Indiana FY 2015
Preventive Health and Health Services Block Grant

Work Plan

Revised Work Plan for Fiscal Year 2015
Submitted by: Indiana
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Executive Summary

- On June 8 the Advisory Committee reviewed and recommended programs for funding, contingent upon the receipt of funding for FY2015.
- On June 15, the Public Hearing was convened.
- On August 10 the Advisory Committee reviewed and approved additional activities and objectives added to the Work Plan for FY2015.
- This Work Plan is for the Preventive Health and Health Services Block Grant (PHHSBG) for Federal Year 2015. It is submitted by the Indiana State Department of Health as the designated state agency for the allocation and administration of PHHSBG funds.
- **Funding Assumptions**: The total award for the FY2015 PHHSBG is $2,540,710. This amount is based on an allocation table distributed by CDC.
- Funding for FY2015 Sexual Assault-Rape Crisis (HO IPV 40) activities detailed in the Work Plan: $144,972 of this total is a mandatory allocation to the Indiana Criminal Justice Institute (ICJI) which provides this funding to reduce the prevalence of sexual assault and attempted sexual assault among residents of the State of Indiana, particularly youth through sexual violence outreach and education and direct services. Funds will be used by 16 Subrecipients to provide prevention outreach and education as well as direct services.
- **Program Title**: Chronic Disease, Primary Care and Rural Health
  - HD5-1 Cardiovascular Health, $529,818 of this total will be utilized to reduce the disparities and overall burden of chronic disease in Indiana. The Section on Cardiovascular Health and Diabetes within CDPC seeks to monitor and reduce cardiovascular health (CVH) and Diabetes (DM) disparities and overall burden in Indiana; the Cancer Section within CDPC seeks to monitor and reduce cancer disparities and overall burden in Indiana; the Chronic Respiratory Disease Section in CDPC seeks to monitor and reduce disparities and overall Indiana burden related to asthma and other chronic respiratory diseases CDPC also seeks to address disparities and overall burden of all chronic disease in Indiana through both organizational and public policy initiatives, health systems strategies to improve clinical care, convening statewide partners to address chronic disease, and statewide health communications.
- **Program Title**: Food Protection Program
  - FS-6 Food Preparation Practices in Food Service and Retail Establishments, $120,243 of this total will be utilized to measure and improve the compliance of fast-food and full service restaurants in Indiana with food safety sanitation requirements. Further develop use and import of data into CodePal, the electronic system to capture and evaluate food safety inspection and investigation information.
- **Program Title**: Injury Prevention Program
  - IVP-11 Unintentional Injury Deaths, $155,071 of this total will be utilized to continue the process begun in 2011 of developing a comprehensive injury and violence prevention program at the state health department that provides focus and direction, coordinates and finds common ground among the many prevention partners, and maximizes injury and violence prevention resources. Start developing plans to apply for CDC Injury Center Core Violence and Injury Prevention Program (Core VIPP) Grant Funding and start providing evidence-based primary prevention programs in Indiana.
  - IVP-4 Child Fatality Review of Child Deaths Due to External Causes, $67,791 of this total will be utilized to gain an understanding of the circumstances causing a child's death which will help prevent other deaths, poor health outcomes, and injury or disability in other children.
- **Program Title**: Office of Public Health & Performance Management
  - PHI-2 Continuing Education of Public Health Personnel, $207,585 of this total will be utilized to increase the workforce development and training opportunities for Public Health workers in Indiana utilizing the Indiana IN-TRAIN web-based training system and other eLearning tools.
  - PHI-13 Epidemiology Services, $108,103 of this total will be utilized to increase analytical capacity of epidemiologists and data analysts using SAS through a SAS expert and increasing the number

of surveys of BRFSS. $100,000 (Direct Assistance) will also be used to analyze and interpret data to assess the burden of chronic disease, provide information on the distribution and risk factors for chronic diseases necessary for public health program planning and implementation, and assist in evaluating the success of public health programs.
    - PHI-15 Health Improvement Plans, $230,956 of this total will be utilized to continue to increase the capacity for local health departments and nonprofit hospitals to conduct community health assessments and improvement plans by improving access to county level secondary data to all 92 counties in Indiana through the Indiana Indicators data dashboard website and by hiring contract staff to provide technical assistance.
    - PHI-16 Public Health Agency Quality Improvement Program, $319,069 of this total will be utilized to enhance the capability of Indiana health departments in the area of agency performance management and quality improvement utilizing Lean Six Sigma through a contract with Purdue and by hiring contract staff at ISDH to provide trainings.
- **Program Title**: TB/Refugee Control Program
    - IID-31 Treatment for Latent TB, $120,210 of this total will be utilized to increase the percentage of contacts to sputum smear-positive tuberculosis cases that complete treatment after being diagnosed with latent tuberculosis infection and initiated treatment.
- **Program Title**: Water Fluoridation Program
    - OH-13 Community Water Fluoridation, $202,967 of this total will be utilized monitor water fluoridation programs in communities and schools on a regular basis.
- Administrative costs: associated with the Preventive Health block Grant total $233,915 which is less than 10% of the grant. These costs include funding for the Office of Contracts and Grants Management at ISDH.
- The grant application is prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention objectives in Healthy People 2020.

Funding Priority: State Plan (2014), Under or Unfunded, Data Trend

Statutory Information

Advisory Committee Member Representation:

County and/or local health department, Medical society or organization, State health department, State or local government, Volunteer organization

Dates:

Public Hearing Date(s):	Advisory Committee Date(s):
6/15/2015	3/23/2015
	6/8/2015
	8/10/2015

Current Forms signed and attached to work plan:

Certifications: Yes
Certifications and Assurances: Yes

Budget Detail for IN 2015 V2 R0	
Total Award (1+6)	$2,540,710
A. Current Year Annual Basic	
1. Annual Basic Amount	$2,395,738
2. Annual Basic Admin Cost	($233,915)
3. Direct Assistance	($74,066)
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$2,087,757
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$144,972
7. Sex Offense Admin Cost	$0
(8.) Sub-Total Sex Offense Set Aside	$144,972
(9.) Total Current Year Available Amount (5+8)	$2,232,729
C. Prior Year Dollars	
10. Annual Basic	$0
11. Sex Offense Set Aside (HO 15-35)	$0
(12.) Total Prior Year	$0
13. Total Available for Allocation (5+8+12)	$2,232,729

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$2,087,757
Sex Offense Set Aside	$144,972
Available Current Year PHHSBG Dollars	$2,232,729
B. PHHSBG $'s Prior Year:	
Annual Basic	$0
Sex Offense Set Aside	$0
Available Prior Year PHHSBG Dollars	$0
C. Total Funds Available for Allocation	$2,232,729

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL Year PHHSBG $'s
Chronic Disease, Primary Care and Rural Health	HDS-1 Cardiovascular Health	$529,828	$0	$529,828
Sub-Total		**$529,828**	**$0**	**$529,828**
Food Protection	FS-6 Safe Food Preparation Practices in Food Service and Retail Establishments	$120,243	$0	$120,243
Sub-Total		**$120,243**	**$0**	**$120,243**
Injury Prevention Program	IVP-4 Child Fatality Review of Child Deaths Due to External Causes	$67,791	$0	$67,791
	IVP-11 Unintentional Injury Deaths	$181,005	$0	$181,005
Sub-Total		**$248,796**	**$0**	**$248,796**
Public Health Performance Infrastructure	PHI-2 Continuing Education of Public Health Personnel	$207,585	$0	$207,585
	PHI-13 Epidemiology Services	$108,103	$0	$108,103
	PHI-15 Health Improvement Plans	$230,956	$0	$230,956
	PHI-16 Public Health Agency Quality Improvement Program	$319,069	$0	$319,069
Sub-Total		**$865,713**	**$0**	**$865,713**
Sexual Assault Services - Education and Outreach	IVP-40 Sexual Violence (Rape Prevention)	$144,972	$0	$144,972
Sub-Total		**$144,972**	**$0**	**$144,972**
TB Control Program/Refugee	IID-31 Treatment for Latent TB	$120,210	$0	$120,210
Sub-Total		**$120,210**	**$0**	**$120,210**
Water Fluoridation Program	OH-13 Community Water Fluoridation	$202,967	$0	$202,967
Sub-Total		**$202,967**	**$0**	**$202,967**
Grand Total		**$2,232,729**	**$0**	**$2,232,729**

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

State Program Strategy:

Goal: Between October 2015 and September 2016, the Indiana State Department of Health (ISDH) – Division of Chronic Disease, Primary Care, and Rural Health (CDPCRH) seeks to reduce the disparities and overall burden of chronic disease in Indiana, and improve the quality of life of those individuals affected by chronic diseases. The Section on Cardiovascular Health and Diabetes within CDPCRH seeks to monitor and improve cardiovascular health (CVH) and Diabetes (DM) outcomes, and implement effective strategies for prevention; the Cancer Section within CDPCRH seeks to monitor and reduce cancer disparities and overall burden in Indiana, and improve prevention and screening behaviors; the Chronic Respiratory Disease Section seeks to monitor and reduce disparities and overall burden related to asthma and other chronic respiratory diseases. The CDPCRH also seeks to address disparities and overall burden of chronic diseases in Indiana through both organizational policies, health systems strategies to improve clinical care, convening of statewide partners to address chronic disease, and statewide health communications. Targets in burden reduction include increasing the percentage of individuals in targeted settings with their asthma, diabetes and hypertension under control to decrease morbidity and mortality associated with these conditions. Efforts to increase primary screenings for breast, cervical and colorectal cancers should reduce colorectal and cervical cancer incidence and mortality associated with these cancers. Additionally, clinical quality improvement activity will serve to reduce dependence on emergency department care for individuals with ambulatory sensitive conditions, specifically asthma, diabetes and hypertension.

Program Priorities:

- Improve surveillance, analysis, and communication of CVH, DM, Cancer, and Asthma indicators and risk factors in Indiana
- Lead coordinated statewide efforts to improve CVH, DM, Cancer, and Asthma outcomes.
- Advance evidence based public health strategies to improve the chronic disease burden in community settings through systems-level change, policy, and health communications.

Primary Strategic Partnership(s):

- Internal: Division of Nutrition and Physical Activity; and Tobacco Prevention and Cessation
- External: Indiana Minority Health Coalition, Indiana Cardiovascular Health and Diabetes Coalition, Indiana Cancer Consortium, Indiana Joint Asthma Coalition, American Heart Association, Indiana Institute on Disability and Community, American Diabetes Association, American Cancer Society, American Lung Association, Indiana Public Health Association, Indiana Primary Health Care Association, and Indiana Rural Health Association.

Role of PHHSBG Funds:

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

Evaluation Methodology:

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

partners. These evaluation methods will be operationalized in the following manner:
IO 1. Address health disparities and improve outcomes by preparing workforce: Evaluation will occur via process and health indicator reporting, in-person learning sessions, process mapping and key-informant interviews. Outcomes and economic data will be collected and assessed. Projects involving complex care management, medication therapy management and non-provider community based interventions are being conducted as pilots so evaluation will focus on identifying best-practices, determining generalizability and portability of processes, and on developing an evaluation protocol for post-pilot implementation, spread and sustainability. Additionally, web-analytics will be used to assess convenience and effectiveness of internet-based resources and learning platforms.
IO 2. Analytic capacity development and expansion: Evaluation will focus on measuring improvements in staff analytic skills, technical capacity and productivity. CDPCRH will work with internal partners (Maternal and Child Health, Tobacco Prevention and Cessation, Women, Infants and Children, and the Epidemiology Resource Center) to develop assessment instruments informed by Council of State and Territorial Epidemiologists and CDC competency standards. Findings will be reported to agency leadership with review by partners with the capacity to support ongoing staff development. Feedback processes will be put in place to act on the findings and further advance staff development. FTE supported through this objective will participate in agency performance evaluation processes.
IO 3. Convene and mobilize state-level stakeholders to address critical health burdens related to chronic disease: Evaluation will be tailored for each stakeholder group and will address process and outcome assessment, as well as effectiveness of partnerships. The division will conduct surveys and key informant interviews with stakeholder organizations to assess reach, scope and effectiveness of activity. Stakeholder activity will be linked to, and performance measures will be based on, HP2020 strategies and objectives. Success stories will be tracked for each organization represented. Monthly conference calls, quarterly progress reports and formal evaluation summaries will facilitate oversight of the respective groups.
IO 4. Identify health disparities and initiatives to improve outcomes: Evaluation will occur via monthly training and support sessions with participating stakeholders representing community audiences. The development of a health improvement plan for communities with physical, emotional or intellectual disabilities and maintenance of a targeted resource database will be key deliverables. Participating partners will be surveyed on overall process and strategic planning activity. Key informant interviews will guide next steps of activity, including implementation of health improvement plan strategies.
IO 5. Systems change to improve access to quality care and team-based management: Evaluation will occur via monthly process and health indicator reporting, quarterly in-person learning sessions with group reporting segments, process mapping and key-informant interviews. Organizational storyboards and video diaries will be incorporated into evaluation activity. Organizations will present summary findings of activity at a public Outcomes Congress. Evaluation findings will be used to inform ongoing activity with new cohorts of comparable organizations, and spread and sustainability within current participants. Additionally, web-analytics will be used to assess convenience and effectiveness of internet-based resources and learning platforms.

State Program Setting:
State health department

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

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

National Health Objective: HO HDS-1 Cardiovascular Health

State Health Objective(s):

Between 09/2014 and 10/2015, Reduce hospitalizations and emergency room admissions and increase self management and prevention of cardiovascular disease, diabetes, asthma, and cancer and chronic obstructive pulmonary disease by mobilizing statewide chronic disease partners, including subject matter coalitions and a 7-county hospital system. Five coalitions will develop and update plans to address Indiana's chronic disease burden and a hospital system will design and implement a training program for paramedics and emergency services personnel to serve nursing home and home-bound individuals with chronic diseases in non-emergent settings.

Baseline:

Indiana adults have high rates of hypertension (34%), smoking (22%), obesity (32%), asthma (10%), high cholesterol (40%), and diabetes (11%). Additionally, the state demonstrates low percentages of screenings for breast (68%) cervical (73%), and colorectal cancer (63%). Surveillance indicates that 60% of hypertensives, 70% of diabetics, and 78% of asthmatics meet minimal standards of control.

Data Source:

ISDH records: BRFSS, hospital discharge data, mortality data, natality data, census, reporting from Indiana Primary Care Learning Collaborative

State Health Problem:

Health Burden:

Chronic diseases such as heart disease, stroke, cancer, chronic lower respiratory diseases and diabetes are the leading causes of death in Indiana. In 2013, more than 60% of all deaths were attributed to these five diseases. The financial impact of chronic diseases on Indiana's economy is substantial. In its milestone report, "An Unhealthy America: The Economic Impact of Chronic Disease," the Milken Institute (MI) illustrates the enormous economic cost of chronic diseases in the United States. Based on the 2014 America's Health Rankings by United Health Foundation and the American Public Health Association, Indiana is ranked 41 out of 50 states for overall health.

Economic Impact of Major Chronic Diseases in Indiana: 2014 (Annual estimated costs in billions)
Treatment Expenditures: **$8.4**
Lost Productivity: **$24.6**
Total Costs: $32.9

Common Chronic Diseases in Indiana:

Heart Disease and Stroke

-Heart disease was the leading cause of death (13,718 deaths) in Indiana in 2013
-Stroke was the fourth leading cause of death (2,972 deaths) in Indiana in 2013
-In 2013, more than 33.5% of Indiana residents reported having high blood pressure
-In 2013, nearly 39.8% of those screened reported having high blood cholesterol, a risk factor for developing heart disease and stroke

Cancer

-Cancer was the second leading cause of death (13,198 deaths) in Indiana in 2013.
-More than 31,000 new cancer cases were diagnosed in Indiana in 2013, which includes 4,527 new cases of breast cancer among women and 2,941 new cases of colorectal cancer.
-Early detection for breast and colorectal cancer improves long-term outcomes, but in populations 50 and older, only 26% have had a blood stool test and 63% have had a sigmoidoscopy or colonoscopy within the recommended time frame. Additionally, only 70% of women 50 and older have had a mammogram within two years.

Diabetes

-Diabetes was the seventh leading cause of death (1,942 deaths) in Indiana in 2013. Although diabetes is

considered to be under-reported as the primary cause of death, risk of death among people with diabetes is about twice as high as people of similar age without diabetes. In the same year, over 5,000 additional deaths in Indiana listed diabetes as a contributing cause.
-In 2013, 11% of adults, over 547,300 individuals 18 and older, reported being diagnosed with diabetes.

Asthma

-Asthma affects an estimated 23 million people every year in the United States. In Indiana, approximately 1 in 10 (10.3%) adults (age 18 years or older) reported having asthma in 2013.
-There were 70,394 emergency room visits related to asthma in 2013 – an increase of nearly 50,147 visits (247.7%) from 2012.
-Nearly 6,657 hospitalizations were recorded due to asthma in 2013, which increased by 8.8 percent from 2012.

Target Population:

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

Disparate Population:

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

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

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

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

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

Asthma: A Business Case for Employers and Health Care

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

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

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

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

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

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

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $529,828
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
Advanced workforce development (ES8)
Between 10/2014 and 09/2015, Parkview Health Network will conduct **2** trainings for paramedics and nursing home personnel in the rapid response method to identify and respond to asthma, cardiac events, chronic obstructive pulmonary disease, and sepsis.

Annual Activities:
1. Community paramedicine protocol and evaluation platform
Between 10/2014 and 09/2015, CDPCRH will work with community based emergency medical service organizations to create protocols, establish best practices, and develop evaluation processes for community paramedicine activity. Community paramedicine will capitalize on the healthcare capacity of paramedics and

EMTs during non-emergent periods to maximize the reach of clinical practices and support self-management behaviors and serve as health coaches and physician extenders for targeted panels of patients to improve blood-sugar management in diabetics, improve compliance in hypertensive individuals, support pre-natal care, mitigate fall risk in seniors, and reduce re-admission for conditions such as CHF and COPD.

Objective 2:

Chronic Disease Coalitions (ES4)

Between 10/2014 and 09/2015, The Cardiovascular and Diabetes Coalition of Indiana, Indiana Cancer Consortium, Indiana Healthy Weight Initiative, Indiana Joint Asthma Coalition, and the Task Force on Disability and Health with the oversight of CDPCRH will provide technical assistance (in the form of communication support, community-clinical linkages, data systems, economic analysis, evaluation, geospatial analysis and statistical analysis) to develop and implement strategic health improvement plans based on current disease burden and evidence-based practices to **5** groups of community-level stakeholders capable of influencing prevention, management and palliation associated with chronic diseases including asthma, cancer, cardiovascular disease and diabetes, and obesity, and populations experiencing health inequities.

Annual Activities:

1. Provide technical assistance to statewide chronic disease stakeholders to improve disease outcomes

Between 10/2014 and 09/2015, CDPCRH will convene and support community-based coalitions to provide technical assistance to **5** community-level stakeholder groups including those for cancer, asthma, obesity, cardiovascular health and diabetes, and disabilities. CDPCRH will work closely with statewide and community-based partners to ensure that strategic plans and activities are informed by scientific research, current surveillance evidence and represent best- or evidence-based practices; maximize the resources available to the coalition for purposes of coordination, communication, and effective work; and address long-term spread and sustainability of effective chronic disease partnerships. CDPCRH will provide technical assistance to the coalition partners in the areas of evidence-based public health programming, organizational policy to address the chronic disease burden in Indiana and health systems initiatives to improve chronic disease outcomes. Additional technical assistance related to data and surveillance, evaluation and geospatial analysis will be provided to coalitions.

2. Evaluation of progress associated w/ chronic disease strategic plans in asthma, cancer & obesity

Between 10/2014 and 09/2015, CDPCRH will provide technical assistance to 5 community partnerships to support their capacity to assess statewide progress associated with their respective disease state strategic plans, including the development of a summary report on current health status for these disease areas or special populations (disabled) impacted by these diseases, a communications platform for the information resulting from the evaluation, and strategies to further progress towards achieving long-term strategic objectives. Specific topics to be addressed include asthma (HP2020 RD-2,-3,-7), cancer (HP2020 C-9,-10,-11,-15,-16,-17,-18), diabetes (HP2020 D-5,-6,-7,-9,-10,-11,-14) and heart disease (HP2020 HDS-7,-12,-24).

3. Strategic Planning

Between 10/2014 and 09/2015, CDPCRH will work with 5 coalitions of statewide community organizations to publish or update strategic health improvement plans associated with asthma (HP2020 RD-2,-3,-7), cancer (HP2020 C-9,-10,-11,-15,-16,-17,-18), diabetes (HP2020 D-5,-6,-7,-9,-10,-11,-14) and heart disease (HP2020 HDS-7,-12,-24), as well as special populations impacted by these conditions (disabilities). Included in this activity will be comprehensive surveillance, communication, and evaluation activity, with special focus on public access dashboards such as Indiana Indicators.

State Program Title: Food Protection

State Program Strategy:

Goal: Between October 2015 and September 2016, continue the development of CodePal, a software applications that captures food inspection data electronically. The application allows users to document any violations or deficiencies found during an inspection and activities related to investigations of foodborne illness cases. This electronic system reduces the reliance of paper for reporting if inspections and investigations. Data, such as food establishment demographics, violations, complaints, and recall and outbreak investigations, can be used on a broader state-wide level to better understand the problems and direct resources toward those issues once they become known through this data collection system.
The program's goal is to continue to enlist local health departments to utilize CodePal as their inspection software. For those jurisdictions that are utilizing another application, CodePal is being designed to accept their food inspection data electronically through Dyna Sync to import data into the CodePal system. The Dyna Sync process will allow the building of a state-wide database of food inspection data, and will be implemented with the development and use of standardized templates.
Program Priorities: The Senior Level Application System Analyst/Developer will develop standardized templates to realize the Dyna Sync import process of food safety information to the CodePal system. As time permits, this position will also support users in their installation and use of this inspection software.
Primary Strategic Partnerships(s):

- **Internal:** ISDH's Food Protection Program and Office of Technology & Compliance
- **External:** Indiana local health departments and universities

Evaluation Methodology: Included in the ISDH strategic plan, strategic priorities include decreasing disease incidence and burden; improving response and preparedness networks and capabilities; better use of information and data from electronic sources to develop and sponsor outcomes-driven programs; and improving relationships and partnerships with key stakeholders, coalitions, and networks throughout the State and the nation. The development of a state-wide database of food inspection and investigation data will aid in addressing these priorities, and progress is tracked in Dashboard metrics reports. These metrics reports include specific objectives related to the functionality and growth of the CodePal system, and quarterly reports are submitted to agency leadership to monitor the progress of annual goals.

State Program Setting:

Local health department, State health department, University or college

FTEs (Full Time Equivalents):

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

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

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

State Health Objective(s):

Between 10/2014 and 09/2015, measure and improve the compliance of fast-food and full service restaurants in Indiana with food safety sanitation requirements. Further develop use and import of data into CodePal, the electronic system to capture and evaluate food safety inspection and investigation information.

Baseline:
Currently there is not a state-wide database of food inspection and investigation data. Fast-food and full service restaurants in Indiana operate under the jurisdiction of the Indiana State Department of Health, 93 local health departments, and 3 universities. The goal is to increase the capacity from 27 to 42 local health departments directly using or importing information into CodePal by September 2016.

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

State Health Problem:

Health Burden:
Consumers continue to be impacted by foodborne illness outbreaks to the tune of 48 million cases, 128,000 hospitalizations, and 3,000 deaths in this country each year (2013 FDA Model Food Code, Scallan et al). Financial burden of $10-83 billion annually in lost productivity, pain and suffering, and medical costs is estimated (2013 FDA Model Food Code, Meade et al). The issue is that with all of our efforts, we continue to have many illnesses and loss of life. Having better and more current data in Indiana is critical so that resources can more effectively be targeted to reduce the foodborne illness risk factors that can lead to cases of disease.

The following was taken from the 2014 update to the Indiana State Health Improvement Plan (I-SHIP): Enteric illnesses are prevalent yet are underreported in Indiana, as well as across the U.S. The table below describes confirmed cases of various enteric illnesses from 2008 to 2012.

Condition	2008	2009	2010	2011	2012	Average
Botulism	1	0	0	1	0	0.4
Campylobacteriosis	686	646	864	750	741	737.4
Cryptosporidium	203	282	285	263	164	239.4
Cyclosporidium	2	1	0	0	0	0.6
Giardiasis*	NR	316	399	325	227	316.75
Hepatitis A	20	19	11	24	11	17
Hepatitis E	2	2	0	3	3	2
Hemolytic Uremic Syndrome (HUS)	1	7	0	2	11	4.2
Listeriosis	10	10	15	11	10	11.2
Salmonellosis	641	590	786	650	782	689.8
Shiga-toxin producing *E. coli* (STEC)	104	97	144	147	191	136.6
Shigellosis	607	76	64	91	161	199.8
Typhoid Fever	1	1	0	4	0	1.2
Vibriosis	5	3	0	2	2	2.4
Yersiniosis	9	7	13	11	10	10

This information was collected from the ISDH Epidemiology Resource Center 2012 Indiana Report for Infectious Diseases.
**Giardiasis was made a newly reportable disease December 12, 2008 with the release of the updated 410 IAC 1-2.3 Communicable Disease Reporting Rule for Physicians, Hospitals, and laboratories.*

These enteric illnesses are identified by passive surveillance through identification by laboratory diagnosis or epidemiologic linkage. Indiana State Department of Health's (ISDH) current system is to follow-up with every reported case. Interviews are conducted by the local health department (LHD) in the county of residence to

collect demographic, clinical, risk factor, and other pertinent information using a standardized questionnaire that is specific to the etiologic agent causing illness. These interviews are not dependent on serotype or PFGE results but are conducted upon initial notification. Information collected from LHD case interviews, reference laboratories, and the ISDH laboratory (serotype and confirmatory testing) is entered into the Indiana National Electronic Disease Surveillance System (INEDSS) for review by the Enteric Epidemiologist. Local clusters with common risk factors or serotypes are identified at this time.

In addition to passive surveillance activities, ISDH also conducts outbreak investigations for enteric illnesses. Improvements in molecular laboratory testing methods of enteric bacteria have made it easier to identify foodborne disease outbreaks at a State and National level. In 2012, ISDH reported 10 confirmed cases of *Listeriosis*, 782 confirmed cases of *Salmonellosis*, and 191 confirmed cases of *Shiga*-toxin producing *E. coli* (STEC) infections. These numbers do not include the suspect, probable, or lost-to follow-up/unconfirmed cases which still required time and resources to investigate.

In the first three quarters of 2014, ISDH Epidemiology Resource Center investigated the following outbreaks or clusters: 9 *E. coli*, 19 Norovirus, 31 *Salmonella*, 4 *Shigella*, 2 Hepatitis A and 19 of an unknown pathogen. Of the 84 clusters or outbreaks investigated, 11 outbreaks implicated a suspect food source and 30 clusters implicated no known mode of transmission. The ISDH FPP took an active role in the investigation of 6 outbreaks.

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

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: $120,243

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

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
CodePal
Between 10/2014 and 09/2015, Senior Level Application System Analyst/Developer will increase the number of Local health departments from 27 to **47**.

Annual Activities:
1. Develop CodePal system with local health departments to build statewide database
Between 10/2014 and 09/2015, Increase the capacity from 27 to 42 local health departments directly using or importing information into CodePal by September 2016. Continue to enlist local health departments to utilize CodePal as their inspection software. For those jurisdictions that are utilizing another application, CodePal is being designed to accept their food inspection data electronically through Dyna Sync to import data into the CodePal system. The Dyna Sync process will allow the building of a state-wide database of food inspection data, and will be implemented with the development and use of standardized templates. A long term electronic data collection system in Indiana will allow for more comprehensive and current data that can be effectively used by state and local food protection programs. The CodePal system can aid in the identification of potential disease causing conditions, thereby helping the regulatory authority mitigate these situations of public health concern more expeditiously.

State Program Title: Injury Prevention Program

State Program Strategy:

Goal: Between October 2015 and September 2016, continue developing an Injury Prevention Program for the State of Indiana that will ultimately lead to a reduction in the number of preventable injuries and deaths.
Health Priorities: The Indiana State Department of Health has continued to develop an organized Injury Prevention Program. The agency has maintained an injury epidemiologist to conduct injury surveillance, prepare epidemiologic reports related to injury and serve as a subject matter expert of injury incidence and risk factors. The ISDH will continue to prioritize the efforts needed to more fully develop an Injury Prevention Program for its citizens.
Primary Strategic Partners:
Internal:
Child Fatality Review
Epidemiology Resource Center
Indiana Violent Death Reporting System Program
Maternal and Child Health
Office of Women's Health
Trauma Program
Vital Records
External:
Attorney General's Prescription Drug Abuse Prevention Task Force
Bi-weekly Health User Group GIS
CDC Injury Center
Great Lakes and Mid-Atlantic Regional Network
Indiana Criminal Justice Institute
Indiana Department of Homeland Security
Midwest Injury Prevention Alliance
Indiana Hospital Association
Indiana Poison Control
Indiana State Trauma Care Committee
Indiana Trauma Network
Safe Kids
Safe States
Senator Head's Substance Abuse and Child Safety Task Force
Indiana Injury Prevention Advisory Council
State and Local Child Fatality Review Teams
State Epidemiology Outcomes Workgroup
Evaluation Methodology: The development of a core Injury Prevention Program that will ultimately lead to acquisition of data, analysis, and development of appropriate activities.

The Indiana Child Fatality Review Program will monitor the success of the projects activities by:

- the number of trainings held, as well as the number of individuals trained
- the number of cases entered into the Child Death Review database accurately
- the decrease in time from child death to case review to entry into the Child Death Review database
- the number of prevention activities that result from thorough case reviews across the state

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

State Program Setting:

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

FTEs (Full Time Equivalents):

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

Position Name: Jessica Skiba
Position Title: Injury Epidemiologist
State-Level: 95% Local: 0% Other: 0% Total: 95%

Total Number of Positions Funded: 1
Total FTEs Funded: 0.95

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

State Health Objective(s):

Between 10/2014 and 09/2015, Prevent an increase of death and hospitalization of children due to external causes through implementing best-practices needed to meet the National Center for the Review and Prevention of Child Deaths (NCRPCD) data quality standards which include reporting of timely and complete review, data entry, and quality assurance procedures so Child Fatality Review (CFR) data may be included in pediatric injury prevention and improved health outcomes.

Baseline:
In Indiana, injury is the leading cause of death for children ages 1-17 years. From 2005-2012 in Indiana, there were 2,041 children who died from injuries. This is an average of 255 preventable deaths per year. SIDS/SUID deaths account for almost half of all categories of deaths in infants, and SIDS and suffocation make up the majority of SUID deaths.

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

State Health Problem:

Health Burden:
In Indiana, injury is the leading cause of death for children ages 1-17 years. From 2005-2012 in Indiana, there were 2,041 children who died from injuries. This is an average of 255 preventable deaths per year. From 2011-2013, there were more than 6,000 hospitalizations and more than 430,000 ED visits. The human suffering and financial burden of pediatric injuries in Indiana is staggering.

Also, in Indiana, infants die at a higher rate than any other age group. In 2012, of the children who died of injury in Indiana, 43% of them were under the age of 1 year. In 2013, 594 infants died (all reported causes) in Indiana, resulting in an IMR of 7.22. At 7th in the United States, Indiana's infant mortality rate is consistently one of the worst in the country. SIDS/SUID deaths account for almost half of all categories of deaths in infants, and SIDS and suffocation make up the majority of SUID deaths. According to the CDC, "inconsistent practices in the investigation and cause-of-death determination of infant deaths, hampers the ability to monitor trends, ascertain risk factors, and design and evaluate programs to prevent these deaths".

It is impossible to know the true nature of Indiana's infant mortality crisis without improving the data collection and cause and manner of classification in reported SUID deaths.

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

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: $67,791
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
First Responders Direct on Scene Education
Between 10/2014 and 09/2015, The Indiana State Child Fatality Review staff will provide train-the-trainer Direct on Scene Education (DOSE) to identify unsafe infant sleep environments, remove hazards and provide education while on scene during emergency and non-emergency calls to **150** First Responders.

Annual Activities:
1. Collaborate with the Indiana first responder agencies.
Between 10/2014 and 09/2015, The Indiana State Child Fatality Review staff will work with Indiana Department of Child Services, Indiana Safe Sleep Collaborative, Indiana Fire Chiefs Association, Indiana

Volunteer Fire Chief's Association, Indiana Law Enforcement Academy, and the Indiana Emergency Medical Services Commission to provide training opportunities for First Responders to participate in the DOSE train-the-trainer program. This collaboration will also help ensure data collection from DOSE education, and referrals to the Safe Sleep Collaborative by First Responders to help ensure all caregivers in need of safe sleep environment for their infant have access to a crib along with safe sleep education

2. Collaborate with Maternal and Child Health application developers to improve data.
Between 10/2014 and 09/2015, Child Fatality Review Staff will work with MCH application staff to develop a web-based data entry portal that will allow DOSE trained First Responders to enter information regarding the education provided while directly after the call. This data will be linked to the Safe Sleep Collaborative data and birth and death records, which will help track outcomes associated with providing safe sleep education and crib resources.

Objective 2:
Provide statewide training on improving child death investigation.
Between 10/2014 and 09/2015, Child Fatality Review Teams will provide child death investigation training to to **74** of Indiana's coroners.

Annual Activities:
1. Statewide Trainings
Between 10/2014 and 09/2015, The Indiana State Fatality Review staff, will collaborate with the Indiana Coroner's Training Board, Indiana Coroner's Association, Indiana Prosecuting Attorney's Council, and the Indiana Law Enforcement Academy to provide subject matter experts on the topics of standardizing child death/injury investigations, improving collaboration and the multidisciplinary team process, and improved evidence and data collection.

Objective 3:
Support injury prevention efforts resulting from Child Fatality Review at the local level.
Between 10/2014 and 09/2015, Child Fatality Review staff will conduct **2** funding opportunities for the local child fatality review teams to support injury prevention efforts resulting from child fatality review at the local level.

Annual Activities:
1. Request for Proposal
Between 10/2014 and 09/2015, Child Fatality Review staff will develop a request for proposal process to distribute to the local teams. Funding to the local teams will be based on evidence of need, approach, activities, expected outcomes and evaluation process.

National Health Objective: HO IVP-11 Unintentional Injury Deaths

State Health Objective(s):

Between 10/2014 and 09/2015, The division of trauma and injury prevention will work towards reducing the number of unintentional injury deaths in Indiana by 10% through the continued development of a comprehensive injury and violence prevention program at the state health department. The program will provide prevention partners focus and direction from the state to maximize injury and violence prevention resources. The program will also start developing plans to apply for CDC Injury Center Core Violence and Injury Prevention Program (Core VIPP) Grant Funding.

Baseline:

The age-adjusted mortality rate for Indiana in 2013 was 42.9 per 100,000. The division of trauma and injury prevention hopes to improve this rate by 10% to 38.6 per 100,000.
The Healthy People 2020 goal is 36.0 per 100,000.

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

State Health Problem:

Health Burden:
Injuries are a serious public health problem in Indiana. Injuries often result in trauma, possible lifelong disabilities, or even death. In Indiana, unintentional injury is the leading cause of death among persons 1 to 4 years of age and the fifth leading cause of death overall following heart disease, malignant neoplasms(cancer), chronic lower respiratory disease and stroke. Fatality rates and hospitalization rates are highest among persons over the age of 75. The age-adjusted mortality rate for unintentional injuries in Indiana in 2013 was 42.9 per 100,000. The two leading causes of injury death in Indiana in 2013 were unintentional poisoning and unintentional motor vehicle traffic. Unintentional injuries contribute to the greatest years of potential life lost before age 65 in Indiana, meaning younger residents are more affected by injuries than other causes and residents ages 35-44 years have the highest age-adjusted rate death rate due to unintentional injuries at 6.9 per 100,000. Within the same year, more than 17,300 Indiana residents were hospitalized due to unintentional injury and an additional 414,600were treated in emergency departments. In addition, injury fatalities caused by intentional acts, such as homicide or suicide were among the top four causes of death in Indiana in all age groups from age 5 to 54. Unfortunately, prior to 2011, Indiana lacked the resources to support a program devoted to injury prevention. Injury prevention is a key component of the developing statewide trauma system.

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

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: $181,005
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:

Injury Prevention Primary Programming

Between 10/2014 and 09/2015, Injury Prevention Program Coordinator will implement **2** primary prevention programs in the state of Indiana focusing on older adult falls and child passenger safety.

Annual Activities:

1. Injury Prevention Primary Programming - Master Trainer status

Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will achieve "Master Trainer" status in a variety of evidence-based prevention programs to reduce injury in Indiana's leading causes of injury by attending master trainer education events in areas focused on older adult falls and child passenger safety.

2. Injury Prevention Primary Programming - Technical Assistance

Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will work with the injury prevention coordinators around Indiana by providing technical assistance on their various projects, activities.

3. Injury Prevention Primary Programming - Collaboration

Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will participate in coalitions and work groups to help foster collaboration at the local level with the statewide goals and initiatives in injury prevention. The Injury Prevention Program Coordinator will also assist the division in planning the 2nd Annual Injury Prevention conference that will further enhance collaborative learning and educational initiatives that will feature the topics of older adult falls and child passenger safety.

4. Injury Prevention Primary Programming - Continuing Education

Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will attend conferences such as Safe States as a representative of Indiana. Attending these continuing education events will give the coordinator the opportunity to bring back findings to the local coalitations and work groups that can be implemented at the local level.

5. Injury Prevention Primary Programming - Social Media Outreach

Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will increase social media activities via twitter and facebook by creating actionable content that can be utilized at the local level by coalitations and work groups.

6. Injury Prevention Primary Programming - Health Communications
Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will create communications-working to update our website, distribute and share information with partners, grantees and the CDC.

7. Injury Prevention Primary Programming - Reporting
Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will help in the writing of any CDC-required report.

8. Injury Prevention Primary Programming - Grant Activities
Between 10/2014 and 09/2015, The Injury Prevention Program Coordinator will identify injury prevention grants and lead application process.

Objective 2:
Injury Prevention Resource Guide
Between 10/2014 and 09/2015, ISDH and the Injury Prevention Advisory Council (IPAC) will distribute the ISDH Injury Prevention Resource Guide to **250** injury prevention workers, specialists, health care workers, Indiana IPAC, Indiana Department of Child Services, and emergency departments in Indiana.

Annual Activities:
1. Conducting Injury Surveillance
Between 10/2014 and 09/2015, The State will conduct injury surveillance by expanding its data collection systems to include: EMS (includes collecting naloxone/narcan use), hospital, INVDRS and rehabilitation facility databases. The injury prevention epidemiologist will provide analysis for motor vehicle injuries, fall-related injury data in collaboration with other State agencies, intentional injury data collected in the INVDRS database and poisoning and overdose data.

2. Maintain Partnerships in Support of Injury Prevention
Between 10/2014 and 09/2015, Maintain partnerships with local community coalitions or organizations to promote safety, injury prevention, or violence prevention to develop injury prevention plan. The Indiana Injury Prevention Advisory Council's goal is to reduce the number and severity of preventable injuries in Indiana through leadership and advocacy. The goal is through improved collection and dissemination of data and coordination of injury prevention and control efforts, the Indiana State Department of Health will reduce injury-related morbidity and mortality in Indiana.

3. Yielding injury surveillance data
Between 10/2014 and 09/2015, The injury surveillance will yield data which we will use to drive the 5-year Injury Prevention Plan, communicate with injury prevention professionals and the general public through the development and publication of fact sheets regarding specific types of injuries, and be reported on the Trauma and Injury Prevention website of the ISDH and publish epidemiologic reports related to injury such as: a tri-annual report on injuries in Indiana, an annual Fireworks Injuries report, trauma data accuracy report, etc.

State Program Title: Public Health Performance Infrastructure

State Program Strategy:

Goal: Between 10/2015 and 09/2016, continue to improve the overall quality and capabilities of Indiana's public health system through training events. There will be a specific focus on the quality improvement, performance management, workforce development, and other data and system infrastructure activities to support the work for public health and public health accreditation
Health Priorities: To improve the health of Indiana, the public health infrastructure is a critical component. Improved technology for electronic reporting systems for food safety and TB; a learning management system to improve the education and flow of information to public health professions; electronic display of public health data in Indiana; and the goal of improving health outcomes through quality improvement are the foundations of public health in the 21st Century.

Primary Strategic Partners: Indiana University, Purdue University, local health departments, NGOs, and other state universities

Evaluation Methodology: Number of trainings, attendance at trainings, pre- and post-evaluations to compare and record knowledge gained from trainings,

State Program Setting:
Local health department, State health department

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

Position Name: TBD
Position Title: Workforce Development Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Name: Patricia Truelove
Position Title: Performance Improvement Manager
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 2
Total FTEs Funded: 2.00

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

State Health Objective(s):
Between 10/2014 and 09/2015, increase the workforce development and training opportunities for Public Health workers in Indiana.

Baseline:
The U.S. Department of Health and Human Services 2010 report on *Priority Areas for Improvement of Quality in Public Health* cited Workforce Development as a priority area to improve public health. Numerous challenges continue to face the public health workforce, including job cuts, non-competitive wages, and lack of education opportunities. Increasing opportunities through distance education, partnerships, and required

trainings focusing on public health, health care regulation, and public health accreditation related activities. The Office of Public Health Performance Management (OPHPM) currently has 8 program areas utilizing the IN-TRAIN system.

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

State Health Problem:

Health Burden:
The public health workforce in Indiana currently lacks many of the core competencies necessary to fully and positively impact the health of the populations they serve. While the majority are competent in their own individual duties, most are not competent in the 10 essential public health services and how their duties fit in to the overall provision of these services. This is not an issue that is unique to Indiana. The National Academy for Sciences' 2002 report on *The Future of the Public's Health in the 21st Century* cited figures released jointly by the CDC and the Agency for Toxic Substances and Disease Registry in 2001 which indicated that "80% of the current public health workforce lacks formal training in public health." According to the Association of Schools of Public Health, many physicians, nurses and other health professionals graduate with little to no ground in the concept of prevention or population health (2011). In 2012, Indiana opened two recognized schools of public health. Although this is a major accomplishment, the improvement in training won't be recognized for several years. As public health departments continue to lose jobs and an aging workforce, the question for Indiana is will public health departments replace those jobs with more educated and properly trained individuals as they will cost the health departments more money.

This lack of basic public health competencies is widespread. It is seen in both small, rural local health departments and in large, urban local health departments. The problem continues to worsen in many areas because new employees are often only trained in their day-to-day functions and are not provided with the complete picture of public health. Subsequently, most public health agencies in Indiana do not operate at full efficiency. Therefore, the target population is the workforce of local health departments in Indiana as well as the Indiana State Department of Health. The workforce will include the workforce in public health as well as local boards of health.

The workplan includes offering continuing education opportunities to local health departments through health officer meetings, monthly webcasts, and public health nurses meetings and conferences. Additional opportunities will be developed through the ISDH partnership with the Public Health Foundation and the purchase of TRAIN (subscription maintenance is made possible through Block Grant). The Workforce Development Coordinator, who is funded through PHHS Block Grant will be launching this system and developing future learning opportunities with both internal and external partners for public health in Indiana. ISDH will also be funding a position for an E-Learning Developer to assist in the creation of online learning modules for Public Health Professionals within the state of Indiana.

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

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

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Board Standards and Measures

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

Total Current Year Funds Allocated to Health Objective: $207,585
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
Provide access to educational resources and trainings
Between 10/2014 and 09/2015, ISDH and contractors will conduct **10** trainings/education opportunities for public health workforce.

Annual Activities:
1. Annual Public Health Nurses Conference
Between 10/2014 and 09/2015, Continue conducting an annual conference for Public Health Nurses including providing CNEs.

2. New Public Health Nurse Orientation
Between 10/2014 and 09/2015, Continue the New Public Health Nurse Orientation and offer CNEs for participants.

3. Health Officer Training Program
Between 10/2014 and 09/2015, Continue the health officer training program that has 2 live trainings per year and archive presentations and publish presentations on the Health Officer Training section of the Local Health Department (LHD) website.

4. Continuing Medical Education Support
Between 10/2014 and 09/2015, Continue to provide Continuing Medical Education (CMEs) for the live meetings.

5. Analyze training data
Between 10/2014 and 09/2015, Continue to collect data from training participants to determine success of the training and assess gaps in training that will be addressed in future educational events.

6. E-Learning modules
Between 10/2014 and 09/2015, Develop E-Learning position to work with internal ISDH to create online learning modules to be hosted on ISDH LMS, IN-TRAIN.

7. Local Health Departments and IN-TRAIN
Between 10/2014 and 09/2015, Identify new training opportunities for LHDs through the IN-TRAIN learning management system and collect evaluation and assessment data.

8. Support continuing education events
Between 10/2014 and 09/2015, Public Health conference registration fees, including events such as the Indiana Environmental Health Association, for ISDH employees. Provide continuing education opportunities, such as Leadership At All Levels, for ISDH employees.

9. Workforce Development and Public Health Accreditation
Between 10/2014 and 09/2015, Domain 8 is focused on workforce development and is a requirement for Public Health Accreditation. ISDH is one of the primary resources for LHDs to receive continuing education and workforce development activities.

10. Educational Resources and Training that Address the ISDH Priority Areas
Between 10/2014 and 09/2015, The Office of Public Health and Performance Management (OPHPM) will provide educational resources, training and events that focus on the agency's top priorities: infant mortality, adult obesity and adult smoking.

National Health Objective: HO PHI-13 Epidemiology Services

State Health Objective(s):

Between 10/2014 and 09/2015, Increase analytical capacity of epidemiologists and data analysts using Statistical Analysis Software (SAS).

Baseline:
Our agency's epidemiologists and data analysts have a general knowledge of SAS, but have requested assistance for managing datasets pertaining to their specific program area (e.g., removing duplicates, date formatting issues); how to produce a variety of output (e.g., tables, graphs); and how to program the SAS logic for complicated data extractions. These staff had also requested assistance with SAS Proc Tabulate and Operational Data Store (ODS), and two seminars have been provided on these topics. Matt Kaag, contract SAS Senior Data Analyst, now provides SAS tips a few times a month via list serve that discuss the answers to SAS questions from the epidemiologists and data analysts.

Data Source:
Records kept by Matt Kaag, contract Senior Data Analyst/SAS Programmer

State Health Problem:

Health Burden:
In order to monitor health outcomes, timely and accurate data are required. It currently takes more than 14 months to produce final natality and mortality datasets, which delays the analysis of interventions in place to improve the health of residents. Continuing to reduce the time needed to produce final natality and mortality datasets will permit epidemiologists and data analysts faster access to factors affecting health outcomes, including infant mortality, and deaths from drug overdose and chronic diseases. For example,

new innovative programs are being put in place to decrease infant mortality, especially for African Americans (Indiana had the second highest black infant mortality rate in 2013). Access to timely data is needed to monitor changes in such risk factors as smoking during pregnancy, access to care, prenatal visits and low birth weight in addition to the number of infant deaths. The sooner this information is available to analysts, the faster it can be determined what interventions reduce infant deaths in our state.

Target Population:
Number: 6,570,901
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Business and Merchants, Safety Organizations

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: $108,103
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
Epidemiological Consultation and Assistance
Between 10/2014 and 09/2015, LCDR Michelle Sandoval will provide general epidemiological consultation and assistance to **1** Chronic Disease division within the ISDH.

Annual Activities:
1. Ensuring collaboration with surveillance and evaluation activities at ISDH.
Between 10/2014 and 09/2015, LCDR Michelle Sandoval will provide general epidemiological consultation and assistance to the Chronic Disease divisions within the Indiana State Department of Health and ensure collaboration with surveillance and evaluation activities among ISDH divisions. Periodic travel may be necessary to ensure efficient collaboration, education, and support. Sandoval will provide assistance to analyze and interpret data to assess the burden of chronic disease, provide information on the distribution and risk factors for chronic diseases necessary for public health program planning and implementation, and

assist in evaluating the success of public health programs. She will encourage collaboration and linkage among the ISDH Chronic Disease Division and other divisions in the use of data collection tools and development of various reports.

Objective 2:

Expand data analytics and decrease time required to produce final reports and datasets

Between 10/2014 and 09/2015, Matt Kaag, contract Senior Data Analyst, along with DAT staff, will decrease the number of months it takes to produce the final mortality and natality datasets from 15 to **12**.

Annual Activities:

1. Expand data analytics produce mortality and natality reports and datasets

Between 10/2014 and 09/2015, ISDH Data Analysis Team (DAT) will continue to expand the information available from our natality, mortality, hospitalization and BRFSS datasets to agency program areas and the general public (HP2010 PHI-7, -8, -14, -15).

This activity will be accomplished by providing descriptions of tables added to our annual mortality and natality reports, published tables using hospital discharge data by county, monthly datasets provided to specific program areas, and BRFSS newsletters topics. Examples: (1) the DAT provided additional data in the 2013 Indiana natality report, published in June 2015. The tables for outcome indicators (counties and select cities), births by age of mother, and reported pregnancies by age of mother had previously been provided for the total, white and black populations. The 2013 natality report added tables to provide that information by ethnicity of mother to greater assist program areas working to improve the health of this growing population. (2) Up-to-date files of out-of-state Indiana births and deaths are now sent on a monthly basis to MCH to monitor infant deaths. (3) The BRFSS Coordinator will also continue to collaborate with chronic disease staff to produce BRFSS newsletters that provide additional information on these conditions, especially those affecting populations at risk.

2. Reduce time to produce mortality and natality reports and datasets

Between 10/2014 and 09/2015, ISDH DAT will provide annual natality and mortality datasets 12 months after year end (e.g., December 2015 for 2014 data). Annual mortality and natality reports will be published 14 months after year end.

Objective 3:

Increase Analytic Capacity of Epidemiologists and Data Analysts

Between 10/2014 and 09/2015, Matt Kaag, contract Senior Data Analyst, will maintain **2** training seminars.

Annual Activities:

1. Increase analytic capacity of epidemiologists and data analysts in the use of SAS

Between 10/2014 and 09/2015, ISDH DAT will continue to conduct a series of training seminars for agency epidemiologists and data analysts on data management, analysis and presentation using SAS as the software platform.

2. Provide consultation for epidemiologists and data analysts

Between 10/2014 and 09/2015, The Senior Data Analyst will also provide individual consultation/assistance to epidemiologists and data analysts regarding SAS programming and analysis.

Objective 4:

Increase number of surveys completed in the 2016 Indiana BRFSS survey

Between 10/2014 and 09/2015, Linda Stemnock and contractor will conduct **580** surveys for the 2016 Indiana BRFSS.

Annual Activities:

1. Increase number of BRFSS surveys completed to increase data availability and demographic detail
Between 10/2014 and 09/2015, An estimated 580 landline and cell phone interviews will be added to the Indiana 2016 BRFSS survey via contract with Clearwater Research, Inc. (BRFSS contractor for Indiana). The percent of cell phone interviews will be determined in the fall of 2015 (30% is the baseline established by CDC, and this will most likely increase). These additional surveys will aid in the tracking of risk factors and preventive actions, identify health disparities, and support strategic health improvement plans (HP2020 PHI-7, 8, 14, 15). The Advisory Committee voted to approve funding to be allocated for BRFSS data collection.

National Health Objective: HO PHI-15 Health Improvement Plans

State Health Objective(s):

Between 10/2014 and 09/2015, Continue to increase the capacity for local health departments and nonprofit hospitals to conduct community health assessments and improvement plans by improving access to county level secondary data to all 92 counties in Indiana through the Indiana Indicators data dashboard website.

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

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

State Health Problem:

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

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

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

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

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

Educational Institutions, Business and Merchants

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Standards and Measures

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

Total Current Year Funds Allocated to Health Objective: $230,956
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
Data Warehouse Maintenance
Between 10/2014 and 09/2015, ISDH, Indiana Hospital Association, Indiana Business Research Center will update **1** data dashboard website.

Annual Activities:
1. Community Health Assessments
Between 10/2014 and 09/2015, Community Health Assessments are required by both nonprofit hospitals to demonstrate community benefit for the IRS requirements under the Patient and Protection Affordable Care Act. Local health departments are required to do a local health assessment for public health accreditation. In addition, both the state department of health and the local health departments are required to have a data profiles report for public health accreditation (Domain 1). Local health departments will utilize the Indiana Indicators website to provide the data needed to do their local health assessment for public health accrediation. This website will assist all interested parties in accomplishing their goals while also reducing staff time at ISDH for individual data requests.

2. Partner meetings
Between 10/2014 and 09/2015, Conduct quarterly meeting with partners and partner with appropriate agencies to ensure policies and procedures.

3. Indiana Indicators data plan
Between 10/2014 and 09/2015, Develop a data plan for appropriate data to be included on the website including enhancements on the website that will allow for downloadable PDF data spreadsheets, maps, and other tools to increase transparency of data between counties. Website enhancements include: updating the website with new tools and data layout, update data and evaluate the website.

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

State Health Objective(s):

Between 10/2014 and 09/2015, Enhance the capability of Indiana health departments in the area of agency performance management and quality improvement utilizing Lean Six Sigma.

Baseline:

ISDH has worked toward an agency-wide performance management system that also includes Lean Six Sigma quality improvement methodology. Through the National Public Health Improvement Initiative, ISDH has trained 20 Green Belts in Lean Six Sigma for Public Health and 80 Yellow Belts in Lean Six Sigma for Public Health. The goal is to expand training within ISDH and LHDs throughout Indiana for basic LSS skills.

Data Source:

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

State Health Problem:

Health Burden:

Local health department funding has been reduced each and every year. ISDH provides $7,000,000 across the 93 local health departments but this will be reduced by 3% next funding cycle. Health departments' budgets were reduced due to legislation changes on property taxes and the downward turn of the economy. With the implementation of ACA, local health departments will need to start moving toward efficiency and performance driven results. As both state and federal dollars are requiring more outcome driven data sources, quality improvement training and performance management training will help LHDs become quality driven organizations

Resources:

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

Target Population:

Number: 93
Infrastructure Groups: State and Local Health Departments

Disparate Population:

Number: 93
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Public Health Accreditation Board
Public Health Foundation

Indiana Census

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $319,069
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
LSS QI Skill Building Training
Between 10/2014 and 09/2015, ISDH, Purdue Healthcare Advisors will implement **3** LSS QI Skill Building Workshops at ISDH.

Annual Activities:
1. Training ISDH staff in Quality Assurance/Quality Improvement (QA/QI)
Between 10/2014 and 09/2015, Train 200 state health department staff in Quality Assurance (QA)/Quality Improvement (QI) skills. The QA/QI training series is a multi-week program that provides the opportunity for staff to obtain their QI green and yellow belts based on the Lean Six Sigma methodology.
Quality Improvement is a key foundation for public health accreditation and is required for each domain and is the key component for Domain 9. To achieve accreditation ISDH must demonstrate quality improvement implementation and trained staff.

Objective 2:
Performance Management Training
Between 10/2014 and 09/2015, ISDH will implement **4** Performance Management Trainings.

Annual Activities:
1. LHD Training
Between 10/2014 and 09/2015, Reach a total of 180 LHD staff members on agency performance management through in-person trainings and also the use of the new learning management system, IN-TRAIN. The performance management system training will support the quality improvement training. The impact of these trainings will result in a more knowledgeable, informed workforce in Indiana.

2. ISDH Training
Between 10/2014 and 09/2015, Implement trainings at ISDH for Agency Performance Management system, reaching a total of 100 ISDH staff members. Performance management systems are supportive of the agency strategic plan, the agency dashboards, and quality improvement. The impact of these trainings will result in a more knowledgeable, informed workforce in Indiana.

3. Workforce Development Training
Between 10/2014 and 09/2015, provide workforce development plan trainings to local health departments interested in public health accreditation. Developing a workforce development plan is supportive of developing an agency performance management system. The impact of these trainings will result in a more knowledgeable, informed workforce in Indiana.

State Program Title: Sexual Assault Services - Education and Outreach

State Program Strategy:

Goal: Between 10/15 and 09/2016, continue to reduce the prevalence of rape and sexual violence in the State of Indiana.
Program Priorities: Local victim service providers awarded SAS funds will provide sexual violence prevention outreach and education to targeted audiences in their local communities and also provide direct services to victims of sexual violence.
Primary Strategic Partnerships(s):

- **External:** ISDH and 16 service providers in all areas of the state.

Evaluation Methodology: Evaluation methodology includes presentation evaluations and data on numbers reached through outreach and education and through direct victim services. These numbers include: number of youth and adults reached through prevention education initiatives funded through this grant broken out by age group; number of contacts with victims of sexual violence broken out by gender and age; and how victims were served (number of victims provided services through crisis intervention, crisis hotlines, support groups and other services).

State Program Setting:

Community based organization, Faith based organization, Rape crisis center, Schools or school district, University or college

FTEs (Full Time Equivalents):

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

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

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

State Health Objective(s):

Between 10/2014 and 09/2015, The purpose of the SAS program is to reduce the prevalence of sexual assault and attempted sexual assault among residents of the State of Indiana, particularly youth through sexual violence outreach and education and direct services. Funds will be used by 16 Subrecipients to provide prevention outreach and education as well as direct services.

Baseline:

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

- **Non-reports**

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

Data Source:
NIBRs, ICJI Victims Compensation Claims

State Health Problem:

Health Burden:
Practitioners and researchers estimate only three in ten victims actually report a sexual assault. Anecdotal evidence comes in from across the state of victims seeking counseling months and sometimes years following an unreported assault. However, for planning and funding purposes some sort of hard data is required. In that regard, the fact that Indiana is one of only two states without mandatory UCR data reporting somewhat handicaps our ability to provide quantitative hard data as other states can provide. Our data analysis center reports that approximately 40% of our 92 counties report and those cover more than 85% of the population of Indiana.
In order to most accurately reflect the number of rape/sexual assaults in the state, our researchers look at two numbers: 1) the available UCR data (raw data; not formulized by the FBI to fill in missing data) and 2) the number of forensic medical exam claims submitted by hospitals for payment by the state Victims Compensation area.

- **Reported rapes/sexual assaults**

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

- **Non-reports**

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

On December 14, 2011, the Center for Disease Control released the National Intimate Partner and Sexual Violence Survey which listed Indiana as having the **8th highest rate of interpersonal violence in the country**. IPV combines rape, physical violence and stalking. Indiana continues to deal with the serious problem of sexual violence. Anecdotally we hear from hospital staff and Sexual Assault Nurse Examiners (SANEs) that the number of child sexual assault cases is “exploding”, to quote one SANE in the Indianapolis area.
Economic Costs: In 2008, National Institute of Justice researchers estimated that each **rape costs** approximately. $151,423 (DeLisi …. Hidden **costs** in health care). The costs to the state of this public health problem include the following:

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

There continue to be higher than average rates of sexual violence in Indiana and the need for prevention, intervention, and treatment programs is ever pressing. The continuation of funding will allow for continued prevention outreach and education as well as the provision of direct services. The anticipated outcome is that the number of sexual violence incidents can be further reduced particularly among the youth of the state.

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

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

Other: •Intervention to Reduce Distress in Adult Victims of Sexual Violence or Rape: a Systematic View (2013 Regehr, Alaggia, Dennis)
•Trauma Informed Care and Structured and unstructured Interaction Programs (Chard, 1995)
•Sanctuary Model of Trauma Informed Care
•Trauma Informed Care Protocols and Best Practices (www.NSVRC.org/Trauma)
•Mayo Clinic Healthy Lifestyles: Stress Management Validated Support Group Model
•Trauma Informed Art Therapy ®(PTSD approach)
•Trauma Focused Cognizant Behavioral Therapy

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $144,972
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $144,972
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
Extend coordinated, audience-appropriate sexual violence prevention outreach and education programs.
Between 10/2014 and 09/2015, Subrecipient prevention outreach education presenters will provide presentations to **8000** students and adults in Indiana.

Annual Activities:
1. Provide sexual violence prevention outreach and education.
Between 10/2014 and 09/2015,

- Provide current and generally accepted sexual violence prevention programs within local area, ensuring coordination with current RPE (Rape Prevention) program providers when appropriate. Examples include Teen Dating and Healthy Relationships, Love is Respect, Campus Sexual Assault and Relationship Violence Prevention program, and others which incorporate behavior and social change theories into the programs.
- Provide workshops and training that meet the needs of the community including training for athletic teams, EMS first responders, law enforcement, prosecutors, etc.
- Provide prevention and intervention information on an informal basis to individuals; during a counseling session, on a crisis line call, etc.

PERFORMANCE MEASURES
Below are examples of performance measures that will be included in SAS reports at the end of each quarter:
1. Number of youth and adults reached through prevention education initiatives funded through this grant broken out by age group.

2. Number of contacts with victims of sexual violence broken out by gender and age.

(a) How victims were served (number of victims provided services through crisis intervention, crisis hotlines, support groups and other services):
- Number of hotline crisis calls.
- Individual counseling hours broken out by age and gender.
- Group session counseling hours broken out by age and gender.

Objective 2:
Improve and enhance service and response initiatives to victims of sexual violence.
Between 10/2014 and 09/2015, Sub awards will be administered by state staff in the Indiana Criminal Justice Institute's Victim Services Division. Direct victim services will be provided by qualified staff of ICJI's sixteen SAS funded Subrecipients. Some are rape crisis centers and others are dual Domestic

Violence/Sexual Assault centers. They will provide services to **225** victims of sexual violence.

Annual Activities:

1. Provide direct service to victims of sexual violence.

Between 10/2014 and 09/2015, Trained educators or counselors will provide a variety of trauma-informed care from emergency response to a hospital to meet with a victim, to explaining the rape examination process to further medical and legal education as needed. Services may be provided to any victim of sexual violence at any point in the life span continuum.

State Program Title: TB Control Program/Refugee

State Program Strategy:

Goal: Between 10/2015 and 09/2016, the goal of the TB Control, Prevention and Elimination Program is to oversee, manage, and facilitate activities that assure early identification and proper treatment of persons with tuberculosis; prevent transmission of *Mycobacterium tuberculosis* to others; increase the percentage of newly diagnosed infection (Latent TB Infection) cases that start and complete treatment; and provide education to both the public and health care workers.

Program Priorities:

1. Early diagnosis of TB disease and infection
2. Completion of appropriate therapy for all cases of TB disease and infection
3. Prompt identification and evaluation of high and medium risk contacts through effective contact investigation activities
4. Screening and treatment of TB infection in persons in targeted high-risk populations

Primary Strategic Partnerships(s):

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

Evaluation Methodology:

By Indiana administrative code, all counties report TB cases and contact investigation data to ISDH using a standard case report and contact investigation worksheet. Reported cases are verified according to the TB case definition for public health surveillance. Treatment for latent TB infection reduces the risk that TB infection will progress to disease. Being a recent contact of an infectious TB case is one of the high-risk of progressing to disease.

Therefore contacts with TB infection that start and complete treatment will decrease the number of cases that progress to TB disease reducing the incidence of TB in Indiana. Having a user-friendly computerized contact investigation worksheet that collects all needed information and provides space for notes on each contact will make data gathering more timely and complete and data analysis more accurate. Success of progress goals will include the completion of enhancements to the current computer application to make it more user-friendly, provide space for notes and all inclusion of all needed variables.

The overall success of the project will be evaluated by an increase in the number of contacts with TB infection that complete their recommended therapy. The numerator will be the number of persons completing treatment for latent tuberculosis infection (LTBI) who, during the contact investigations of AFB sputum-smear positive TB cases, have been found to have LTBI and initiated treatment. The denominator will be Number of persons who, during the contact investigations of AFB sputum-smear positive TB cases, have been found to have LTBI and initiated treatment.

State Program Setting:

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

FTEs (Full Time Equivalents):

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

Total Number of Positions Funded: 0

Total FTEs Funded: 0.00

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

State Health Objective(s):

Between 01/2014 and 12/2017, Increase the percentage of contacts to sputum smear-positive tuberculosis cases that complete treatment after being diagnosed with latent tuberculosis infection and initiated treatment to 64% for cohort year 2013, 73% for cohort year 2014 and 79% for cohort year 2015.

Baseline:
The baseline set for Healthy People 2020 is 68.1% (from 2007). Indiana's baseline for 2012 which is the most recent year for which data is available is 52%.

Data Source:
Aggregate Reports for Tuberculosis Program Evaluation; Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (CDC/NCHHSTP).

National TB Surveillance System (NTBSS)

Indiana Tuberculosis Control Program--2014 Annual Report

State Health Problem:

Health Burden:
Racial and ethnic minorities and the foreign-born continue to be disproportionately affected by TB. In Indiana in 2014 the incidence rate for TB among Asians was 24.9/100,000; among blacks 3.8%; among Hispanic/Latino 3.5% and among foreign-born in aggregate 19.2%, while the rate among U.S. born and whites were both 0.8/100,000. Of the 108 cases of TB in 2014 over half were foreign born and 67% required a contact investigation.
Contact investigations are more complex among foreign-born contacts due to language and cultural barriers. Each case of pulmonary TB in Indiana has on average between 13-15 community contacts which must be found, evaluated and convinced that treatment is in their best interest. In schools and other aggregate settings such as prisons and nursing facilities expanded screenings are often required in which hundreds of individuals are screened as part of a contact investigation. Treatment varies from three months to nine months. All of this must be reported accurately and timely to the ISDH TB Program.

Computer applications with logical, user-friendly and complete information are needed if local health departments are to gather information efficiently and report timely and accurately. In addition to the barriers already mentioned, management and reporting of contacts are hampered by the TB Program's current computer application which is confusing, outdated and does not allow the local health departments to keep important information in the application and therefore requires both paper and computer records. This is very inefficient and lends itself to the gathering of incomplete and inaccurate data.

Target Population:
Number: 6,596,855
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male

Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 936,754
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White, Other
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: United States Census Bureau--http://quickfacts.census.gov/qfd/states/18000.html

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

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

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

Total Current Year Funds Allocated to Health Objective: $120,210
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:

Enhancement of computer application for contact investigations

Between 10/2014 and 09/2015, Contract program developer--Swamy Buddha; TB epidemiologist--Kelly Richardson; chief nurse--Midia Fulano; regional nurses--Dawn Sipes and Jill Brock will develop **2** areas in the current application which are logical flow of variables and information, and clearly defined variables such as outcomes of contact investigation. Completion of the two new areas which are addition of notes field option for each contact entered and a search function so that the database can be searched to see if a new TB patient has ever been a contact to an active case of TB before. Provision of a webinar to local health department nurses on how to use the enhanced contact investigation module.

Annual Activities:

1. Review logical flow of variables and business rules in the contact investigation module

Between 10/2014 and 09/2015, The TB/Refugee Epidemiologist, chief nurse and focus group from local health departments will review the contact investigation module and make recommendations on how to make the application more user-friendly. Example: have contacts listed alphabetically, open the second page of the application and begin data entry without needing to go to the first page and then go out of the module and then reenter to access the second page.

2. Identification of variables that will accurately portray the outcomes of the contact investigation
Between 10/2014 and 09/2015, The TB/Refugee Epidemiologist with identify independent outcomes along with the definitions of the outcomes so that end users can easily identify which outcome is the appropriate outcome for that contact when the record is closed. Example: evaluation completed, treatment started, treatment completed, lost while on treatment, lost before evaluation completed, never contacted etc.

3. Build the enhanced functionality of logical flow of information, etc.
Between 10/2014 and 09/2015, The IT programmer will develop a more logical flow of information, outcome variables and business rules recommended by the staff on the development server and then test it's functionality on the test server and finally move the new functionality to the production server.

4. Build the new functionality of a note field, search option, & the related business rules
Between 10/2014 and 09/2015, The IT programmer will develop the note fields for each contact where additional information about the contact can be recorded and saved. Example: phone numbers, directions, times available, relation to the TB case, where they had contact with the case, etc. The search option and related business rules will make it possible for the regional nurses and the epidemiologist nurses to search for and identify if a current patient or contact has been named in prior contact investigations. This will help identify potential places of transmission resulting in better identification of contacts that may have TB infection and need to be treated.

5. Provide training on use of new functionality in the contact investigation module
Between 10/2014 and 09/2015, Via a webinar to be broadcast to all county health departments, the epidemiologist and the IT programmer will provide training on the new module so that local health department nurses will be able to easily use the newly enhanced module and comply with timely and accurate reporting of contact outcomes including completion of treatment.

State Program Title: Water Fluoridation Program

State Program Strategy:

Goal: Between 10/2015 and 09/2016, the goal of the Water Fluoridation Program is to promote water fluoridation and monitor water fluoridation systems across the state to assure that the majority of the population of the state of Indiana continue to receive the benefits of water fluoridation

Program Priorities:

> Inspect water fluoridation systems in communities and schools across the state to ensure they maintain optimum fluoride levels.

>Educate mayors, town councils, water system boards and citizens as to the benefits, cost effectiveness and safety of water fluoridation to prevent the elimination of water fluoridation in communities.

Primary Strategic Partnerships(s):

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

Evaluation Methodology: The field staff is expected to make at least 260 inspections of water fluoridation systems per year and to respond to any high fluoride levels (2.0ppm or above) within five business days. Field staff is expected to train any new water fluoridation system operators within 10 business days of being notified of the new operator and to retrain existing operators as needed. Field staff is also required to attend at least two professional water treatment operators meetings in order to keep up with water treatment technology and network with water fluoridation operators. The staff is also required to input up to date data into the Water Fluoridation Reporting System (WFRS). The program will evaluate progress through regular reports to the program director.

State Program Setting:

Schools or school district, State health department

FTEs (Full Time Equivalents):

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

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

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

National Health Objective: HO OH-13 Community Water Fluoridation

State Health Objective(s):

Between 10/2014 and 09/2015, monitor water fluoridation programs in communities and schools on a regular basis.

Baseline:
Prevent the reduction in the number of fluoride systems that operate at optimum levels and maintain the 90% optimal level of fluoride systems that the state has maintained for many years.

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

State Health Problem:

Health Burden:
Over the last several years there has been an ever increasing number of towns, cities, or water districts that have or are considering the elimination of their water fluoridation programs. This is primarily due to budget issues or anti-fluoridation activities. Studies have shown that when a community discontinues water fluoridation, the decay rates return to pre fluoridation levels. Maintaining water fluoridation programs in communities prevents an increase in dental decay levels which contributes to the overall health of those who live in those communities.

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

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

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The fluoridation program follows the CDC guidelines for fluoride system operation by working with fluoride system operators to maintain fluoride at the optimal levels and perfecting testing procedures. Recent changes in the recommended level of fluoride in drinking water implemented by HHS have led the CDC to prepare operational tolerance guidance that will be implemented by the Indiana Fluoridation Program.

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

Total Current Year Funds Allocated to Health Objective: $202,967
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

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

Objective 1:
Maintain Water Systems with Optimal Fluoride Levels
Between 10/2014 and 09/2015, James Powers will maintain **95%** - the percentage of people in Indiana on public water supplies that have access to fluoridated water.

Annual Activities:
1. Monitor Fluoride Samples
Between 10/2014 and 09/2015, Staff will monitor fluoride samples from all water supplies for optimal levels. Staff will respond when out of range by reviewing, on a weekly basis, the test results from all the fluoride samples sent in to the state lab for that period. When a community's test results indicate that the fluoride level is out of range, the fluoridation field staff schedule a visit or contact the community water plant operator to resolve the issue as soon as possible.

2. Consultations with town/city official or waste district board members
Between 10/2014 and 09/2015, When city/town officials or a water district board is considering the discontinuation of fluoridation, staff will meet with them to discuss the public health benefits of continuing. Staff will also recruit local dentists in the area to help.