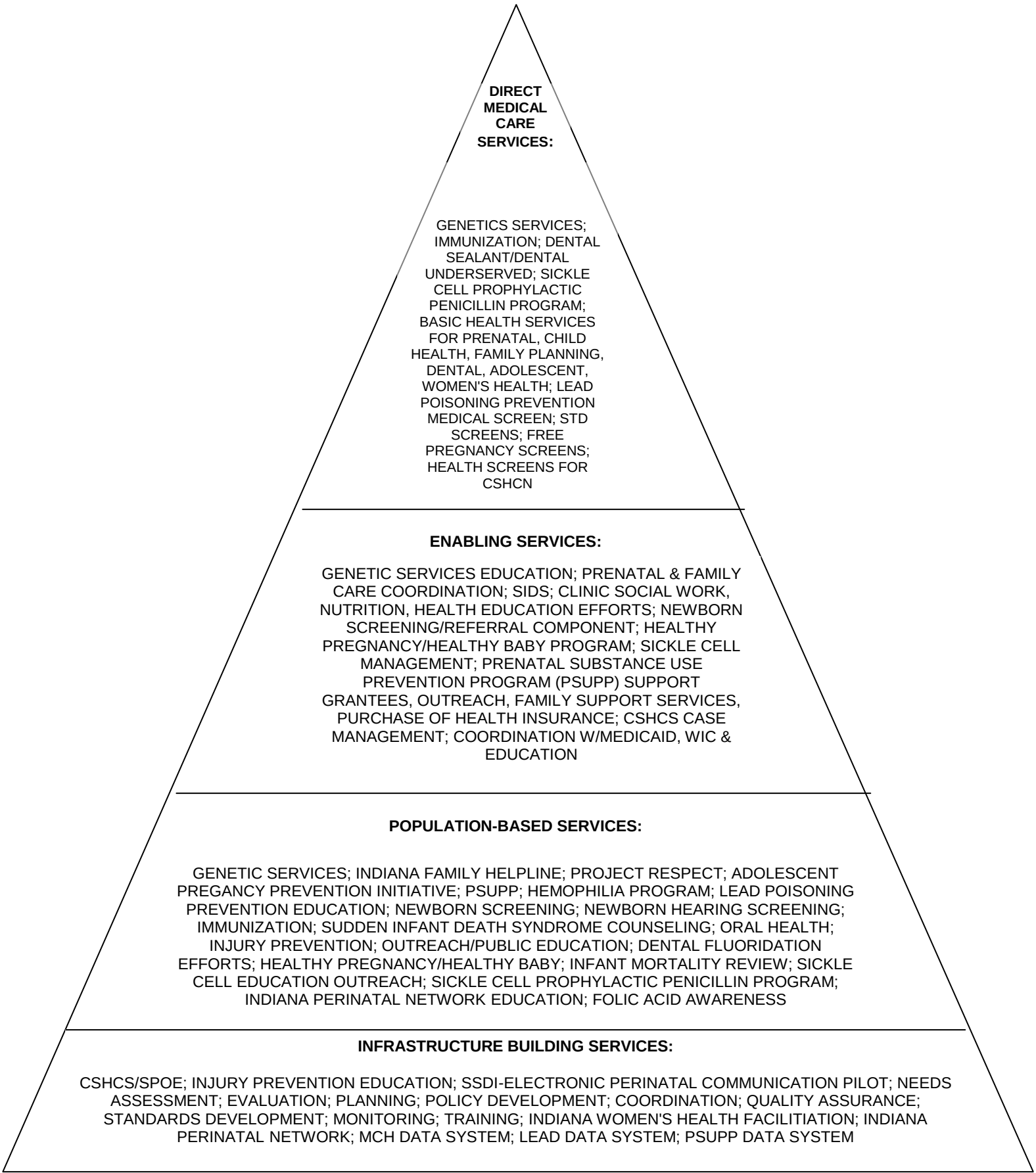
VII. Appendices……(Pages 53 - 56)

Appendix 1 Performance Objective Summary

Appendix 2 Definitions

Appendix 3 Descriptions for Final or Best Working Diagnosis Table

FIGURE1: 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 MCH 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 MCH funds. The Narrative should be supported by the statistical report and completed work plan. It should provide a complete picture of your MCH 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.
- 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 annual # is lower). 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 MCH data reports. Summarize the data problems – incomplete collection or program challenges – indicating the specific areas. Review the charts to determine whether 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 Genetic Services in Fiscal Year 2015, 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	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
TERATOGEN CALL CENTER**											
OTHER INDIVIDUALS > 22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2015/2014 proposal.
**If applicable

Totals Should Match

Table 2. Number of Return Visit Individuals Who Received Genetic Services in Fiscal Year 2015, 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	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
TERATOGEN CALL CENTER											
OTHER INDIVIDUALS > 22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2015/2014 proposal.

Totals Should Match

Table 3. Number of New Individuals Who Received Services Provided or Paid for in Whole or in Part by MCH Funds in Fiscal Year 2015, 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 MCH Funds in Fiscal Year 2015, 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 Genetic 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					
Genetic Counseling Only					
Consultations					
Telephone Contacts					
Teratogens Call Line*					
Referrals To MCH Clinic					
Referrals To First Steps					
Referrals To CSHCS					
Referrals To PSUPP					
Referrals To WIC Clinic					

*only if applicable.

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

Table 6: Educational Genetic Outreach Activities

	Number of Education Sessions Completed	Average Number of Participants per Session	Overall Score From Evaluation Sheets
General public (e.g. high school students, support groups, etc.)			
Health care professionals and college or graduate level students ***not*** in the field of genetics			
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: Genetics 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 Genetic Services								
Clinical Genetic Services								
TOTAL								

Table 8: Primary Indication For Prenatal Genetic Services

	FY 13	FY 14	FY 15
1. Advanced Maternal Age	_____	_____	_____
2. Personal or Family History of Chromosomal Abnormality	_____	_____	_____
3. Personal or Family History of Metabolic Disorder	_____	_____	_____
4. Personal or Family History of Neural Tube Defect	_____	_____	_____
5. Personal or Family History of Other Heritable Disorder or Birth Defect	_____	_____	_____
6. Personal or Family History for Hemoglobinopathy	_____	_____	_____
7. Maternal Serum Screen indicates an increased risk for a Neural Tube Defect	_____	_____	_____
8. Maternal Serum Screen indicates an increased risk for a chromosomal abnormality	_____	_____	_____
9. Previous Spontaneous Abortions/Stillbirths	_____	_____	_____
10. Teratogen Exposure	_____	_____	_____
11. Abnormal Ultrasound (without other indication)	_____	_____	_____
12. Parental Concern/Anxiety (without other indication)	_____	_____	_____
13. Other	_____	_____	_____
14. Primary Indication Not Recorded or Unknown	_____	_____	_____
TOTAL	_____	_____	_____

Table 9: Results of Prenatal Genetic Patient Evaluations

I. Outcome of Prenatal Evaluations Performed	FY 13	FY 14	FY 15
1. No fetal abnormality found	_____	_____	_____
2. Fetal abnormality found	_____	_____	_____
3. Findings of uncertain significance	_____	_____	_____
4. Results impossible to interpret or not obtained due to unsatisfactory evaluation	_____	_____	_____
5. Evaluation performed, but results unreported	_____	_____	_____
SUBTOTAL OF PRENATAL EVALUATIONS COMPLETED	_____	_____	_____
II. No Prenatal Evaluations Done or Recommended; Prenatal Evaluations Not Completed by Reporting Unit			
1. Testing not indicated in opinion of staff	_____	_____	_____
2. Testing declined or not completed by patient	_____	_____	_____
3. Spontaneous pregnancy loss before procedure	_____	_____	_____
4. No prenatal evaluations done; reason Unknown	_____	_____	_____
SUBTOTAL OF PRENATAL EVALUATIONS NOT COMPLETED	_____	_____	_____
III. Evaluation Status Unknown	_____	_____	_____
TOTAL	_____	_____	_____

Table 10: Primary Indication for Reason for Referral to Clinical Genetic 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 11: Final or Best Working Diagnosis for Clinical Genetic Patients

	FY 13	FY 14	FY 15
1. No Evidence of Abnormality or Specific Disorder	_____	_____	_____
2. Chromosomal and Single Gene Disorders	_____	_____	_____
3. Metabolic/Endocrine	_____	_____	_____
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.

Table 12: Unduplicated Genetic Patients Seen By County of Residence

COUNTY	PREGNANT WOMEN	CLINICAL PATIENTS	**TOTAL**

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/TA Plans 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).

Genetic Service Providers should complete the following pages addressing MCH performance measures.

A. GENETICS

Performance Measure 1: Provide genetic evaluation and counseling services in designated area(s).

Performance Objective 1:
☐ ***Increase*** the number of patients receiving genetic services by _____%.
☐ ***Maintain*** the number of patients receiving genetic services.

Directions: Report the total number of patients seen in your project population. The estimated number of patients is the number submitted on the grant application. Gray areas do not need to be completed.

Prenatal Genetics Patients

# of Pregnant Women	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Total Number of Patients Seen				
Estimated Number of Patients Seen				
Percent of Estimate Achieved				

Total Number of Teratogens Call Line[1]				
Estimated Number of Teratogens Call Line[1]				
Percent of Estimate Achieved				

[1]*Only if applicable*

Clinical Genetics Patients

# of Patients	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
Total Number of Patients Seen				
Estimated Number of Patients Seen				
Percent of Estimate Achieved				

Percent of Estimate Achieved = [Number of Patients Seen / Estimated Number of Patients Seen] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Appendix A

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

Activity	Staff Responsible	Activity Status	Comments/TA plans
Greater than 90% of families of children < 3 years of age were informed about First Steps		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families were informed about Children's Special Health Care Services (CSHCS)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients/families with children < 5 years of age were informed about Women, Infants, and Children (WIC) clinic		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. GENETICS

Performance Measure 2: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Performance Objective 2a: _____% women of childbearing age seen in clinic will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

Performance Objective 2b: _____% women of childbearing age seen in clinic will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

Performance Objective 2c: _____% women of childbearing age seen in clinic will be educated to the ***positive*** effects of taking ***folic acid***.

Service Projections

Directions: Report the number of patients seen in your project population and from these numbers calculate the corresponding percentages. We expect that at least **90%** of women of childbearing age, 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.

PO 2a: Women of childbearing age who were seen in clinic and educated to the *negative* effects of *smoking* during pregnancy

	FY 2012	FY 2013	FY 2014	FY 2015
Number of women of childbearing age who smoke and were seen in clinic that received **smoking cessation education**				
Number of women of childbearing age who reportedly smoke and were seen in clinic				
Percentage of women of childbearing age who smoke and were seen in clinic that received **smoking cessation education**				

PO 2b: Women of childbearing age who were seen in clinic and educated to the *negative* effects of *alcohol consumption* during pregnancy

	FY 2012	FY 2013	FY 2014	FY 2015
Number of women of childbearing age who were seen in clinic and received education on **alcohol related birth defects**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received education on **alcohol related birth defects**				

PO 2c: Women of childbearing age seen in clinic and educated to the *positive* effects of taking *folic acid*

	FY 2012	FY 2013	FY 2014	FY 2015
Number of women of childbearing age who were seen in clinic and received **folic acid education**				
Number of women of childbearing age who were seen in clinic				
Percentage of women of childbearing age who were seen in clinic and received **folic acid education**				

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

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

Activity	Staff Responsible	Activity Status	Comments/TA plans
Develop and incorporate into your patient intake a protocol asking patients if they took folic acid or had smoked and/or consumed alcohol during pregnancy.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Greater than 90% of patients who admit to smoking, drinking or using drugs and live in an area in which a Prenatal Substance Use Prevention Program (PSUPP) exist were informed about PSUPP.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. GENETICS

Performance Measure 3: Provide educational genetics presentations to health professionals **not** in the field of genetics and the general public.

Performance Objective 3:

Project staff will provide _____ presentations, with at least _____ presentations being given to the general public and at least _____ presentations being given to health care providers **not** in the field of genetics.

Directions: Report the total number of presentations given by your project staff. A ***minimum of 4*** presentations are to be given, with at least 2 given to the general public and 2 being given to health care professionals not in the field of genetics. **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. Please see **Definitions** on page 64 for more information concerning types of audiences.

	# of Talks						
Main audience:	**FY 2013 Actual**	**FY 2014 Actual**	**FY 2014 Estimated**	***FY 2014 % Completed***	**FY 2015 Actual**	**FY 2015 Estimated**	***FY 2015 % Completed***
General Public (e.g. high school students, support groups, etc.)							
Health care professionals and college or graduate level students ***not*** in the field of genetics							
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/TA plans for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	**Staff Responsible**	**Activity Status**	**Comment/TA Plans**
Evaluation sheets will be collected for each talk.		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Audience size will be counted at each talk. (**Note**: attendance or evaluation sheets may be used to determine these numbers)		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
		☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. GENETICS

Performance Measure 4: Provide confirmation of birth defects to the Indiana Birth Defects and Problems Registry (IBDPR).

Performance Objective 4: 100% of children in the appropriate age group with a confirmed diagnosis are reported to the IBDPR.

Directions: Report the **total** number of children < 3 years old with a reportable birth defect that you will see in your clinic. **If you have not already submitted a report for these children, please do so in the near future**. A list of reportable conditions and PDF version of the reporting form can be found at http://www.in.gov/isdh/programs/ibdpr/reporting.htm.

Reporting to the IBDPR

	# of Patients			
	FY 2012 (Baseline)	**FY 2013**	**FY 2014**	**FY 2015**
Number of children < 3 years of age* with at least 1 reportable birth defect that **were** reported to the IBDPR				
Total number of children < 3 years of age* with at least 1 reportable birth defect				
Percentage of observed birth defects reported to IBDPR				

*up to 5 years of age for autism or FAS

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

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

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
Report form for each patients < 3 years of age (5 years for FAS and autism) that are born with a reportable condition is completed and faxed to ISDH.		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

A. GENETICS

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

	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	Staff Responsible	Activity Status	Comments/TA Plans
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

A. GENETICS

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2013	FY 2014	FY 2015
	%	%	%
	%	%	%
	%	%	%

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Staff Responsible	Activity Status	Comments/TA Plans
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
		☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

Appendix 1

Genetic Services
Performance Objective Summary
FY 2014

FY 2014

	MET	
PERFORMANCE OBJECTIVE 1:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2a:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2b:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2c:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 3:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 4:	☐ ***YES***	☐ ***NO***

Percent of MCH Required Performance Objectives Met _____

Number of Project Chosen Objectives Met _____

Total Number of Project Chosen Objectives _____

Percent of Project Chosen Objectives Met _____

Appendix 2

Genetic 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

Prenatal Genetics Patient – All pregnant women seen by the project who request or receive services relating to the outcome of the pregnancy, e.g. focused on the fetus.

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

Genetic Counseling Only – A communication which deals with the human problems associated with the occurrence or risk of recurrence of a genetic 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.

Pre-diagnosis counseling – Counseling performed in the absence of any screening or diagnostic test results.

Post-diagnosis counseling – Counseling performed after a diagnosis is suggested/made by a screening or diagnostic test.

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.

Table 8

Advanced Maternal Age – Age 35 or older at EDC, although it is recognized that some programs may use a different age cutoff. This is a count of all women with AMA chosen as their primary indication.

Personal or Family History of Chromosome Abnormality – A known or suspected chromosomal abnormality in a relative where either of the patient's parents are known to have normal chromosomes or the parental chromosome status is unknown. This includes a family with a previous child with trisomy 21 or a deceased sibling with clinically diagnosed Down Syndrome with no known chromosome analysis completed. This also includes a family history where one of the parents is known to have a confirmed balanced or unbalanced translocation or is at risk for a translocation, but has not been tested.

Personal or Family History of Metabolic Disorder – A known or presumed metabolic defect which is inherited as an autosomal or polygenic trait in either the pregnant women herself (ex. diabetes mellitus or PKU) or in a previous child.

Personal or Family History of Neural Tube Defect – An open or skin-covered defect (anencephaly, spina bifida with or without hydrocephalus, or encephalocele) without other unrelated defects.

Personal or Family History of Other Heritable Disorder – Includes any other type of heritable mental retardation or genetic disorder which does not fit into any of the above categories.

Personal or Family History of Birth Defects – Includes any other type of heritable birth defect which does not fit into any of the above categories.

Personal or Family History of Hemoglobinopathy – Based on carrier testing and/or racial or ethnic risks, as well as family history.

Maternal Serum Screen Positive for NTD – Based on initial results at the local usage upper cutoff after adjustment for gestational age, maternal weight, race, and diabetes. This cutoff may be higher or lower in different locales.

Maternal Serum Screen Positive for Chromosomal Abnormality – Based on initial results at the local usage lower cutoff, which is usually correlated with maternal age for women under institutional cutoff for advanced maternal age.

Previous Spontaneous Abortions/Stillbirths – Based on local definitions (usually referring to two or more events of this nature).

Teratogen Exposure – Exposure to any exogenous substance or agent in the home, at the worksite, or in the outside environment which may predispose one to an increased risk of birth defects, mental retardation, fetal death, or other adverse perinatal outcome. This also includes medications with known teratogenic effects. This does not include endogenous maternal disorders, such as diabetes or PKU.

Abnormal Ultrasound – A fetal abnormality is seen or suspected after ultrasound examination, in absence of any other listed indication.

Parental Concern/Anxiety – A desire for prenatal diagnosis and/or testing which cannot be appropriately entered in any of the above categories.

Other – Any indication which does not fit the above entries as defined.

Performance Measure 3

Health professionals *not* in the field of genetics - Any individual who has received a degree, is currently employed, or is seeking employment in a healthcare field. This includes residents and fellows not specializing in genetics.

College or graduate level students *not* in the field of genetics – 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.)

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MCH DEFINITIONS
FY 2014 & FY 2015

Client/Patient – A recipient of services that are supported by program expenses funded in whole or in part by MCH dollars

Program Expenses – Any expense included in the budget that the MCH project proposes for funding by MCH dollars (includes staff, supplies, space costs, etc.)

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

MCH 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 MCH projects to include all clients seen that are funded by MCH dollars in their client count. They will also allow projects to enroll all clients that are served by staff paid with MCH 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 systematically involve 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 MCH SYSTEMS DEVELOPMENT CONSULTANT ASSIGNMENTS

CONSULTANT NAME	COUNTIES COVERED
MALORIE HENSLEY **Genomics Program Director** **317/233-7019** ***MHensley@isdh.in.gov***	Statewide Genetics Program (Grantees in Allen, Clark, Delaware, Jefferson, Harrison, Lake, LaPorte, Marion, Monroe, St. Joseph, Tippecanoe, Vanderburgh and Vigo)

INDIANA MEDICAID

Hoosier Healthwise Pediatric Provider Participation
As of 01/12/2010

COUNTY	PED PMP ENROLLMENT (1)	PED PMP PANEL SLOTS AVAILABLE (2)	MEMBERS LINKED TO PED PMPS (3)	PCT PED PMP PANELS FULL (4)	AVG MEMBERS PER PED PMP (5)
01-ADAMS	1	1,500	1,030	68.66%	1,030
02-ALLEN	97	51,106	30,120	58.93%	311
03-BARTHOLOMEW	16	3,496	4,505	128.86%	282
04-BENTON	1	500	194	38.80%	194
05-BLACKFORD	4	3,000	1,185	39.50%	296
06-BOONE	9	2,368	2,373	100.21%	264
07-BROWN	3	925	581	62.75%	194
↓08-CARROLL	3	1,975	1,429	72.35%	476
09-CASS	13	7,155	3,261	45.57%	251
10-CLARK	29	17,929	7,469	41.65%	258
11-CLAY	9	9,750	2,342	24.02%	260
12-CLINTON	10	1,900	2,094	110.21%	209
13-CRAWFORD	1	1,000	740	74.00%	740
14-DAVIESS	13	4,675	2,370	50.69%	182
15-DEARBORN	19	8,825	3,097	35.09%	163
16-DECATUR	13	3,012	1,941	64.43%	149
17-DEKALB	17	3,010	2,823	93.78%	166
18-DELAWARE	32	13,265	11,339	85.48%	354
19-DUBOIS	15	3,549	2,353	66.30%	157
20-ELKHART	62	14,231	14,777	103.83%	238
21-FAYETTE	6	3,072	2,397	78.02%	400
22-FLOYD	27	14,078	6,718	47.71%	249
23-FOUNTAIN	2	1,500	962	64.13%	481
24-FRANKLIN	5	945	1,037	109.79%	207
25-FULTON	9	9,050	1,867	20.62%	207
26-GIBSON	10	3,102	1,681	54.19%	168
27-GRANT	15	15,700	7,395	47.10%	493
28-GREENE	6	4,350	1,431	32.89%	239
29-HAMILTON	29	5,745	5,161	89.83%	178
30-HANCOCK	19	2,390	2,044	85.52%	108
31-HARRISON	10	3,005	2,258	75.14%	226
32-HENDRICKS	22	3,101	2,970	95.75%	135
33-HENRY	15	11,619	3,977	34.22%	265
34-HOWARD	20	11,999	7,739	64.49%	387
35-HUNTINGTON	17	9,850	2,600	26.39%	153
36-JACKSON	14	4,604	2,038	44.26%	146
37-JASPER	12	9,637	1,891	19.62%	158
38-JAY	9	3,300	1,652	50.06%	184
39-JEFFERSON	17	3,336	2,831	84.86%	167
40-JENNINGS	6	6,375	2,190	34.35%	365
41-JOHNSON	36	16,967	8,816	51.95%	245
42-KNOX	12	4,153	4,042	97.32%	337
43-KOSCIUSKO	28	5,644	4,506	79.83%	161

44-LAGRANGE	7	2,900	1,635	56.36%	234
45-LAKE	176	167,411	58,362	34.86%	332
46-LAPORTE	37	15,651	9,581	61.21%	259
47-LAWRENCE	18	7,840	4,423	56.41%	246
48-MADISON	54	20,794	12,862	61.85%	238
49-MARION	224	168,482	96,948	57.54%	433
50-MARSHALL	21	4,900	3,258	66.48%	155
51-MARTIN	3	766	602	78.59%	201
52-MIAMI	9	4,169	2,632	63.12%	292
53-MONROE	26	12,942	8,563	66.16%	329
54-MONTGOMERY	3	1,953	1,992	101.99%	664
55-MORGAN	15	5,537	4,634	83.69%	309
56-NEWTON	3	3,650	655	17.94%	218
57-NOBLE	10	4,500	2,115	47.00%	212
58-OHIO	1	500	379	75.80%	379
59-ORANGE	7	2,775	1,757	63.31%	251
60-OWEN	6	2,725	1,120	41.08%	187
61-PARKE	4	2,503	467	18.63%	117
62-PERRY	7	2,250	1,002	44.53%	143
63-PIKE	4	1,075	790	73.48%	198
64-PORTER	30	13,878	6,501	46.84%	217
65-POSEY	7	3,900	1,462	37.48%	209
66-PULASKI	8	3,900	1,173	30.07%	147
67-PUTNAM	12	4,850	2,519	51.93%	210
68-RANDOLPH	9	13,750	2,035	14.80%	226
69-RIPLEY	15	2,703	1,662	61.48%	111
70-RUSH	8	3,550	1,127	31.73%	141
71-ST. JOSEPH	113	51,504	28,339	55.02%	251
↓ 72-SCOTT	11	3,139	2,313	73.68%	210
73-SHELBY	12	2,813	2,737	97.28%	228
74-SPENCER	7	2,438	1,061	43.50%	152
75-STARKE	5	5,650	2,278	40.31%	456
↓76-STEUBEN	5	2,550	2,038	79.92%	408
77-SULLIVAN	10	13,100	2,320	17.70%	232
78-SWITZERLAND	2	400	412	103.00%	206
79-TIPPECANOE	14	4,963	5,343	107.65%	382
80-TIPTON	6	1,008	677	67.16%	113
81-UNION	2	200	208	104.00%	104
82-VANDERBURGH	63	29,425	17,056	57.96%	271
83-VERMILLION	6	4,810	1,847	38.38%	308
84-VIGO	57	31,396	11,431	36.40%	201
85-WABASH	16	5,841	2,277	38.97%	142
86-WARREN	2	4,000	775	19.37%	388
87-WARRICK	15	3,840	2,188	56.97%	146
88-WASHINGTON	7	4,600	1,490	32.39%	213
89-WAYNE	13	8,214	6,255	76.15%	481
90-WELLS	14	5,300	2,485	46.87%	177
91-WHITE	5	4,970	1,728	34.76%	346
92-WHITLEY	11	3,800	1,818	47.84%	165
94-IFSSA	12	2,070	661	31.94%	55
99-OUT OF STATE	37	5,625	11	0.18%	0

STATEWIDE	1,882	988,199	502,218	50.82%	267

(1) Pediatric PMP enrollment includes providers with active PMP segment, primary specialty 316, 318 or 345, and age restriction specification that includes ages 18 and/or under.
(2) Available panel slots are divided by two for PMPs with active segments in two counties. For PMPs with active "panel hold", available slots = linked slots.
(3) Member enrollment is reported by PMP county, and includes pending members.
(4) Field (3) divided by field (2), multiplied by 100.
(5) Field (3) divided by field (1).

Counties with 80% or greater panels full (risk zone) are highlighted.

↑ Counties new to the risk zone.

↓ Counties that have been in the risk zone within the past 6 months, but currently are not.

Appendix E

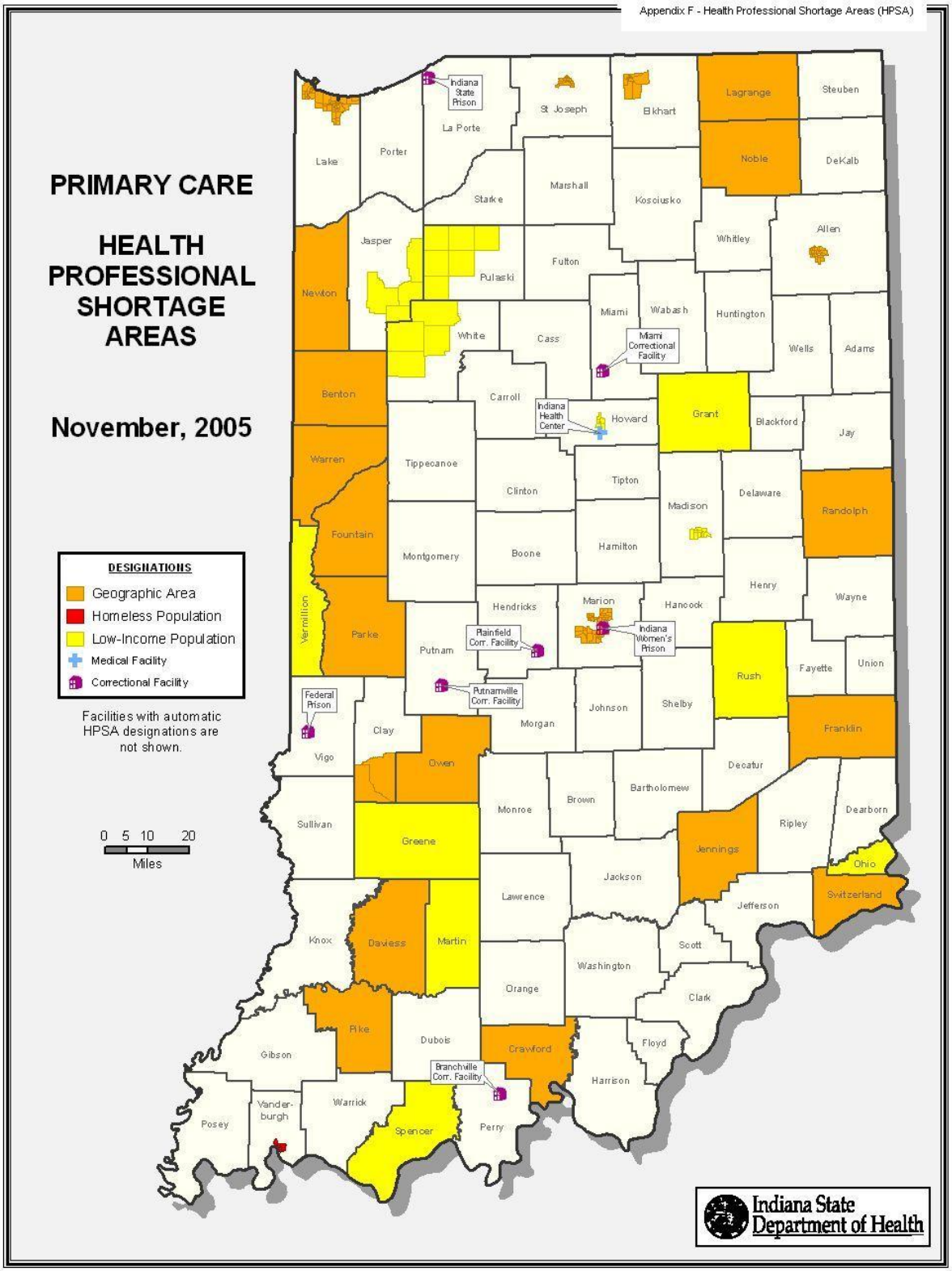
1. Indiana Counties with highest rates of percentage of mothers who smoked during pregnancy (2003):

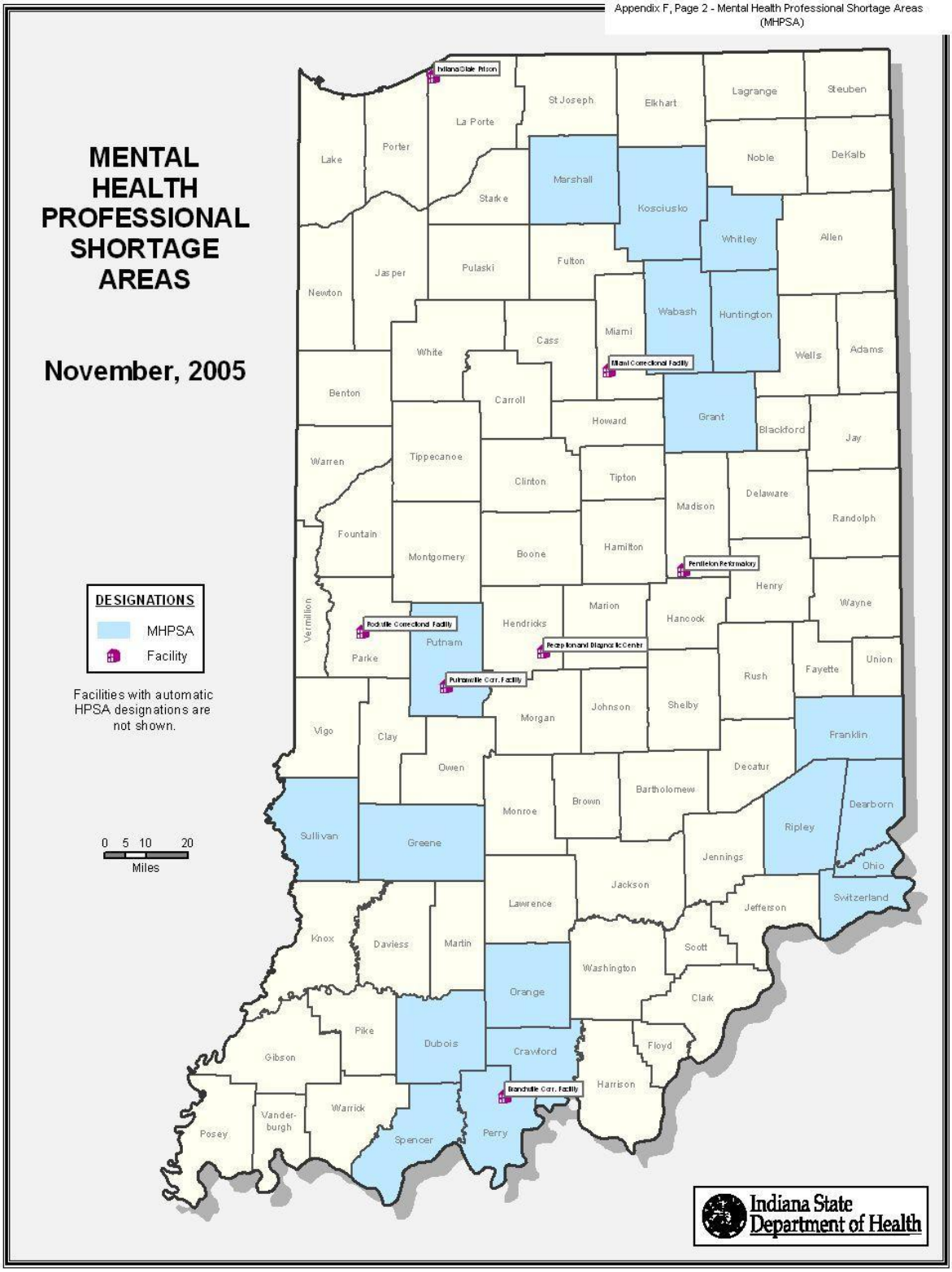
County	Rate (%)	Ranking
Vermillion	35.5	1
Perry	32.6	2
Crawford	31.9	3
Scott*	31.1	4
Jefferson	31.0	5
Knox*	30.8	6
Parke	30.7	7

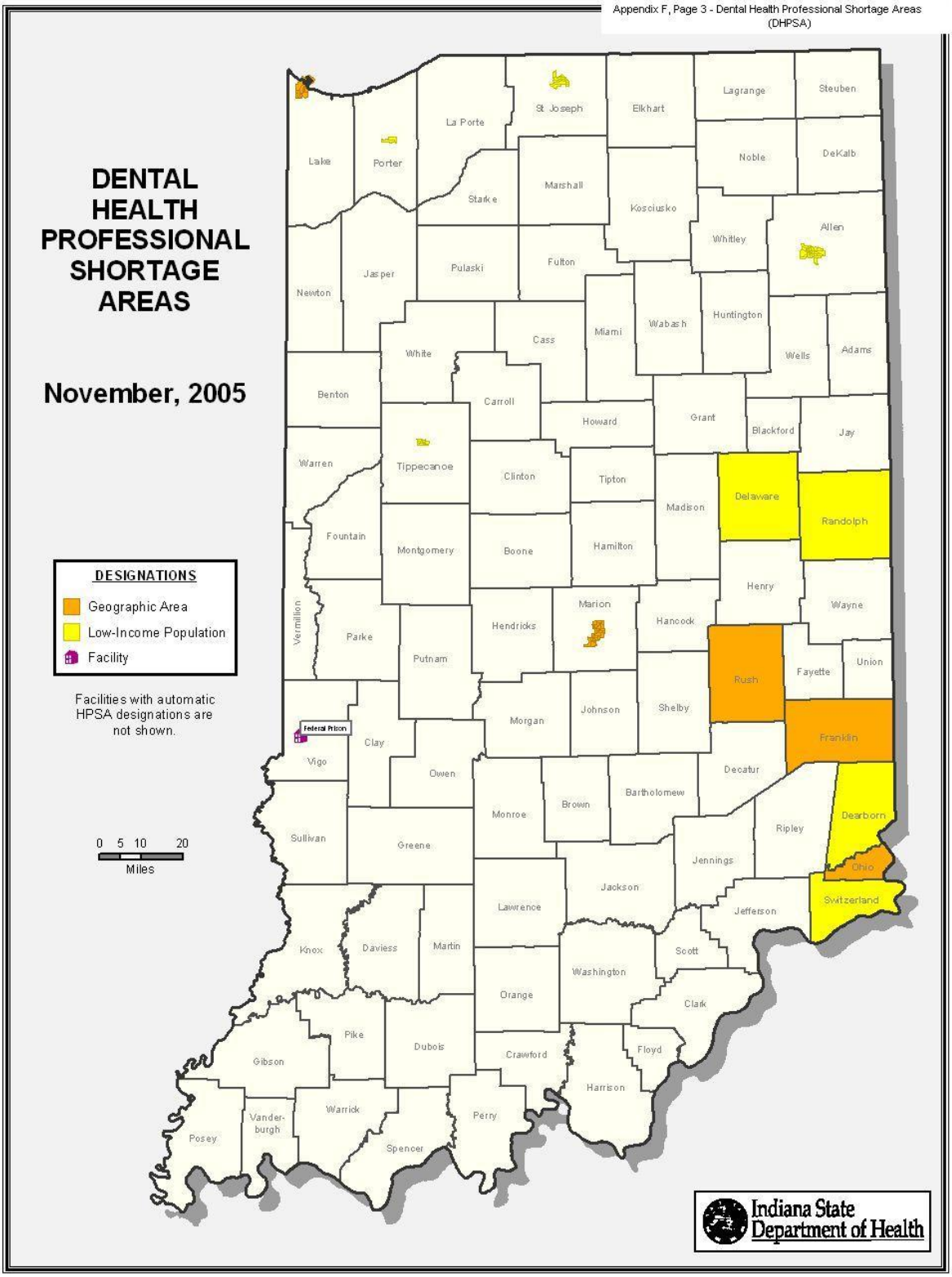
*Focus Counties (overall priorities)

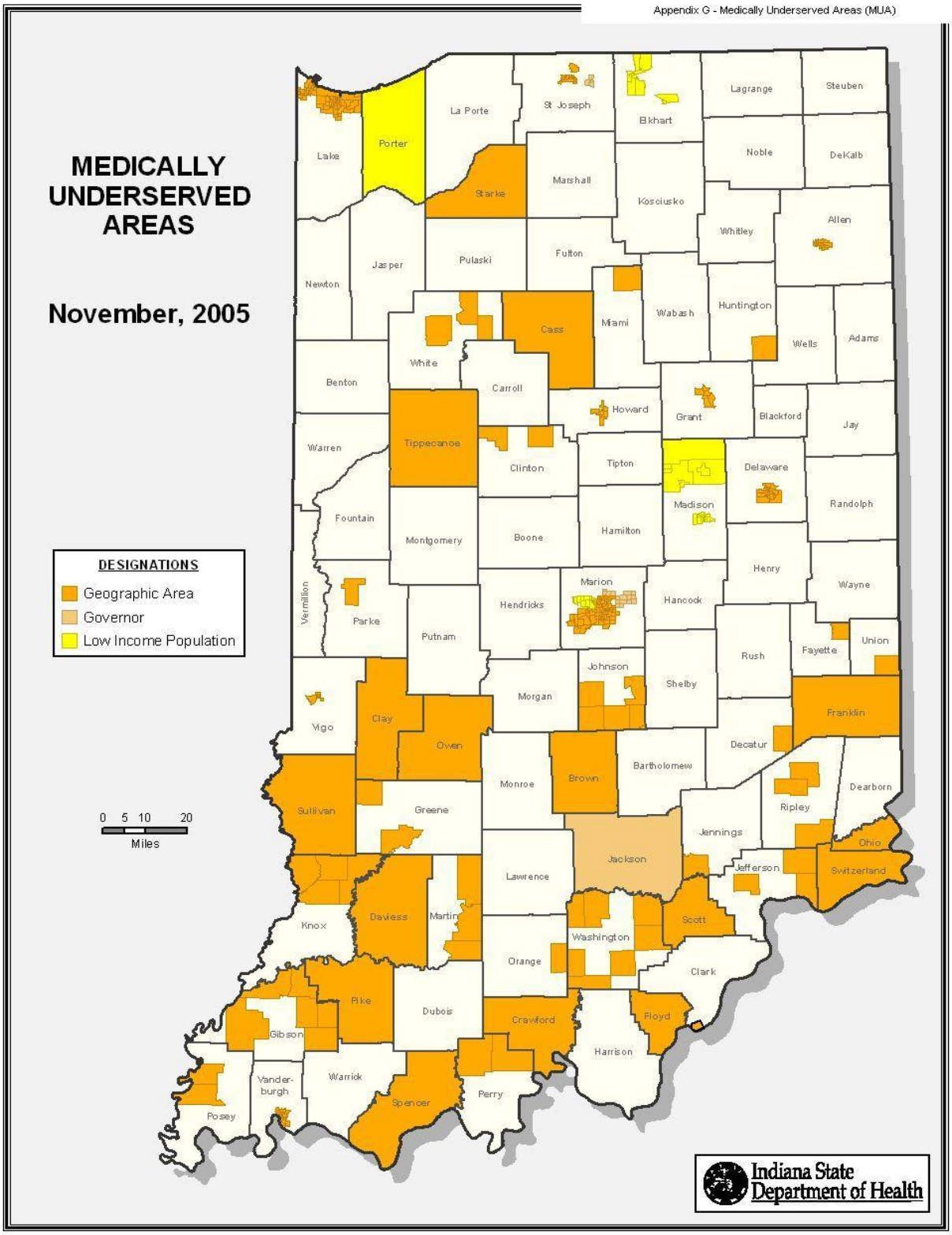
2. Focus Counties (overall priorities)

Allen
Clark
Daviess
DeKalb
Delaware
Elkhart
Fayette
Grant
Howard
Jackson
Knox
Lake
LaPorte
Madison
Marion
Monroe
Montgomery
Noble
Putnam
Scott
St. Joseph
Tippecanoe
Vanderburgh
Vigo
Wayne


Appendix F - Health Professional Shortage Areas (HPSA)
PRIMARY CARE
HEALTH PROFESSIONAL SHORTAGE AREAS
November, 2005
DESIGNATIONS
Geographic Area
Homeless Population
Low-Income Population
Medical Facility
Correctional Facility
Facilities with automatic HPSA designations are not shown.
0 5 10 20
Miles
Indiana State Prison
Miami Correctional Facility
Indiana Health Center
Plainfield Corr. Facility
Indiana Women's Prison
Putnamville Corr. Facility
Federal Prison
Branchville Corr. Facility
Lake
Porter
La Porte
St Joseph
Elkhart
Lagrange
Steuben
Noble
DeKalb
Starke
Marshall
Kosciusko
Whitley
Allen
Jasper
Pulaski
Fulton
Newton
Miami
Wabash
Huntington
White
Cass
Wells
Adams
Benton
Carroll
Howard
Grant
Blackford
Jay
Warren
Tippecanoe
Clinton
Tipton
Madison
Delaware
Randolph
Fountain
Montgomery
Boone
Hamilton
Henry
Wayne
Vermillion
Parke
Hendricks
Marion
Hancock
Putnam
Rush
Fayette
Union
Clay
Morgan
Johnson
Shelby
Franklin
Vigo
Owen
Decatur
Monroe
Brown
Bartholomew
Dearborn
Sullivan
Greene
Jennings
Ripley
Ohio
Jackson
Lawrence
Switzerland
Jefferson
Knox
Daviess
Martin
Scott
Washington
Orange
Clark
Pike
Dubois
Crawford
Floyd
Gibson
Harrison
Posey
Vander-burgh
Warrick
Spencer
Perry
Indiana State Department of Health


Appendix F, Page 2 - Mental Health Professional Shortage Areas (MHPSA)
MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS
November, 2005
DESIGNATIONS
MHPSA
Facility
Facilities with automatic HPSA designations are not shown.
0 5 10 20
Miles
Indiana State Department of Health
Lake
Porter
La Porte
St Joseph
Elkhart
Lagrange
Steuben
Noble
DeKalb
Starke
Marshall
Kosciusko
Whitley
Allen
Newton
Jasper
Pulaski
Fulton
Wabash
Huntington
Wells
Adams
White
Cass
Miami
Miami Correctional Facility
Benton
Carroll
Howard
Grant
Blackford
Jay
Warren
Tippecanoe
Clinton
Tipton
Madison
Delaware
Randolph
Fountain
Montgomery
Boone
Hamilton
Henry
Wayne
Vermillion
Putnam
Hendricks
Marion
Hancock
Parke
Rush
Fayette
Union
Vigo
Clay
Morgan
Johnson
Shelby
Franklin
Owen
Decatur
Monroe
Brown
Bartholomew
Dearborn
Sullivan
Greene
Ripley
Jennings
Ohio
Jackson
Switzerland
Lawrence
Jefferson
Knox
Daviess
Martin
Scott
Washington
Orange
Clark
Pike
Dubois
Crawford
Floyd
Gibson
Harrison
Posey
Vander-burgh
Warrick
Spencer
Perry


Appendix F, Page 3 - Dental Health Professional Shortage Areas (DHPSA)
DENTAL HEALTH PROFESSIONAL SHORTAGE AREAS
November, 2005
DESIGNATIONS
Geographic Area
Low-Income Population
Facility
Facilities with automatic HPSA designations are not shown.
0 5 10 20
Miles
Lake
Porter
La Porte
St Joseph
Elkhart
Lagrange
Steuben
Noble
DeKalb
Starke
Marshall
Kosciusko
Whitley
Allen
Newton
Jasper
Pulaski
Fulton
Miami
Wabash
Huntington
Wells
Adams
White
Cass
Benton
Carroll
Howard
Grant
Blackford
Jay
Warren
Tippecanoe
Clinton
Tipton
Madison
Delaware
Randolph
Fountain
Montgomery
Boone
Hamilton
Henry
Wayne
Vermillion
Parke
Putnam
Hendricks
Marion
Hancock
Rush
Fayette
Union
Federal Prison
Clay
Vigo
Morgan
Johnson
Shelby
Franklin
Owen
Decatur
Monroe
Brown
Bartholomew
Dearborn
Ripley
Sullivan
Greene
Jennings
Ohio
Jackson
Switzerland
Lawrence
Jefferson
Knox
Daviess
Martin
Scott
Washington
Orange
Clark
Pike
Dubois
Crawford
Floyd
Gibson
Harrison
Vander-burgh
Warrick
Perry
Posey
Spencer
Indiana State Department of Health


Appendix G - Medically Underserved Areas (MUA)
MEDICALLY UNDERSERVED AREAS
November, 2005
DESIGNATIONS
Geographic Area
Governor
Low Income Population
0 5 10 20
Miles
Lake
Porter
La Porte
St Joseph
Elkhart
Lagrange
Steuben
Noble
DeKalb
Starke
Marshall
Kosciusko
Whitley
Allen
Newton
Jasper
Pulaski
Fulton
Cass
Miami
Wabash
Huntington
Wells
Adams
White
Benton
Carroll
Howard
Grant
Blackford
Jay
Warren
Tippecanoe
Clinton
Tipton
Madison
Delaware
Randolph
Fountain
Montgomery
Boone
Hamilton
Henry
Wayne
Vermillion
Parke
Putnam
Hendricks
Marion
Hancock
Rush
Fayette
Union
Vigo
Clay
Morgan
Johnson
Shelby
Franklin
Owen
Decatur
Monroe
Brown
Bartholomew
Dearborn
Ripley
Sullivan
Greene
Jennings
Ohio
Jackson
Jefferson
Switzerland
Lawrence
Knox
Daviess
Martin
Scott
Washington
Orange
Clark
Pike
Dubois
Crawford
Floyd
Gibson
Harrison
Vander-burgh
Warrick
Spencer
Perry
Posey
Indiana State Department of Health

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

FY 2014 & FY 2015 MCH 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 MCH 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. Doctor McBurney has granted permission of use of this adaptation.**

3.0 MCH Proposal Narrative (15 points)

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

____ Relates to MCH 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)

- MCH 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
____ MCH and Non-MCH 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 address 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
____ Disparities are addressed if county has significant numbers of minority population(s)

Comments:

5.0 Score:_____
(18 points maximum)

5.1 Statement of Need – Clinic or Service Provision Locations

____ Services located in a focus county (See Attachment E)
____ Services located in a HPSA (See Attachment F)
____ Services located in a MUA (See Attachment G)
____ Services located in an at-risk lead concentration area (See Attachment H)
____ Child health clinic(s) located in a county with inadequate child health providers as identified by OMPP (See Attachment D)
____ Services located in a former focus county and is a previously funded clinic location or in-home services project

NOTE: Primary and Secondary Reviewers do not need to evaluate section 5.1.
ISDH GIS/ERC staff will evaluate this section.

5.0 Score:_____
(7 points maximum)

6.0 Tables

____ MCH 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 Measure 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, identify/ies staff member(s) 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 identified

____ Methods used to address identified quality assurance problems are identified

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 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 is included and current
____ 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
MCH 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.

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