



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

**State Narrative for
Indiana**

**Application for 2014
Annual Report for 2012**



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I. General Requirements

A. Letter of Transmittal

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

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and Certifications are kept on file at the Indiana State Department of Health in the Office of Grants Management. They are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. Public Input

The State Title V program solicited public comments for this application using several methods. The first method was to place a request for public comments on the Maternal and Child Health (MCH) web page for ongoing public input. The web page encourages the public to comment on the previous, and the current years Title V Block Grant. This includes the Narrative, Forms, and a 2010 Executive Summary which is updated yearly.

A second method for soliciting public comments involved the use of surveys for identifying priority needs for the Five Year Needs Assessment from providers, partners, collaborators, disparity families and families of children with special healthcare needs. The surveys were either used for collecting comments of individuals in group settings, mailed by request to individuals, or electronically e-mailed to professionals. Professionals who were surveyed in small group settings included but were not limited to: Prenatal Substance Abuse (PSUPP) statewide directors, the Indiana Coalition to Improve Adolescent Health (ICIAH) steering committee, the Healthy Families of Indiana Think Tank, Indiana State Department of Health's Chronic Disease Division, State Perinatal Advisory Board, Indiana State Nutrition Council, an Indiana University-Purdue University-Indianapolis nursing class, a Butler University health class, Sunny Start core partners group, Sunny Start Family Advisory Subcommittee, Sunny Start Evaluation Subcommittee, WIC Breastfeeding Committee, the Breast Feeding Center at Clarian, WIC Steering Committee, Indiana Dietitian Associations Meeting, Indiana Nutrition Council, Infant Health & Survival Council, and Indiana's FIMRs.

Needs assessment surveys were sent by e-mail to the 139 member Virtual Advisory Committee, 92 Local Health Departments (LHD) and listed on the LHD Sharepoint, all community health centers, and to all MCH clinics. Surveys were mailed to any professional upon their request. A copy of the Completed Title V Block Grant will be e-mailed to the states public library system for access in their government document sections.

In surveying these small groups and individuals MCH was able to obtain input from a cross

section of disciplines. It included but was not limited to the following professions: health service directors, physicians, registered nurses, public health professionals, students, educators, social workers, lactation specialists, Healthy Family Workers, clinic staff, early childhood service providers, outreach workers, WIC staff, registered dietitians, and fundraisers. These individuals reside in over two-thirds of Indiana's 92 counties, but their service delivery systems represent all of Indiana.

A third method for soliciting public comments before the submission of the Title V Block Grant involved the use of a twenty-page MCH Title V Block Grant Executive Summary. The summary was sent out the first week of June 2010 to the expanded 250 Virtual Advisory Committee members, all LHDs, MCH clinics, 131 Indiana libraries, community health centers, MCH Network/Community Partners, and the Minority Health Coalitions. All groups were advised that the Title V Five Year Needs Assessment and Grant Application had to be submitted no later than July 15, 2010. Therefore their deadline for submitting comments could be no later than Friday, June 25th. As of July 6, over 15 reviewers submitted comments. Title V staff have reviewed all comments and have incorporated as many comments as possible into the needs assessment. All public comments received after submission of the current Title V Block Grant will be used during the preparation of the application for the following year.

Loren Robertson, Deputy Commissioner at Indiana State Department of Health (ISDH) commented that smoking during pregnancy is an extremely important issue. A sampling of other public comments include:

"I have read and agree with the goals outlined to meet the state's priority health issues and needs. I found the ten goals that have been identified as needed areas for improvement in Indiana to be appropriate and necessary. I believe the work plan outlined with each of these goals will allow Indiana to attain the projected outcomes."

Kerri A. Kraus, R.N.

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"The goal over the next five years is to reduce the proportion of births that occur within 18 months of a previous birth, to the same mother, to the level of 10% from (INCLUDE CURRENT LEVEL) I WOULD SUGGEST WORKING WITH FATHERHOOD INITIATIVE ON THIS ONE TOO! THEY NEED EDUCATION ABOUT THIS ISSUE MORE THAN MOMS!"

Sarah M. Stelzner, MD

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"As the CEO of Learning Well school-based clinics in Marion County, I would like to offer the mention of our relationship with the State in order to add the power of our large, 9 year collaboration with healthcare providers; school partners; and advisory partners (including local foundations, the United Way of Central Indiana, Health & Hospital Corporation, Clarian....and many others) to an already strong proposal. I have attached a list of the working partnerships and collaborations that are presently in place. I noted there are many areas where Learning Well could be utilized as a prime example of how the State of Indiana has been successful in creating programs that are based upon partnerships and collaborations."

Donna A. Stephens, MBA
CEO

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/2012/Title V staff continue to reach out to providers, parents, families, partners, and collaborators for continued input into Title V programs and policies. As an example of the importance of public input, Title V staff have strengthened statewide partnerships with specialty physicians, hospitals, and other relevant entities and created a Perinatal Quality Improvement Collaborative. Also this year, we are working on an interactive web-based presentation of the Title V Five Year Needs Assessment. We also encourage collaboration by making it a requirement of grant sub-awards. Subsequent to the Title V Five Year Needs Assessment, we have conducted two additional needs assessments -- one focused on home visiting and the other focused on pregnant and parenting teens. In both instances, we sought public input through surveys and meetings to make our needs assessments the strongest they could be. We are continuing to seek out public input, especially from pregnant and parenting teens and their families. To this end, IU is convening a three-day community conversation with pregnant and parenting teens and the community that is scheduled for summer 2011. The conversation will be facilitated by research sociologists from Indiana University. "Families served by MCH and CSHCS programs routinely encounter opportunities both informal and formal to share their input. These opportunities via surveys, public forums and advisory work are a key piece of the family partnership that enhances MCH and CSHCS." -- Rylin Rodgers, Family Voices Indiana//2012//

/2013/ MCH has continued in its efforts to work with community and public partners. As an example, Sunny Start recently completed a statewide Community Survey. The distribution of the survey resulted in 508 individual responses from 152 families and 356 community providers. Forty-eight of the 92 counties in Indiana were represented. As an example, one respondent said, in response to an open-ended question about actions needed to ensure services are coordinated, cost effective and community based, that "We really need a one-stop shopping - one place families can go to get information and access resources." The information from this survey will guide Sunny Start's activities in the next few years.//2013//

II. Needs Assessment

In application year 2014, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

III. State Overview

A. Overview

Indiana is a state rich with the history of an industrial and agricultural past and the promise of an agricultural and high tech future. Like the rest of the country, this past year has forced the State to deal with serious changes and hardships due to the United States' economic downturn. However, Indiana has fared far better than most of its neighbors and most of the country. Under Governor Mitch Daniels' administration, innovative programs have emerged to combat high unemployment and the lack of health insurance that accompanies such changes.

State Introduction

The Indiana State Department of Health (ISDH), one of the largest state agencies, serves the population in a wide variety of ways including providing environmental public health, food protection services, health facility licensing, public health preparedness, health promotion programs, statistical information, direct health services, and many other infrastructure building programs.

The Mission of the ISDH supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities. To achieve this mission, ISDH has adopted principles that guide policy development and programs. These principles mandate that ISDH and its Commissions:

- Focus on data-driven policy to determine appropriate evidence-based programs and initiatives.
- Evaluate activities to ensure measurable results.
- Engage partners and include appropriate intra-agency programs in policy-making and programming.
- View essential partners to include local health departments, physicians, hospitals and other health care providers, other state agencies and officials as well as local and federal agencies and officials, community leaders, businesses, health insurance companies, Medicaid, health and economic interest groups, and other groups outside the traditional public health model.
- Actively facilitate the integration of public health and health care activities to improve Hoosiers' health.

/2013/ ISDH adopted a new Mission, Vision, and Strategic Priorities in 2012. They are as follows.

Mission:

"Promoting and providing essential public health services to protect Indiana communities"

Vision:

A healthier and safer Indiana

Agency Strategic Priorities:

The Indiana State Department of Health believes that the following agency priorities will have the most impact on the way it operates and on its ability to deliver on its Mission and Vision:

- Decrease disease incidence and burden
- Improve response and preparedness networks and capabilities
- Reduce administrative costs through improving operational efficiencies
- Recruitment, evaluation, and retention of top talent in public health
- Better use of information and data from electronic sources to develop and sponsor outcomes-driven programs
- Improve relationships and partnerships with key stakeholders, coalitions and networks throughout the State of Indiana//2013//

In its desire to make Indiana the healthiest state in the country, ISDH also recognizes that key factors such as prevention of disease, ensuring access to health care, and promoting personal responsibility of individual Hoosiers for their own health must also be an integral part of the state's initiatives. ISDH works hard to collaborate effectively with its many partners in policy-making and

programming. ISDH also works hard to develop an environment of respect -- for those who serve Hoosiers in the public health field and the public it serves -- by honoring diversity, equality of opportunity, cultural differences, and ethical behavior.

As of January 2010, the State's Priority Health Initiatives included activities that support data driven efforts for both health conditions and health system initiatives; INShape Indiana; and integration of medical policy that values public health principles; and preparedness. The state is emphasizing the integration of health care policies with evidence-based and results oriented programming. It also continues to highlight preparedness and effective responses to threats that cannot be prevented.

In particular, InShape Indiana is a statewide initiative designed to help Hoosiers make healthier choices about food, physical activity and tobacco. Governor Daniels began this program and remains heavily involved in support of this program. The website link (<http://www.in.gov/inshape/>) provides access to valuable information and resources that can help Hoosiers live a more healthful life. As a result of the initiative, thousands of Hoosiers have decided to start living a healthier lifestyle by choosing to eat better, move more and avoid tobacco.

Health Status and Health Needs of Hoosiers

In comparison to other states, the health status of Hoosiers is below average. However, Indiana does have certain strengths including a low rate of uninsured population at 11.9%, increasing immunization coverage of children, and decreasing cardiovascular deaths. In the past ten years, immunization coverage increased from 41.8% to 78.4% of children ages 19 to 35 months who received complete immunizations. Since 1990, the rate of deaths from cardiovascular disease decreased from 425.0 to 310.0 deaths per 100,000 population.

In terms of state challenges, Indiana ranks poorly on the prevalence of smoking at 26.0% (the same rate as in 1999); high levels of pollution at 13.2 micrograms of fine particulate per cubic meter; 49th in public health funding at \$36 per person; and a high percentage (23.3%) of children in poverty. In the past five years, the percentage of children in poverty increased from 13.7 % to 23.3 % of persons under age 18. Additionally, Indiana ranks 37th in cardiovascular deaths; 37th in cancer deaths; and 39th in overall infant mortality. Compared to 43 other states that have sufficient data, Indiana ranks 40th in terms of black infant mortality. (Infant mortality rates by state 2004-2006, Statehealthfacts.org)/2012/The percentage of adults smoking decreased to 23.1% in 2009 according to the BRFSS.//2012// /2013/Most recently, the Indiana Smoke Free Air Law began on July 1, 2012, which will make nearly all public places, including restaurants and workplaces, smoke free.//2013//

Health disparities are also a very large issue in Indiana. Obesity is more prevalent among non-Hispanic blacks than non-Hispanic whites at 36.7% vs. 27.2 % respectively. The prevalence of diabetes also varies by race and ethnicity in the state; 12.9 % of non-Hispanic blacks have diabetes compared to 7.7 % of Hispanics and 8.4 % of non-Hispanic whites.

In 2007, the total infant mortality rate in Indiana was 7.5 per 1,000. The white non-Hispanic rate was 6.5 per 1,000, the black non-Hispanic rate was 15.7 per 1,000 and the Hispanic rate was 6.8 per 1,000. The low birth weight for infants in Indiana in 2007 was 8.5 % of births. The percentages were 7.8% for white non-Hispanic, 14.1% for black non-Hispanic and 7.2% for Hispanic for low birth weight infants in Indiana in 2008. /2013/In 2009, the infant mortality rate increased to 7.8 while the percent of low birth weight infants decreased to 8.3%.//2013//

Demographics

The State of Indiana is located in the Great Lakes Region of the United States. Indiana is ranked 38th in land area, and is the smallest state in the continental U.S. west of the Appalachian Mountains. Its capital and largest city is Indianapolis, the largest of any state capital east of the Mississippi River. As of 2008, Indiana is the 38th most populated state in the United States with 6,376,792 people living in 2,795,024 households. Indiana has several metropolitan areas with

populations greater than 100,000 as well as a number of smaller industrial cities and small towns. Residents of Indiana are known as Hoosiers./2012/Based on the 2010 census, Indiana's population is now 6,483,802. Since 2000, Indiana's population has increased by 6.6% which is below the national average of 9.7%./2012//

Indianapolis ranks as the 13th largest city and 11th largest metropolitan area in the United States, and also the 3rd largest city in the Midwest. The Indianapolis Metropolitan Area, defined as Marion County and the counties immediately surrounding it, is among the fastest-growing metropolitan areas in the US, with the largest growth centering in the counties surrounding Marion County. (FY2008, US Census Bureau.)

In the state, 26.9% of the population are under the age of 18, 6.9% are under the age of five and 12.8% are 65 years of age or older. The median age is 36.4 years. In 2005, 77.7% of Indiana residents lived in metropolitan counties. In Indiana, the population is 51% female and 49% male.

Indiana has limited cultural diversity outside of its metropolitan areas with over two-thirds of its counties reporting white, non-Hispanic populations of more than 95%. Indiana's overall Hispanic population is 5.2%, its white, non-Hispanic population is 83.2%, and its black non-Hispanic population just over 9%. This contrasts highly with Indiana's largest county, Marion County, which has an African-American population of 25.9%, a Hispanic population of 7.4%, and a white, non-Hispanic population of 63.8%. Asians and people reporting two or more races account for almost all of the remaining 2.9%.

Indiana's economy is considered to be one of the most business-friendly in the United States. This is due in part to its conservative business climate, low business taxes, relatively low union membership, and labor laws. The doctrine of at will employment, whereby an employer can terminate an employee for any or no reason, is in force. Despite its reliance on manufacturing, Indiana has been much less affected by declines in traditional rust belt manufactures than many of its neighbors. According to the Bureau of Labor Statistics, Indiana is one of very few states where the unemployment rate declined from March 2009 to March 2010 (10.1 vs. 9.9%). The explanation appears to be certain factors in the labor market. First, much of the heavy manufacturing, such as industrial machinery and steel, requires highly skilled labor, and firms are often willing to locate where hard-to-train skills already exist. Second, Indiana's labor force is located primarily in medium-sized and smaller cities rather than in very large and expensive metropolises. This makes it possible for firms to offer somewhat lower wages for these skills than would normally be paid. Firms often see in Indiana a chance to obtain higher than average skills at lower than average wages.

Indiana is home to the international headquarters of pharmaceutical company Eli Lilly in Indianapolis, the state's largest corporation, as well as the world headquarters of Mead Johnson Nutritionals in Evansville. Overall, Indiana ranks fifth among all the states in total sales and shipments of pharmaceutical products and second highest in the number of biopharmaceutical related jobs.

Indiana is located within the U.S. corn and grain belts. The state has a feedlot-style system raising corn to fatten hogs and cattle. Along with corn, soybeans are also a major cash crop. Indiana's proximity to large urban centers, like Chicago and Indianapolis, supports dairying, egg production, and specialty horticulture. Other crops include melons, tomatoes, grapes, mint, popping corn, and tobacco in the southern counties.

Poverty

For all age groups, Indiana has less people living in poverty than the nation as a whole. However, Indiana has slightly more children than the nation as a whole who live in households lower than 100% of the Federal Poverty Level. Additionally, Indiana's median income, \$50,303 is below the national average. (www.statehealthfacts.org)

In terms of poverty rate by race/ethnicity, Indiana's black population is significantly more affected by poverty than the rest of the black population in the United States. The black population living in Indiana is almost three times more likely to suffer from poverty. According to a 2007 GAO report titled, *POVERTY IN AMERICA: Economic Research Shows Adverse Impacts on Health Status and Other Social Conditions As Well As the Economic Growth Rate*, economic research suggests that individuals living in poverty face an increased risk of adverse outcomes, such as poor health and criminal activity, both of which may lead to reduced participation in the labor market. While the mechanisms by which poverty affects health are complex, some research suggests that adverse health outcomes can be due, in part, to limited access to health care as well as greater exposure to environmental hazards and engaging in risky behaviors.

Additionally, exposure to higher levels of air pollution from living in urban areas close to highways can lead to acute health conditions. Data suggest that engaging in risky behaviors, such as tobacco and alcohol use, a sedentary life-style, and a low consumption of nutritional foods, can account for some health disparities between lower and upper income groups.

The relationship between poverty and adverse outcomes for individuals is complex, in part because most variables, like health status, can be both a cause and a result of poverty. These adverse outcomes affect individuals in many ways, including limiting the development of skills, abilities, knowledge, and habits necessary to fully participate in the labor force.

Low-income children are less likely to be covered by healthcare and thus are more likely to lack primary care and other necessary medical services. Because of these disparities, providing services to children from low-income households is of paramount concern for our nation and has led to national coverage programs for children. Healthcare financing sources for low-income and disabled children include Medicaid and SCHIP funding, administered in Indiana through Hoosier Healthwise which includes a risk-based managed care (RBMC) program, Care Select for aged, blind, disabled, and other special populations, and fee-for service Medicaid programs.

According to information compiled by *Covering Kids and Families (CKF)* in Indiana, there are 1,680,000 children under the age of 19 in Indiana. Of these children, about one in 10 (or 161,000) has no health insurance. /2013/The number of uninsured children in Indiana has decreased to 9.1% (or 148,000) in 2009.//2013//

- Indiana ranked 35th in the nation in 2006 for the number of children living in poverty.
- 95.3% of Indiana's uninsured children are members of working families. (Families USA)
- In 2007, 7% of Indiana's children under the age of 6 were uninsured.
- In 2007, 8% of Indiana's children between the ages of 6 and 12 were uninsured; 14% of children between the ages of 13 and 18 were uninsured.
- 48.2% of Indiana's uninsured children live in families with annual incomes at or below twice the federal poverty level (Families USA 2008)
- Indiana had the highest per capita rate of individual medical bankruptcies in the nation in 2006.
- From 1999 to 2005, Indiana had the nation's highest percentage drop in workers who receive employer-sponsored health insurance.

At the Governor's direction, Indiana is working diligently to improve the economic status of Hoosier children and their families.

Racial/Ethnic Disparity

Like the rest of the United States, Indiana is growing more diverse culturally, racially, and ethnically. This change will continue to increase over the coming years and will enrich Indiana as a state and help to expand its global perspective. However, while there are many positive outcomes due to this growth, there are also problems, such as inadequate health delivery.

The National Institutes of Health states that "Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the US." It is racial and ethnic minorities that are facing a

disproportionately greater burden of disease, injury, premature death, and disability. Indiana's MCH and CSHCS programs are aware of racial and ethnic health disparities in Indiana and are working to impact the many contributing factors that influence an individual's health. These factors include but are not limited to the environment, lifestyle choices, cultural beliefs, poverty, past experiences, insurance status, and employment. Additionally, racial and ethnic minorities also experience barriers to health including access to care; limited English proficiency; no continual source of health care; limited health education; racial and ethnic assumptions; and lack of diverse employment skills.

Reducing health disparities among racial and ethnic groups in Indiana requires the cooperation of legislators, governments (both local and state), providers of health care, and the community. Improved data collection, better access to care, essential preventative care, and community involvement are also necessary to improve current health status and conditions of all racial and ethnic minority groups.

Minority, racial, and ethnic populations in Indiana make up more than 15% of the current population. Overall, blacks have the highest age-adjusted death rates, followed by whites and Hispanics.

In Indiana, the black non-Hispanic population consistently has more severe health outcomes than the white non-Hispanic population. The infant mortality rate for black non-Hispanic is about two and a half times that of the white non-Hispanic population. The percentage of low birth weight infants for black non-Hispanics is nearly double that of the white non-Hispanic infants. The percentage of black non-Hispanic and Hispanic mothers who received adequate prenatal care or who received prenatal care in the first trimester is much lower than the white non-Hispanic mothers. The percentage of mothers receiving late or no prenatal care is much higher for black non-Hispanic and Hispanic mothers compared to white non-Hispanic mothers. The percent of black non-Hispanic mothers who initiated breastfeeding is well below that of the white non-Hispanic mothers.

This information has helped to guide the development of the newly revised State Performance Measures and will be used to determine the judicious allocation of scarce Title V resources.

Geography

In Indiana, 70% of the population lives in a metropolitan area while 30% lives in a rural area. According to the Indiana Rural Health Association, rural communities have higher rates of chronic illness and disability and poorer overall health status than urban communities. Rural residents tend to be older and poorer than urban residents. Eighteen percent of rural residents are over 65 compared to 15% of urban residents and more rural residents live below the poverty level compared to urban residents.

Chronic conditions such as heart disease and diabetes are more prevalent in rural areas. Injury-related deaths are 40% higher in rural communities than in urban communities. Cancer rates are higher in rural areas. People living in rural areas are less likely to use preventive screening services, exercise regularly, or wear safety belts. These disparities among rural and urban Hoosiers may be caused by a number of reasons including:

Transportation--Many individuals lack access to treatment because appropriate transportation is too expensive, limited by weather factors, or because the patient is too sick to use the options that are available.

Lack of Providers --Residents of rural areas have less contact and fewer visits with physicians. Although 20% of Americans live in rural areas, only 9% of the nation's physicians practice in rural areas and only 10% of specialists practice in rural areas. In addition, 81% of urban counties and 98% of rural counties in Indiana fail to meet the national benchmark for an adequate ratio of primary care specialists per 100,000 population that affects services to children with special

healthcare needs. There are 6,000 unfilled nurse positions in our hospitals. Both urban counties (65%) and rural counties (87%) fail to meet the U.S. benchmark for an adequate ratio of RNs per 100,000 population. Indiana has a shortage of 1,000 primary care physicians. If current trends continue, we will need almost 2,000 additional primary care physicians and 20,000 registered nurses (RNs) in Indiana by 2020.

Lack of Services-- Nationally, many rural hospitals have negative operating margins and, from 1984 to 1997, over 500 rural hospitals closed. Several counties in Indiana, such as Pike and Crawford counties in southwest Indiana, do not have a hospital and a number of areas in Indiana have limited or no trauma services at all. In west central Indiana (this geographic area includes Indiana to the Illinois state line on the west, Lebanon on the north, Sullivan on the south, and Bloomington/Indianapolis is on the east), Hoosiers have to travel more than 50 miles to a trauma center.

Limited Services--Rural residents are more likely to report that their provider does not have office hours at night or on weekends.

Insurance--One national study found that almost 20% of rural residents were uninsured compared with 16% of urban residents. Rural residents under 65 are disproportionately uninsured. According to the National Association of Community Health Centers, Indiana had 18 Federally Qualified Health Centers (FQHC) and 86 delivery sites in 2008. These FQHCs saw a total number of 218,738 patients seen in 2008. Of those patients, 4,526 were migrant/seasonal workers and 8,810 were homeless. On average, 42% of clients were uninsured, 40% had Medicaid and 5% were Medicare clients. Twenty-nine percent resided in a rural area.

Urbanization

Since the 2000 Census, the population has increased 7.2% in the U.S. and 4.4% in Indiana. Within Indiana, metropolitan areas experienced population gains, while other areas experienced population declines. The fastest growth during both time periods was in the Indianapolis metropolitan area. (Urban Institute and Kaiser Commission on Medicaid and the Uninsured)

Urbanization can have a serious impact on health and many of the negative impacts are suffered by the poor and minorities in greater disproportion. Urbanization is associated with changes in diet and exercise that increase the prevalence of obesity with increased risks of Type II diabetes and cardiovascular disease; vulnerability to sexual abuse and exploitation; and separation from social support networks. Many of these conditions affect the most vulnerable segment of the population - women, children and the elderly.

Environmental contaminants, although not restricted to urban settings, can alter the reproductive process and increase the risk of abortion, birth defects, fetal growth and perinatal death. Particularly in cities, motor vehicles are an important source of air pollution and studies in Indiana are associating pesticides in water with poor birth outcomes. Children are especially susceptible to disease in an urban environment. Not only can they suffer from overcrowding, poor hygiene, excessive noise, and a lack of space for recreation and study, they also suffer from stress and violence that such environments create.

Many of the ill effects of urban life affect people from all incomes. Although most people living in the city take basic public services such as drinking water supply, housing, waste disposal, transportation, and health care for granted, these services are often either deficient or nonexistent for the poor.

Private Sector Title V Service Delivery Challenges

The three private sector challenges in providing Title V services are (1) lack of providers who accept Medicaid reimbursement, (2) lack of cultural competency, and (3) location of services.

Medicaid Providers -- Indiana has a risk based managed care system for all MCH populations on

Medicaid. Providers in some counties have refused to participate in Medicaid reimbursement for pregnancy and infant care until the infants are on CHIP. These counties tend to have poorer pregnancy outcomes.

A serious challenge in Indiana over the past few years is not only the number of physicians who do not accept Medicaid reimbursement but also a flawed Medicaid enrollment system that has left many eligible women and infants without insurance coverage throughout the pregnancy and critical first few months of age. In an effort to overcome enrollment challenges for pregnant women, Indiana Medicaid began Presumptive Eligibility (PE) on July 1, 2009. Even so, there are areas of the state where providers are less likely to accept Medicaid reimbursement. Of 92 counties, five have no providers participating in Presumptive Eligibility. Due to the small numbers of prenatal care providers participating in presumptive eligibility, twenty-two (22) counties have lower numbers of pregnant women enrolling in prenatal care.

Lack of Cultural Competency -- Lack of cultural competency has played a role in driving black-to-white perinatal disparities higher. In 2006, three counties had a black infant mortality rate greater than 30 per 1,000, approaching third-world statistics. MCH is targeting 5 counties in Indiana that have 80% of the black population and the highest disparity issues. MCH has worked with these counties to increase the cultural competency knowledge of providers and funded programs to address disparate issues.

To address these disparities, MCH is utilizing a life course perspective to impact change. For Indiana to make a difference in black disparities, MCH must work at the neighborhood level to educate and empower high risk populations that encounter cultural barriers to equitable health care services. MCH has been collaborating with the ISDH Office of Minority Health, the Indiana Minority Health Coalition (IMHC), and local minority health coalitions in the five disparity counties. The Indiana Perinatal Network (IPN) and the IMHC both provide agency cultural competency training.

Immigrant populations are also facing barriers to healthcare. An increasing Hispanic population is facing barriers to care from lack of insurance, interpreters, and educational materials and forms that are translated into Spanish. Hispanic centers around the state do not have the capacity to assist all Hispanic families in need.

Indiana also has the largest Burmese population outside of Burma than anywhere else in world. While there are services in place to help this population, they may not be adequate to ensure the Burmese have access to culturally appropriate healthcare services.

Location of Services -- Indiana's counties are all autonomous. Efforts in the past to regionalize health systems were not accepted. This has led to lack of accessible services for all Title V populations. The majority of Indiana's primary care physicians are located within 5 counties. Seventeen counties are without a hospital. The only two specialty children's hospitals are both located in Marion County (Indianapolis). Families in some parts of the state must travel long distances to receive specialty care during pregnancy and for children. A large population of pregnant women and children seek health care services in four neighboring states -- Illinois, Ohio, Kentucky and Michigan. Service in the State of Indiana may improve because three large healthcare systems in Indianapolis are buying hospitals around state and providing an increase in services in some counties. MCH will address regionalization of hospitals providing perinatal services over the next five years. /2013/As of 2012, 29 of the 92 Indiana counties do not have a delivery hospital./2013//

Current and Emerging Issues

In terms of MCH, an overriding issue is the effectiveness of our interventions and programs. Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this phenomenon, it is an issue that we are in the process of addressing. First, we have renewed our commitment to improve the

health and well being of mothers, children, and women of childbearing ages. Second, we have rethought our strategies and are focusing on evidence-based interventions. Third, we are defining and implementing a life course health perspective and intend to partner with many more providers and communities to make a difference. With a fresh eye and renewed energy, we are moving in a new and exciting direction.

From our five year needs assessment, we have identified 10 top State priority issues -- two are continuing, three have been modified, and five are new. The following paragraphs provide a brief overview of these issues. More discussion on these issues can be found in the State Performance Measures and the Five Year Needs Assessment.

Pregnancies occurring at short interval are an important issue because they increase the risk for adverse outcomes such as low/very low birth weight babies, premature births, and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to increase opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns.

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions, initiation of a recognition program acknowledging Baby Friendly Hospitals, and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers. /2012/ Indiana's breastfeeding rate increased to 67.1%.//2012// /2013/ Indiana's breastfeeding rate increased to 69.9% in 2009.//2013//

Two problems concerning infants require a special focus: (1) prematurity rates, and (2) accidental suffocation under one year of age. Although premature birth rates are approximately at the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Steering Committee, which is driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will also include communication of safe sleep practices, updates to nurse managers/nursing staff, and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network (IPN), and local community organizations in the four largest counties to conduct training and educational sessions. /2013/ Indiana's infant mortality rate increased to 7.8 per 1000 live births in 2009.//2013//

Concerns involving children and adolescents involve lead poisoning, sexually transmitted infections (STIs), obesity, and social-emotional health of very young children. Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and work with Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated. Reduction in the number of STIs is another state objective. Strategies to reduce the STI numbers include providing education and materials to providers treating adolescents, conducting a needs assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Family Health Council to increase screening for STIs.

Obesity in high school age children is also a state concern. Recent data indicates that 13.8% of youth have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks, and increased physical activity. /2013/ In 2011, the number of youth in Indiana with a BMI greater than the 95th percentile for their age and sex increased to 14.7%.//2013//

Addressing issues pertaining to the social-emotional health of children under the age of 5 is also an initiative. Foremost among these issues is the lack of qualified service providers to treat children in this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refugees/immigrants, and children of deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area.

The CSHCS division will be focusing its efforts with families and other partners in two main areas. First, the mission of the Integrated Community Services (ICS) Program started in 2008 within the division of Children's Special Health Care Services (CSHCS) is to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. This is a new initiative for the Indiana CSHCN program that has traditionally concentrated on reimbursing medical services for children with specific chronic conditions. Indiana was one of six states to be awarded federal funding from HRSA/MCHB to support system improvement for CYSHCN and their families and began working on systems improvement on June 1, 2009. Indiana is addressing objectives that fill gaps for CYSHCN in Indiana in each of the six core outcomes of successful systems of care for CYSHCN while synthesizing the goals into "umbrella" or overarching goals focused on 1) Medical Home Implementation, 2) Transition to Adult Care, and 3) The Indiana Community Integrated Systems of Services (IN CISS) Advisory Committee development in order to sustain the project. /2012/Indiana is working to address IN CISS sustainability through the formation of the Indiana Child Health Improvement Partnership, to be called "CHIP IN for Quality", a model that is self-sustaining through grants and partnerships.//2012//

/2013/The CSHCN Division will continue focusing its efforts with families and other partners to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered and culturally competent. The CSHCN Division continues to provide reimbursement for gap filling direct care medical services for children with specific chronic conditions. Over the past 3 years the CSHCN Division has made significant improvements in the area of QI efforts in Medical Homes; Transition to adult healthcare, work and independence and the establishment of a Child Health Improvement Partnership (CHIP-IN) to continue the work of the IN CISS Project to support and promote QI in Medical Homes and the many systems of care CYSHCN and their families encounter. The CSHCN Division has recently begun working with its partners in an Action Learning Collaborative model to create a statewide strategic plan to address Ease of Use of Services for Latino families with CYSHCN in Indiana. CSHCN will also continue to use the CDC's Act Early, Learn the Signs materials to not only educate families and providers regarding early screening and diagnosis of Autism, but to coordinate community-based service systems for CYSHCN and their families in the state.//2013//

The second emerging area of focus involves Indiana's CSHCS program reimbursement of providers for direct service expenses related to the CSHCS participants' medical condition. With the present economic climate the program faces continuing challenges to provide the past level of benefits within the current budget constraints.

B. Agency Capacity

In terms of services during the fiscal year 2010, MCH was able to use Title V grant money to fund 12 family planning projects; five genetics centers (providing information, education and services to families of children with genetic disorders or birth defects); 11 infant health projects (providing primary, direct care services to children from birth to less than one year of age); nine prenatal care clinics (providing direct pre-natal medical care by an OB provider), 11 child health clinics (providing direct medical health services to children); six sites provide adolescent health services (three of them are school based providing direct health care services, education and referrals to high school students); one high risk infant follow-up program (providing follow-up care to newborns who were diagnosed with neurological or developmental problems); 15 prenatal care coordination (providing in-home visiting program to high risk pregnant women); six prenatal substance use prevention programs (providing high risk, chemically dependent pregnant women with education, referrals for treatment, and follow-up); six family care coordination programs (providing assessments, education, referrals, and advocating for families); and four dental projects. The narrative that follows provides some insight into the extensive partnership system that helps to ensure services, at all pyramid levels, to the Title V populations. (Please refer to Section B.2 of the Five Year Needs Assessment for a full listing of all partnerships.)

State Program Collaboration with Other State Agencies and Private Organizations

Collaboration with other state agencies and private organizations is key to continued capacity building to meet the needs of the Title V populations. At the State level, at least two agency partnerships have been pivotal in meeting the needs of the Title V population. These include the Family & Social Services Administration (FSSA) and Department of Education (DOE). Under FSSA, the Office of Medicaid Planning & Policy (OMPP) assists not only with payment issues but also with protocol and policy issues that help to establish uniformity and quality of care for women of childbearing age, pregnant women, children, and children with special needs. Collaboration with the DOE ensures that the needs of children/children with special needs are met in the educational venue. The partnership with DOE also provides an entryway for educational curricula on public health issues such as HIV/AIDS, STIs, and fetal alcohol spectrum disorders.

Partnerships with private organizations provide a mechanism for growing capacity beyond the reaches of government. Especially important are the partnerships with professional organizations in the healthcare industry. Examples include the American Academy of Pediatrics (Indiana Chapter) and the Indiana Academy of Family Physicians, which have been key partners in the Community Integrated Systems of Services project. The Indiana chapter of the American College of Obstetricians and Gynecologists and Indiana Certified Nurse Midwives assist in creation and implementation of prenatal standards of care as well as participating on initiatives such as decreasing prematurity. Organizations, such as the Indiana Perinatal Network and the Indiana Chapter of March of Dimes, are also instrumental in bringing issues on health/healthcare for the Title V populations to the legislative forefront, and disseminating perinatal health information throughout the state.

/2012/ New Partners - MCH is particularly excited about its new partnership with Goodwill Industries of Central Indiana. Specifically, through the Maternal, Infant, and Early Childhood Home Visiting Program, ISDH is funding Goodwill Industries to implement Nurse Family Partnership (NFP) in high risk communities in Indiana. This innovative public / private partnership will be the state's first implementation of NFP. Goodwill will wrap its innovative program, Goodwill Guides (Guides), around NFP. Guides is Goodwill's early childhood initiative. Guides works with the entire family, which in this case would be the family members of the NFP participants to:

1. Provide holistic services such as education, financial literacy, workforce development, and health;
2. Early childhood development by navigating quality childcare options; and
3. Continue a relationship with the family and NFP clients after the NFP program ends after the child's second birthday.

Goodwill is well-positioned in central Indiana and has the capacity to implement such a new and broad-reaching program in Marion County, the most heavily populated county in the state. Goodwill can easily position itself in the high-risk areas identified in Marion County and is able to assist with leveraging MIECHV funds. Once families are through the NFP portion of the program, its program, Goodwill Guides will accept its participants to ensure continuity of support services until the child reaches age 5. //2012//

State Support for Communities

Limited staff at the State level means that resources must be used in a judicious manner to support the local communities. Dedicated State staff serve as a focal point or clearing house, providing local communities with information and research on evidence-based protocols and best practices. Since staff at the State level are aware of a wide range of programs across the state, Title V staff members also provide a means of connectivity between projects. This connectivity allows the sharing of information concerning successes and challenges in the implementation of a variety of local programs.

One example of an interface with local programs is the prenatal care coordination (PNCC) program. This program develops and coordinates access to community-based health care services for pregnant women and their families at risk for poor pregnancy outcomes. The PNCC project provides outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women and some non-Medicaid clients.

One further example of state and local collaboration is the Early Hearing Detection and Intervention (EHDI) project. EHDI screens newborns for possible hearing impairment. Any infants testing positive for hearing impairment receive early intervention services. EHDI coordinates with Indiana First Steps, hospitals, providers, and other local agencies to provide intervention and follow-up services.

MCH also funds the Indiana Family Help Line (IFHL) which provides a means of connecting families with community level services. For example, during calendar year 2009, the top five needs were dental, transportation, food & clothing, health/medical, and financial assistance, respectively. A strong relationship between MCH staff and MCH clinic directors also allows for a sharing of information concerning local participation in community programs such as school wellness projects.

/2012/ During calendar year 2010, the top five information needs were transportation, dental, health/medical, Spanish Services, and Medicaid Services, respectively.//2012//

Coordination with Health Components of Community-Based Systems

Key health components in community systems include access to care, insurance coverage, prevention initiatives, and a medical home for children with special needs. At the state level, MCH and CSHCS collaborate with the OMPP, in the Indiana FSSA, to ensure a woman's access to prenatal care via the "presumptive eligibility" program. Children's Special Health Care Services (CSHCS) also collaborates with OMPP to provide supplemental medical coverage to families of children with chronic medical conditions. Community-based staff provide feedback to MCH staff concerning strengths and issues associated with these processes. Prevention programs are a key component in addressing issues, especially those associated with pregnancy. Examples of such initiatives include smoking cessation during pregnancy and prematurity prevention. IPN and the Coalition to Prevent Smoking in Pregnancy (CPSP) are two examples of organizations that provide a conduit between state and local advocates in support of these initiatives.

The medical home is an especially important component for children/children with special needs.

Currently, the pediatric staff at Indiana University School of Medicine is working with the Community Integrated System of Services on the medical home learning collaborative. This collaborative involves 9 pediatric and family practice members and is charged with establishing medical homes in these practices and others.

/2012/ The Medical Home Learning Collaborative has now expanded to 18 pediatric and family practices statewide. //2012//

Coordination of Health Services with Other Services at the Community Level

Indiana has at least two major mechanisms to coordinate health services with other community services. The IFHL is a centralized clearing house which connects families with services located in their respective counties/communities on a statewide basis. IFHL participates in the Indiana 211 Partnership, a regionalized information and referral service. IFHL is also involved with Connect2Help which provides a forum for discussion/implementation of standards, resources and policies concerning information and referral systems. The second mechanism of coordination of services concerns the contractual agreement with each of the MCH clinics providing services. Inclusion of Memorandums of Understanding (MOUs) with community organizations providing support services is strongly encouraged and reviewed with each clinic grant application.

/2012/ IFHL is also a member of Alliance for Information and Referral Systems (AIRS) which provides guidelines for implementation of standards, resources and policies concerning information and referral systems.//2012//

State Statutes Related to Title V Authority

In terms of state statutes, the following summaries present the most recent legislation that affects the Title V populations.

Newborn Screening Law (IC 16-41-17) -- Requires screening for 44 genetic and metabolic conditions.

Universal Newborn Hearing Screening (IC 16-41-17-2) -- Requires newborn hearing screening prior to infants leaving the hospital. This statute also requires appropriate referrals for confirmed positive test results.

Birth Defect Information (IC 16-38-4 and rule 410 IAC 21-3) -- Requires the collection and maintenance of birth defect information. This provides for the creation and support of the Indiana Birth Defects and Problems Registry.

Funding for Children with Special Health Care Needs (IC 16-35-2 and IC 16-35-4) -- Requires provision for and distribution of funds for children with special health care needs.

Workplace Lactation Support (SEA 219; P.L.13-2008) -- Requires government and private employers to provide a private space and access to cold storage for women to express breast milk while at work.

Tobacco Warning During Pregnancy (HEA 1118; P.L. 94-2008) -- Requires all retail outlets that sell tobacco products to post a warning of the dangers of smoking during pregnancy and post the toll-free Indiana Quitline number.

Family Planning Waiver (SEA 572; P.L. 20-2005) -- Requires the OMPP to submit a waiver to the federal government extending Medicaid coverage for up to two years postpartum for family planning services.

Prenatal Substance Use Report (HEA 1314; P.L. 86-2006)--Requires the ISDH to assess the

incidence and factors associated with substance abuse use during pregnancy in the State of Indiana.

Prenatal Substance Use Commission (HEA 1457; P.L. 193-2007) -- Establishes a statewide, multi-agency, bi-partisan commission to make recommendations on how to reduce substance use during pregnancy in the State of Indiana.

Cigarette Tax Increase (HEA 1678; P.L. 218-2007) -- Increases the tax on cigarettes and designate funds to support smoking-cessation activities, covering uninsured individuals and immunizations.

Other legislative activities include efforts to implement a smoking ban in public places; however, this effort failed. One highlight in tobacco-related legislation involved the failed attempt to abolish the Indiana Tobacco Prevention and Cessation Agency's Executive Board, dissolve the agency, and transfer the assets of the ITPC to the ISDH a part of SB 298.

As reported in the Indianapolis Star (3/23/10), Governor Daniels suspended future enrollments for childless adults in the Healthy Indiana Plan, blaming the healthcare reform package passed by Congress. Daniels said the state should continue to enroll families for the immediate future so it would not be forced to forfeit federal stimulus dollars.

Based on Senate Act 226, the health finance commission is studying the topic of teen suicide, including the root causes and prevention, during the 2010 legislative session. Finally, House enrolled Act 1320, which controls the selling and purchase of ephedrine and pseudoephedrine, also requires the legislative council to assign study topics on this issue. It was signed into law by Governor Daniels on 3/18/10.

/2012/

SEA 04, suicide prevention

Effective July 1, 2011, SEA 04 allows a school's governing body to adjourn its schools to allow teachers to participate in a basic or in-service course of education and training on suicide prevention and recognition of signs that a student may be considering suicide. The Division of Mental Health and Addiction (DMHA) is required to provide information and guidance to local school corporations on evidence-based programs for teacher training on the prevention of child suicide and recognition of signs that a child may be considering suicide. After June 30, 2013, an individual may not receive an initial teaching license unless he/she has completed training on suicide prevention and the recognition of signs that a student may be considering suicide.

Family Planning Services

Language regarding Indiana's long-standing attempts to implement a family planning waiver was incorporated into SB 461, Health Care Reform Matters, which also stipulates that a state agency may not implement or prepare to implement the federal Patient Protection and Affordable Care Act. Before January 1, 2012, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human Services for approval of a state plan amendment (SPA) to expand the population eligible for family planning services. The SPA must include women and men, set income eligibility at 133% of the federal income poverty level, and incorporate presumptive eligibility for services to this population. In addition, the law requires OMPP to report on the progress of the SPA to the Medicaid oversight committee during its 2011 interim meetings.

Perinatal HIV

SB 581, HIV Testing of Pregnant Women was passed with widespread support. The law now permits consent by a pregnant woman to have HIV testing to be documented in the pregnant woman's medical chart instead of requiring a written statement of consent. It also requires the issue of general HIV consent to be addressed by a summer study committee.

Abortion and Reproductive Health Care Services

National attention has focused on HB 1210, which ends the use of public funds for Planned Parenthood of Indiana (PPIN), prohibits Medicaid payment for PPIN services, sets a 20 week cutoff for abortions, and requires physicians to notify patients of a link between abortion and infertility, fetal pain and numerous other provisions.

On June 1, the US Department of Health and Human Services Center for Medicare and Medicaid Services (CMS) rejected the Indiana Office of Medicaid Policy and Planning (OMPP) request to block Medicaid recipients from receiving care at PPIN, saying that such a provision is in violation of federal law. Indiana has 60 days to appeal the decision if it chooses. In response, state officials have said they will continue to follow and enforce the law, and are seeking guidance from the Indiana Attorney General's office. PPIN and the American Civil Liberties Union have filed suit against the law. Their request for an immediate injunction to cease its enforcement was initially denied, then granted by US District Judge Tanya Walton Pratt while she considers the case.

Tobacco and Other Drugs

Efforts to pass comprehensive smokefree air legislation failed once again when a heavily-amended HB 1018, Smoking Ban in Public Places, was voted down by Senate committee. The Indiana Campaign for Smokefree Air will continue meeting over the summer to assess strategies for the 2012 session. HB 1233, State Boards and Commissions, moved the Indiana Tobacco Prevention and Cessation Agency into the Indiana State Department of Health. Tobacco-prevention funds were cut by over \$2 million. The subject of substance use by pregnant women will be examined by a summer study committee, as required by HB 1502.

Newborn Screening

In 2011, the Indiana legislature added pulse oximetry to Indiana's newborn screen. Per 16-41-17-2, effective January 1, 2012, all birthing facilities in Indiana will be required to perform pulse oximetry screening on all newborns to detect critical congenital heart defects. The ISDH Newborn Screening Program is working with neonatologists, nurses, pediatric cardiologists, and high-risk obstetricians to finalize the screening protocols; identify any guidelines or recommendations related to purchasing, upgrading, or standardizing pediatric pulse oximetry equipments; and identify the type of data that will be required for reporting to ISDH. //2012//

State Title V Capacity

Preventive and Primary Care Services for Pregnant Women, Mothers, and Infants

MCH and CSHCS are committed to providing quality, comprehensive, holistic health care to low-income pregnant women, mothers and infants in community settings and decreasing infant mortality and low birth weight babies. In FY 2010-2011, Indiana Title V funded 36 direct care services in 24 counties. These direct care services provided care to 26,016 pregnant women, 89,607 infants, 73,030 children 1 to 22 years of age, and 6,551 children with special health care needs.

MCH provides the "Free Pregnancy Test Program", a population-based enabling service intervention to reduce infant mortality and encourage women to access early prenatal care. The program provides agencies serving women of childbearing age free pregnancy tests to use as an outreach service for hard-to-reach clientele. The program also helps pregnant women obtain early prenatal care through Hoosier Healthwise, WIC, and prenatal care coordination. Furthermore, it assists the entrance of non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. Currently, Free Pregnancy Test program is in 58 counties and served 14,382 clients in FY 2009.

/2012/From October 1, 2009 to September 30, 2010, clinics funded to provide free pregnancy tests offered a total of 9,438 tests. Of these tests offered, 60.5% were offered to patients who

were White; 21.5% to patients who were Black; 10.4% to patients with an Unknown Race; 2.4% were offered to patients who were Asian/Pacific Islander or American Indian; and 19.5% were offered to patients who were Hispanic / Latino. In addition, nearly 2 in 3 patients (61.4%) were at or below 150% of the poverty level. Over 1 in 3 (34.2%) were not high school graduates and nearly 1 in 10 (9.4%) were currently attending high school. Over 8% of all patients were under the age of 17, while 45.2% were between the ages of 18 to 24 and another 25% were between the ages of 25 and 30. Of all tests, 40.1% were Positive while 57.7% of the tests were Negative. Of all patients, two out of three (66.3%) had no insurance. One in three patients (33.9%) was a smoker. Over 8,200 referrals were made as a result of the pregnancy tests. The FPTP is one of the most cost effective ISDH Title V programs considering the volume of data generated by each test that is not available elsewhere. FPT's provide the "proof of pregnancy" required by Medicaid for enrollment in PNC much earlier in their pregnancy than they would have without it. With only \$8,677 available for this program during the project period, an incredible number of women were served and invaluable data was gathered regarding low-income women of childbearing age who engage in sexual activity. //2012//

MCH provides enabling services for pregnant women, mothers and infants through grants to five prenatal care coordination programs. Prenatal care coordination grantees provide outreach and home visiting by certified professionals and paraprofessionals to Medicaid eligible women. The program targets pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCH staff also oversees the training and certification of community health workers to assist prenatal care coordinators.

MCH supports pyramid level enabling services for smoking, alcohol and drug use cessation in the Prenatal Substance Use Prevention Program (PSUPP). MCH receives money from the State's Division of Mental Health and Addiction (DMHA) to fund all or part of eight of the grantees, Tobacco Settlement funds three grantees and Title V funds all or part of five grantees, including one site that receives partial funding from both Title V and DMHA.

/2012/ MCH now operates three new federally-funded programs that serve women of childbearing age and their families: (1) Social Immersive Media for Lifecourse Education [SIMPLE]; (2) Pregnant and Parenting Adolescent Support Services [PPASS]; and (3) Maternal and Infant and Early Childhood Home Visiting Program [MIECHV].

SIMPLE is an innovative social marketing approach to increase public awareness of the importance of integrating the life-course perspective into preconception planning and care. To improve health and pregnancy outcomes, new and expectant parents must first be aware of protective and risk factors that may affect birth outcomes. The purpose of this program is to (1) increase knowledge of life-course perspective for pregnant and parenting women and their families; (2) increase knowledge of life-course perspective for the local community; (3) decrease poor birth outcomes utilizing a social immersive interactive media tool to teach healthy habits; and (4) expand public health professional's ideas of teaching tools to include new technology.

At the foundation of the SIMPLE project is SNIBBEInteractive's InfoTiles (<http://www.snibbeinteractive.com/platforms/socialscreen/products/infotiles>). With InfoTiles, people can browse large amounts of information in a playful social game. People move a game tile over a series of boxes. When they rest the selection box, the tile turns over and reveals video, images, and text. By making information browsing a game, people are engaged and excited to explore all the information. SIMPLE targets populations on all levels of the Social Ecological Model - the individual new or expectant parent, those that provide social and medical support to the new or expectant parent, communities identified as high risk, and the general population. SIMPLE brings public health initiatives to the communities of Indiana through the use of a social media website and an interactive media device. The evaluation piece of this unique and innovative project will provide MCH with necessary data to assist the state of Indiana in reducing adverse health outcomes among first time parents and their children by increasing the knowledge

that the public holds on conception and the course of pregnancy. The SIMPLE tool will be used at local community health fairs, baby expos and exhibits, health centers, and other nonprofit and for profit resources used by expecting parents, their family members, and their friends. SIMPLE truly acts as a public health program which enters into the community instead of asking the community to come to us-- "mobile" information in this sense. This program reaches mothers, fathers, family members and friends of those expecting a new baby across the state of Indiana. The SIMPLE tool is being taken into 5 Indiana counties which represent the urban, rural, and suburban populations during the course of its three year federally funded research stage. Specific counties were chosen to help us better understand how social media outlets and interactive devices impact the knowledge that one can gain on public health through such formats.

The purpose of PPASS is to work with community partners to implement evidence-based programs at high schools and community organizations to provide assistance and support for pregnant and parenting teens. MCH developed a survey to assess perceptions of stakeholders to identify community perceptions, partnerships, resources and challenges related to the population of pregnant and parenting adolescents. All 92 of Indiana's counties were represented in the responses. There were 197 respondents who began the survey and 137 who completed the survey. Results from the web-based survey supported that stakeholders felt many services available to pregnant and parenting teens were lacking or missing.

MCH works in collaboration with community partners to increase public awareness about Indiana's Early Childhood Comprehensive Systems (ECCS) project, Sunny Start, and enrollment by pregnant and parenting teens in Text4baby. MCH and its funded partners employ a life course approach to the services provided to pregnant and parenting teens through the PPASS grant opportunity, allowing for needs to be met in areas such as perinatal and child health care, child development, nutrition, adolescent development, case management, education, mental health, domestic violence, and strengthening families. Through this program, at least six sub-grantees will be awarded funding to provide direct services and programs and/or research and evaluation of pilot studies that better assist pregnant and parenting teens in completing school and achieving improved health outcomes. With the PPASS grant, ISDH's MCH division hopes to strengthen infrastructure in the state so comprehensive sets of services are available to pregnant and parenting teens. MCH has created a Life Course Model for the PPASS Program that demonstrates the need to create systems of services involving both traditional and non-traditional partners. Accordingly, MCH is not funding applicants that propose single agency/organization solutions. Rather, MCH is requiring grantees to partner with other service agencies to wrap comprehensive services around a pregnant and/or parenting adolescent and his/her family.

The last of the three grants is the Home Visiting Program (MIECHV) under the Affordable Care Act, to support evidence-based home visiting programs focused on improving the wellbeing of families with young children. Through the Maternal, Infant, and Early Childhood Home Visiting Program, nurses, social workers, or other professionals meet with at-risk families in their homes, evaluate the families' circumstances, and connect families to the kinds of help that can make a real difference in a child's health, development, and ability to learn, such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance. There is strong research evidence that these programs can improve outcomes for children and families and also yield Medicaid savings by reducing preterm births and the need for emergency room visits. In Indiana, the MIECHV program is co-let by MCH and the Department of Child Services (DCS) which is Indiana's Child Welfare Agency. A statewide needs assessment was conducted to find the areas of greatest need for home visiting services.//2012//

/2013/ MCH contracted with the IU Neonatology Division to develop the first "Circles" national resource center. Circles is a program to assist individuals who want to get out of poverty.//2013//

Preventative and Primary Care Services for Children

MCH provides preventative and primary care for children through grants to 11 child health care clinics and 6 adolescent health care clinics. These clinics provide both direct medical and enabling services. Many of these grantees are community health centers or are a part of a larger health care facility. MCH provides additional enabling services through six family care coordination programs. Family care coordinators are trained professionals who make home visits to coordinate services for high risk families. In addition coordinators provide referrals, education, and support.

Children's Special Health Care Services (CSHCS)

Indiana's CSHCS provides supplemental medical coverage to help families of children who have serious, chronic medical conditions, age birth to 21 years of age. The program serves families with an income before taxes no greater than 250% of the federal poverty level. Statewide partnerships include family support organizations, Medicaid, hospitals and providers of medical services. CSHCS has gone from covering a few diagnoses to providing coverage for well over a thousand specific conditions. The caseload has grown from the original 12 to more than 8,500 participants.

/2012/ In 2011, CSHCS is expanding Care Coordination Services at the central state level. The number of enrolled children has fallen from 8,500 to 5,000 due to a number of factors including lack of a central application system, budget decreases and decreased marketing.//2012//

The Integrated Community Services (ICS) Program focuses on building collaborative relationships with agencies and organizations to integrate family-centered and culturally competent service systems for Children and Youth with Special Healthcare Needs (CYSHCN). The ICS Program was awarded a three year (6/1/2009-5/31/2012) HRSA grant to improve access to quality, comprehensive, coordinated community-based systems of services for CYSHCN and their families.

The Indiana Community Integrated Systems of Services (IN CISS) Project is focused on three primary objectives including (1) implementing Medical Homes within primary care practices throughout the State; (2) transitioning youth with special healthcare needs to adult healthcare, work and independence, and (3) building systems sustainability through the organization of a Statewide Advisory Committee representing CYSHCN, their families, and the organizations that serve them.

/2012/Indiana is working to address sustainability through the formation of the Indiana Child Health Improvement Partnership, to be called "CHIP IN for Quality", a model that is self-sustaining through grants and partnerships.//2012//

ICS partnerships include CYSHCN and their families, family support organizations, Indiana American Academy of Pediatrics (AAP), Indiana Academy of Family Physicians(AFP), governmental, State and local agencies, medical professionals/providers, medical institutions and local communities.

/2012/ The ICS program is working with the Vermont Child Health Improvement Partnership to adopt their model for Indiana.//2012//

Core partners include (1) the IU School of Medicine (IUSOM)that provides a project facilitator, parent consultants, and project evaluator, (2) the Center for Youth and Adults with Conditions of Childhood (CYACC) that provides a website and educational office visits to help youth with special healthcare needs transition to adult healthcare, and (3) About Special Kids (ASK) that provides meeting support and stipends for families and youth.

/2012/Indiana is working with CYACC on training for youth and young adults with chronic conditions who will be trained as leaders for the "Be Your Own Boss" Chronic Disease Self-

Management workshop, that will be conducted throughout the state //2012//

To enhance the capacity of CSHCS to access family-centered, community based coordinated care, the IN CISS project has recruited nine healthcare practices to participate in a medical home learning collaborative. This project is aiding the nine practices in developing and implementing quality improvement efforts. Teams are participating in biweekly teleconferences and face-to-face site visits. A face-to-face kick-off meeting was held in October 2009 and a follow-up large group meeting was held in May 2010.

/2012/The Indiana CISS project held a second annual meeting in October 2010 and conducted a follow-up meeting with the practices in May 2011. //2012//

Cultural Competence

In an effort to address health disparities in Indiana, the General Assembly passed legislation creating the Indiana Council on Black and Minority Health (IC 16-46-6 1992) and directed ISDH to create an Interagency Council on Black and Minority Health. This council includes representation from both government and State agencies. According to the Interagency Council on Black and Minority Health's Report for 2008, some of the key issues in minority health include teen pregnancy and entrance into prenatal care in the first trimester. The teen pregnancy rate is significantly higher for minorities and the percentage of minorities who have early entry into prenatal care is much lower than whites.

MCH staff work with the Director of the Office of Minority Health and the Minority Health Epidemiologist on disparity issues such as prematurity, low birth weight, very low birth weight, and infant mortality. MCH also encourages all grantees, especially those in areas with large or growing minority populations, to work with local Minority Health Coalitions to develop culturally competent staff and materials.

MCH funds prenatal care coordination (case management) and support services for pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Training in cultural competency is provided by one of MCH's grantees, IPN, on an as requested basis.

The Indiana Minority Health Coalition (IMHC) director serves on the Steering Committee of Core Partners for Early Childhood Comprehensive Systems (ECCS) initiative. IMHC also participates in programs such as "Have a Healthy Baby", "Operation Fit Kids", and "Diabetes Self Management".

MCH also collaborates with local minority coalitions in Indianapolis, Gary, South Bend, Fort Wayne, Elkhart and Evansville to assist with development of local coalitions to address local perinatal disparity issues, conduct town meet

C. Organizational Structure

The Honorable Mitchell (Mitch) E. Daniels, Jr. (R) was sworn in January 2005 as Indiana's 49th Governor. The Governor was re-elected for his second and final term in November 2008. In February 2005, Dr. Judith Monroe was appointed State Health Commissioner, the first woman to head ISDH. She led the Health Department until her resignation in March 2010 to take a position at the Centers for Disease Control as the Deputy Director and Director of the new Office of State, Tribal, Local and Territorial Support.

The new State Health Commissioner, Dr. Gregory N. Larkin, M.D., FAAFP, was appointed by Governor Daniels as the Indiana State Health Commissioner in March 2010. At that time, he was asked by the Governor to continue the State's progress in immunizing children, reporting and reducing medical errors, and improving the health culture of Indiana. Prior to his appointment, Dr.

Larkin served as the Chief Medical Officer for the Indiana Health Information Exchange, which promotes health information technology for the advancement of quality patient and community care. He is a recognized leader in the promotion of health information and technology and will extend Indiana's recognized preeminence in that area. Before joining the Indiana Health Information Exchange as its Chief Medical Officer, Dr. Larkin was the Director of Corporate Health Services for Eli Lilly and Company. During his tenure at Eli Lilly, Dr. Larkin was the company's Global Medical Director managing five domestic health care clinics, the domestic employee and retiree health plan and was the global liaison for the company's world affiliates for occupational and corporate health care. He has been a member of the Healthy Indiana Plan task force, served as Chairman of the Board of the Indianapolis Medical Society and the Indiana Blood Center, and volunteered with many other medical and community organizations.

ISDH is one of several major agencies in State government. ISDH has five commissions overseen by the State Health Commissioner and Deputy Health Commissioner (Please refer to the attached organizational chart). Loren Robertson M.S., R.E.H.S. was appointed Deputy Commissioner in June 2009. Prior to his appointment, Loren served as the Assistant Commissioner for Public Health and Preparedness at ISDH. For more than 30 years, he was associated with the Ft. Wayne - Allen County Department of Health before he began his career with ISDH in May 2005./2012/Loren Robertson resigned in May, 2011. Dr. Larkin appointed Sean Keefer as Chief of Staff on April 14, 2011. Prior to his appointment, Mr. Keefer served as Deputy Secretary of State and Chief of Staff in the Indiana Secretary of State's office. Before joining the Secretary of State's office, he served as the Director of Global Health & Science Policy for the American College of Sports Medicine (ACSM). One of his key responsibilities was to spear-head legislative efforts at the state and federal level on various health-related initiatives with the NFL, NCAA, American Academy of Pediatrics and Centers for Disease Control and Prevention, among other organizations. He also served on many committees to promote physical activity and healthy lifestyles, including serving as one of the U.S. liaisons for Raza/PANA (Physical Activity Network of the Americas), and served as chair of the Media and Policy Committee for the "Exercise is Medicine" initiative which worked directly with the U.S. Surgeon General's office. He also worked with leadership from the Pan American Health Organization (PAHO) to execute a Memorandum of Understanding between ACSM and the World Health Organization to tackle health issues such as diabetes, obesity and built environment in urban settings in North and Central/South America.

Mr. Keefer also served as the Deputy Commissioner for the Indiana Department of Labor under the Daniels' administration. In his role as Director of the State OSHA Consultation program-INSafe Indiana, he managed a team that worked to educate and ensure workplace safety and health. In 2008, in his role as Director, Indiana was awarded for the first time the US Department of Labor's Excellence in OSHA Consultation Program Award. Additionally, he was co-chair of the state's largest Work Safety and Health conference from 2007-2010. He also served as the Legislative Director and Public Information Officer.//2012//

The five commissions at the ISDH include Laboratory Services, Public Health and Preparedness, Operational Services, Health Care Quality and Regulatory, and Health and Human Services, which is where the Title V Program resides. As of June 2010, Dawn Adams is the Interim Assistant Commissioner of the Health and Human Services (HHS) Commission. HHS includes the Office of Women's Health, Nutrition and Physical Activity, WIC, Chronic Disease, Children's Special Health Care Services (CSHCS) and Maternal and Child Health (MCH). MCH and CSHCS are responsible for administering and coordinating all parts of the Title V Block Grant for Indiana. //2013// The Operational Services Commission is no longer. The responsibilities of that Commission have been assumed by the Chief of Staff.//

Dawn M. Adams, J.D., has been with ISDH since 2006 and currently serves as the Interim Assistant Commissioner of the Health and Human Services Commission. She was hired as a Staff Attorney in the Office of Legal Affairs and was recruited by the former Assistant Commissioner of the Public Health and Preparedness Commission, Loren Robertson, to serve as

his Operations Manager in the fall of 2008. Her work with public health began in 1993 when she worked as an Environmental Health Specialist for the Grant County Health Department. As the Operations Manager, Ms. Adams took on special projects and served as a resource to the division directors for all things "operational" (finances, contracts, legal issues, human resources, IT, etc.). In addition to these duties, she serves as the Preventive Health and Health Services Block Grant Coordinator on behalf of the agency and frequently takes on other special assignments as requested by the Deputy State Health Commissioner. /2013/ Dawn Adams resigned from her position in December, 2011. Ellen Whitt was appointed Assistant Commissioner of the Health and Human Services Commission at the same time. Ms. Whitt previously served as deputy chief of staff and senior advisor for health promotion in the office of the governor, working as liaison to the Indiana State Department of Health (ISDH), Indiana Tobacco Prevention and Cessation (ITPC), and the statewide trails plan initiated by Governor Daniels and managed by the Indiana Department of Natural Resources (DNR). She also participated fully in the development of the statewide obesity prevention plan called the "Indiana Healthy Weight Initiative," serving for a time as the director of the Division of Nutrition and Physical Activity at ISDH.//2013//

Judith A. Ganser, M.D., M.P.H. is Medical Director for Maternal and Child Health, Children's Special Health Care Services and WIC at ISDH. In this position, she is responsible for providing public health leadership, policy development, and medical guidance to programs including prenatal, child and adolescent health, CSHCS, Genomics Program, PSUPP, Indiana RESPECT teen pregnancy prevention, WIC, Early Childhood Comprehensive System planning and Community Integrated Systems of Service for children with special health care needs (CSHCN). She works with a multidisciplinary professional team and administrative staff. Dr. Ganser received her medical degree from Temple University Medical School and her Masters in Public Health from the University of North Carolina at Chapel Hill. She is board certified in Pediatrics and did a Preventive Medicine residency. Prior to joining ISDH in 1991, she served five years as the Medical Director of the Adolescent Health Program for MCHD. She has also worked as a Pediatrician in a Community Health Center in Pueblo, Colorado and Physician-team leader in School-Based Pediatric/Adolescent Clinics in Dallas, Texas. /2013/ Dr. Ganser retired from ISDH in February, 2011. ISDH has not hired a replacement as of this writing. However, Dr. Joan Duwve, State Medical Director, and Dr. Meena Garg, Director of Chronic Disease, are available to answer questions and address any concerns.//2013//

In the Health and Human Services Commission, Mary M. Weber, MSN, RN, NEA-BC, became the new Director of the Maternal & Child Health Division in October 2009. Kimberly Minniear became the new Director of CSHCS in February 2010, after serving as the Director of Integrated Community Services since May 2007. Also, in April 2010, James R. Miller, DDS was hired as the Director of Oral Health.

Mary Weber, MSN, RN, NEA-BC, joined ISDH as the Director of the Division of Maternal and Child Health in October of 2009. Prior to joining ISDH, Ms. Weber served in leadership roles related to maternal and child health for over twenty years in both for-profit and not-for-profit corporations. Most recently, she was the administrator for Women's Health for the Clarian Health System in Indiana, responsible for strategic planning, program development, labor management, and overall operational administration. Specific programs included perinatal outreach, childbirth education, Clarian Breastfeeding Center, perinatal bereavement, postpartum home visits, postpartum mood disorders, support groups for mothers of infants and toddlers, and an interpreter-doula program for Spanish speaking maternity patients.

Ms. Weber has been active on many volunteer boards, including IPN, the Indiana University National Center of Excellence for Women's Health, and the Indiana Mothers' Milk Bank, and CKF. She led the effort to establish the Indiana Mothers' Milk Bank, which pasteurizes human milk from screened donors and distributes it to newborn intensive care units throughout the Midwest. Ms. Weber received her Master's degree in Nursing Administration from Indiana University School of Nursing, and is board certified as a Nurse Executive Advanced.

Kimberly K. Minniear is the Director of the Children's Special Health Care Services (CSHCS) Division. With a BA from Indiana University in Social and Behavioral Sciences, she received the honor of the 2004 Marion County Social Worker of the Year. Ms. Minniear's professional experience includes serving for seven years as a Marion County Family Case Manager at the Department of Child Services, for two years as the Executive Director for the Kokomo Academy in Kokomo, IN., and for five years as the Executive Director of the Carroll County Department of Family & Social Services in Delphi, IN. Among her many accomplishments, Ms. Minniear developed treatment programming for a new juvenile male residential treatment; wrote grants, secured funding, and established Peer Counseling Program for children; developed programs to enhance parenting skills for at-risk families; served as a member of the Child Protective Team; and is a Certified Child Protective Social Worker.

Dr. Jim Miller joined the HHS Commission as the Oral Health Director in April 2010. He has over twenty-five years combined experience in teaching, practice, and dental public health research. He holds D.D.S. and M.S.D. degrees from the Indiana University School of Dentistry, and was a Senior Fellow for five years in the Department of Dental Public Health Sciences at the University Of Washington School Of Dentistry. He also holds a Ph.D. degree in Epidemiology from the University of Washington.

Although not housed in the same commission, MCH works closely with the Office of Primary Care, Lead and Healthy Homes, HIV/STI, Public Health and Preparedness, Immunization, and the Epidemiology Resource Center which are housed in the ISDH Public Health and Preparedness Commission. MCH programs and staff also work closely with the ISDH Operational Services Commission for Finance, Information Technology, (HIPAA) Compliance, Public Affairs, the Office of Minority Health, Legal (and Legislative) Affairs, and Vital Records.

Title V Program Administration

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

MCH Business and Grants Management staff manages all contracts, grants, MOUs and MOAs, prepares Grant Application Procedures (GAP), facilitates review of grant and contract applications, and monitors grant and contract expenditures for the MCH Division and the CSHCS Division. This section makes Title V budget and planning recommendations and coordinates all applications for funding, including primary responsibility of preparing Title V Budget and Budget Narrative and Budget. The staffs coordinate all contracting, procurement and programmatic financial tracking and provide clerical support for the MCH Division. Since July 2007, Vanessa Daniels, MPA, MRC, CRC, has managed this Section.

D. Other MCH Capacity

Title V funds enable 86 full-time employees and 34 contractors (16 part-time and 18 full-time for MCH and CSHCS). Title V funds also support one dentist and one secretary in the Oral Health Program, one Information Technology Service (ITS) professional, and two contractual positions in ITS. Outside the HHS Commission, Title V funds support the following staff: one Director, two Environmental Scientists, one Administrative Assistant and one Data Processing Operator for Indiana Lead and Healthy Homes; one Chemist for LRC Chemistry Lab; and four fluoridation staff which include two General Sanitarians, and two Fluoridation Consultants.

Mary Ann Galloway joined the MCH Division on April 19th as the Director of Life Course Health Systems. Ms. Galloway has an MPH from the University of South Carolina and received a PMP certification in 2006. She established and directed the Project Management Office at MPlan, a

large health care insurer in Indiana, for three years. Prior to that engagement, she founded and directed a national consulting firm for over 20 years that specialized in healthcare system delivery development, project management and managed healthcare. Her company worked with primary care and other providers in over 20 states who served mothers, infants and children. She manages a team of seven Life Course Health Systems staff. The team oversees the MCH grantees, collaborations and partnerships. They also implement evidence based strategies to improve MCH outcomes with recognition of all socio-economic factors that impact health at the community level.

/2012/ The Life Course Health Systems Team (LCHST) has grown substantially in the past year, primarily due to the award of three new grants. Currently, the LCHST has seven state staff positions and eight contracted positions. Recruitment is underway for two additional contracted positions to help with the Statewide Home Visiting Program. This increased capacity has enabled MCH to improve the reach and depth of programs and services. //2012// /2013/ The LCHST has eight state positions and seven contracted staff.//2013//

Bob Bowman has served five years as Director of Genomics and Newborn Screening Program at ISDH. As Director, he oversees the Newborn Screening Program, the Early Hearing Detection and Intervention (EHDI) program, and Genomics program, including the Indiana Birth Defects and Problems Registry. Previously, Mr. Bowman served as Genetic Specialist for ISDH, where he had direct oversight of the Birth Defects and Problems Registry. Prior to joining ISDH, Bob received a Master's degree in Genetic Counseling from Indiana University, as well as two prior Master's degrees in Secondary Education and Developmental Biology and Genetics from West Virginia University.

Andrea L. Wilkes joined ISDH as a Public Health Administrator in MCH in November 2000. She serves as the Project Manager for the Early Childhood Comprehensive Systems grant (Indiana's Sunny Start: Healthy Bodies, Healthy Minds initiative) and supervises two professional staff in the program area of child health. She earned two bachelor degrees (English and Psychology) from Miami University in Oxford, OH, Prior to her employment with MCH, Ms. Wilkes joined State service with the Disability Determination Bureau of FSSA. She served as a manager of a disability claims adjudication unit for many years, during which time she was assigned as a consultant to the Office of the Commissioner at Social Security Administration Headquarters in Baltimore, MD.

/2012/ Charrie Buskirk, MPH joined ISDH as a contractor to serve as the Women's Health Coordinator for women of childbearing ages in October 2010. She has since joined ISDH full-time at 1.0 FTE in April 2011 and now serves as the Public Health Administrator of Women's Health ages 14-44. In this capacity, Ms. Buskirk oversees staff operating the three new federally-funded programs that serve women of childbearing ages: (1) PPASS; (2) SIMPLE; (3) MIECHV. In addition, Ms. Buskirk directs the operations of the Free Pregnancy Test Program and is in the process of ensuring that data collection and reporting as well as ordering methods are streamlined for optimal efficiency. Ms. Buskirk is also responsible for working with statewide partners on the child-spacing state priority measure and to ensure that women of childbearing age in Indiana are receiving adequate and timely preconception and interconception care. Finally, Ms. Buskirk serves as a Title V consultant with ISDH-funded clinics throughout the southern parts of the state. With 10 years of nonprofit programming and fundraising experience, Ms. Buskirk, comes with expertise in procuring and managing federal, state, and private grants and foundation funding after serving as the Director of Grants for a county health and hospital system. After graduating from Purdue University School of Science with a major in Psychology in 2005, Charrie earned her Master of Public Health degree with a concentration in Behavioral Health Science from Indiana University School of Medicine in 2009. /2013/Charrie Buskirk left her position in October 2011. Carolyn Runge was hired as her replacement and began work in June 2012.//2013//

Stephanie Woodcox, MPH, CHES, joined ISDH in 2006 and was promoted to Public Health

Administrator in 2010. Ms. Woodcox serves as the State Adolescent Health Coordinator and oversees the Adolescent Health Services (AHS) Program. AHS focuses on serving young people ages 10-24. In this position Ms. Woodcox is the Program Manager for Indiana RESPECT, the state's teen pregnancy prevention initiative; is the state's administrator for the Indiana Family Planning Partnership; is a consultant to school-based adolescent health clinics; and provides leadership to the Indiana Coalition to Improve Adolescent Health (ICIAH) by serving as its facilitator. Ms. Woodcox also supervises the Youth Risk Behavior Survey (YRBS) Coordinator. /2013/ Stephanie Woodcox resigned her position in August 2011. Jeena Siela, her replacement, began work in January 2012. //2013//

Beth Johnson joined ISDH in 1993 and currently serves as the State Perinatal Health Coordinator. Ms. Johnson oversees the State Perinatal Quality Improvement that is developing hospital levels of care standards for obstetric and neonatal care, establishing a State Perinatal Database, and addressing a state transport program for mothers and infants. In addition, Ms. Johnson oversees the state Prenatal Care Coordination Program, the State Community Health Worker Program, the Infant Health and Survival Council, and maternal and infant mortality programs. //2012//

Larry S. Nelson, Public Health Administrator, serves as a Team Leader and the Training Manager for MCH. Larry has a B.S. from Indiana State University with a concentration in Public Administration and Political Science. Larry has served in the position of Prenatal Substance Use Prevention Director for one year, CSHCS Team Leader for ten years and in his current position as MCH Team Leader for five years.

/2012/ Larry Nelson, Team Leader and the Training Manager for MCH, retired. His position will be used to add capacity to the Business and Grants Management section. //2012// /2013/Larry resigned in May 2011. Recruitment is underway for his position. //2013//

Vanessa Daniels, MPA, MRC, CRC, became the Business and Grants Management section's manager and supervises the Assistant Grants Manager and the MCH Administrative Support Section. Vanessa has a Bachelors of Science in Business Management and Human Resource Management. She also has two Masters Degrees: one an MPA in Public Affairs and Nonprofit Management as well as a MRC in Counseling and is a licensed Rehabilitation Counselor with 12 years of grants management and grant writing experience. Additional staff that are a part of the Business Management Section includes an Assistant Grants Manager with over 15 years experience in State government, an Administrative Assistant, three support staff, and one contract support staff.

/2012/ December 2010, Ms. Daniels was promoted to serve as the Director of Grants and Business Management. This change ensures continuity of services provided to grantees of Title V and compliance with all federal and state requirements. //2012//

The MCH Data Analysis Section provides data entry, technical support, and data analysis. The Data Analysis team gathers the majority of the data for the Title V annual report as well as the needs assessment process. The team also contributes to the Data Integration Steering Committee that is responsible for overall data integration and data sharing efforts agency-wide. The data gathering effort involves collecting data from programs and agencies such as all of the MCH projects and clinics in order to provide detailed data required for the Title V Block Grant. The Data Analysis Section is headed by Joel Conner, a Public Health Administrator with a BS in Education and over twenty years of data analysis experience. Joe Haddix, MPH, serves as epidemiologist for Title V programs.

/2012/ Joel Conner who headed the Data Analysis Section also retired. Plans are underway to expand the Data Analysis section to become an MCH Epidemiology, Data Analysis and Surveillance group. //2012//

//2013/ During 2012, MCH developed an Epidemiology Surveillance and Data Analysis team that resides in the same area as MCH program staff. Joe Haddix, MPH, heads a team of five epidemiologists.//2013//

Hope Munn is a social worker who began her career in 2000 after completing her undergraduate studies and earning a Bachelor of Social Work degree from Indiana University. In 2006, she earned a Master of Social Work degree also from Indiana University. Ms. Munn has served in numerous social service settings with various populations including families with low income; veterans with mental illness; persons who are homeless; individuals/families of domestic violence; and children with mental illness and/or behavioral challenges. Ms. Munn's experience as a social worker includes eligibility determination for public assistance programs, provision of in-home counseling to at-risk children/families, and facilitation of care coordination of mental health services. Ms. Munn was recently hired as supervisor of the IFHL and brings social work expertise to the MCH leadership team.

The CSHCS Division's management team includes the CSHCS Director, CSHCS Eligibility Manager, CSHCS Claims Manager, CSHCS Prior Authorization Manager, CSHCS Provider Relations Manager and the CSHCS System Manager. In 2007, the CSHCS division added the Integrated Community Services Program and a manager were hired to lead that program. In 2009, the Integrated Community Services Program was awarded a HRSA/MCHB grant to work on systems of care improvement for children and youth with special healthcare needs and their families. The project employs five contract staff to facilitate the work of the project. Two of the team members are parents with children having special health care needs.

Role of Parents of Special Needs Children

Parents of children with special health care needs are members of MCH and CSHCS as paid staff and serve in the important role of providing support and leadership to families navigating the complexities of determining diagnosis, treatment, and follow up necessary for their children. Staff support the EHDI Program Director and the Guide By Your Side program. The EHDI program has employed parents via contract agencies since June 2007. Currently, the EHDI program includes three parents as staff members, all of whom are contracted through Indiana Hands & Voices, a parent support organization. One parent works as the Parent Program Coordinator. They oversee the two EHDI parent consultants, is the primary contact for families of children diagnosed with hearing loss through EHDI, and is the coordinator of the Guide By Your Side (GBYS) Program. GBYS is a parent-to-parent mentor program that is offered jointly through EHDI and Indiana Hands & Voices. The primary role of the two EHDI Parent Consultant is to conduct follow-up activities (phone calls and letter generation) to families of the nearly 2,000 children who are referred to EHDI annually after receiving a did not pass newborn hearing screening result. One parent consultant is bilingual (Spanish). The other parent consultant has a child who has been diagnosed in the past year and so is highly familiar with negotiating the current process of hearing loss identification and early intervention.

Additionally two other parent consultants serve on the IN CISS project and provide parent perspective to the Project in developing/selecting educational materials and information and developing policies and procedures. They assist in IN CISS Advisory Committee and Learning Collaborative and training meeting preparation, staffing of the IN CISS Advisory Committees, reviewing Learning Collaborative/Quality Improvement Tool Kit materials, and providing parent perspective training and technical assistance to the quality improvement medical home team practices participating in the Learning Collaborative. Parent consultants assist the project and the practices in the identification, recruitment, and training of parents for participation on practice teams and IN CISS Advisory committee representation. They assist with the development of the agendas for the conference calls and conferences, scheduling practice visits (currently nine pediatric/family practices), and helping collect data.

//2012/ The Medical Home Learning Collaborative has now expanded to 18 pediatric and family

practices statewide. //2012//

The About Special Kids (ASK) contract supports parent involvement by using trained and experienced Parent Liaisons to provide peer support, information and referral, and education and training for families of CSHCN. Activities include sending a monthly e-newsletter, developing and sending out educational materials, operating an information "hotline" and a system of follow-up contact with families, conducting training sessions, and assessing the ongoing and changing needs of families with special health needs. ASK, utilizes family input to develop strategies to address issues such as childcare, community resources, early intervention, and health care financing.

E. State Agency Coordination

Organizational Relationships

Title V staff excel in the area of collaboration. In many cases MCH and CSHCS provide leadership in coordinating efforts among the many public and private organizations concerned with the Title V populations.

Public Health -- The local health departments operate independently in the State of Indiana. However, the ISDH Local Health Department's Outreach Office hosts a monthly conference call and webcast. Agenda topics are gathered from the various commissions at ISDH. The MCH Division uses this opportunity to broadcast updates to the 92 counties throughout the State. In addition, the Outreach Office has established an online communication tool which allows not only a sharing of information but also coordination of events.

Mental Health & Alcohol and Substance Abuse -- The Division of Mental Health and Addiction (DMHA) provides input to the Social, Emotional & Training Committee of the Early Childhood Comprehensive Systems (ECCS) initiative. For example, DMHA recently awarded \$50,000 to MCH to further the goal of developing a certification program for infant and toddler mental health professionals. DMHA also provides supplemental funding support for seven PSUPP sites and collaborate on the Access to Recovery (ATR) program for pregnant women with substance abuse problems. A representative from DMHA participates in the Indiana Coalition to Improve Adolescent Health (ICIAH)./2013// DMHA and MCH submitted a joint application for Project LAUNCH funds in July 2012. If awarded, the grant will begin in October 2012. //2013//

Education -- DOE is a core partner in the Early Childhood Comprehensive Systems initiative and Indiana Community Integrated Systems of Service (IN CISS) Project Advisory Committee. DOE is also instrumental in the administration of the Youth Risk Behavior Survey (YRBS). DOE participates on the EHDI Advisory Committee and is an integral partner with CSHCS on early and late transition committees. DOE also assists in training and curricula on HIV and sexuality issues for adolescents (This includes a recent MCH-DOE partnership on a recent federal grant application for a new statewide teen pregnancy prevention program).

Vocational Rehabilitation/Disability Determination/Rehabilitation Services -- MCH and CSHCS work closely with several divisions in FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps, which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps, Indiana's Early Intervention Program, also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Medicaid, SCHIP/Social Security Administration -- OMPP, under FSSA, is a key collaborator in the establishment of payment policies and procedures for CSHCS and the development of the

Family Information & Resource Directory, Sunny Start Financial Fact sheets, and the Sunny Start Developmental Calendar in both English and Spanish. OMPP has also been instrumental in several prenatal initiatives including PNCC and FCC education for Medicaid Managed Care Organizations; creation of the physician's Notification of Pregnancy forms for prenatal first visits; development of a new Prenatal Risking tool sensitive to psychosocial and nutrition issues; and participation in Quality Improvement Initiatives and setting of performance measures such as Neonatal Quality Outcomes and prenatal smoking cessation. OMPP is also assisting in the assessment and review of child health with the development of the 'State of the Hoosier Child' report. Working with MCH, IPN, Indiana March of Dimes (MOD), and Indiana Primary Health Care Association, OMPP restructured presumptive eligibility for pregnant women in July 2009.

/2012/ As of July 1, 2011 Medicaid will no longer reimburse targeted case management for Prenatal Care Coordination and HIV Case Management. However, MCH is working to see how this service can be provided through the state's home visiting program or partially funded through Title V.//2012//

Corrections -- MCH partners with the Department of Corrections (DOC) to provide funding for "Wee Ones Nursery" (WON). WON is located at the Indiana Women's Prison and provides care for children from birth up to 18 months. The goal of the program is to reduce infant placement into foster care and allow an opportunity for bonding and attachment between mothers and their newborns. DOC also offers the Mother and Child Safe Care and Development program and works with Craine House, a step down program for early release of mothers.

Federally Qualified Health Centers -- In 2010, ISDH is funding 46 community health centers (CHCs) that have over 85 locations throughout Indiana. The Office of Primary Care (OPC) provides CHC support with funds from the Master Tobacco Settlement as authorized by the Indiana General Assembly in March 2009. Nineteen community health centers are designated FQHCs. The CHCs are located in 43 of 92 counties. Ten counties have more than one CHC. There are an additional 58 Rural Health Centers in Indiana.

The OPC and MCH share information on statewide needs and how funding is distributed. MCH funds four CHCs for prenatal care coordination. Many CHCs were originally funded as MCH clinics, but they have now developed into comprehensive primary care centers. MCH staff share health information and educational materials with Indiana CHCs through the OPC mailing lists. In addition to sharing of information via staff, activities are also coordinated between MCH, CHCs, and local health departments using a web-based tool.

Primary Care Associations -- The Indiana Primary Health Care Association (IPHCA), advocates for quality health care for all persons residing in Indiana and supports the development of community-oriented primary care initiatives. IPHCA partners regularly with MCH by providing staffing on many MCH committees and councils.

MCH Medical Director works with IPHCA to increase primary care physicians in Indiana through the J-1 Visa Waiver program. IPHCA participates in the development of the Oral Health Coalition.

Tertiary Care Facilities -- The CSHCS program funds an enrollment office at Riley Children's Hospital in Indianapolis, Indiana. CSHCS also trains other hospitals on how to enroll children needing services. Title V also funds five hospital-based genetics clinics throughout the State. These clinics provide both local and outreach services, expanding the effective number of clinics to 13. Services provided at these clinics cover both prenatal genetic counseling as well as pediatric consultation. Prenatal counseling includes the management of high risk pregnancies and provides services such as ultrasound, amniocentesis, and first trimester screening. Several specialty clinics address issues including bone dysplasia, neurogenetics, fetal alcohol syndrome and Marfan syndrome.

Representatives from the Indiana Hospital Association and representatives from several hospitals have been particularly active on committees and coalitions to improve perinatal outcomes. Hospital medical staff serve on our Prematurity Prevention Initiative Committee. Several hospital staff have committed to assisting in the development of obstetric and newborn levels of care in FY 2011.

Technical Resources and Health Professional Educational Programs and Universities -- IUSOM provides research and evaluation, particularly on adolescent health and behavior, for committees and grantees. Indiana University also participates in the Leadership Education in Neurodevelopmental and Related Disorders (LEND) program. Purdue University provides technical assistance and maintains websites, especially those related to adolescent health. The National Association for Social Workers provides professional certification of prenatal care coordinators. IPN provides professional education pertaining to prenatal care. Organizations such as the Indiana Society for Public Health Education (InSOPHE) provide public health seminars and forums to allow sharing of information and relationship-building.

MCH Medical Director facilitates a month-long elective in Public Health/Preventative Medicine for eight to ten senior medical students per year. In addition, students pursuing a Master's degree in public health frequently perform their internship and project at MCH.

Coordination of Title V Programs with Other Federal Programs and Providers

MCH collaborates with numerous providers and many federal programs to ensure that services are available and accessible to members of the MCH population. In addition, MCH partners with other organizations in the sharing of data and the funding of services. Some examples of collaborative efforts follow.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) -- HealthWatch/EPSDT is the coordinated program established by OMPP to provide periodic screening for children under the age of 19. Information concerning Title V and Medicaid providers can be obtained using the toll-free number to the IFHL.

Womens, Infants and Childrens (WIC) -- WIC has numerous partnerships with Divisions within the HHS Commission as well as within ISDH. The IFHL, funded and administered by MCH, provides referrals not only to WIC but also other appropriate agencies. Twenty-one of the WIC clinics house the MCH Free pregnancy testing program. WIC also partners with the immunization program that promotes immunization across the State. The Indiana Lead Safe and Healthy Homes program (ILHHP) collaborate with WIC in the use of the I-LEAD web application to produce consistent and effective risk assessments and environmental information.

Disability -- Both MCH and CSHCS work closely with several divisions in the FSSA. The Division of Disability and Rehabilitative Services (DDRS) is the parent agency for First Steps which partners with CSHCS to create a combined enrollment procedure for children with special needs. First Steps also provides intervention services to children identified by positive Newborn Screening (NBS) and children who do not pass the Universal Newborn Hearing Screening and/or children at risk for later acquired hearing loss. Vocational Rehabilitation Services, under FSSA, also provides referrals and partners with CSHCS.

Family Planning Programs -- The Indiana Family Planning Partnership is a partnership among the Indiana Family Health Council (IFHC), ISDH, the Indiana Department of Child Services (IDCS) and FSSA. These agencies have agreed that the coordinated funding of family planning services in Indiana will increase access to services ensure quality of services, and minimize administrative overhead. All funds have been granted to the IFHC, Indiana's Title X agency. IFHC contracts with local agencies in locations with the highest risk populations to provide comprehensive reproductive health and family planning services to the citizens of Indiana. The goal of the coordinated funding is to use the public family planning funds as efficiently and effectively as

possible to target the women most in need, to provide complete services to all low income women, to maximize Indiana competitive position family planning funding regionally, and to minimize the amount of paperwork for the providers.

OMPP has had a Family Planning Waiver request at the federal level for at least two years. Under the Health Care Reform legislation, states now have the option to expand Medicaid eligibility for family planning services without obtaining a federal waiver. The IPN has shared this new information with representatives from the OMPP, ISDH, and others involved in efforts to secure the waiver's approval. Whether changes can be made under current fiscal constraints is unknown at this time.

//2012/ OMPP has chosen to not pursue the option to expand family planning services without a waiver. The Indiana state legislature addressed Indiana's long-standing attempts to implement a family planning waiver by incorporating language into SB 461, Health Care Reform Matters, which also stipulates that a state agency may not implement or prepare to implement the federal Patient Protection and Affordable Care Act. Before January 1, 2012, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human Services for approval of a state plan amendment (SPA) to expand the population eligible for family planning services. The SPA must include women and men, set income eligibility at 133% of the federal income poverty level, and incorporate presumptive eligibility for services to this population. In addition, the law requires OMPP to report on the progress of the SPA to the Medicaid oversight committee during its 2011 interim meetings. The bill passed and was signed by the Governor.
//2012//

Identification of Pregnant Women and Infants Eligible for Title XIX

In 2009, Indiana initiated a presumptive eligibility program for pregnant women who might qualify for Medicaid. The need for the program resulted from a flawed enrollment system that caused long delays in eligibility determination. To participate in the Presumptive Eligibility Program, Indiana requires that health care providers (clinics, OB/GYN, pediatricians, etc) enroll with Indiana Health Coverage Programs (IHCP). These providers must collect basis income information on clients and submit it to Medicaid. They may then provide services which will be reimbursed by Medicaid even if the woman does not turn out to be eligible for Medicaid. The pregnant woman has the responsibility to submit a full application to Medicaid within a certain time period so that she will be enrolled with a Hoosier Healthwise managed care program. MCH assists this mission with its Free Pregnancy Test program. The program focuses on outreach to sexually active women of child-bearing age to improve access to primary, prenatal, and family planning care to impact the State's high infant mortality rate.

//2012/ The presumptive eligibility (PE) process relies on Qualified Providers (QPs) that volunteer to assist pregnant women with the PE Application process. In the first 18 months of the PE program there were 270 Qualified Providers signed up in 66 counties. Over 15,000 pregnant women have been enrolled in PE, about 25% of all pregnant women on Medicaid. Roughly 78% enrolled in PE become Medicaid approved. MCH and IPN are assisting OMPP with promoting the program through newsletters, trainings, requirement for Title V grantees.

Department of Child Services - ISDH works closely with the Indiana Department of Child Services (IDCS) for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). IDCS operates the Healthy Families program throughout the state while ISDH contracts with Goodwill Industries of Central Indiana to implement Nurse Family Partnership program. This partnership ensures that all federally-recognized home visiting programs in operation throughout the state are coordinated for optimal service provision, recruitment of highest-need families, and non-duplication of efforts.//2012//

State Disabilities Determination and Vocational Rehabilitation -- CSHCS works through DDRS in the Indiana FSSA to determine services and rehabilitation for children with special health care needs. First Steps, Indiana's early intervention program, coordinates services for/with CSHCS.

Healthy Families Indiana, another early intervention program, identifies, at the time of birth, those families that are at risk of child abuse. CSHCS provides financial support for the training efforts involved in this statewide home visiting program. CSHCS coordinates with developmental disabilities programs primarily through interactions with the First Steps Program and with the UNHS/EHDI follow-up efforts. Coordination with vocational rehabilitation programs is conducted primarily through the database of providers maintained by the IFHL. IFHL provides appropriate referral contacts to statewide vocational rehabilitation offices and agencies.

/2012/ The Sunny Start initiative (MCHB- ECCS) is working collaboratively with other state agencies to increase capacity for social and emotional health of young Hoosier children. This year, the Department of Mental Health and Addiction, the State Head Start Collaboration Office and the Department of Child Services all contributed significant financial funding to the effort.

MCH's Sunny Start initiative has a very active Family Advisory Committee. Among other activities the Family Advisory group is working with the Riley Child Development Center to create a Family Leadership Institute. The Initiative has created a portfolio to track leadership development and a set of leadership competencies (tiered across three levels) that complement the Maternal and Child Health Leadership Competencies.

Indiana is very supportive of state agency coordination and collaboration. In this regard, MCH has initiated two large projects with a number of state agencies. The first project, the Prenatal Substance Abuse Cross Agency Committee, began in August, 2010. The Committee meets monthly to address the significant prenatal substance abuse problem in Indiana. Collaborative state agencies include Indiana State Department of Health (ISDH), Department of Education, Office of Medicaid Policy and Planning, Department of Child Services, and the Division of Mental Health and Addiction. The second project is the Statewide Home Visiting Program. The governor appointed ISDH and the Department of Child Services as co-lead agencies to implement the Indiana Maternal, Infant, and Early Childhood Home Visiting Program.

The Adolescent Health Services Program within MCH has benefited from some unique, new partnerships during FY11. Through the Indiana Coalition to Improve Adolescent Health, which is facilitated by the State Adolescent Health Coordinator (SAHC) in MCH, came the opportunity to partner with a design and marketing firm to help the Coalition produce an adolescent handbook-- a pocket-sized guide for young people about a variety of health issues (dating violence, STIs, binge drinking, stress and depression) and important facts and resource information. Also through the Coalition, the MCH has formed a partnership with a local medical magnet school for high school students. The magnet school is currently participating in a pilot study of the handbooks developed by the Coalition. The Adolescent Health Services Program and MCH also forged a new partnership with individuals at the Indiana Division of Mental Health and Addiction. The SAHC and other injury-prevention staff at ISDH teamed up to write a large federal grant for SAMHSA funding for suicide prevention among young people. Grant announcements are anticipated in the fall of 2011//2012//

F. Health Systems Capacity Indicators

IV. Priorities, Performance and Program Activities

A. Background and Overview

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to promote integration of public health and health care policy, strengthen partnerships with local health departments, and collaborate with hospitals, providers, governmental agencies, business, insurance, industry, and other health care entities. ISDH will also support locally-based responsibility for the health of the community. ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, MCH and CSHCS continue to strive to meet the performance goals established by national initiatives such as MCHB's National Performance Measures as well as State initiatives, based on the latest needs assessment. The needs assessment results focused on health system capacity indicators and health status indicators, including asthma hospital discharges, Medicaid/SCHIP screening, prenatal care adequacy, low/very low birth weight, fatal/non-fatal injuries, chlamydia rates, dental screening, and adolescent tobacco use.

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

Outcome measure data for infant mortality, black/white infant mortality disparity, neonatal mortality, post-neonatal mortality, perinatal mortality, and the child death rate are also monitored and reported annually.

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

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

Progress toward the achievement of our national and State performance goals is reported in Sections C and D following. MCH and CSHCS continue to build on previous years successes.

This year's annual report reflects that for 2009, MCH and CSHCS continue to make progress on eight of the thirteen national performance measures that are not reported through the CSHCN survey. Progress was made on the five performance measures that are reported through the CSHCN survey.

MCH and CSHCS are proposing a new set of State negotiated performance measures (SPM) based on the results of the needs assessment. Two of the new SPM's are identical to the previous SPM's and one has been modified. There are seven entirely new proposed SPM's and some of the previous SPM's are being discontinued. These are enumerated in Sections B and D.

B. State Priorities

Indiana comprehensively evaluated quantitative and qualitative information to develop the State's priority healthcare needs. Indiana allocated \$4,982,945 for FY 2009 in grants to community-based organizations. In the coming year, Title V staff will re-evaluate the distribution of money based on the new state priorities.

For pregnant women, priority healthcare needs include decreasing smoking during pregnancy, with emphasis on the Medicaid population; increasing the number of black women having adequate prenatal care; decreasing the proportion of births occurring within 18 months of a previous pregnancy to the same mother; and increasing the number of women who initiate exclusive breastfeeding. These priorities are related to State Performance Measures (SPM) 2, 3, 4, 6, and 7, along with National Performance Measures (NPM) 11, 15 and 18. Indiana's capacity to work on these priorities include collaboration with partners at Medicaid, Indiana Tobacco Prevention and Cessation, new initiative development for minorities, educational programs for breastfeeding mothers, and further program expansion within the State Department of Health.

Smoking during pregnancy increases the risk for both a preterm delivery as well as a low birth weight baby. Although the smoking during pregnancy rate has declined in general in Indiana, the rate is still very high for certain populations or locales. Activities to address this issue include providing training and materials to prenatal Medicaid providers; assessing/comparing counties with highest and lowest smoking rates to determine successful anti-smoking strategies; and working with Indiana Tobacco Prevention and Cessation (ITPC)/Indiana Preventing Smoking in Pregnancy Initiative to explore successful cultural and literacy appropriate educational messages targeted to low income women.

During the period from 2002 to 2006, the percentage of women, overall, receiving prenatal care within the first trimester declined from 80.5% to 77.6%. The black percentage decreased from 68.6% to 65.6% over this time period. To address the low level of entry into prenatal care for black women the new focus will target counties having a lower percentage of black women entering prenatal care in the first trimester. Initiatives will include free pregnancy tests, development of a Premature Birth Initiative especially for African American women, and collaboration with the National Fatherhood Initiative on train the trainer workshops.

Short interval pregnancies are an important issue because such pregnancies increase the risk for adverse outcomes, such as low/very low birth weight babies; premature births and small for gestational age infants. Activities to address birth spacing will include training providers and clinic staff on preconception best practices and new family planning methods; application of quality improvement techniques to reduce opportunities for screening and health promotion to women, before, during and after pregnancy; and integration of reproductive health messages into existing state health promotion campaigns

Although breastfeeding rates have consistently increased over the past several years to an overall rate of 66.5%, Indiana's breastfeeding rate still falls below not only the national average

but also the Healthy People 2010 goal of 75%. Black women, in particular, have low levels of breastfeeding rates. Efforts to increase the rates of breastfeeding in Indiana during the next five years will focus on continued collaboration with state-wide groups to support local coalitions; initiation of a recognition program acknowledging Baby Friendly Hospitals; and collaboration with partners to build tiers of support for breastfeeding from community drop-in centers providing support to mothers to education on breast milk storage for day care centers,

Two problems concerning infants require a special focus: prematurity rates and accidental suffocation under one year of age. Although prematurity birth rates are at about the national average, prematurity rates for blacks are more than double that of the overall rate. Creation of a statewide plan that addresses prematurity issues is proposed with the Preterm Birth Executive Group driving system change through policy, standards and tools. Increasing both public and provider awareness as to all aspects of prematurity is also a goal. These priorities are related to State Performance Measures (SPM) 1 and 7. Indiana's capacity to work on these priorities include collaboration with the First Candle Project and Indiana Perinatal Network. Indiana has started a premature birth coalition with public and private agencies that increases the State's capacity for these priorities.

The infant mortality rate for 2007 was 7.5 deaths per 1000 live births, higher than the Healthy People 2010 goal of 4.5 deaths. Reducing the number of suffocation deaths in infants will impact this mortality rate. MCH activities to impact this number will center around communication of safe sleep practices/updates to nurse managers/nursing staff and provision of parent education. MCH will also work with First Candle, Indiana Perinatal Network, and local community organizations in the four largest counties to conduct training and educational sessions.

Concerns involving children and adolescents center around lead poisoning, STDs, obesity, and social-emotional health of very young children. These priorities are related to State Performance Measures (SPM) 5, 8, 9, and 10, along with National Performance Measures (NPM) 7, 14 and 16. Indiana is increasing the capacity to improve these priorities. Indiana will continue to work with Medicaid, and the Lead and Immunization Programs to improve children's health. The State is also increasing capacity by funding new positions that focus on youth risks, which include STD's, physical activity, and weight and nutrition. Indiana will increase capacity over the next 5 years to improve social-emotional health for children.

Although the number of confirmed cases of lead poisoning in children (below age 72 months) has declined, lead poisoning remains a silent menace that can cause irreversible damage. MCH will continue to work with Medicaid to increase the number of children screened and to work with the Indiana Lead and Healthy Homes Program (ILHHP) to increase the number of homes remediated.

Reduction in the number of sexually transmitted diseases (STDs) is another state objective. Strategies to reduce the STD numbers include providing education and materials to providers treating adolescents, conducting a needs assessment to determine barriers to condom use among adolescents in high-risk populations, and partnering with the Indiana Family Health Council to increase screening for sexually transmitted infections.

Obesity in high school age children is also a state concern. Recent data indicate that 13.8% of youth to have a BMI greater than the 95th percentile for their age and sex. MCH will be partnering with the Division of Nutrition and Physical Activity in the deployment of the Indiana Healthy Weight Initiative that targets increased consumption of fruits and vegetables, decreased consumption of sugar-sweetened drinks and increased physical activity.

Addressing issues pertaining to the social-emotional health of children under the age of 5 is the final initiative. Foremost among these issues is the lack of qualified service providers to treat children in this age bracket. Children at risk for social, emotional, and behavioral problems include cases of neglect, homeless children, children of refugees/immigrants, and children of

deployed military personnel. The proposed state initiative targets capacity building to increase the number of service providers qualified in this area.

C. National Performance Measures

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	100	98	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	160	184	190	207	
Denominator	160	184	190	207	
Data Source	ISDH - NBS	ISDH - NBS	ISDH- NBS	ISDH- NBS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	100	100	100	100	

Notes - 2011

Data is final.

Notes - 2010

Data is final.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
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9.				
10.				

b. Current Activities

c. Plan for the Coming Year

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:							
Reporting Year:							
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)		
	No.	%			No.	No.	No.
Phenylketonuria (Classical)							
Congenital Hypothyroidism (Classical)							
Galactosemia (Classical)							
Sickle Cell Disease							

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	60	60	59.3	60	73
Annual Indicator	59.3	59.3	59.3	72.6	72.6
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	73	74	74	75	

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
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10.				

b. Current Activities

c. Plan for the Coming Year

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	55	55	54.6	55	50
Annual Indicator	54.6	54.6	54.6	48.5	48.5
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	52	54	56	58	

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

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

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	62	62	61.8	62	62
Annual Indicator	61.8	61.8	61.8	58.6	58.6
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	63	63	64	64	

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

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

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
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b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	95	95	94.3	95	66
Annual Indicator	94.3	94.3	94.3	65.9	65.9
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	68	70	72	74	

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

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

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	41.5	41.5	41.1	42	44
Annual Indicator	41.1	41.1	41.1	43.7	43.7
Numerator					
Denominator					
Data Source	SLAITS	SLAITS	SLAITS	SLAITS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	45	46	47	48	

Notes - 2012

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are

not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

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

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	84	85	89.5	90.5	90.5
Annual Indicator	89.1	89.1	90.5	90.5	
Numerator					
Denominator					
Data Source	ISDH - Imm. Pgm	ISDH - Imm. Pgm	ISDH - Imm Pgm	ISDH - Imm Pgm	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	91	91.5	92	92	

Notes - 2011

Data based on trend analysis.

Notes - 2010

Figure provided without numerator or denominator.

Source of data: ISDH Immunization program.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	20.1	20	19.8	19.6	19.8
Annual Indicator	20.5	20.8	20.5	20	
Numerator	2728	2730			
Denominator	132756	131357			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	19.6	19.4	19.2	19	

Notes - 2011

Figure projected from past data.

Source of past data: ISDH ERC

Notes - 2010

Figure projected from past data.

Source of past data: ISDH ERC

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1.				
2.				
3.				
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	49	50	50	24	24.5
Annual Indicator	49	50	24	24	
Numerator					
Denominator					
Data Source	ISDH - Oral Hlth	ISDH - Oral Hlth	ISDH - Oral Hlth	ISDH- Oral Hlth	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	25	25.5	26	26.5	

Notes - 2011

Data is final.

Notes - 2010

For the years 2005-2010 the Annual Performance Objective was based on the CDC Healthy People 2010 goal of increasing to 50% by year 2010 the proportion of children aged 8 years who had received dental sealants on their molar teeth.

For the years 2011-2020 the Annual Performance Objective will be based on the CDC Healthy People 2020 Target (OH-12.2) of increasing to 28.1% by the year 2020 the proportion of children aged 6-9 years who have received dental sealants on one or more permanent first molars.

Notes – 2008-2010

The Annual Indicators for years 2008-2010 were projected values based on questionnaire survey data obtained by the ISDH in years 2000-2005. Based on these projections, the ISDH has met its goals for each of these years.

However, for years 2011-2020 the ISDH has decided to use Indiana Medicaid data to determine

what proportion of children aged 6-9 years have received dental sealants on one or more permanent first molars.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	3	2.8	3.3	3.2	1.9
Annual Indicator	3.6	2.0	2	1.9	
Numerator	47	27			
Denominator	1311912	1318933			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	1.8	1.8	1.7	1.7	

Notes - 2011

Projected based on data provided in previous years.

Source of data: ISDH - ERC

Notes - 2010

Projected based on data provided in previous years.

Source of data: ISDH - ERC

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	35	36	37	38	39
Annual Indicator	35.4	31.4	35	37	
Numerator					
Denominator					
Data Source	US CDC Report	US CDC Report	US CDC Report	US CDC Report	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	40	41	42	43	

Notes - 2011

Based on trend analysis.

Notes - 2010

Projection based on trend analysis.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	99.7	98.5	99.6	99.7	99.7
Annual Indicator	99.5	99.5	99.6	99.7	
Numerator	87076	85695			
Denominator	87520	86126			
Data Source	ISDH - UNHS	ISDH - UNHS	ISDH - UNHS	ISDH - UNHS	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a					

3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	99.8	99.8	99.8	99.8	

Notes - 2011

Based on trend analysis.

Notes - 2010

Based on trend analysis.

Source of data: ISDH UNHS

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	8.5	7.5	7.3	7	6.7
Annual Indicator	6.7	7.0	7.0	6.8	
Numerator	106000	111256	126000		
Denominator	1584681	1589365	1800000		
Data Source	Kids Count Bk	Kids Count Bk	Kids Count Bk	Kids Count Bk	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	6.5	6.1	6	6	

Notes - 2011

Based on trend analysis.

Notes - 2010

Data is final.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	17	30	36.5	36.5	31
Annual Indicator	30.8	36.5	31.3	31.4	
Numerator	24218	21292	26776	26371	
Denominator	78700	58260	85683	84091	
Data Source	ISDH - WIC pgm				
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	31	30	30	30	

Notes - 2011

Data is final.

Notes - 2010

Data is final.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	15.6	15.6	17.5	17	15.2
Annual Indicator	18.5	15.3	15.3	15.2	
Numerator	16437	13157			
Denominator	88679	86126			
Data Source	ISDH - VR	ISDH - VR	ISDH - VR	ISDH-VR	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	15.1	15.1	15	15	

Notes - 2011

The numbers represent the number of women who smoke during pregnancy -- not just the last three months. Data is not currently available. 2010 and 2011 are based on a trend analysis.

Notes - 2010

The numbers represent the number of women who smoke during pregnancy -- not just the last three months. Data is not currently available. 2010 and 2011 are based on a trend analysis.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	7.1	6.9	9	9	8.6
Annual Indicator	9.7	8.7	8.7	8.6	
Numerator	44	40			
Denominator	451711	460787			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	8.5	8.5	8.4	8.5	

Notes - 2011

2011 data is provisional based on a trend analysis.

Notes - 2010

2010 data is provisional based on a trend analysis.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	78	80	70	82	87
Annual Indicator	80.7	85.3	86	86	
Numerator		1015			
Denominator		1190			
Data Source	MCH Cons Pgm	MCH Cons Pgm	MCH Cons Pgm	MCH Cons Pgm	

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	87	88	88	89	

Notes - 2011

Data is final.
All data are for the calendar year and not the fiscal year.
Source of data: ISDH MCH Consultant Program.

Notes - 2010

Estimates provided based on trend analysis.
Source of data: ISDH MCH Consultant Program.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	76.6	77.5	66	68	70
Annual Indicator	66.6	66.1	66.5	68	
Numerator	59063	56966			

Denominator	88679	86126			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	72	74	75	76	

Notes - 2011

Data is based on a trend analysis and takes into account the use of the revised birth certificate that went into effect 2007.

Notes - 2010

Data is based on a trend analysis and takes into account the use of the revised birth certificate that went into effect 2007.

a. Last Year's Accomplishments

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

D. State Performance Measures

State Performance Measure 1: *Rate of suffocation deaths of infants.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				15.3	15.2
Annual Indicator	15.7	16.4	15.3	15.3	
Numerator	97	111			
Denominator	619	675			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	15.1	15	14.9	14.8	

Notes - 2011

Data is based on a trend analysis.

Notes - 2010

Data is based on a trend analysis.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 2: *The percentage of mothers who initiate exclusive breastfeeding.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				68.5	69
Annual Indicator	68.5	69.9	68.5	68.5	
Numerator	60765	60189			
Denominator	88679	86126			
Data Source	ISDH/ERC	ISDH/ERC	ISDH/ERC	ISDH/ERC	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	69	70	70	71	

Notes - 2011

Based on trend analysis.

Notes - 2010

Based on trend analysis.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 3: *Percentage of pregnant women on Medicaid who smoke.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				29.5	28.7
Annual Indicator	30.0	28.9	28.9	28.8	
Numerator	11656	11342			
Denominator	38842	39270			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	28.7	28.6	28.6	28.5	

Notes - 2011

Data is based on a trend analysis

Notes - 2010

Data is based on a trend analysis.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 4: *The percent of black women (15 through 44) with a live birth whose prenatal visits were adequate.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	59	59	55	55	56.5
Annual Indicator	54.1	55.7	56	56.5	
Numerator	5654	5668			
Denominator	10447	10168			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	

Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	57	57.5	57.5	58	

Notes - 2011

Data is provisional and based on a trend analysis.

Notes - 2010

Data is provisional and based on a trend analysis.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 5: *The percentage of children less than 72 months of age with blood lead levels (BLL) equal to or greater than 10 micrograms per deciliter.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	0.8	0.7	0.6	0.6	1
Annual Indicator	0.8	0.9	1.1	1.0	
Numerator			777	740	
Denominator			69830	71125	
Data Source	ISDH - LEAD	ISDH - Lead	ISDH - Lead	ISDH - Lead	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	0.9	0.8	0.7	0.6	

Notes - 2011

Data is based on trend analysis.

Notes - 2010

Data is final.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 6: *The percentage of births that occur within 18 months of a previous birth to the same birth mother.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective	16	15	14	36.1	35
Annual Indicator	36.0	35.4	35.2	35	
Numerator	18607	17768			
Denominator	51685	50188			
Data Source	ISDH ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	34.9	34.8	34.7	34.6	

Notes - 2011

Data is final.

Changes are because the data now represents Indiana residents, not edited for birthweight or gestation, and not restricted to singleton births.

Source of data: ISDH ERC

Notes - 2010

Data is based on a trend analysis.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 7: *Percentage of preterm births*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				13	11.8
Annual Indicator	13.3	11.8	11.8	11.8	
Numerator	11762	10192			
Denominator	88585	86126			
Data Source	ISDH - ERC	ISDH - ERC	ISDH - ERC	ISDH-ERC	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	11.7	11.7	11.6	11.6	

Notes - 2011

Data is based on a trend analysis.

Notes - 2010

Data is based on a trend analysis.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 8: *The percentage of women 18 to 44 who are overweight/obese.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				61	52
Annual Indicator		60.9	52.1	52	
Numerator		3294	2819		
Denominator		5408	5410		
Data Source		BRFSS	BRFSS	BRFSS	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	52	51	51	51	

Notes - 2011

2011 data not available, based on trend analysis.

Notes - 2010

Data is final.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 9: *Percentage of high school students who become infected with STI.*

Tracking Performance Measures

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

Annual Objective and	2008	2009	2010	2011	2012

Performance Data					
Annual Performance Objective				1	1
Annual Indicator	0.5	0.8	1.2	1.1	
Numerator	2044	3883	5710		
Denominator	451711	460787	460000		
Data Source	ISDH - STD/HIV	ISDH - STD/HIV	ISDH - STD/HIV	ISDH - STD/HIV	
Is the Data Provisional or Final?				Provisional	
	2013	2014	2015	2016	2017
Annual Performance Objective	1	0.9	0.9	0.8	

Notes - 2011

Rate based on trend analysis.

Notes - 2010

Nominator is final. Denominator is provisional and based on a trend analysis. rate is final.

a. Last Year's Accomplishments

b. Current Activities

c. Plan for the Coming Year

State Performance Measure 10: *Build capacity for promoting social and emotional health in children from birth to age 5.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2008	2009	2010	2011	2012
Annual Performance Objective				0.1	0.1
Annual Indicator			0.1	0.2	
Numerator			5	22	
Denominator			92	92	
Data Source			ISDH/LHCS	ISDH/LHCS	
Is the Data Provisional or Final?				Final	
	2013	2014	2015	2016	2017
Annual Performance Objective	0.2	0.3	0.3	0.4	

Notes - 2011

Data is final.

The Numerator is the number of counties that have endorsed or certified early childhood mental health providers for families. The denominator is the total number of counties in the state.

Notes - 2010

This is the first year for this new performance measure. The Numerator is the number of counties that have endorsed or certified early childhood mental health providers for families. The denominator is the total number of counties in the state.

a. Last Year's Accomplishments

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities

c. Plan for the Coming Year

E. Health Status Indicators

F. Other Program Activities

In terms of maternal and child health, the effectiveness of our interventions and programs is an overriding issue. Many of our health status indicators and health outcome indicators over the past years have remained stagnant or gotten worse. While Indiana is not alone in this phenomenon, it is an issue we are addressing in a number of ways as discussed in the following paragraphs.

As discussed in Section III, State Overview, Indiana is near the bottom of all states in receipt of federal health dollars. Indiana ranks 48th for the amount of federal funding for public health from the CDC in FY 2009, 50th for Federal funding from HRSA, and 47th for the amount states provide for public health services. This lack of funding adversely impacts capacity. To combat these low funding levels, we will be examining all funded projects in the coming year to ensure their effectiveness.

Additionally, we are aggressively seeking additional grants that will allow Indiana to supplement Title V funding for maternal and child health programs. Examples of grants for which we are applying include:

Teen Outreach Program (TOP) -- The Indiana State Department of Health (ISDH), in partnership

with the Indiana Department of Education (DOE), Health Care Education and Training, Inc. (HCET) and the Center for Sexual Health Promotion (CSHP) at Indiana University recently submitted an application to the newly created federal Office of Adolescent Health to implement the Teen Outreach Program (TOP), an evidence-based, youth development and community service focused program to prevent teen pregnancy. This program is proposed to be implemented in 19 counties state-wide that have the highest rates of births among teens ages 15-19. Two goals of TOP are to reduce pregnancy rates and increase high school graduation rates. /2012/Indiana was not awarded this grant.//2012//

Innovative Social Media -- The purpose of this grant is to improve birth outcomes through socially interactive educational media. The media will improve understanding of the consequences of behavioral and environmental life choices on pregnancy outcomes. Socially interactive media will provide engaging, challenging and educational experiences that will be able to be spread beyond the original participants through shared media access.

MCH is proposing to develop and implement The Social Immersive Media Project for Life-course Education (SIMPLE). SIMPLE is an innovative social marketing approach to increase public awareness of the importance of integrating the life-course perspective into preconception/interconception planning and care; to reduce adverse outcomes and improve reproductive health; and to increase public awareness of the importance of preparing couples for transitioning into their roles as new parents./2012/Grant was awarded. Program has been implemented. See Title V capacity section for more details.//2012//

ACA Maternal, Infant and Early Childhood Home Visiting Program Application -- Research indicates that healthy human development is connected to preventing poor outcomes that occur during the youngest years of a child's life. Early health indicators, including birth weight, immunization rates, and parental knowledge of proper child development, all are significant predictors of school performance and social engagement in later years. Problems apparent at this young age have been accurate predictors of IQ, educational attainment, criminal behavior, and even the probability of becoming a teenage mother. Programs that focus on comprehensive family-based programs have yielded strong outcomes for children, especially when they begin as early as possible. Home visitation programs that train new parents to be the "first teachers" of their young children have been very successful, especially if these programs work with parents over a period of several years.

In keeping with the partnership between HRSA and ACF, Indiana's Governor, the Honorable "Mitch" Daniels, has also recognized that the goal of an effective, comprehensive early childhood system is broader than the scope of any one agency. He has designated The Indiana State Department of Health (ISDH), through the Maternal and Child Health (MCH) Title V Division, and the Indiana Department of Child Services (DCS) as co-lead agencies for the State of Indiana's application for the Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program. Indiana will use this funding for two programs. Specifically, Indiana proposes to expand Healthy Families services within the already existing statewide network of Healthy Families providers, and to pilot the Nurse-Family Partnership home visiting services through a public-private partnership between ISDH/MCH and Goodwill Industries of Central Indiana./2012/Updated State Plan was completed as well as one formula grant and one competitive grant.//2012// /2013/Competitive funding in the amount of \$9 million was awarded to Indiana.//2013//.

We are also defining and implementing an evidence-based, life course health perspective that supports the knowledge that health is more than the absence of disease. As MCH moves in this direction, we are addressing a life course approach at the organizational level; developing and testing programs that incorporate a life course perspective; promoting pilot projects to test models that can be adopted and adapted in other locales; and sharing strategies and outcomes with non-traditional partners such as Goodwill Industries to further enhance knowledge, theory and practice./2012/See Title V capacity section for how this program is developing.//2012//

/2012/MCH was awarded the Pregnant and Parenting Teen grant. The award amount is \$2 million a year for three years. With this award, MCH is providing four large subawards for direct services to pregnant and parenting teens 15 to 19 years old and funding research to identify effective ways to deliver health messages. MCH also completing a needs assessment to identify high risk communities. In August 2011, MCH will be seeking additional input from the community through a facilitated process.//2012//

/2013/MCH has applied for a Project LAUNCH grant and has entered into a contract with the IU Division of Pediatrics to develop the first regional center, Circles of Indiana, to help people get out of poverty. MCH has also applied for an Abstinence Education Grant.//2013//

G. Technical Assistance

National Fatherhood Initiative

Indiana State Department of Health (ISDH) is requesting technical assistance for Best Practices training for new fathers on the basics of child health and safety. This will teach fathers how to take care of their children during the pregnancy and after they are born. Early involvement of males in the pregnancy has positive benefits well beyond the birth of the child. For example, trainings engaging new dads and fathers in addressing the babies needs while in the womb and after delivery have shown to assist mothers in receiving early, continuous, and adequate prenatal care. This can be due to the fact that the mothers have a support system from the start.

Unmarried mothers, or mothers where the fathers are absent from the home, are less likely to obtain prenatal care and more likely to have a low birth-weight baby. Researchers find that these negative effects persist even when they take into account factors such as education, which often distinguish a single parent from two-parent families. Expectant fathers can play a powerful role as advocates for prenatal care. Research has shown that 2/3rds of women whose partners attended a breastfeeding promotion class initiated breastfeeding. When the father or other family male(s) were involved, the mother received more prenatal care once enrolled.

ISDH is requesting technical assistance regarding the National Fatherhood Initiative (NFI). NFI offers Best Practices curriculums that actively involve fathers in the child's health care from conception and throughout childhood. Their curriculums include a variety of tools and resources for supporting fathers in many diverse settings. For example, they offer military programming, school-based programming, correctional programming, and Christian-based programming. For our purposes, we are interested in their health care programming which includes but is not limited to "Doctor Dad", "When Duct Tape Won't Work", and "Daddy Pack" (Exclusively for New Dads).

Bright Futures

ISDH is requesting training on the usage of the Bright Futures developmental tools for families and providers to address social and emotional health in children 0 through 5. This training should address each child's uniqueness due to the fact that all children face social and emotional challenges in early childhood, including learning how to control their emotions and tantrums and learning how to share, take turns, and play with others. With the use of Bright Futures tools, providers and families can begin a conversation together about how best to support healthy social and emotional development in infants, children, and teens. The tools encourage families who have any questions or concerns about their child's development to "check it out" and offer a number of tips for when, where, and how to seek assistance from local, state, or national resources.

Customized training, consultation, and technical assistance are available from Bright Futures at Georgetown University and the National Technical Assistance Center for Children's Mental Health. Through these organizations, ISDH would be able to utilize these tools in a variety of settings and for multiple purposes.

Capacity building for coalitions

ISDH is requesting technical assistance for infrastructure building and capacity building for coalitions. The Indiana Coalition to Improve Adolescent Health (ICIAH) was formed in late 2006. In May 2009, ICIAH released the state's first adolescent health plan. The focus of ICIAH is on the implementation of this plan with and through its partner organizations. However, ICIAH is struggling to get buy-in and commitment from its partners to take greater ownership in the implementation of the plan and promotion of ICIAH's work.

Cultural Competency Training

General issue-cultural competency training for MCH and its partners would be beneficial because Maternal and Child Health (MCH) faces diversity and health disparities among the population it serves. ISDH did provide annual training opportunities and refresher courses on cultural competency; however, such opportunities are no longer available. It is important for MCH staff and those we partner with and fund to have skills in this area in order to provide the best services for its clients. This type of training is available through MCHB and the National Center for Cultural Competency./2012/ MCH would like to focus on this training in FY12.//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	11770865		11662428			
2. Unobligated Balance <i>(Line2, Form 2)</i>	1985939		910310			
3. State Funds <i>(Line3, Form 2)</i>	17877130		15795389			
4. Local MCH Funds <i>(Line4, Form 2)</i>	889823		889823			
5. Other Funds <i>(Line5, Form 2)</i>	2312108		2312108			
6. Program Income <i>(Line6, Form 2)</i>	2795620		2795620			
7. Subtotal	37631485		34365678			
8. Other Federal Funds <i>(Line10, Form 2)</i>	2755805		9061151			
9. Total <i>(Line11, Form 2)</i>	40387290		43426829			

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	5663424		5601748			
b. Infants < 1 year old	2429785		2423081			
c. Children 1 to 22 years old	8398315		8393237			
d. Children with	20389961		17215212			

Special Healthcare Needs						
e. Others	0		0			
f. Administration	750000		732400			
g. SUBTOTAL	37631485		34365678			
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0			
b. SSDI	88601		65357			
c. CISS	0		0			
d. Abstinence Education	0		1047703			
e. Healthy Start	0		150000			
f. EMSC	0		0			
g. WIC	0		0			
h. AIDS	0		0			
i. CDC	1484604		155650			
j. Education	0		0			
k. Home Visiting	0		4592841			
k. Other						
INSTEP/HD			400000			
PPASS			2000000			
PSUP			400600			
UNHS	250000		249000			
ECCS	132000					
INSTEP	400000					
PSUPP	400600					

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2012		FY 2013		FY 2014	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	16252811		16729029			
II. Enabling Services	7138101		5247328			
III. Population-Based Services	5547532		5208239			
IV. Infrastructure Building Services	8693041		7181082			
V. Federal-State Title V Block Grant Partnership Total	37631485		34365678			

A. Expenditures

Indiana continues to implement cost cutting initiatives that include elimination of non-crucial State positions and to require that all new or replacement State positions be approved by the State Strategic Hiring Committee, regardless of funding source. The long-term impact will result in significant expenditure reductions for both state and federal funds. Additionally, there is significant difference is budgeted versus expended funds due to a required increase in state reserves. This has greatly impacted the amount of funds that were allowed to be expended in the over state/federal Title V partnership. See Forms 3, Form 4 and Form 5.

In FY 2011, Indiana maintained its initiative to hold costs steady by only funding priority projects and has continued to fund local projects for Children with Special Health Care Services (CSHCS). In FY2011, Indiana reinitiated grants to Community Health Centers. None of Indiana's community grantees received increases in total amounts awarded to them.

Maintenance of State Effort

Indiana's Maintenance of State Effort is \$11,539,520.00. In FY 2011, the MCH expected award was \$11,770,865.00 and the state had available \$36,761,391.00. The State support is comprised of state and local funds that CHCS is authorized to spend on behalf of children with special health care needs. It also includes money for the 30% match required of local projects.

B. Budget

For FY 2013, Indiana has budgeted \$3,349,450.00 or 28.7% of its annual budget for services to pregnant women, mothers and infants up to age one. Indiana has budgeted \$3,615,353.00 or 31% of its annual budget for family-centered, community-based, coordinated care and the development of community-based systems of care for children with special health care needs and their families. Indiana has budgeted \$3,965,225.00 or 34.0% of its annual MCH budget to provide services to preventive and primary care services for child and adolescents. Also included in this amount is \$732,400.00 or 6.3% for Administrative Costs. This is 100% of the total MCH grant award.

\$16,729,029.00 has been budgeted for Direct Medical Care Services which includes all community grants that provide direct services and projected medical claims for CSHCS.

\$5,247,328.00 has been budgeted for Enabling Services which include all community grants that provide enabling services, and all other CSHCS state funds not projected for direct medical care services.

\$5,208,239.00 has been budgeted for Population Based Services these services include all community grants that will provide population based services, Newborn Screening funds, and Indiana RESPECT funds.

\$7,181,082.00 has been budgeted toward Infrastructure Building Services and these funds include salaries for all staff and other operating expenses, less insurance premiums and community grant funds, the statewide needs assessment, data systems, and the Indiana Perinatal Network.

FY'13 Unobligated Funds

The projected unobligated balance for FY'13 is \$910,310.00. These funds are a combination of funds that were unable to be expended due to the overall statewide cost cutting measures.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.