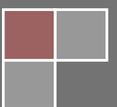
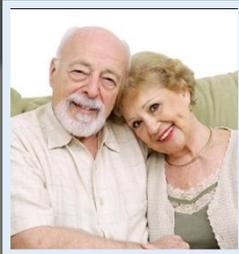


2011 -
2016

INDIANA STATE HEALTH IMPROVEMENT PLAN (I-SHIP)

Partnering for the Public's Health



INDIANA STATE HEALTH
IMPROVEMENT PLAN
(I-SHIP)
2011 – 2016

*Partnering For The
Public's Health*

JULY 2011

MULTI-STATE LEARNING COLLABORATIVE: LEAD STATES IN PUBLIC HEALTH QUALITY IMPROVEMENT IS MANAGED BY THE NATIONAL NETWORK OF PUBLIC HEALTH INSTITUTES AND FUNDED BY THE ROBERT WOOD JOHNSON FOUNDATION



Mitchell E. Daniels, Jr.
Governor

Gregory N. Larkin, M.D., F.A.A.F.P.
State Health Commissioner

Dear State Health Improvement Plan Reader:

The Indiana State Department of Health is pleased to present the 2011-2016 *Indiana State Health Improvement Plan*. The Indiana State Health Improvement Plan was created among a collaboration of executive committee members who represented a wide variety of organizations. Without their diligent work and commitment this document would not exist.

Indiana's needed health improvement will only occur with strategic and productive interaction with all elements that influence Hoosier health. This requires a statewide systematic and consistent approach that creates a dynamic network of health promotion, measured outcomes, and improved delivery of critical services.

All parties interested in public health are encouraged and challenged to review this document and determine your role in the future of moving public health forward in Indiana. There are numerous challenges and opportunities for every entity to play a critical role: hospitals, health departments, nonprofits, universities, food establishments, surgery centers, etc.

The goals, objectives and activities contained in the Indiana State Health Improvement Plan are geared toward improving the lives of all Indiana residents. This plan will be implemented and evaluated over the next five years. Successful implementation can only occur through collaboration among individuals, public, private, governmental, and nonprofit organizations. The Indiana State Department of Health is confident that with strong and committed partners, the Indiana State Health Improvement Plan will move forward in a successful manner.

Sincerely,

Gregory N. Larkin, MD, F.A.A.F.P., F.A.C.O.E.M.
State Health Commissioner

*A LETTER FROM THE CO-CHAIRS:
ON BEHALF OF THE
INDIANA STATE HEALTH IMPROVEMENT PLAN
EXECUTIVE COMMITTEE*

Dear Public Health Partners:

For the past year, it has been our privilege to lead the Indiana State Health Improvement Planning process. We are pleased to have had the opportunity to work with a committed and talented Executive Planning Committee. This broad-based group of individuals represented health care providers, academia, non-profit health organizations, state and local public health departments, and state governmental agencies who subscribed to a broad definition of health.

We are pleased to present the Indiana State Health Improvement Plan to the Governor, the State Health Commissioner and to you, our Indiana public health system partners. This plan was created for all of you who are dedicated to improving the health of all Hoosiers.

The State Health Improvement Plan envisions *optimal mental, physical, environmental, social, and intellectual well-being for all Hoosiers leading to a healthy, productive, vibrant and prosperous state.*

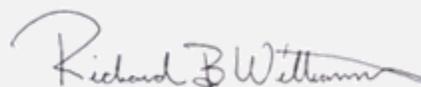
The Plan focuses on several health priorities, as well as key system improvements that, when achieved, will significantly impact health in Indiana. Goals and objectives relating to these priorities, as well as suggested strategies comprise the health improvement plan.

It is the hope and intent of the State Executive Planning Committee that each and every public health system partner will identify activities in the Plan which will enable them to contribute to the improvement of health outcomes in Indiana. No single organization has the capacity or depth of resources needed to improve health to an optimal level or even to maintain it at its current level. The State Health Improvement Plan is founded on the premise that together, Indiana Public Health System partners can make a difference.

Sincerely,



Dr. Deborah McMahan



Dean Richard Williams

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INDIANA STATE HEALTH IMPROVEMENT PLAN

Partnering for the Public's Health

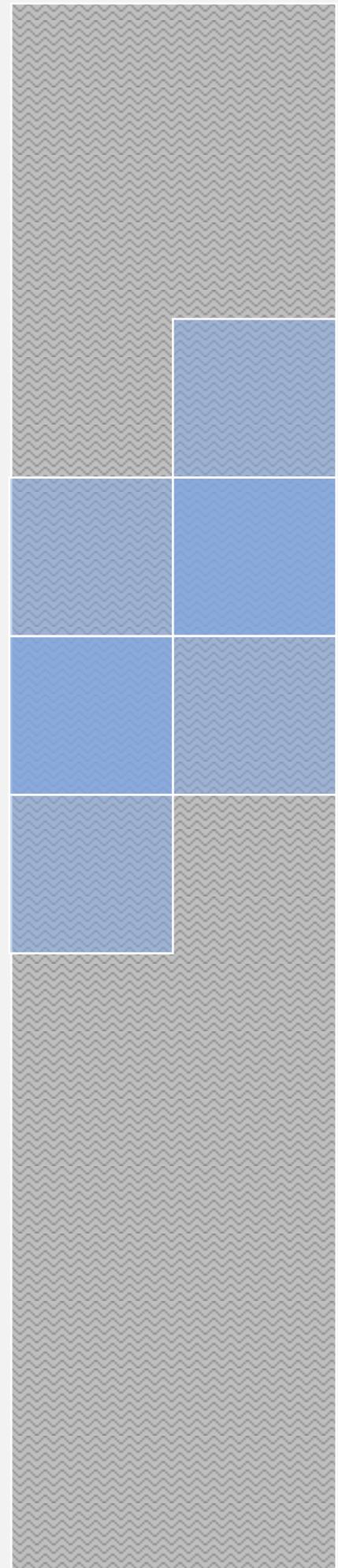
EXECUTIVE SUMMARY

Effective state health improvement planning that provides a statewide, systematic, and consistent approach linking health promotion to measurable change in health outcomes and optimal delivery of services is critical in today's ever-changing public health environment. This Indiana State Health Improvement Plan (I-SHIP) is a comprehensive implementation plan that sets out goals, identifies data-driven priorities, and provides a process for managing and measuring progress. The Plan is part of a framework to focus the public health workforce and all state and local public health system partners on primary, secondary and tertiary prevention efforts to impact Indiana's most pressing population health issues. The long-term goals and accountability measures of the Plan have been established in alignment with the Indiana State Department of Health (ISDH) Strategic Program Plans.

I-SHIP incorporates the work of a State Health Improvement Plan Committee that has dedicated their time and expertise over the past year to develop this document. The Plan is a concise document that is intended to serve as a guide and a tool for health improvement planning for the Indiana State Department Health, as well as all public health system stakeholders and communities statewide. It outlines an approach that generates goals and performance measures for accomplishing the overall vision of the Committee.

The ongoing process of implementing I-SHIP will bring together stakeholders and ISDH staff on a periodic, regular basis through a public-private advisory committee to review health priorities, progress, and accountability measures as part of ongoing evaluation. Important to this Committee will be the need to evaluate new health data that provides indication of the need for additional or emerging health or system infrastructure priorities in the state.

I-SHIP is not intended to be a final report or "end document." It is intended to be the beginning of a process that will monitor and evaluate health priorities and system infrastructure in an ongoing manner. I-SHIP provides an approach that is structured in nature and specific enough to guide decisions, but flexible enough to respond to new health challenges. Its inclusive process represents a framework for all stakeholders.



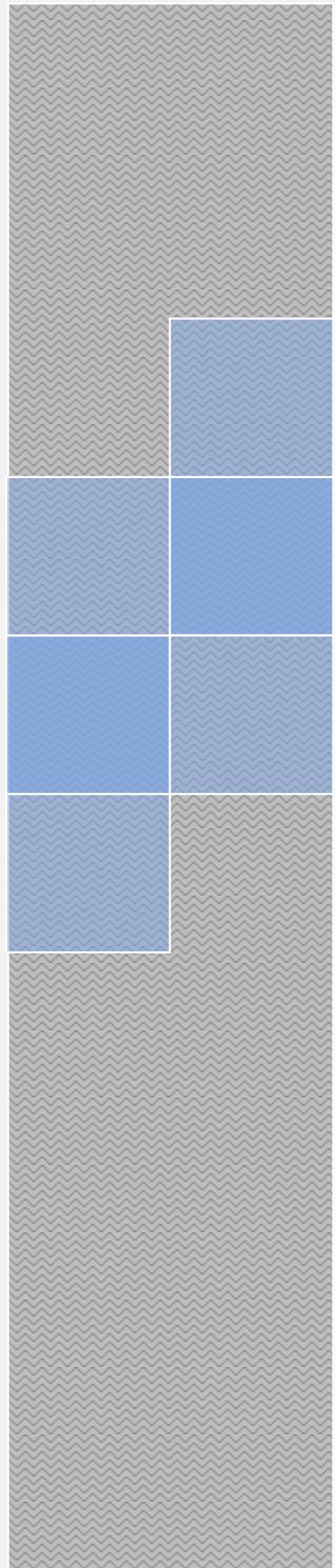
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RECOMMENDATIONS FOR HEALTH PRIORITIES

The six health priorities listed below are presented in alphabetical order and are not prioritized. They represent what is determined to most significantly influence health and illness in Indiana and align with selected Centers for Disease Control and Prevention (CDC) health priorities as identified by Dr. Thomas Frieden. In addition, each is influenced by associated behavioral, environmental, and social contextual factors.

- Assure **Food Safety** by reducing infectious/intoxication associated with food-borne illness outbreaks due to pathogens commonly transmitted through foods.
- Reduce **Healthcare Associated Infections** by reducing the standardized infection ratio for healthcare associated infections in healthcare facilities.
- Reduce the burden of **HIV, Sexually Transmitted Diseases** and **Viral Hepatitis** by decreasing incidence in Indiana.
- Reduce **Infant Mortality** by decreasing the percentage of preterm births in Indiana.
- Increase Hoosiers at a Healthy Weight by reducing the prevalence of **Obesity** in Indiana.
- Decrease **Tobacco Usage** to reduce the tobacco burden on Indiana.



INDIANA STATE HEALTH IMPROVEMENT PLAN

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RECOMMENDATIONS FOR SYSTEM PRIORITIES

The 10 Essential Public Health Services are intended to represent the core functions of public health. As outlined below, they serve as the underlying foundation that supports the planning, delivery and evaluation of public health practice. The public health core functions and 10 essential services include:

ASSESSMENT

- ES1 Monitor health status to identify and solve community health problems.
- ES2 Diagnose and investigate health problems and health hazards in the community.

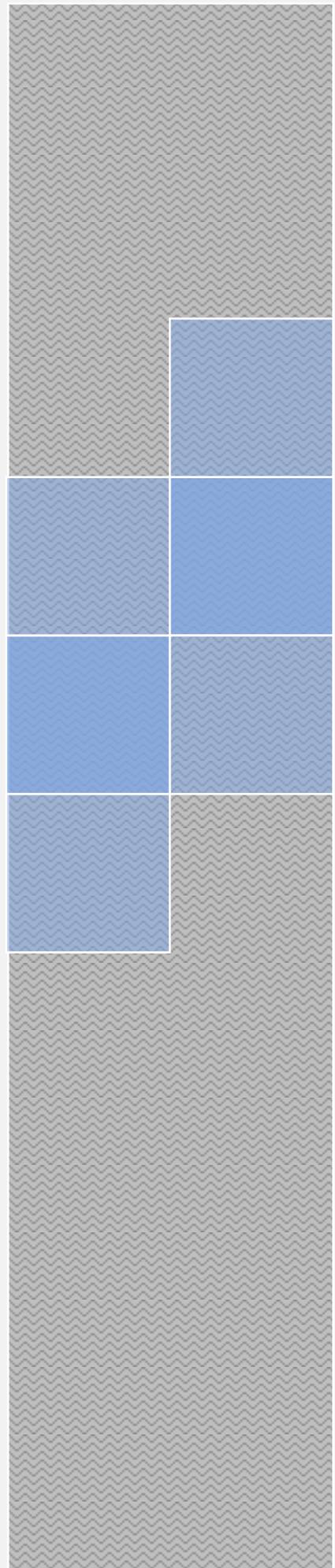
POLICY DEVELOPMENT

- ES3 Inform, educate and empower people about health issues.
- ES4 Mobilize community partnerships and action to identify and solve health problems.
- ES5 Develop policies and plans that support individual and community health efforts.

ASSURANCE

- ES6 Enforce laws and regulations that protect health and ensure safety.
- ES7 Link people to needed personal health services and ensure the provision of health care when otherwise unavailable.
- ES8 Assure a competent public and personal health care workforce.
- ES9 Evaluate effectiveness, accessibility, and quality of person and population-based health services.
- ES10 Research for new insights and innovative solutions to health problems.

Public health system partners that contribute to the delivery of these services in every community in Indiana must have a strong infrastructure to effectively meet health goals and improve health outcomes of the populations they serve.

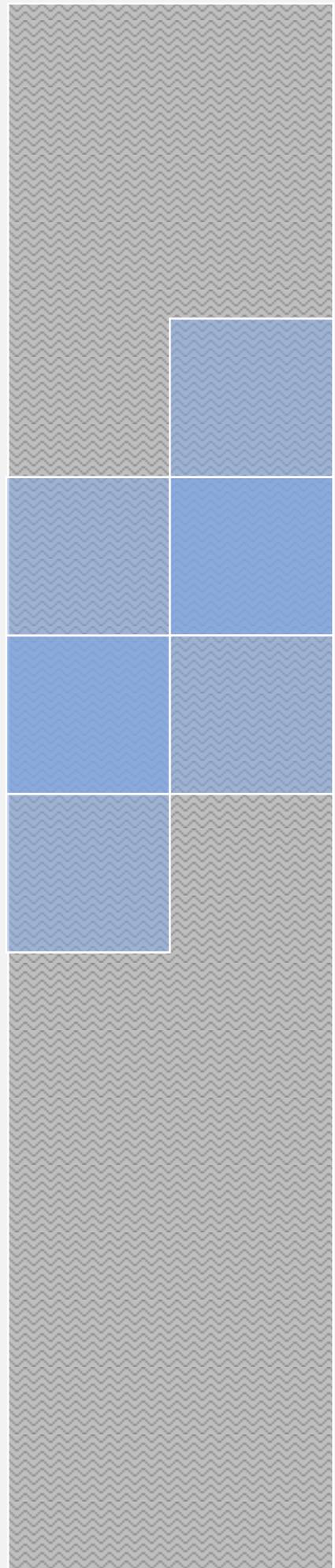


INDIANA STATE HEALTH IMPROVEMENT PLAN

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The list below represents infrastructure priorities, as identified by the Planning Committee. They are based on the 10 essential public health services, recognizing their key importance in underlying public health practice at all levels toward improved health outcomes.

- Enforcement of Laws and Regulations (ES6)
- Public Health Workforce Development (ES8)
- Data and Community Health Profiles (ES1)
- Diagnosing and Investigating Health Hazards (ES2)
- Public Health Policy Development (ES5)
- Informing, Educating and Empowering the Public (ES3)
- Integrated Healthcare Delivery (ES4, ES7, ES9)



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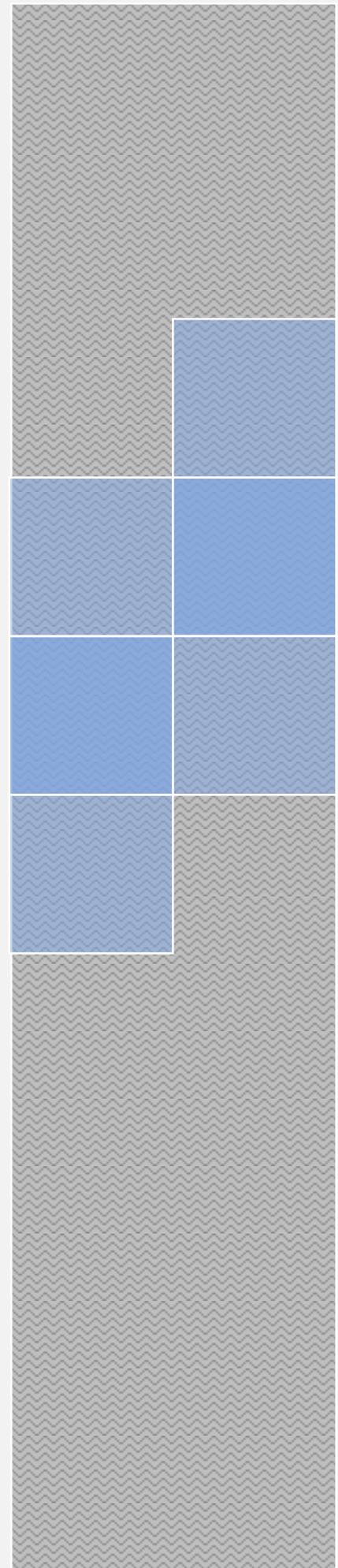
INDIANA: BACKGROUND

As of 2010, Indiana's population was 6,483,802 people, with a median age of 36.4 years. Statewide, Indiana's population grew by approximately six percent between 2000 and 2010, with the majority of the growth resulting from more births than deaths and people moving into Indiana. Indiana is a home-rule state comprised of 92 counties, 93 local public health jurisdictions, and 10 preparedness districts (Appendix A). Nearly one-half of Indiana counties are designated as being rural, with 50% of Indiana counties having Healthcare Professional Shortage Areas (HPSA) and 61% of counties having designated Medically Underserved Areas (MUA).

Whites make up 84.3% of Indiana's population. Approximately 9% of the state's population is Black. Marion County (Indianapolis) and Lake County (Gary) have the highest concentrations of Blacks, representing approximately 25% of each county's population. At 1.6% of Indiana's population, Asians are the fastest growing minority, with the highest concentration of 5.3% in Tippecanoe and Monroe Counties. In addition, Hamilton County has 4.2% Asian representation. Indiana also has the third largest population of Old Order Amish in the nation, with 19 settlements in the state, representing a population of more than 35,000. The Pokagon Band of Potawatomi Indians, a federally recognized Indian tribe of 3,150 members that speak Algonquian, also resides in northwestern Indiana and southwestern Michigan.

The largest increase among Indiana's population has been the Hispanic/Latino ethnic group. Hispanics/Latinos make up 6% of the state's population with the greatest concentration in Lake County (15.1%), followed by Elkhart County at 14.0%. Other counties with significant Hispanic/Latino population growth include Allen, Marion, Porter, and Tippecanoe.

The median income per capita annually for residents of Indiana in 2009 was \$45,424. Between 1999 and 2002, Indiana's poverty rate increased from 8.7% to 9.6%; increased to 12.2% in 2006, and was 12.9% in 2008. LaGrange County, in northwestern Indiana has consistently had one of the highest unemployment rates in the state (greater than 17%), (Indiana Department of Workforce Development), largely due to laid off Amish workers who have now filed for unemployment. Elkhart County, in northern Indiana, where the largest Old Order Amish settlement is



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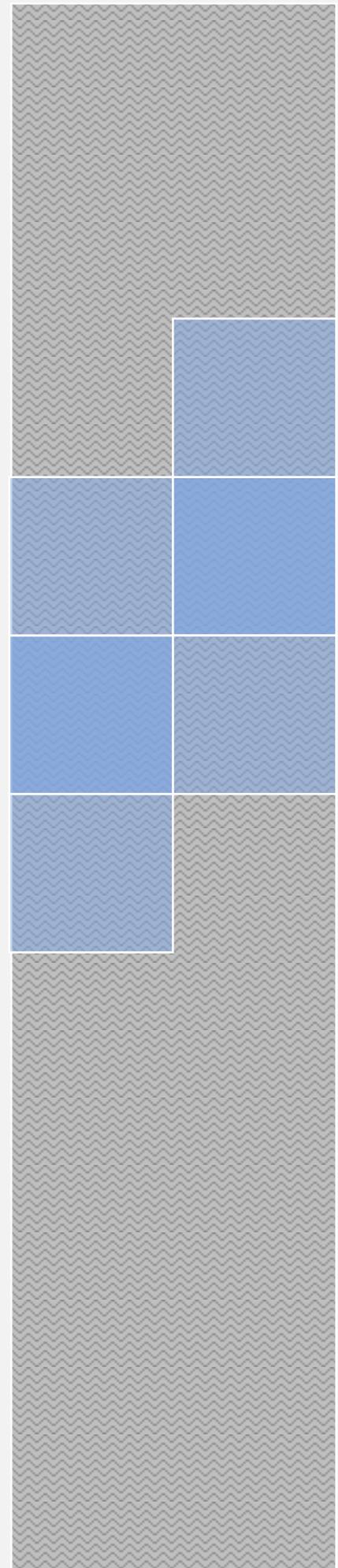
located, has had a consistently high unemployment rate of approximately 17-18%. Of Indiana residents, 25 years of age or older, only 78.8% have a high school diploma. The percent of adults, 25 years of age or older, with BS, BA or graduate degrees is 17.6%.

Infant mortality rates in Indiana are some of the highest in the nation. In 2006, Black infant mortality rates in Allen and St. Joseph counties were over 30 per 1,000 live births, the equivalent of rates in countries such as Honduras, Indonesia, and Nicaragua. In addition, Indiana has one of the highest smoking rates during pregnancy of all states. Likewise, almost 11% of births in Indiana are preterm and nearly 9% of infants born in Indiana are of low birth weight.

Indiana is challenged by a number of health behavior factors impacting outcomes in the state. For example, childhood and adult obesity rates in Indiana are of epidemic proportions (14.6% for children 10-17 years and 30% for adults). Over 26% of residents self-report a history of high blood pressure, and over 38% have ever been told they have elevated cholesterol, both higher than the national average. Leading causes of death in Indiana for men and women continue to be heart disease, cancer, chronic lower respiratory infections and stroke, which can all be attributed to obesity. These issues are further addressed and explored in this plan.

Counties in numerous regions of the state have spent the past three years recovering from devastating floods in 2008. Flooding displaced significant numbers of Indiana residents from their homes temporarily or permanently. In one regional hospital, the flooding led to the temporary closure of the Emergency Department, pharmacy, and laboratory as those areas were inundated. Events such as these have highlighted the need and the impact of effective preparedness training and response in Indiana for natural disasters. Indiana is also located near the Wabash Valley Fault, where the risk of earthquake in the next 20 years is a significant threat.

In 2007, the Environmental Integrity Project named 12 Indiana coal-burning power plants, including one on the Southside of Indianapolis, among the 50 "dirtiest" in the country for producing health-damaging pollutants. The report underscores the potential health threat from power company smokestacks throughout Indiana.



INDIANA STATE HEALTH IMPROVEMENT PLAN

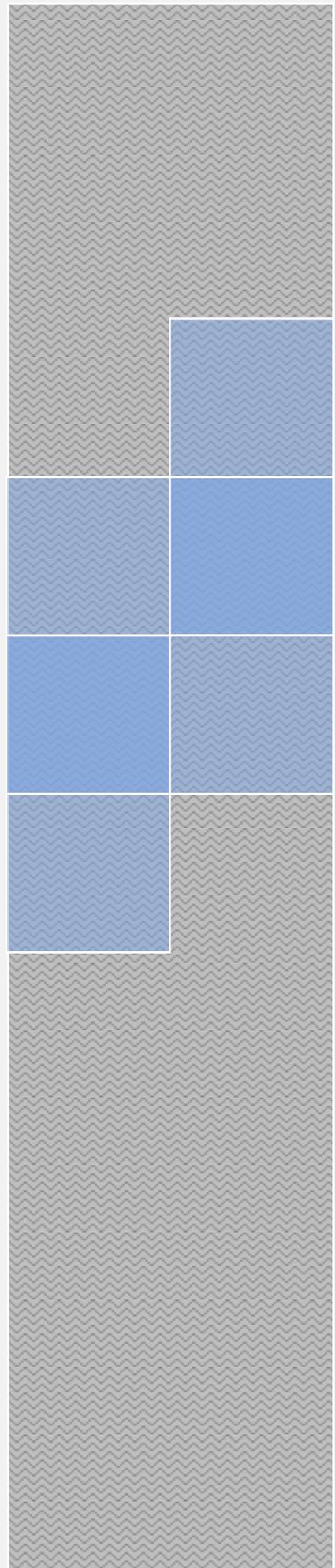
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In an effort to improve effectiveness and capacity of preparedness planning and response in Indiana, the state moved from an infrastructure of county-level preparedness coordinators to a district-level approach and infrastructure in 2009. Governmental local public health continues to be structured at the county level, with 93 local health departments located in Indiana's 92 counties.

The effectiveness of efforts to improve health indicators in Indiana is limited by the insufficient numbers of public health workers and insufficient training of those workers in counties throughout the state. Indiana has only 46 workers per 100,000 population, compared to the national average of 138 workers per 100,000 (U.S. Department of Health and Human Services, 2000)ⁱ. Federal public health funding to Indiana now ranks 50th, with only \$12.47 per capita from the Centers for Disease Control and Prevention, compared to the national average of \$17.60. In addition, funding from the Health Resources and Services Administration (HRSA) provides \$10.32 per capita, compared to the national average of \$21.43, ranking Indiana 49th (Trust for America's Health, 2009)ⁱⁱ. A 2008 study concluded that an investment in evidence-based public health programs could save Indiana \$343 million dollars annually within five years, with a return on investment of \$5.52 for every \$1 invested (Trust for America's Health, 2009)ⁱⁱ.

ⁱU.S. Department of Health and Human Services (2000). The Public Health Work Force Enumeration Accessed from:
<http://www.uic.edu/sph/prepare/courses/chsc400/resources/phworkforce2000.pdf>

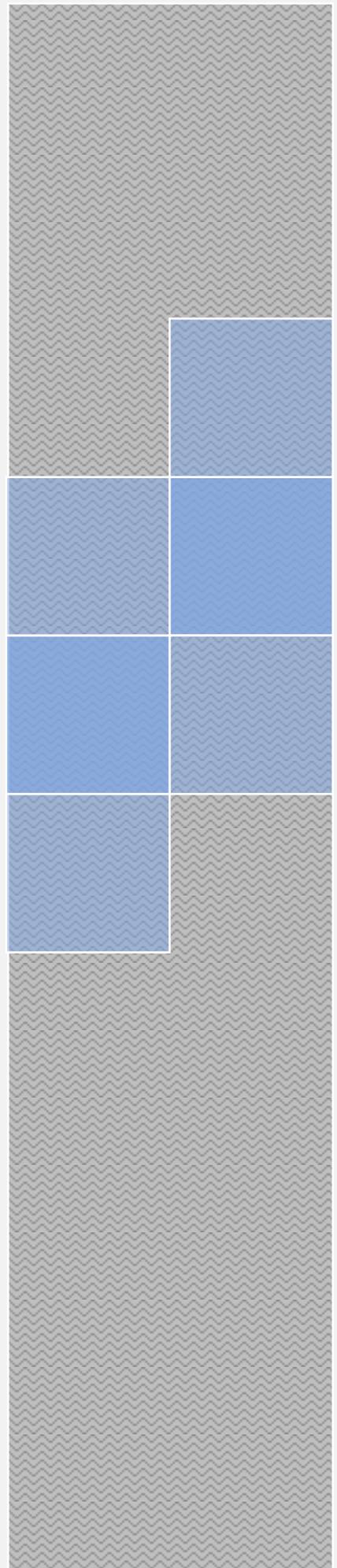
ⁱⁱTrust for America's Health, 2008 report (2009). Access from:
<http://www.rwjf.org/publichealth/product.jsp?id=39808>



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VISION STATEMENT FOR HEALTH IN INDIANA

Optimal mental, physical, environmental, social, and intellectual well-being for all Hoosiers leading to a healthy, productive, vibrant and prosperous state.



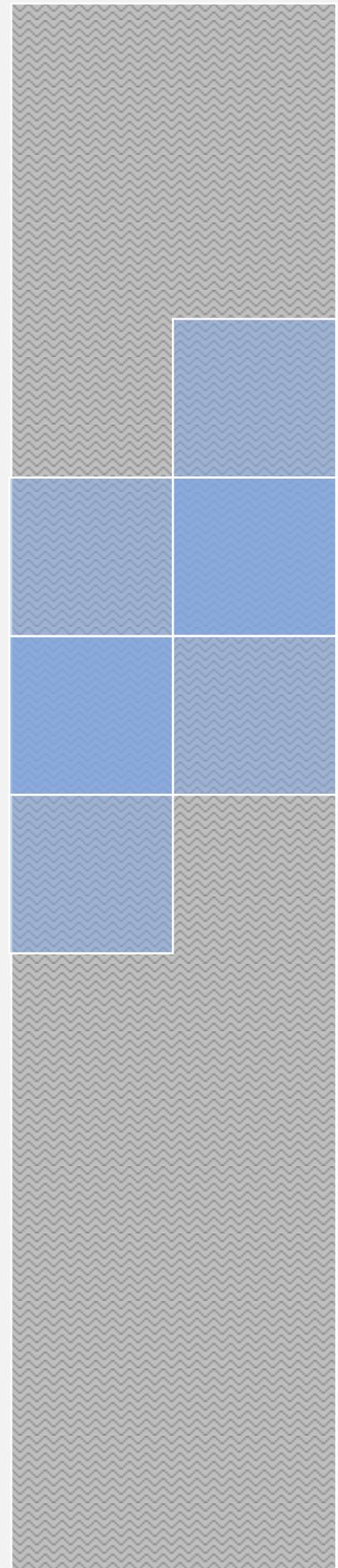
INDIANA STATE HEALTH IMPROVEMENT PLAN

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PROCESS FOR DEVELOPING THE PLAN

The implementation and evaluation process of I-SHIP is key to understanding the difference between a comprehensive implementation plan and a strategic plan. The I-SHIP planning process began with identification of a vision for the public's health by the State Health Improvement Planning Committee, comprised of broad-based partnership and key stakeholders. The Committee, in partnership with the ISDH, established priorities that were reflective of current health needs data and system infrastructure needs. Health priorities are supported by multi-level performance measures and activities that incorporate primary, secondary, and tertiary interventions for each. The system infrastructure priorities are supported by measureable goals and objectives to build a stronger system for public health and service delivery. The measures included in the Plan will enable the ISDH and the ongoing I-SHIP Advisory Committee to systematically track progress towards identified priorities over time. The overall approach is a shift from being reactive towards an approach that is more 'proactive' in nature to create a healthier Indiana. The Plan builds on a foundation of:

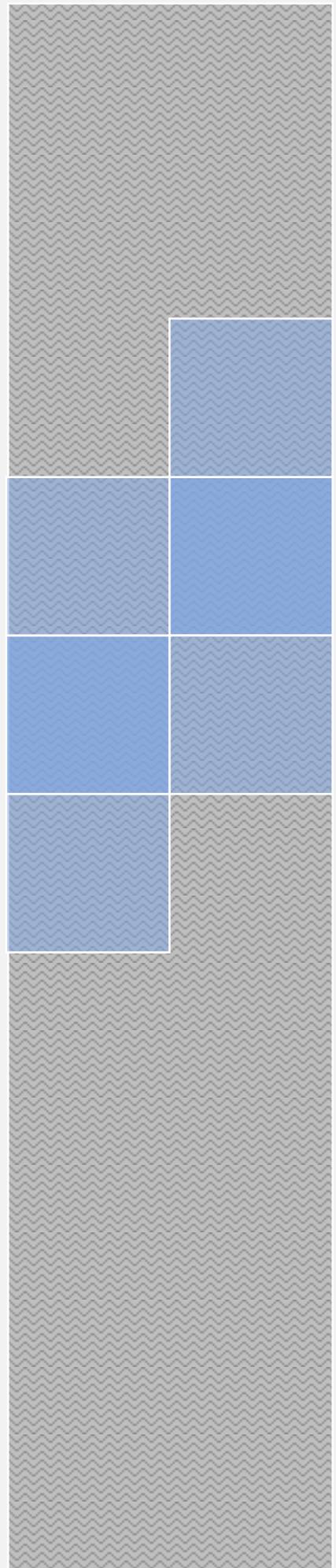
- Building, sustaining and creating where necessary, collaborative public health system **partnerships**.
- Health **promotion** and disease **prevention**.
- Closing gaps in the **system infrastructure** for more effective delivery of services and protection of the public's health.



INDIANA STATE HEALTH IMPROVEMENT PLAN
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SECTION 1: THE STATE OF HEALTH IN INDIANA

This section presents a general overview of some of the major health problems in Indiana. In the first part of this section, demographic trends and their implications for public health are presented. In the second part, trends in health status are examined. This includes infant mortality rates, premature birth rates, low birth weight rates, and coronary heart disease, cerebrovascular disease, and diabetes death rates, as inferences can be made from the data and conclusions drawn about the general good or poor health status of the population.



INDIANA STATE HEALTH IMPROVEMENT PLAN

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FIGURE 1.2 PERCENT CHANGE IN MINORITY POPULATION BY COUNTY, INDIANA 2000-2010

COUNTY SIZE

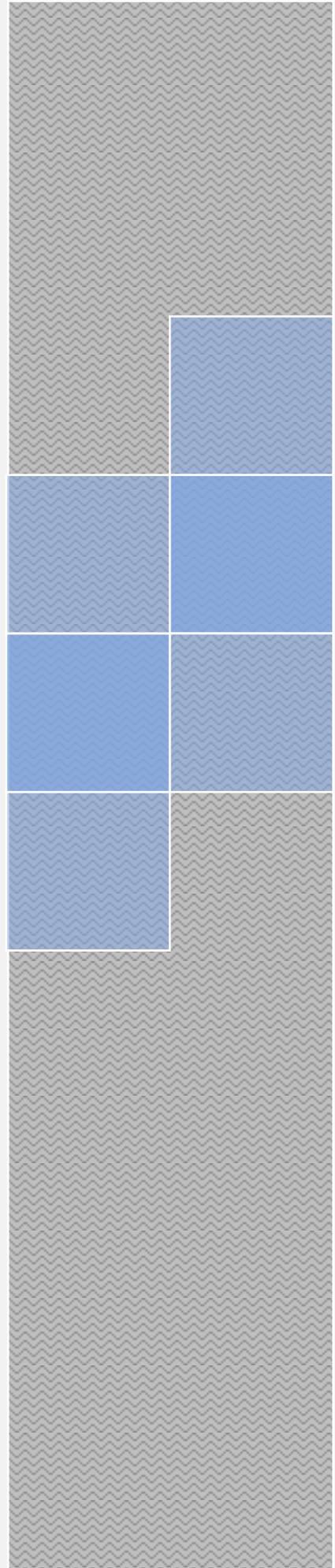
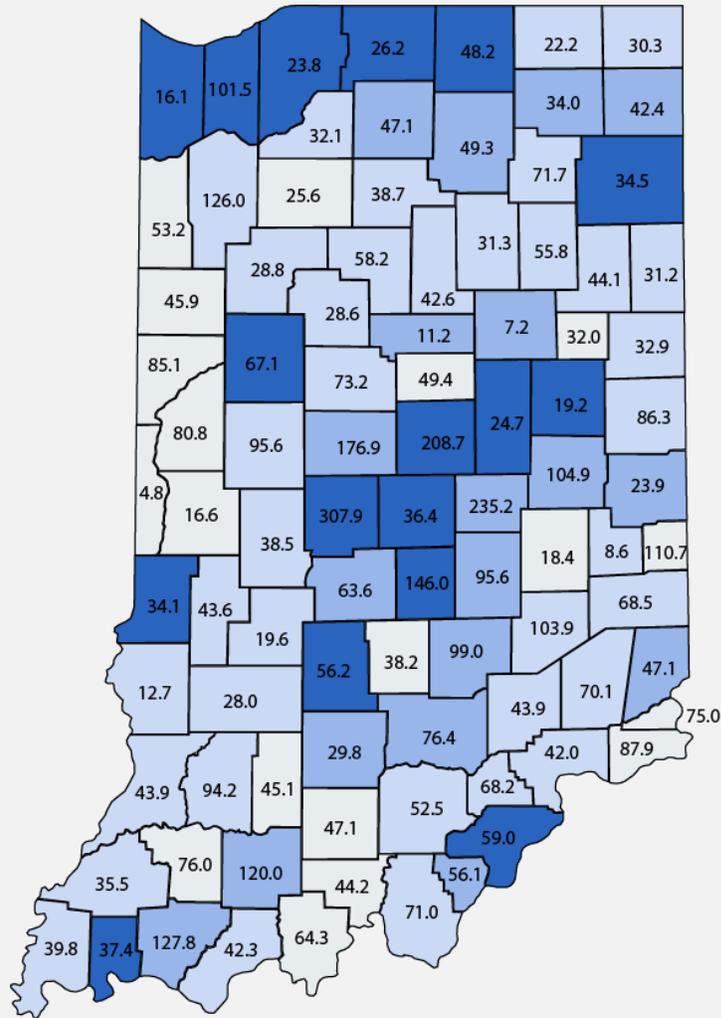
Small 0 - 19,999

Medium 20,000 - 39,999

Large 40, - 89,999

Extra Large 90,000 +

Source: US Census 2010



INDIANA STATE HEALTH IMPROVEMENT PLAN
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TABLE 1.1 INDIANA POPULATION AND PRIMARY HEALTHCARE SERVICES BY COUNTY

COUNTY	POPULATION	RURAL HEALTH CLINIC	FQHC	COUNTY	POPULATION	RURAL HEALTH CLINIC	FQHC
<i>Total Urban/Rural Population</i>							
Urban	3,598,000						
Rural	1,946,000						
<i>Population By County (Blue = Counties with more than 50% urban population)</i>							
Adams	34,256	1		Lawrence	45,842		
Allen	353,888			Madison	131,417		2
Bartholomew	76,063			Marion	890,879		13
Benton	8,613			Marshall	46,903		
Blackford	13,051			Martin	9,946	3	
Boone	56,287			Miami	36,001		
Brown	14,548	1		Monroe	130,738		
Carroll	19,752			Montgomery	37,862		
Cass	39,065		1	Morgan	70,876		
Clark	108,634			Newton	13,736	2	
Clay	26,533	3		Noble	48,028		
Clinton	34,367			Ohio	5,909		
Crawford	10,540	2		Orange	19,559	2	
Daviess	30,620	7		Owen	22,397	2	
Dearborn	50,502			Parke	16,896		
Decatur	25,079			Perry	18,812		
DeKalb	42,060			Pike	12,259	2	
Delaware	115,192		1	Porter	163,598		3
Dubois	41,419			Posey	26,004		
Elkhart	200,502		1	Pulaski	13,614		
Fayette	24,101			Putnam	36,837		
Floyd	74,426			Randolph	25,696	5	
Fountain	16,852	1		Ripley	27,421		
Franklin	23,148	1		Rush	17,175	1	
Fulton	20,265			St. Joseph	267,613		2
Gibson	32,750	1		Scott	23,624	2	
Grant	68,796	2	1	Shelby	44,503		
Greene	32,463	4		Spencer	20,039	1	
Hamilton	279,287			Starke	23,530	3	
Hancock	68,334			Steuben	33,579	1	
Harrison	37,562			Sullivan	21,153	1	
Hendricks	140,606			Switzerland	9,675	1	
Henry	47,827	3		Tippecanoe	167,964		1
Howard	82,895		1	Tipton	15,892		
Huntington	37,777			Union	7,040		
Jackson	42,362		1	Vanderburgh	175,434		4
Jasper	32,816	1		Vermillion	16,172	1	
Jay	21,117			Vigo	105,967		
Jefferson	33,010			Wabash	32,558		
Jennings	28,043	2		Warren	8,491	1	
Johnson	141,501	1	3	Warrick	58,521		
Knox	37,907			Washington	27,729		
Kosciusko	76,499			Wayne	67,552	2	
LaGrange	37,204	3		Wells	27,566		
Lake	494,211		3	White	23,452	1	
LaPorte	111,063			Whitley	32,861		

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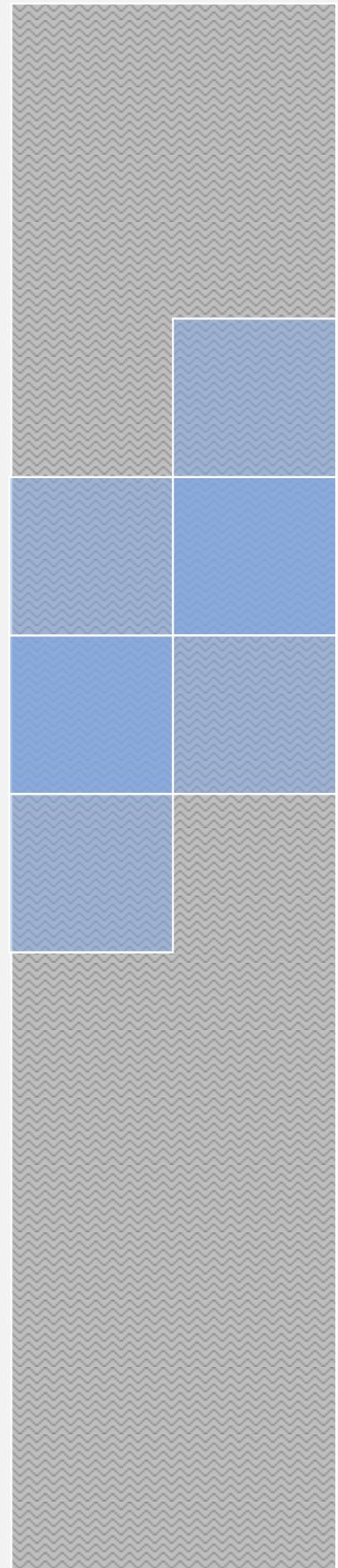
Geographically, Indiana has a land area of 36,418 square miles, ranking it 38th of all states in size. The vast plains across the state, bisected by the Wabash River, comprise the majority of the state's geography and are the basis for the strong agricultural economy in Indiana. A high percentage of Indiana's income also comes from its manufacturing sector.

Indiana's population is diverse, with the median age of all Hoosiers being 36.4 years. The state's population has increased nearly 16% in the past two decades. Approximately 12.9% of the current population is over the age of 65, nearly a 10% increase in the past decade and a number that is expected to continue to grow. Table 1.2 identifies the 2000 and 2009 populations in Indiana, by age and race, demonstrating growth over the past decade. Indiana's total population is expected to continue to increase; however, that increase will notably be most significant in the 45 and over age group population.

While the *overall* population growth has been minimal to moderate in the state over the past decade, when compared to that of the U.S. overall, the racial and ethnic diversity of the state continues to increase. Table 1.2 reveals that the non-White population is currently more than 10% of the total population, comprised primarily of Blacks¹.

The greatest growth since 2000 is in the Hispanic/Latino and Asian populations, with an 81.7% and 73.3% increase respectively (2010 U.S. Census). In Indiana, as in the U.S., the number of persons belonging to minority groups continues to increase. The state's major minority groups include Blacks, Hispanics/Latinos, and Asians, being distributed across the state, but primarily in more urban areas. Counties with largest minority populations include Hamilton, Lake, Marion, Monroe, and Tippecanoe counties.

It is important to note, for purposes of health improvement planning, that subgroups also exist within the major minority groups and can differ significantly with regard to language, health beliefs and cultural health practices. Asian populations in Indiana, for example, may include Chinese, Filipino, Japanese, Korean, Vietnamese and other groups. The Hispanic/Latino population, similarly, may include Cuban, Mexican, Puerto Rican, South American, or others.



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In addition, other minority groups and special populations live in Indiana, and represent special populations that are recognized within the context of health improvement planning. These include Native Americans, Amish, and Burmese, as well as migrant seasonal farm workers in some counties.

TABLE 1.2 INDIANA POPULATION BY AGE AND RACE/ETHNICITY

POPULATION	2000	% OF POPULATION	2009	% OF POPULATION	% CHANGE
<i>Total Population</i>					
Indiana	6,091,649	100%	6,423,113	100%	5.6%
United States	282,171,957	100%	307,006,550	100%	9.1%
<i>Population by Age</i>					
Preschool (0-4)	423,264	6.9%	445,604	6.9%	5.3%
School age (5-17)	1,151,661	18.9%	1,143,761	17.8%	0.7%
College age (18-24)	618,463	10.2%	643,920	10%	4.1%
Young adult (25-44)	1,788,402	29.4%	1,689,050	26.3%	5.5%
Older adult (45-64)	1,356,138	22.7%	1,672,187	26%	23.3%
Older (65+)	753,721	12.4%	828,591	12.9%	9.9%
<i>Population by Race/Ethnicity</i>					
White	5,436,650	89.2%	5,637,786	87.7%	3.7%
Black	517,872	8.5%	588,163	9.2%	13.6%
Hispanic or Latino	216,741	3.6%	350,676	5.5%	61.8%
American Indian / Alaskan Native	16,738	0.3%	20,698	0.3%	23.7%
Asian	61,520	1%	93,813	1.5%	52.5%
Native Hawaiian / Pacific Island	2,389	.04%	3,276	.05%	37%
Two or more races	56,480	.9%	79,377	1.2%	40.5%

Source: 2010 US Census

Economically, the median household income of Hoosiers is \$45,427, (2009) compared to the national median income of \$50,221. This represents a 7.5% decrease in median income in Indiana since 2000. The percent of Indiana residents living in poverty has increased 63.6% from 8.8% in 2000 to 14.4% in 2010 (+5.6%), and the percent of children in poverty has increased 64.5% from 12.1% in 2000 to 19.9% in 2010 (+7.8%) (Table 1.3). Figure 1.2 demonstrates the additional significant racial/ethnic differences in median income among groups.

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TABLE 1.3 INDIANA SOCIOECONOMIC FACTORS

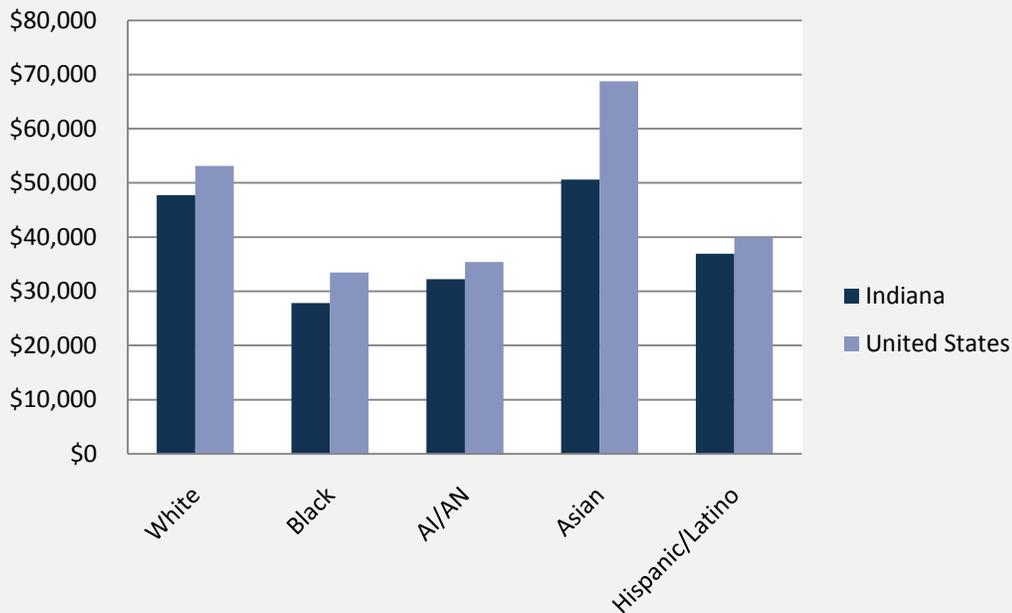
	INDIANA	U.S.
Income		
Median household income	\$45,427	\$50,221
Poverty Levels		
Percent living in poverty	14.4%	14.3%
Percent under 18 living in poverty	19.9%	20%
Unemployment		
Unemployment rate (Nov. 2010)	9.4%	9.3%
Uninsured (2009)		
Total	902,000 (14%)	50,674,000 (17%)
Under Age 65	898,000 (16%)	49,998,000 (19%)
Under Age 18	141,000 (9%)	7,513,000 (10%)
Age 65+	5,000 (0.6%)	676,000 (1.8%)

Source: Stats Indiana. (2010).

Retrieved from <http://www.stats.indiana.edu/>; <http://www.stats.indiana.edu/>;

U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009* -- <http://www.census.gov/prod/2009pubs/p60-236.pdf>

FIGURE 1.3 MEDIAN HOUSEHOLD INCOME BY RACE/ETHNICITY INDIANA 2009



AI/AN = American Indian/Alaskan Native

Source: U. S. Census Bureau. (2010).

2009 American Community Survey, one-year estimates.

Retrieved from <http://factfinder.census.gov/>

2009 American Comm. Survey: IN: white=\$47,721; black=\$27,815; AIAN=\$32,238;

Asian=\$50,629; Hispanic=\$36,913 US: white=\$53,131; black=\$33,463; AIAN=\$35,381;

Asian=\$68,780; Hispanic=\$39,923

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In 2009, of the nearly 3.9 million Hoosiers age 25 and over, 17.9% had not graduated high school (or earned the equivalent GED), which represents a 26.3% decrease since 2000. Eighty-two percent of the population in Indiana had a high school diploma or higher and 19.4% had a bachelor's degree or higher (Table 1.4).

TABLE 1.4 INDIANA EDUCATION ATTAINMENT BY AGE

EDUCATION	2000	PERCENT OF POPULATION 25+	2009	PERCENT OF POPULATION 25+
<i>Total Population</i>				
Population 25+	3,489,470	100%	3,893,278	100%
<i>Education level attained</i>				
Less than 9th grade	297,423	8.5%	206,540	5.3%
9th to 12th grade, no diploma	552,591	15.8%	489,000	12.6%
HS graduate (incl. equivalency)	1,333,093	38.2%	1,447,734	37.2%
Some college, no degree	578,705	16.6%	768,856	19.7%
Associate's degree	184,717	5.3%	225,535	5.8%
Bachelor's degree	321,278	9.2%	475,247	12.2%
Graduate or professional degree	221,663	6.4%	280,366	7.2%

Source: Stats Indiana. (2010).

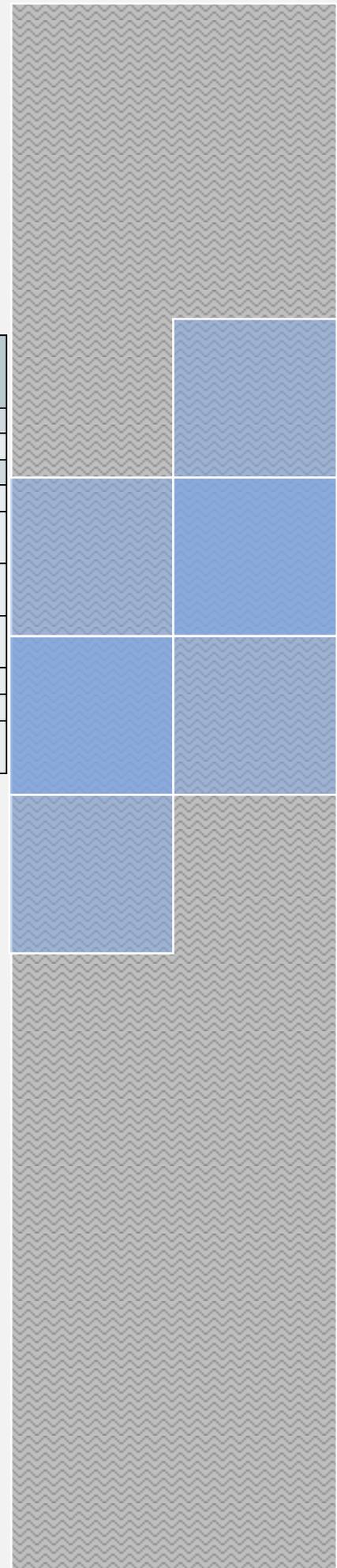
Retrieved from <http://www.stats.indiana.edu/>; <http://www.stats.indiana.edu/>

State health improvement planning in Indiana must take into account the racial, cultural, and linguistic diversity of the residents of Indiana, and the impact which educational level and economic status, rural residence or other factors may have on obtaining access to public health and health care services, as well as engaging in health promotion activities.

Significant demographic trends to consider in planning include:

- Substantial number of small, rural counties
- Aging of the state's population
- Growth of racial/ethnic minority populations
- Increase in poverty status over the last decade
- Racial/ethnic disparities in median income
- High school dropout rate

ⁱ Indiana currently uses the 1977 Office of Management and Budget (OMB) standards for collecting data on race and ethnicity. These standards are in use by all states who have not yet revised their birth certificates to meet the 1997 OMB standards for collecting race and ethnicity information. The 1977 standards are also the standards used by the National Vital Statistics System for national reporting.

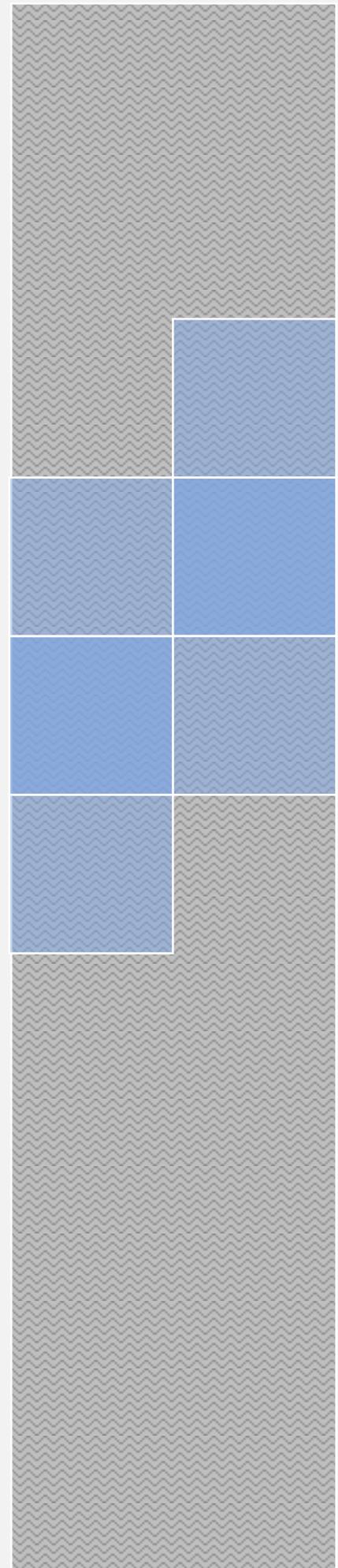


INDIANA STATE HEALTH IMPROVEMENT PLAN

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HEALTH CONDITIONS/HEALTH RISK FACTORS

This section presents information on morbidity, with data reflecting Indiana's population that is affected by selected conditions/risk factors. Some data, where noted, are derived from the Behavioral Risk Factor Surveillance System (BRFSS). BRFSS is a state-based computer-assisted telephone interviewing effort conducted in collaboration with the Centers for Disease Control and Prevention. Adults are randomly selected via telephone across Indiana and surveyed on a monthly basis. Survey questions are constructed to determine individual behaviors that may affect risk of developing chronic diseases that lead to premature mortality and morbidity and are useful in broad, population-based health improvement planning.



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DISEASES OF THE HEART

Diseases of the heart remain the leading cause of death in Indiana, as well as across the U.S. Deaths due to this cause showed a decrease in both the number and the age-adjusted rate during the period of 2003 (15,411/245.39) to 2007 (13,715/203.47). Overall, over the past five years, the prevalence of diseases of the heart in adults has remained unchanged.

TABLE 1.5 PREVALENCE OF HEART DISEASE

YEAR	%	CI
2005	5.0	(4.4-5.6)
2006	5.3	(4.7-5.9)
2007	5.2	(4.6-5.8)
2008	5.0	(4.3-5.7)
2009	4.9	(4.3-5.5)

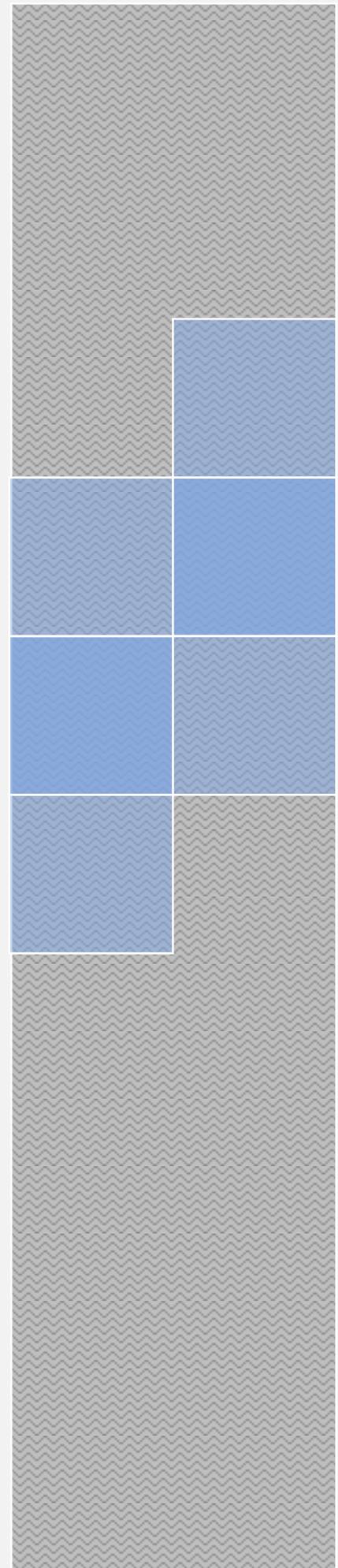
*% = Percentage, CI= Confidence Interval, n = cell size.
 Percentages are weighted to population characteristics
 Source: 2005-2009 Indiana BRFSS*

When residents of Indiana were asked if they had ever been told they had a heart attack (myocardial infarction) BRFSS data revealed that for all age groups, with the exception of adults ages 55+ year olds, Indiana rates were similar to the median representing the U.S. and Washington D.C. (Table 1.6)

TABLE 1.6 EVER TOLD YOU HAD A HEART ATTACK (MI)

State:		18-24	25-34	35-44	45-54	55-64
Indiana	% CI n	0.5 (0.0-1.5) 1	0.6 (0.0-1.4) 3	2.1 (0.7-3.5) 17	3.6 (2.5-4.8) 75	8.5 (6.6-9.8) 155
Estimated adult population affected		31,345	50,032	18,211	33,179	57,576
Nationwide (States and DC)	Median % # states	0.4 25	0.6 45	1.1 51	2.7 51	5.8 51

Source: 2009 Indiana BRFSS



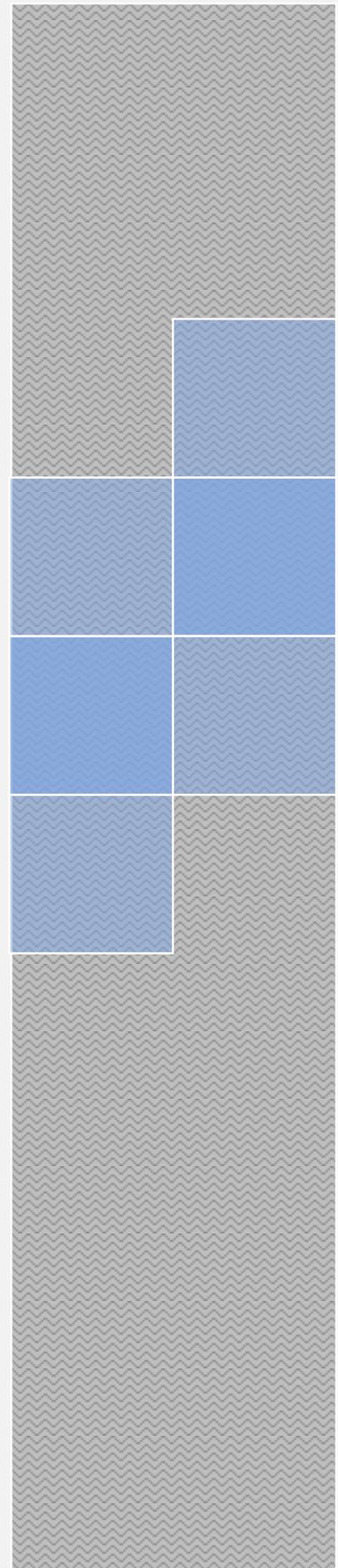
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When asked if they had ever been told they had angina or coronary artery disease, Indiana BRFSS results reveal rates higher than the national average for all age groups. (Table 1.7)

TABLE 1.7 EVER TOLD YOU HAD ANGINA OR CORONARY ARTERY DISEASE

State:		18-24	25-34	35-44	45-54	55-64
Indiana	% CI n	N/A	1 (0.0-2.4) 4	2.3 (0.7-3.9) 20	3.1 (1.9-4.3) 68	9.1 (7.5-10.7) 167
Estimated adult population affected		n/a	8,402	19,940	28,354	63,020
Nationwide (States and DC)	Median % # states	0.4 24	0.4 44	1 51	2.6 51	6.5 51

Source: 2009 Indiana BRFSS



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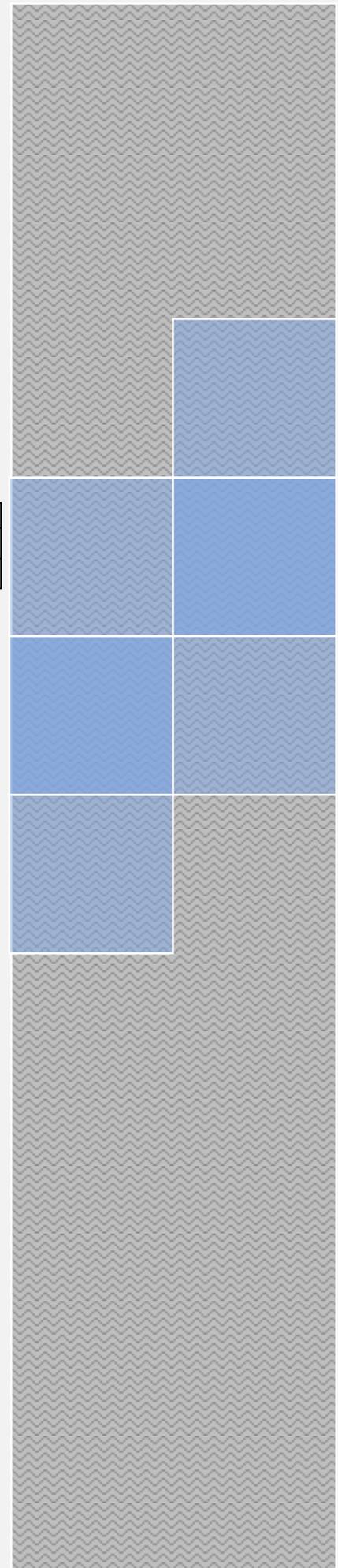
CANCER

Malignant neoplasms (cancers) of all types were responsible for 12,750 deaths in Indiana in 2007. Cancer was responsible for 23.7% of all deaths in Indiana in 2007 and remains the second leading cause of death in the state. The age-adjusted rate for cancer in Indiana is 192.77 per 100,000 population. Table 1.8 below reflects the incidence of cancer over the past five years, measured as cases diagnosed per year. The age-adjusted rate per 100,000 reflects a decrease over the past five years.

TABLE 1.8 INCIDENCE OF CANCER

	2003	2004	2005	2006	2007
Cancer incidence cases per year	30,455	30,277	30,599	31,390	31,028
Age-adjusted rate per 100,000	488.2	479.3	478.1	482.7	469.0

Source: ISDH Cancer Registry Report Generator accessed 2/22/11



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CEREBROVASCULAR DISEASE

In 2009, deaths from cerebrovascular disease were the third leading cause of death in Indiana, causing 2.6% of all deaths. Over the past five years, the prevalence of stroke for adults ages 18 years and older has been stable.

TABLE 1.9 PREVALENCE OF CEREBROVASCULAR DISEASE (2005-2009)

YEAR	%	CI	n =
2005	2.6	(2.2-3.0)	174
2006	2.7	(2.3-3.1)	244
2007	2.9	(2.5-3.3)	252
2008	2.8	(2.3-3.4)	205
2009	2.6	(2.3-3.0)	397

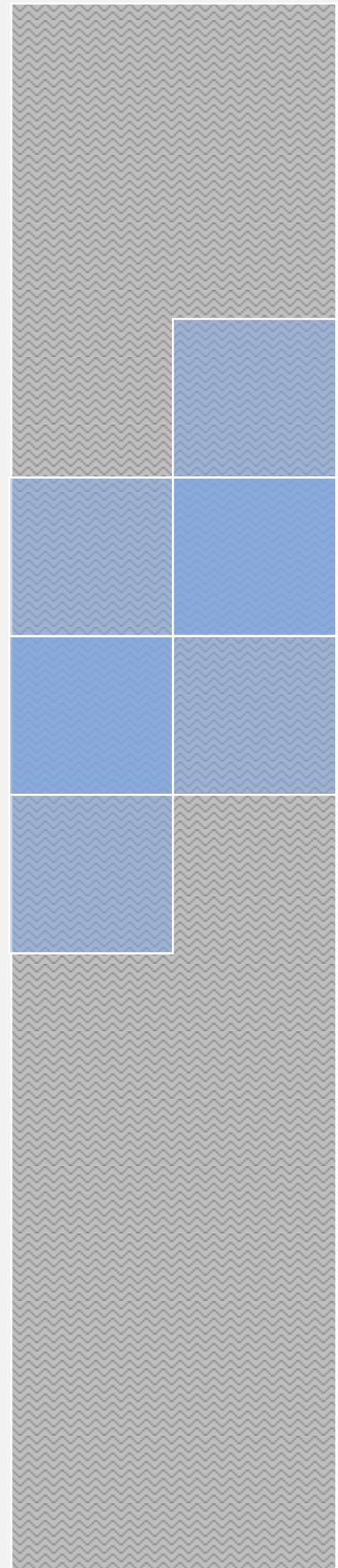
Source: 2005-2009 Indiana BRFSS

When residents of Indiana were asked if they had ever been told they had a stroke, Indiana's prevalence was similar to the national median. (Table 1.10)

TABLE 1.10 EVER TOLD YOU HAD A STROKE

State:		18-24	25-34	35-44	45-54	55-64	65+
Indiana	% CI n	0.2 (0.0-0.6) 1	0.5 (0.0-1.3) 2	1 (0.2-1.8) 13	2.3 (1.5-3.1) 56	4.4 (3.2-5.6) 96	7.4 (6.2-8.6) 229
Estimated adult population affected		4,206	8,690	21,207	30,910	60,641	1,251
Nationwide (States and DC)	Median % # states	0.5 33	0.4 47	0.8 51	1.9 51	3.4 51	7.8 51

Source: 2009 Indiana BRFSS



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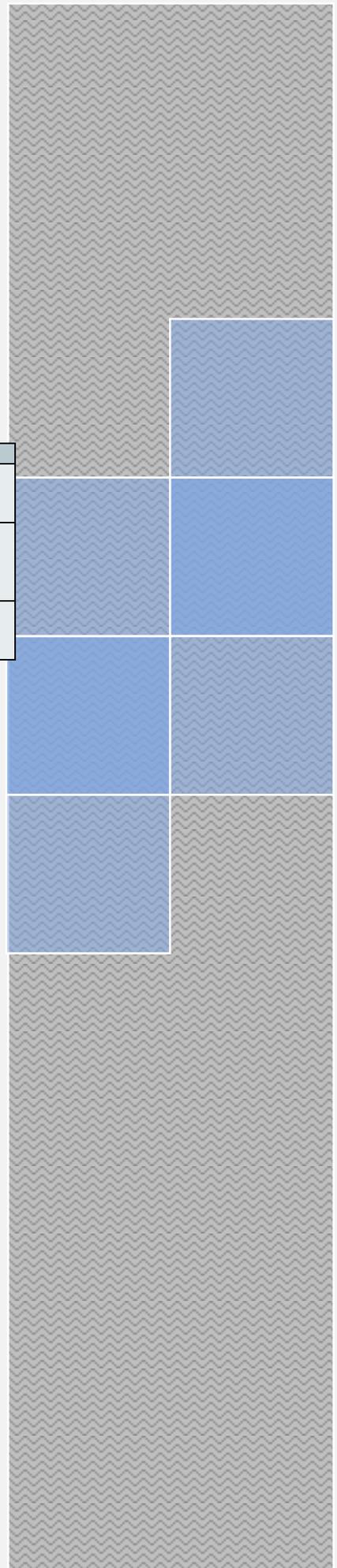
DIABETES

In 2007, there were 1,564 deaths of Indiana residents with diabetes mellitus designated as the underlying cause of death. Diabetes mellitus was the seventh leading cause of death, with an age-adjusted death rate of 23.42 per 100,000 population. The age-adjusted death rate by race was 22.04 for White and 49.03 for Black populations. Indiana's adult diabetes prevalence was similar to the national median.

TABLE 1.11 EVER BEEN TOLD BY A DOCTOR YOU HAVE DIABETES

State:		18-24	25-34	35-44	45-54	55-64	65+
Indiana	% CI n	1.3 (0.0-2.7) 4	1.1 (0.3-1.9) 16	3.3 (2.1-4.5) 51	9.7 (7.9-11.5) 215	18.4 (16.2-20.6) 385	22.3 (20.3-24.3) 651
Estimated adult population affected		8,149	9,284	28,700	89,639	129,452	183,232
Nationwide (States and DC)	Median % # states	1.1 46	2.0 51	4.1 51	8.3 51	14.3 51	19.0 51

Source: 2009 Indiana BRFSS



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BEHAVIORAL RISK FACTORS

OBESITY

Being obese is a risk factor for heart disease, cancer, stroke, and diabetes. Using the BRFSS, being obese is defined as including all responses to questions pertaining to weight and height that had a calculated body mass index greater than or equal to 30. For all races and subgroups, the prevalence of being obese remained fairly steady at 25%-27% until 2009 when the percent of obesity in Indiana rose to 30%.

TABLE 1.12 PREVALENCE OF OBESITY (2003-2009)

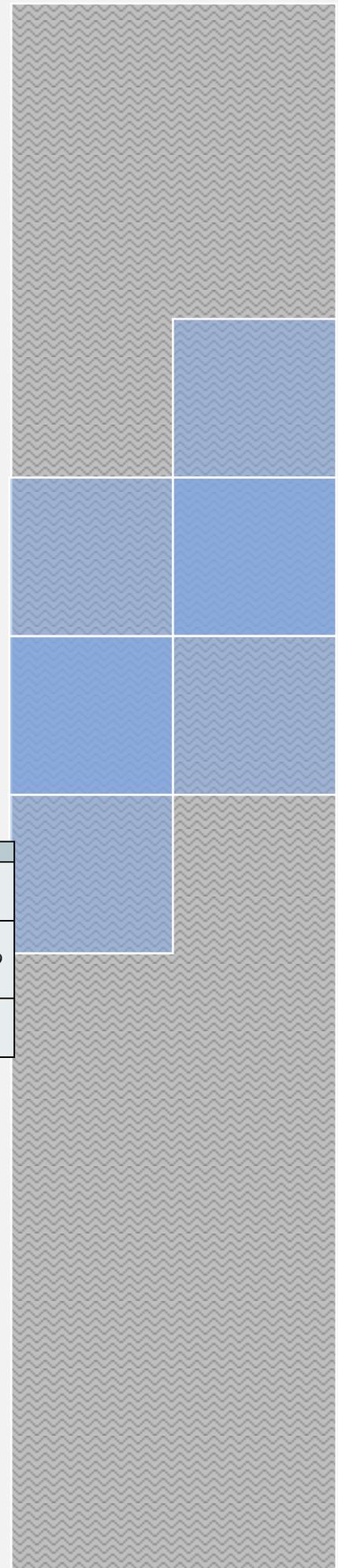
YEAR	%	CI	n =
2003	26.0	(24.7-27.3)	1383
2004	25.5	(24.3-26.7)	1608
2005	27.2	(25.8-28.6)	1458
2006	27.8	(26.4-29.2)	1857
2007	27.4	(25.8-29.0)	1756
2008	27.0	(25.2-28.8)	1414
2009	30.0	(28.6-31.4)	2865

Source: 2003-2009 Indiana BRFSS

TABLE 1.13 WEIGHT CLASSIFICATION BY BODY MASS INDEX (BMI)

State:		18-24	25-34	35-44	45-54	55-64	65+
Indiana	% CI n	19.7 (14.4-25.0) 65	28 (24.1-31.9) 248	29.8 (26.5-33.1) 351	35.0 (32.3-37.7) 663	39.2 (36.5-41.9) 772	24.8 (-28.8) 766
Estimated adult population affected		120,492	223,764	248,075	311,209	263,780	213,279
Nationwide (States and DC)	Median % # states	17.7 48	28.0 51	29.5 51	30.7 51	31.7 51	24.1 51

Source: 2009 Indiana BRFSS



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TOBACCO USE

Tobacco use is also a well-known risk factor for heart disease, cancer, stroke, and diabetes. Using the BRFSS, questions included whether respondents were currently smoking. For all adults, the prevalence of smoking has decreased from 27.6% over the past seven years (2002 to 2009). For most age groups (excluding 18-24 and 65+), however [95% CI contains national median for 18-24 and 65+], as demonstrated in Table 1.15, smoking rates in Indiana remain higher than the national median.

TABLE 1.14 PREVALENCE OF SMOKING (2002-2009)

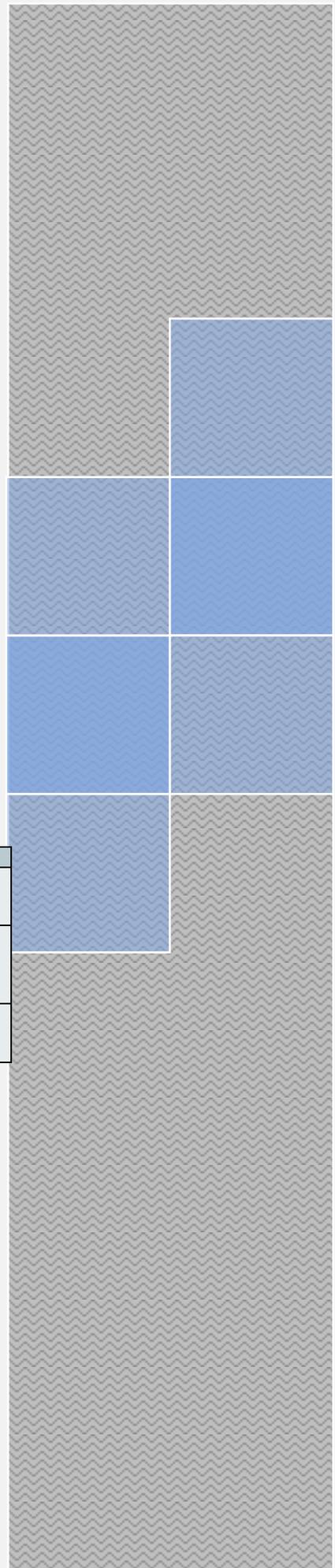
YEAR	%	CI	n =
2002	27.6	(26.2-29.0)	1533
2003	26.1	(24.8-27.4)	1391
2004	24.9	(23.7-26.1)	1529
2005	27.3	(25.9-28.7)	1416
2006	24.1	(22.7-25.5)	1442
2007	24.1	(22.5-25.7)	1359
2008	26.0	(24.0-28.1)	1108
2009	23.1	(21.7-24.5)	1943

Source: 2002-2009 Indiana BRFSS

TABLE 1.15 ADULTS WHO ARE CURRENT SMOKERS (2009)

State:		18-24	25-34	35-44	45-54	55-64	65+
Indiana	%	25.6	32.7	25.6	25.6	19.5	9.3
	CI	(19.7-31.5)	(28.4-37.0)	(22.5-28.7)	(23.2-28.0)	(17.3-21.7)	(7.9-10.7)
	n	79	276	308	546	438	296
Estimated adult population affected		160,225	274,968	222,249	235,667	137,269	75,885
Nationwide (States and DC)	Median %	23.2	23.8	18.1	20.5	16.2	8.2
	# states	46	51	51	51	51	51

Source: 2009 Indiana BRFSS



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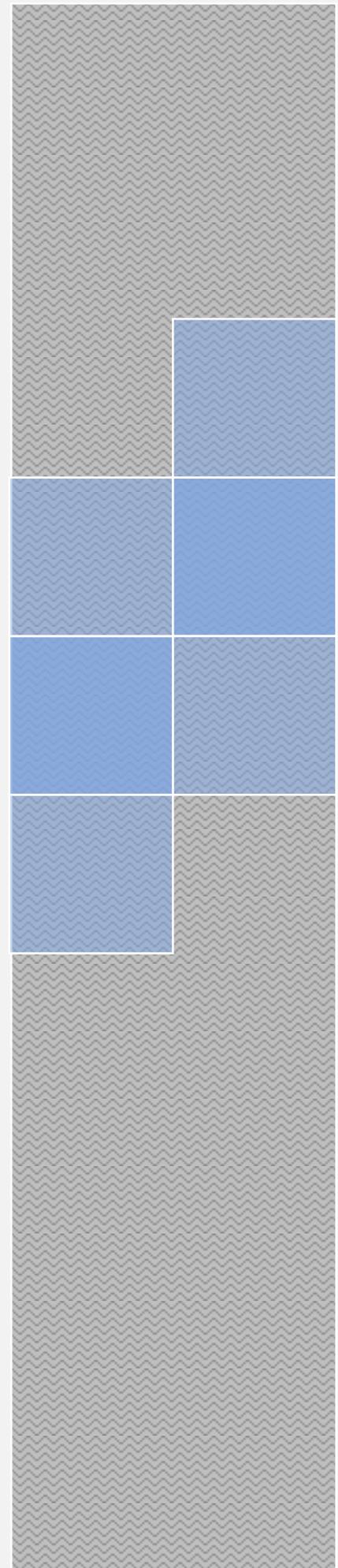
PATIENT SAFETY AND MEDICAL ERROR REPORTING

Since 2006, the Indiana State Department of Health has collected and reported medical errors for six reportable events in hospitals and surgical centers in the state, as outlined in Table 1.16. While some improvements appear to have improved from 2006 to 2009, reportable events of surgical errors and products/devices have not shown improvement. Therefore, patient safety remains of paramount concern in terms of health improvement planning in the state.

TABLE 1.16 MEDICAL ERROR REPORTING BY TYPE OF REPORTABLE EVENT

Reportable Event	2006	2007	2008	2009
Surgical	39	49	48	51
Products or devices	4	2	3	5
Patient protection	0	2	4	2
Care management	33	38	42	27
Environmental	6	5	8	9
Criminal	3	9	0	0

Source: ISDH 2009



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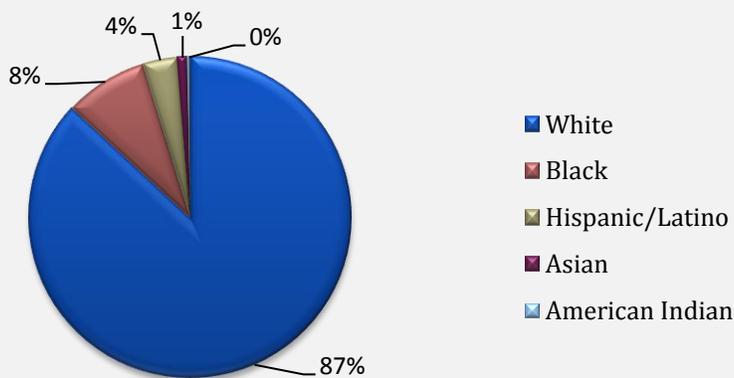
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MEASURING HEALTH STATUS IN INDIANA

LEADING HEALTH INDICATORS

This section provides an overview of the leading issues that affect the health status of residents of Indiana. The health status of the state is a description of the health of its population. The information used to report health status comes from a variety of sources, including birth and death records; hospital discharge data; and health information collected from health care records, personal interviews, physical examinations, and telephone surveys.

FIGURE 1.4 ESTIMATED POPULATION BY RACE

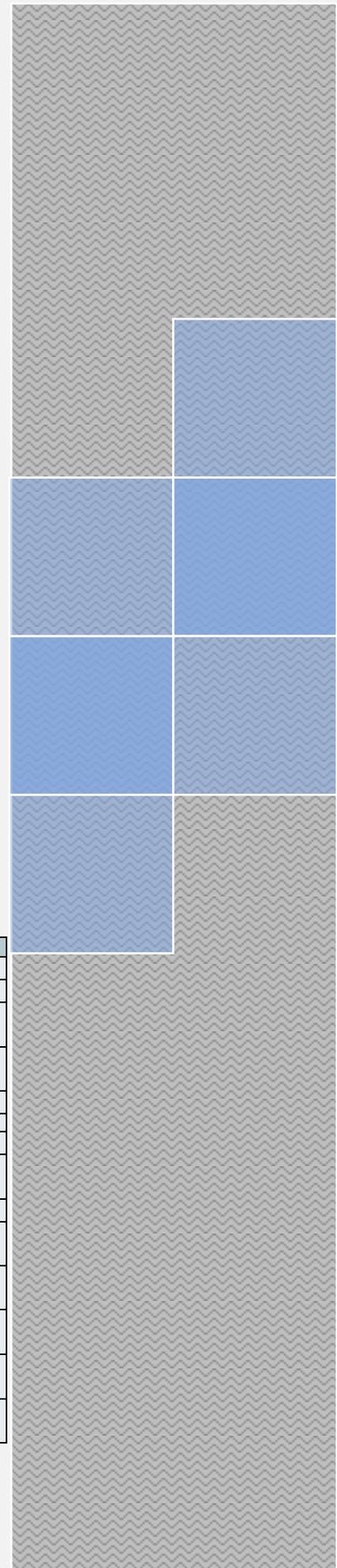


Source: *US Census Bureau, <http://www.census.gov/acs/>, D.C. Department of Health, State Center for Health Statistics

TABLE 1.17 HEALTH STATUS INDICATORS

HEALTH STATUS INDICATORS	WHITE	BLACK	TOTAL
Live Births 2007	77,171	10,303	89,719
Percent Preterm Births 2007	10.1%	16.3%	10.8%
Infant Mortality Rate Per 1,000 Live Births 2007	6.5	15.7	7.5
Percent Births to Mothers Receiving Prenatal Care in First Trimester 2007	69.4%	53.4%	67.5%
Infant Deaths 2007	499	162	677
Percent of Adults Smoking 2009	22.2%	31.6%	23.1%
Percent of Adults Considered Obese Based on BMI (2009)	29.8%	34.5%	30%
Cancer Incidence Per 100,000 2007	27,970	2,041	30,871
Number of Total Deaths from All Causes 2007	49,454	4,282	53,882
Age-Adjusted Death Rate Per 100,000 Population 2007	802.28	995.09	808.06
Heart Disease Age-Adjusted Death Rate Per 100,000 Population 2007	201.85	294.94	203.47
Hypertension Age-Adjusted Death Rate Per 100,000 Population 2007	7.18	14.05	7.58
Cerebrovascular Diseases Age-Adjusted Death Rate Per 100,000 Population 2007	43.76	59.76	44.50

Sources: Birth and death data, Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

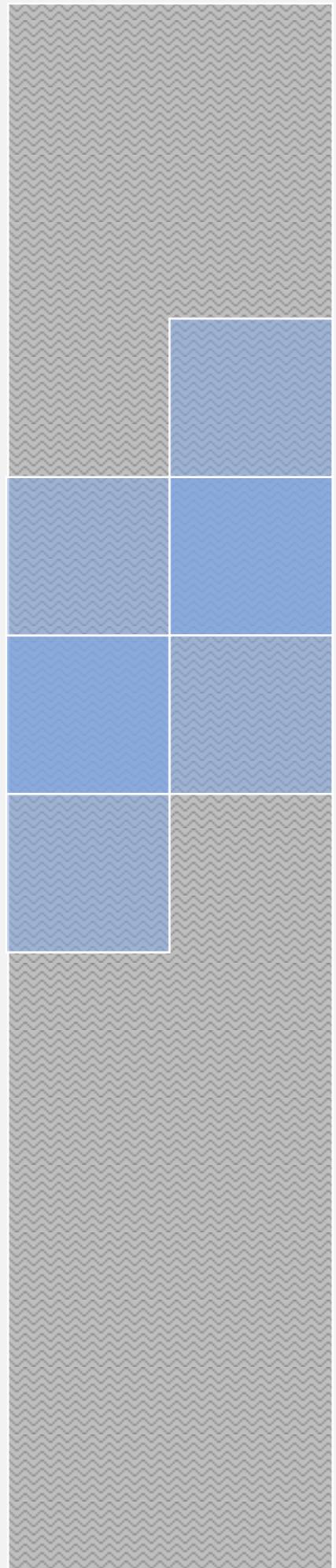


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LEADING CAUSES OF DEATH

Ranking the leading causes of death is one way of tracking those conditions that affect the population the most at any moment in time. Although cause-of-death is only one indicator of the health status of a given population, it is the most significant and severe indicator, and is therefore included in considering health priorities. Leading cause of death and leading morbidities vary by multiple factors, including age, race/ethnicity, gender, income, geographic location and access to healthcare resources.



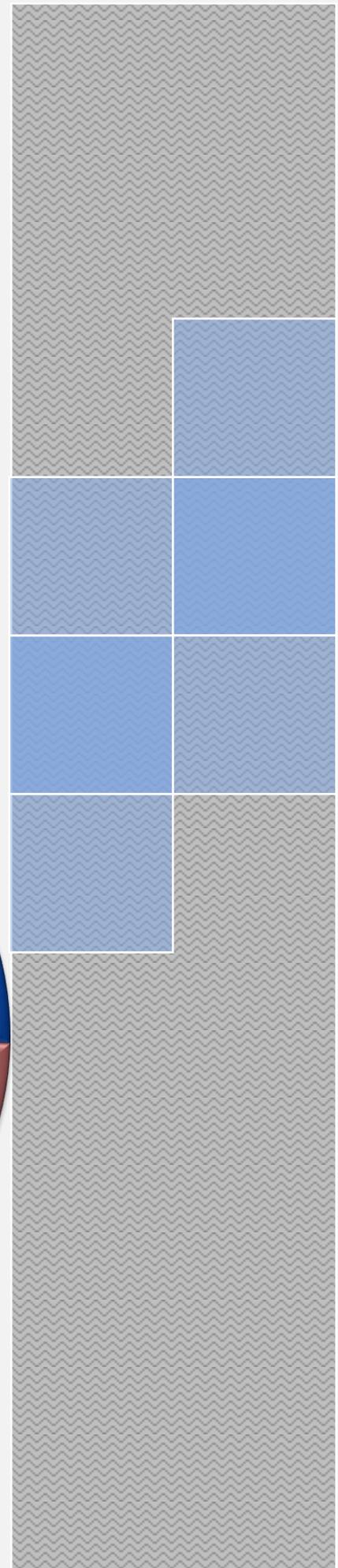
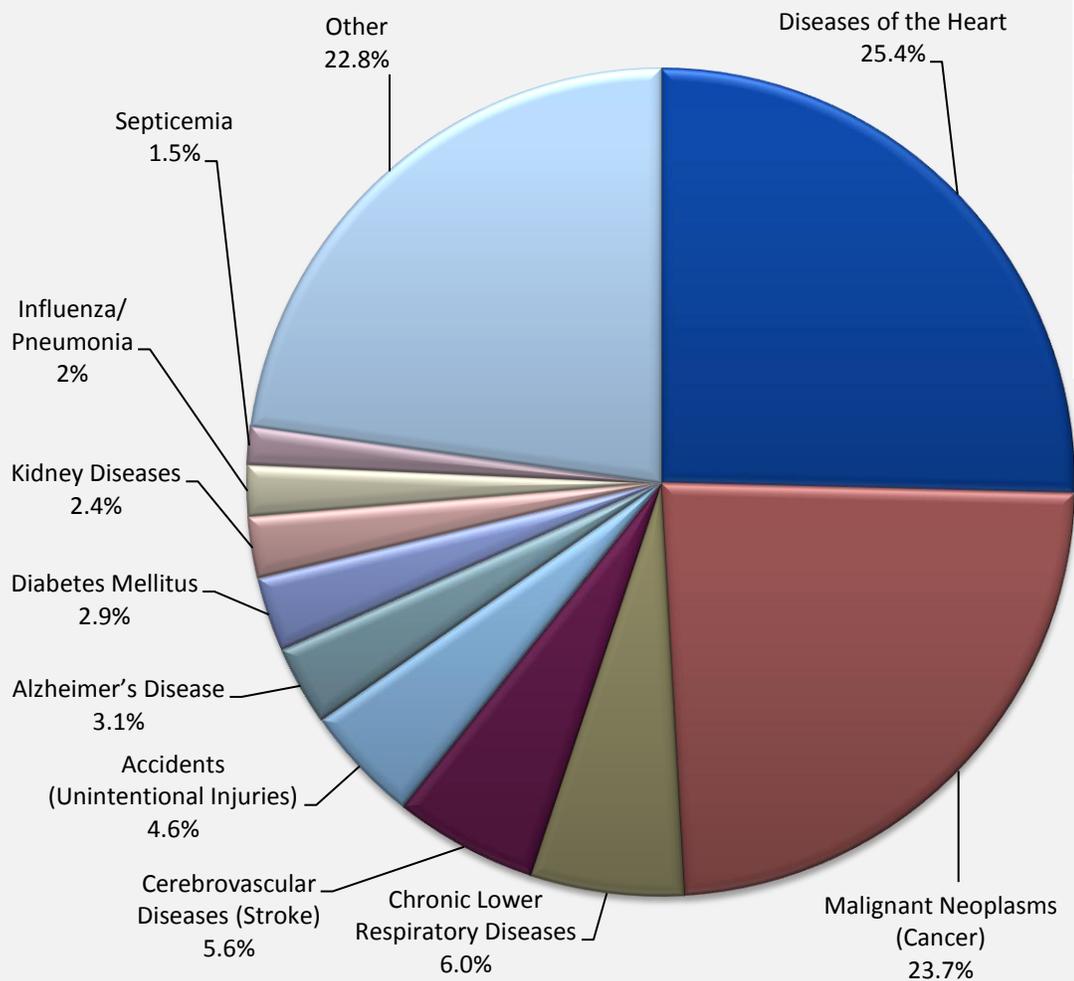
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TABLE 1.18 TEN LEADING CAUSES OF DEATH IN INDIANA (2007)

CAUSE OF DEATH	No.	% recalculated
Diseases of the Heart	13,712	25.4%
Malignant Neoplasms (Cancer)	12,750	23.7%
Chronic Lower Respiratory Diseases	3,224	6.0%
Cerebrovascular Diseases (Stroke)	3,001	5.6%
Accidents (Unintentional Injuries)	2,460	4.6%
Alzheimer's Disease	1,658	3.1%
Diabetes Mellitus	1,564	2.9%
Kidney Diseases	1,296	2.4%
Influenza/Pneumonia	1,095	2.0%
Septicemia	830	1.5%

Source for Table 1.18 and Figure 1.5: 2007 Indiana Mortality Report, Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

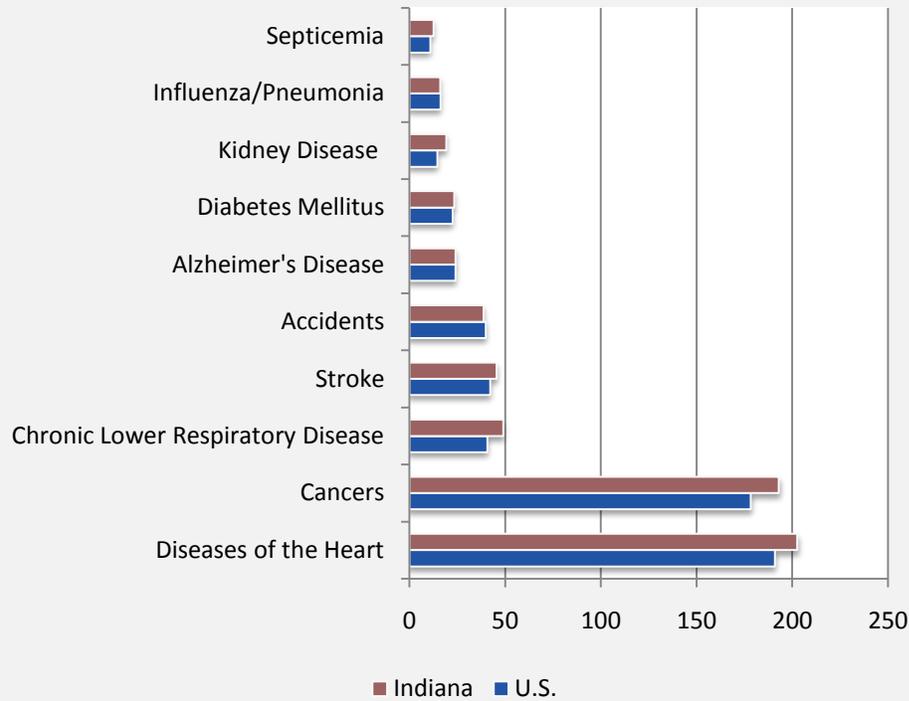
FIGURE 1.5 TEN LEADING CAUSES OF DEATH IN INDIANA



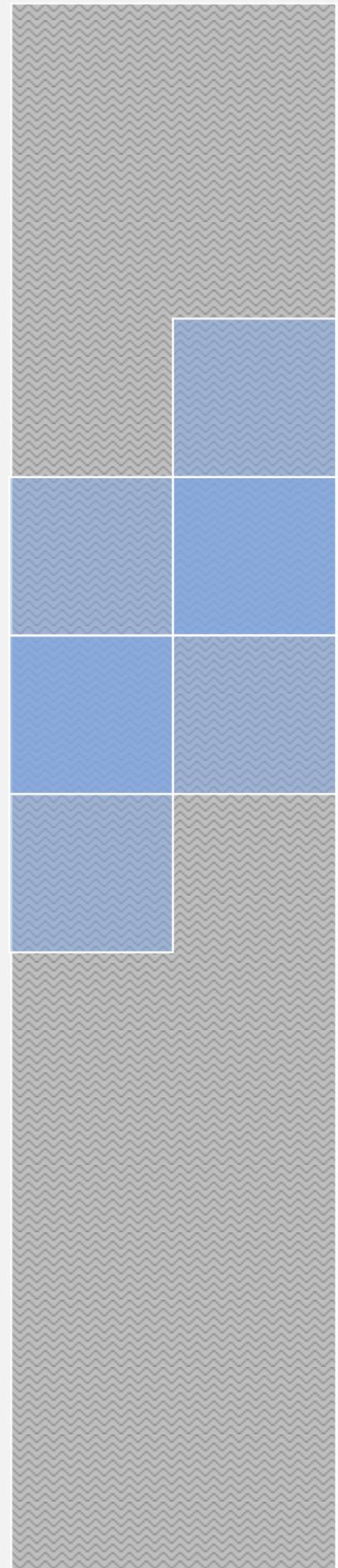
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FIGURE 1.6 COMPARISON OF AGE-ADJUSTED DEATH RATES (INDIANA AND U.S.) FOR TOP TEN LEADING CAUSES OF DEATH



Source: 2007 Indiana Mortality Report, Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team; National Center for Health Statistics



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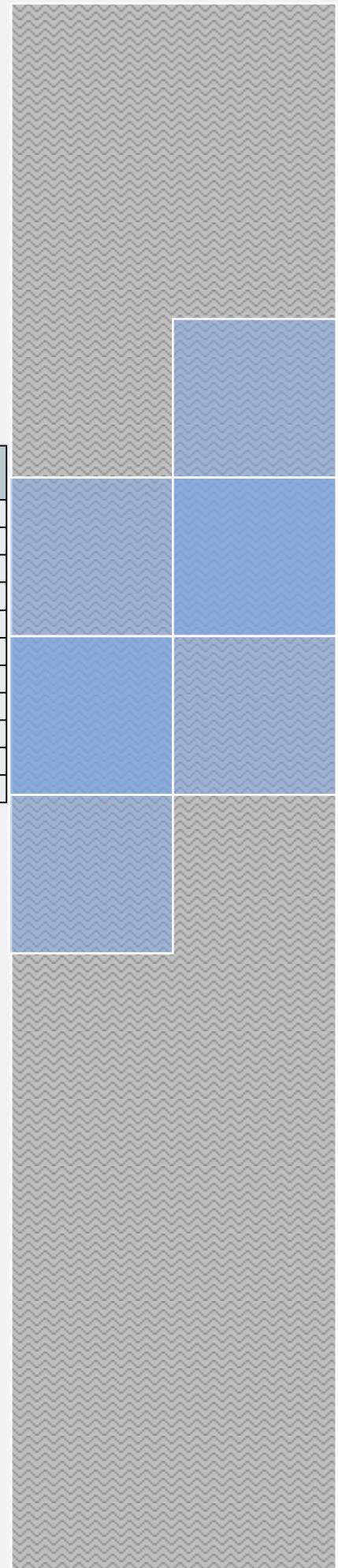
YEARS OF POTENTIAL LIFE LOST (INDIANA)

Years of Potential Life Lost (YPLL) is a measure of premature death. YPLL is an indicator that the younger the age of a person at death, the more years of potential life lost. Therefore, this indicator can be a useful indicator at the population level about the impact of early deaths and loss of contribution to society. Table 1.19 below shows the leading causes of death and the years of life lost for each.

TABLE 1.19 YEARS OF POTENTIAL LIFE LOST

CAUSE OF DEATH	YPLL	% Total YPLL	National % YPLL
Accidents/Unintentional Injuries	50,838	19.3%	20.1%
Malignant Neoplasms	42,312	16.0%	15.8%
Heart Disease	34,891	13.2%	11.8%
Perinatal Period	22,278	8.4%	8.0%
Suicide	16,788	6.4%	6.0%
Homicide	11,791	4.5%	5.1%
Congenital Anomalies	10,038	3.8%	4.2%
Cerebrovascular Disease	5,272	2.0%	2.1%
Diabetes Mellitus	5,026	1.9%	1.9%
Chronic Lower Respiratory Disease	4,963	1.9%	1.4%
All Other Causes	59,501	22.6%	23.6%
INDIANA TOTAL	263,698	100%	

Source: 2007 National Center for Health Statistics, Vital Statistics Systems (via WISQARS)



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INFANT MORTALITY

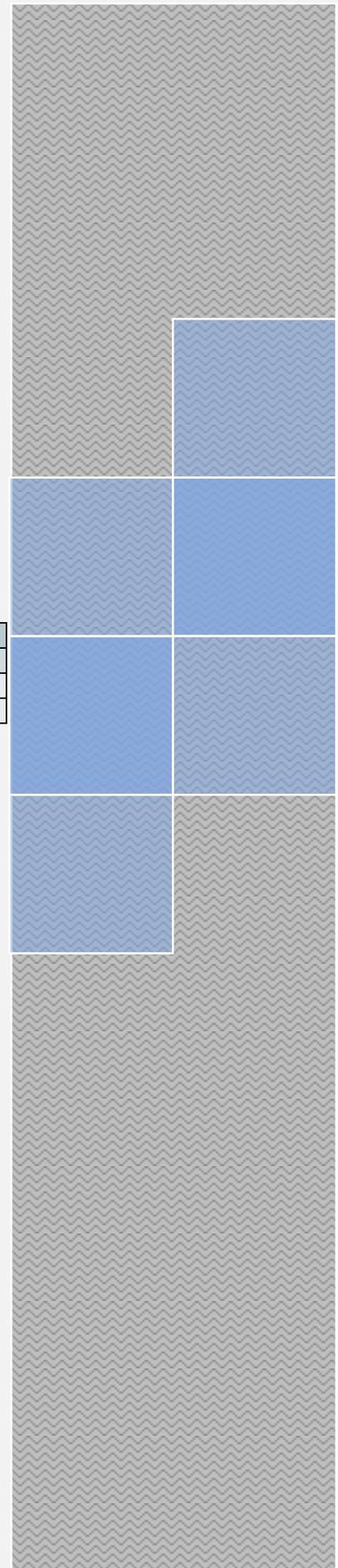
An increase in overall infant mortality rates in Indiana occurred from 1998 to 2004, with a steady decline more recently from 2004 to 2007. White infant mortality rates demonstrate a similar trend, peaking at a rate of 6.9 infants per 1,000 in 2004 and 2005, with a decline to 6.5 in 2007. Black infant mortality rates however, continue to reveal significant disparities. While overall black infant mortality rates have decreased from 17.1 to 15.7 over the past decade, the nearly triple rate when compared to white is a significant concern in Indiana. The neonatal period remains paramount with regard to efforts to reduce infant mortality in the state, as a significant number of infant deaths during this period may be prevented with preconception and prenatal care.

TABLE 1.20 INFANT MORTALITY RATES IN INDIANA

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total	7.5	7.8	7.7	7.6	7.6	7.4	8.1	8.0	7.9	7.5
White	6.3	6.8	6.7	6.8	6.5	6.4	6.9	6.9	6.4	6.5
Black	17.1	17.0	15.9	13.6	15.6	15.9	17.1	16.9	18.1	15.7

Rates per 1,000 live births

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team



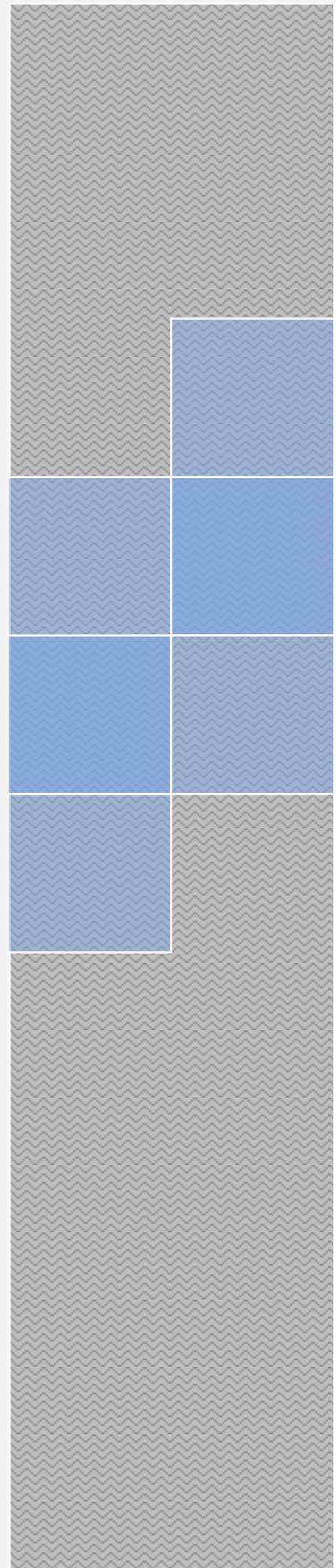
SECTION 2: HEALTH PRIORITIES

FRAMEWORK

Health priorities featured in this plan were arrived at by considering the prevalence of morbidity and mortality in Indiana coupled with selected public health priorities identified by the Centers for Disease Control and Prevention (CDC), also known as the CDC Winnable Battles. Once these priorities were identified, the Executive Committee considered them in light of the 10 essential services of public health.

Therefore, all activities associated with the intended outcomes for the six health priorities were divided into two major categories 1) health promotion and 2) access to care. They were then further segmented categories related to system change, health communication, community intervention, or other. The activities were based on whether they pertained to primary, secondary and/or tertiary prevention. For the sake of efficiency and to avoid duplication, all outcomes, activities and responsible partners were derived from already existing ISDH improvement plans for the majority of the six Indiana health priorities.

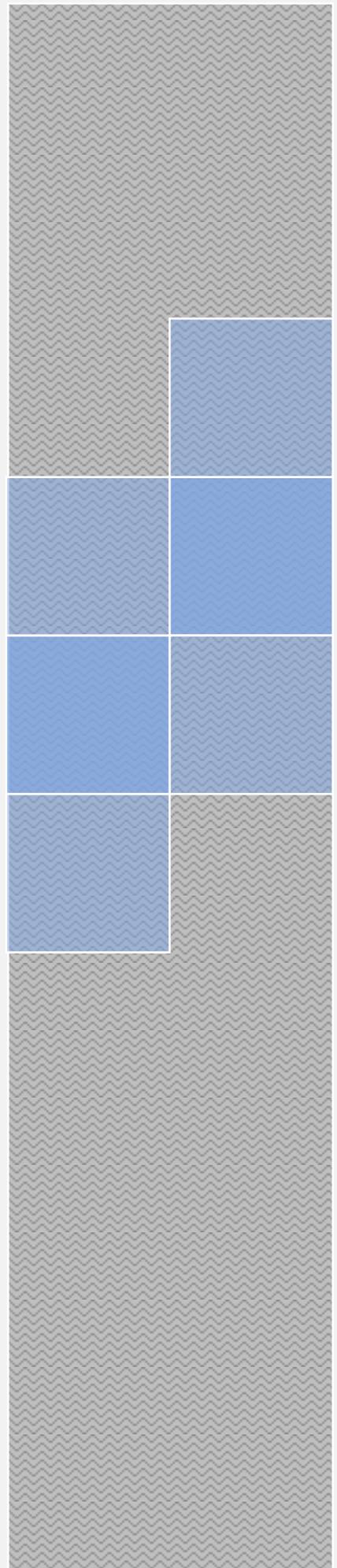
- Assure **Food Safety** by reducing infectious/intoxication associated with food-borne illness outbreaks due to pathogens commonly transmitted through foods.
- Reduce **Healthcare Associated Infections** by reducing the standardized infection ration for healthcare associated infections in healthcare facilities.
- Reduce the burden of **HIV, Sexually Transmitted Diseases** and **Viral Hepatitis** by decreasing incidence in Indiana.
- Reduce **Infant Mortality** by decreasing the percentage of preterm births in Indiana.
- Increase Hoosiers at a Healthy Weight by reducing the prevalence of **Obesity** in Indiana.
- Decrease **Tobacco Usage** to reduce the tobacco burden on Indiana.



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**HEALTH PRIORITY:
INCREASE THE NUMBER OF HOOSIERS
AT A HEALTHY WEIGHT**

GOAL: To reduce the prevalence of obesity in Indiana



INDIANA STATE HEALTH IMPROVEMENT PLAN

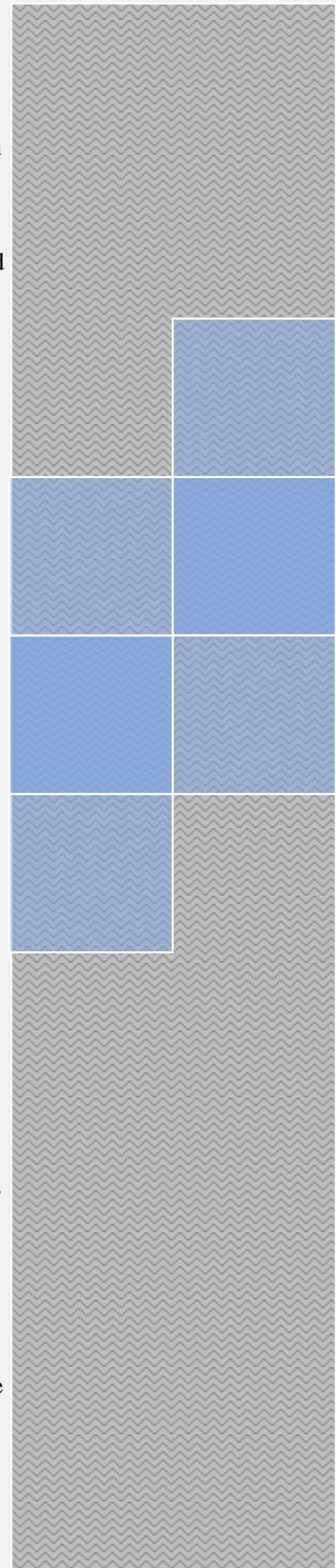
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Over the past three decades, the impact and prevalence of overweight and obesity have increased at an alarming rate, in both Indiana and the nation. In Indiana, 29% of adolescents and 65% of adults are overweight and obese. Poor nutrition and sedentary behaviors are contributing to this epidemic. In Indiana, only 41% of adolescents and 64% of adults meet the recommended levels for physical activity. There has been little success to increase fruit and vegetable consumption—16% of adolescents and 21% of adults consume the recommended servings of fruits and vegetables.

Many factors lead to being inactive, eating poorly, and obesity and chronic diseases. While it is true that, overall, the residents of Indiana often fail to eat the recommended amount of fruits and vegetables or meet the recommended amount of daily physical activity—two behaviors directly linked to weight and overall good health and well-being—many other factors impact weight. The places where we live, learn, work, and play influence whether or not the healthy nutrition or physical activity choice is even an option.

A key milestone in Indiana's efforts to improve its health outcomes was the launch of Governor Mitch Daniels' health initiative, INShape Indiana (INShape), in July 2005. INShape began with a website to provide Indiana residents with information on nutrition, physical activity, and tobacco cessation to help them engage in healthier behaviors. The strength of INShape lies in the many partnerships it has created or inspired over the years. As a result, the groundwork has been laid for Indiana to focus more on addressing overweight and obesity through policy and environmental change that make healthy eating and active living possible. The Indiana Healthy Weight Initiative is Indiana's public health response to the growing need and desire for more communities and settings that support good nutrition and physical activity for all of Indiana's residents. The Initiative seeks to enhance the health and quality of life for all Indiana residents by promoting good nutrition, regular physical activity, and a healthy weight through policy, environment, and lifestyle change.

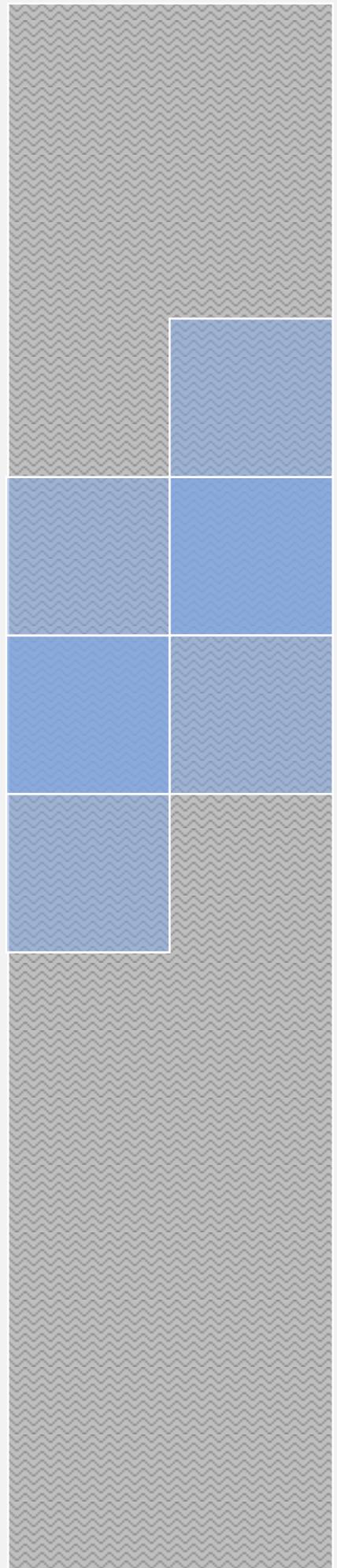
By building on the state's previous efforts while creating new partnerships, the Indiana Healthy Weight Initiative Task Force was established. The Task Force is a diverse group of stakeholders positioned throughout Indiana, representing nutrition, physical activity, transportation, academics, business, professional organizations, and state and local governments. Since December of 2008, the Task Force has been working to develop *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020*, and to create the infrastructure to support the Plan's implementation and evaluation. Using professional and personal resources and the Initiative's speakers bureau and website, the Task Force and a growing network of additional partners have developed the framework for what needs to be done across all sectors of Indiana to address poor nutrition, sedentary behaviors, and obesity with an intensity and reach never seen before in Indiana. Goals, objectives, and strategies from the Plan are provided below. They provide a



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roadmap directing individuals, groups, and organizations toward the creation of healthier environments to support improvements in health behaviors among Indiana's residents.

Adopted from Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020.



Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

- **GOAL 1:** Increase access to and consumption of healthy foods and beverages.
- **GOAL 2:** Increase opportunities for and engagement in regular physical activity.
- **GOAL 3:** Increase efforts aimed at enabling people to achieve and maintain a healthy weight across the lifespan.
- **GOAL 4:** Reduce environmental and policy-related disparities for breastfeeding, nutrition, physical activity, overweight, obesity, and chronic disease.
- **GOAL 5:** Increase the capacity of communities and settings within those communities (e.g., schools, worksites, faith-based organizations, etc.) to develop and sustain environmental and policy support systems that encourage healthy eating and active living.
- **GOAL 6:** Increase state and local strategic partnerships to more effectively coordinate efforts, share resources, and identify and reach priority populations.

Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

PRIMARY PREVENTION

		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources) <i>As implemented at a state level.</i>	PP1. By 2020, increase the number of “Baby Friendly” designated hospitals from 3 to 20. (Source: Baby Friendly Hospital Initiative and CDC National Survey of Maternity Practices in Infant Nutrition and Care [mPINC]) [*]	PP1. Sponsor a summit for key decision-makers from hospitals providing maternity care to highlight best practices and evidence-based interventions for breastfeeding and the role hospitals and birth centers play in supporting breastfeeding mothers. ^{*†}	PP1. State Obesity Prevention Plan partners, including but not limited to: Summit Partners and Indiana hospitals and birth centers providing maternity care
		PP2. By 2014, add nutrition, physical activity, and television viewing recommendations for early childhood settings into the formal and non-formal Child Development Associate (CDA) training. (Baseline: no standard recommendations exist; Source: Inventory existing and future training courses) [*]	PP2. Develop or update a training course(s) focusing on early childhood obesity, providing early care and education providers with practical strategies to address nutrition, physical activity, and television viewing in child-care settings. ^{*†}	PP2. Organizations and colleges statewide offering training courses for the CDA National Credential and Indiana AEYC
		PP3. By 2014, include standard nutrition, physical activity, and television viewing requirements in the Paths to QUALITY (PTQ) rating system standards. (Baseline: no standards exist; Source: FSSA - PTQ Standards) [*]	PP3. Ensure nutrition and physical activity criteria meet national accreditation best practices. ^{*†} PP3. Submit standards with criteria to the FSSA, Bureau of Child Care, for review and consideration ^{*†}	PP3. ISDH, FSSA, Cooperative Extension Service Nutritionists, Indiana AEYC and the IACCRR
		PP4. By 2016, include basic nutrition and physical activity requirements for unlicensed child-care providers in the Child Care and Development Fund (CCDF) voucher program provider eligibility standards. (Baseline: no standards exist; Source: FSSA - CCDF voucher program provider eligibility standards) [*]	PP4. Set standards for nutrition, physical activity, and television viewing. ^{*†} PP4. Provide training and technical assistance to help early child and education providers comply with the new standards. ^{*†}	PP4. Early care and education providers, policymakers, and other key leaders, FSSA, and ISDH

^{*} Taken from *Indiana’s Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

[†] A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources) <i>As implemented at a state level.</i>	PP5. By 2015, amend existing law to require school corporations to provide at least 30 minutes a day of physical activity in elementary schools. (Baseline: no time requirement in the current law; Source: Indiana Code - law is passed with amendment of 30 minutes required)*	PP5. Collect and share success stories and effective strategies from schools and school corporations that provide active, daily recess and incorporate physical activity into lesson plans.*† PP5. Provide information and resources to school board members, CSHAC members, school personnel, and parents on the relationship between physical activity, health, and academic performance and how to incorporate physical activity throughout the school day.*†	PP5. State Obesity Prevention Plan partners, including but not limited to: schools, ICC, IDOE, ISDH, and Indiana School Health Network
		PP6. By 2014, state agencies and state-owned facilities will have implemented additional efforts to support and promote healthy eating and physical activity environments. (Currently do not have baseline data; Source: direct observation and inventory of procurement policies and physical activity opportunities)*	PP6. Provide education and technical assistance to state agencies and/or state-owned facilities with cafeterias and vending options to have strong nutrition standards in place wherever foods and beverages are sold or available and promote the use of stairs by employees and visitors where applicable.*†	PP6. ISDH, INShape Indiana, and IDOA
		PP7. By 2015, increase the number of Complete Streets policies at the MPO and/or local level from 3 to 8. (Source: inventory of MPO and county and city policies)*	PP7. Adopt and implement Complete Streets through a variety of methods that may include executive orders from elected officials, internal memos from directors of transportation agencies, inclusion in comprehensive plans, rewrite of design manuals, and/or ordinances and resolutions.*†	PP7. Health by Design, Indiana AARP, MPOs, local planners and engineers, ISDH, and local elected officials

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† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Health Communications	<p>PP8. By 2015, launch a multi-year statewide initiative to promote healthy eating and physical activity among older adults. (Baseline: no specific initiative has been launched; Source: direct observation of initiative launched with specific evaluation indicators)*</p>	<p>PP8. Convene statewide partners to develop and launch initiative that promotes increased opportunities for healthy eating and physical activity through policy and environmental change strategies, expansion of community programs and services and increases the awareness of the importance of healthy eating and physical activity.**†</p>	<p>PP8. State Obesity Prevention Plan partners</p>
		<p>PP9. By 2013, provide technical assistance and education to support and promote the availability of nutrition information and the availability of healthier food options in restaurants. (Currently do not have baseline data; Source: direct observation and inventory of educational items and activities)*</p>	<p>PP9. Promote and support educational opportunities that focus on using calorie information to achieve and maintain a healthy weight; advocating for restaurants to offer more fresh, locally grown produce; more forms of fruits and vegetables; nutritionally balanced meals for children and adults; and smaller, more economical portions of food, and recognize leaders in the food industry that offer healthier food options.</p>	<p>PP9. State Obesity Prevention Plan partners, including but not limited to: IRA, culinary institutes and chefs’ associations, ISDH and IDA</p>
	Community Interventions <i>To include systems change (policy/resources)</i>	<p>PP10. From 2010 through 2014, increase participation in the CACFP among licensed child-care centers, licensed child-care homes, and unlicensed, registered ministries by 2% each year. (Baseline: TBD; Source: inventory of participants from IDOE)*</p>	<p>PP10. Identify licensed child-care centers, licensed child-care homes, and unlicensed, registered ministries that are not CACFP participants for outreach, training ,and technical assistance and to encourage participation in the CACFP.**†</p>	<p>PP10. IDOE, FSSA, IACCRR, and ISDH</p>
		<p>PP11. By 2013, increase by 10 the number of schools that implement policies, activities, or infrastructure improvements that support walking and bicycling to school. (Currently do not have baseline data; Source: Direct communication and/or observation and participation in the INDOT SRTS program)*</p>	<p>PP11. Promote and support the INDOT SRTS Program.**†</p> <p>PP11. Establish a statewide network of representatives from IDOE, ISDH, and INDOT, as well as bicycle, pedestrian, health, school, and parent advocacy groups, for the promotion of walking and bicycling to school.**†</p>	<p>PP11. State Obesity Prevention Plan partners, including but not limited to: INDOT, ISDH, and Indiana School Health Network</p>

* Taken from *Indiana’s Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Community Interventions <i>To include systems change (policy/resources)</i>	PP12. By 2016, increase by at least 5 rural schools and 1 urban the number of schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours. (Currently do not have baseline data; Source: direct communication and observation with schools and local communities)*	PP12. Collect and share information on effective protocols and successful strategies for joint use agreements to allow the use of schools for recreation by the public during non-school hours.*† PP12. Provide training to school personnel and community organizations on developing partnerships, facilities, and risk-management plans to support the public use of school facilities for physical activity.*†	PP12. State Obesity Prevention Plan partners, including but not limited to: ISDH, schools, and community-based organizations
		PP13. By 2015, at least 10 hospitals will provide and promote healthier food/drink options for all food served or sold to visitors and staff on their hospital campuses. (Currently do not have baseline data; Source: direct communication and observations and surveys of hospitals)*	PP13. Assess the current food and beverage procurement practices and policies for food served or sold to staff and visitors on hospital campuses and update the IHWI Website with evidence-based recommendations and strategies for improving healthy food and beverage access, availability, and affordability on hospital campuses.*†	PP13. ISDH, IHA, and hospital food service personnel
		PP14. By 2013, increase the number of approved Small Employer Qualified Wellness Program Tax Credit applicants by 20%. (Baseline: 2010 - 78 applications were approved; Source: ISDH)	PP14. Promote the tax credit to appropriate employers, wellness, vendors, and industry organizations; ensure the application process is accessible online with all supporting documents for small employers.	PP14. ISDH, INShape Indiana, Indiana Chamber of Commerce, and worksite wellness program vendors
		PP15. By 2014, increase the number of farmers' markets statewide licensed to accept Supplemental Nutrition Assistance Program (SNAP) benefits (e.g., Hoosier Works card) from 1 to 20. (Source: inventory of farmers' markets)*	PP15. Provide training and technical assistance to assist farmers' markets with the licensing process to accept the Hoosier Works card and to successfully implement and promote the acceptance of SNAP.*†	PP15. ISDH, FSSA, Indiana Department of Agriculture, Purdue University Cooperative Extension Service, and the Indiana Cooperative Development Center

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Community Interventions <i>To include systems change (policy/resources)</i>	PP16. By 2016, increase by 20 the number of communities that have implemented evidence-based policy, systems and/or environmental change strategies to support healthy eating and physical activity. (Currently do not have baseline data; Source: inventory of local communities nutrition and physical activity strategies; number of ACHIEVE, Pioneering Healthy Communities, and other initiatives in Indiana)*	PP16. Develop local partnerships to assess the built and social environments as they relate to physical activity and nutrition.**† PP16. Identify strategies for evidence-based nutrition and physical activity policy and environmental change and base them on the community's needs for implementation.**†	PP16. State Obesity Prevention Plan partners, including but not limited to: ISDH, other state agencies, local health departments, local foundations, local community-based organizations, local coalitions, and local decision-makers

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Other	<p>PP17. Increase the percentage of black mothers who initiate breastfeeding from 49% to 57% by 2016. (Source: ISDH)*</p>	<p>PP17. Launch a social marketing campaign to promote early, exclusive and continued breastfeeding among black mothers.**†</p>	<p>PP17. ISDH, IPN, Black Breastfeeding Coalitions, and State Obesity Prevention Plan Partners</p>
		<p>PP18. Increase the percentage of mothers who breastfeed their babies from 71% to 73% by 2016. (Source: ISDH, PHPC, ERC, Data Analysis Team, and CDC 2007 National Immunization Survey.)*</p> <p>PP19. Increase the percentage of mothers who breastfeed their babies exclusively at 3 months from 29% to 34% by 2016. (Source: ISDH, PHPC, ERC, Data Analysis Team, and CDC 2007 National Immunization Survey.)*</p> <p>PP20. Increase the percentage of mothers who breastfeed their babies at 6 months from 43% to 50% by 2016. (Source: ISDH PHPC, ERC, Data Analysis Team, and CDC 2007 National Immunization Survey.)*</p> <p>PP21. Increase the percentage of mothers who breastfeed their babies at 12 months from 17% to 21% by 2016. (Source: ISDH, PHPC, ERC, Data Analysis Team, and CDC 2007 National Immunization Survey.)*</p>	<p>PP 18-21. Implementation of the State Obesity Prevention Plan strategies and other selected evidence-based interventions that are successful in practice.</p> <p>PP 18-21. Improve maternity care practices in hospitals.</p>	<p>PP 18-21. State Obesity Prevention Plan partners, including but not limited to: ISDH, IPN, local breastfeeding coalitions, and Indiana hospitals and birth centers providing maternity care</p>

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Other	<p>PP22. Increase the percentage of adults who meet the recommended amounts of physical activity per day from 64% to 65% by 2020. (Source: Indiana BRFSS)*</p>		
		<p>PP23. Increase the percentage of high school students who meet the recommended amounts of physical activity per day from 41% to 46% by 2016. (Source: Indiana YRBS)*</p>	<p>PP 22-27. Implementation of the State Obesity Prevention Plan strategies and other selected evidence-based interventions that are successful in practice.</p>	
		<p>PP24. Decrease the percentage of adults who drink 1 or more sugar-sweetened beverages per day from 69% to 64% by 2016. (Source: Indiana BRFSS)*</p>	<p>PP 22-27. Maintain and enhance state and local infrastructure to implement priority nutrition and physical activity policies and environmental changes across all settings and special populations.</p>	<p>PP 22-27. State Obesity Prevention Plan partners, including but not limited to: ISDH, other state agencies, state coalitions, local health departments, state and local policy-makers, academia, health organizations, community-based organizations, and local communities</p>
		<p>PP25. Decrease the percentage of high school students who drank a can, bottle, or glass of soda or pop 1 or more times per day during the past 7 days from 30% to 26% by 2016. (Source: Indiana YRBS)*</p>	<p>PP 22-27. Educate on the need for adequate funding and resources for nutrition, physical activity, and obesity prevention interventions.</p>	
		<p>PP26. Increase the percentage of adults who eat the recommended amounts of fruits and vegetables per day from 21% to 22% by 2016. (Source: Indiana BRFSS)</p>	<p>PP 22-27. Provide information to policymakers and other key leaders on the importance of changing policies and environments to create healthier communities and settings.</p>	
		<p>PP27. Increase the percentage of high school students who eat the recommended amounts of fruits and vegetables from 16% to 18% by 2020. (Source: Indiana YRBS)</p>	<p>PP 22-27. Maintain a surveillance system and evaluation activities to monitor and track progress.</p>	

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Other	<p>PP28. By 2014, provide training and technical assistance to parents, early care and education providers, and others that focus on nutrition, physical activity, and lactation support in child-care settings. (Currently do not have baseline data; Source: Inventory of state and local conferences and training events)*</p>	<p>PP28. Build upon existing training resources and activities to provide a variety of offerings using multiple methods of dissemination. *†</p>	<p>PP28. Indiana AEYC, IACCRR, FSSA, Indiana Head Start Collaboration Office, Indiana Head Start Association, provider support organizations, parents, and early care and education providers</p>
		<p>PP29. By 2013, establish a system for childhood obesity surveillance using annual statewide, school-based BMI collection among students in at least three representative grades. (Baseline: no system exists; Source: direct observation)*</p>	<p>PP29. Maintain an interagency collaboration between the IDOE and ISDH to support annual school-based body mass index (BMI) collection and reporting. *†</p> <p>PP29. Provide information to school board members, CSHAC members, school personnel, and parents on the importance and benefits of measuring and reporting student BMIs. *†</p>	<p>PP29. IDOE, IHWI, Indiana School Health Network, Indiana Association of School Nurses, ISDH, and Clarian Health Partners</p>
		<p>PP30. By 2013, establish a least one state, regional, or local food policy council. (Currently do not have baseline data; Source: inventory of food policy councils)*</p>	<p>PP30. Establish a strong, diverse network of stakeholders from many sectors of the food system (e.g., production, consumption, processing, distribution, and waste recycling) to participate. *†</p> <p>PP30. Apply national recommendations and best practices for the structure and practices of food policy councils. *†</p>	<p>PP30. State Obesity Prevention Plan partners including but not limited to: ISDH, Indiana Department of Agriculture, Purdue Extension, and local communities</p>

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

		PRIMARY PREVENTION		
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Access to Care	Systems Change (Policy/Resources)	<p>PP31. By 2015, develop and disseminate a protocol for use by health care providers to integrate obesity prevention into office practice. (Baseline: no standard protocol recommended at this time; Source: protocol is available and widely distributed)*</p>	<p>PP31. Identify and/or develop a protocol for the prevention and assessment of overweight/obesity; promote the use of existing resources such as <i>Exercise Is Medicine</i> prescription, <i>Ounce of Prevention 12 Well-Child Visit</i> prescriptions, and the American Academy of Pediatrics (AAP) <i>Healthy Active Living</i> prescription.**†</p> <p>PP31. Provide training and technical assistance to health care providers and office staff to ensure the effective integration of obesity prevention into office practice.**†</p>	<p>PP31. State Obesity Prevention Plan partners, including but not limited to: local chapters of the AAP, AAFP, Nurses Associations, other professional associations representing health professionals, and individual health care providers</p>
	Health Communications			
	Community Interventions			
	Other	<p>PP32. By 2013, offer and promote annual continuing education opportunities for health care professionals and health educators focused on evidence-based breastfeeding, nutrition, physical activity, and obesity prevention practices. (Currently do not have baseline data; Source: inventory of opportunities most used by local health care professionals and health educators)*</p>	<p>PP32. Identify and promote evidence-based continuing medical education/continuing education (CME/CE) programs that address obesity prevention, assessment, and treatment.**†</p> <p>PP32. Work with colleges and universities to include competencies in nutrition, physical activity, breastfeeding, and obesity prevention in programs that train future health professionals.**†</p>	<p>PP32. Professional associations representing health professionals, individual health care providers, and colleges and universities</p>

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

SECONDARY PREVENTION			
OUTCOMES		ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources)		
	Health Communications		
	Community Interventions		

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.
 † A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

SECONDARY PREVENTION

		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion		<p>SP 1. Increase the percentage of adults who are at a healthy weight from 35% to 36% by 2016. (Source: Indiana BRFSS)*</p> <p>SP2. Increase the percentage of high school students who are at a healthy weight from 71% to 73% by 2016. (Source: Indiana YRBS)*</p> <p>SP3. Increase the percentage of adults who meet the recommended amounts of physical activity per day from 64% to 65% by 2016. (Source: Indiana BRFSS)*</p> <p>SP4. Increase the percentage of high school students who meet the recommended amounts of physical activity per day from 41% to 46% by 2016. (Source: Indiana YRBS)*</p> <p>SP5. Decrease the percentage of adults who drink 1 or more sugar-sweetened beverages per day from 69% to 64% by 2016. (Source: Indiana BRFSS)*</p> <p>SP6. Decrease the percentage of high school students who drank a can, bottle, or glass of soda or pop 1 or more times per day during the past 7 days from 30% to 26% by 2016. (Source: Indiana YRBS)*</p> <p>SP7. Increase the percentage of adults who eat the recommended amounts of fruits and vegetables per day from 21% to 22% by 2016. (Source: Indiana BRFSS)*</p> <p>SP8. Increase the percentage of high school students who eat the recommended amounts of fruits and vegetables from 16% to 18% by 2016. (Source: Indiana YRBS)*</p>	<p>SP 1-8. Implementation of the State Obesity Prevention Plan strategies and other selected evidence-based interventions that are successful in practice.</p> <p>SP 1-8. Maintain and enhance state and local infrastructure to implement priority nutrition and physical activity policies and environmental changes across all settings and special populations.</p> <p>SP 1-8. Educate on the need for adequate funding and resources for nutrition, physical activity, and obesity prevention interventions.</p> <p>SP 1-8. Provide information to policymakers and other key leaders on the importance of changing policies and environments to create healthier communities and settings.</p> <p>SP 1-8. Maintain a surveillance system and evaluation activities to monitor and track progress.</p>	<p>SP 1-8. State Obesity Prevention Plan partners, including but not limited to: ISDH, other state agencies, state coalitions, local health departments, state and local policy-makers, academia, health organizations, community-based organizations, and local communities</p>
	Other			

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† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

SECONDARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Access to Care	Systems Change (Policy/Resources)	SP9. By 2015, develop and disseminate a protocol for use by health care providers to integrate obesity prevention into office practice. (Currently do not have baseline data; Source: inventory of opportunities most used by local health care professionals and health educators)*	SP9. Provide training and technical assistance to health care providers and office staff to ensure the effective integration of obesity prevention into office practice.*†	SP9. State Obesity Prevention Plan partners, including but not limited to: local chapters of the AAP, AAFP, Nurses Associations, other professional associations representing health professionals, and individual health care providers
	Health Communications			
	Community Interventions			
	Other	SP10. By 2013, offer and promote annual continuing education opportunities for health care professionals and health educators focused on evidence-based breastfeeding, nutrition, physical activity, and obesity prevention practices. (Currently do not have baseline data; Source: inventory of opportunities most used by local health care professionals and health educators)*	SP10. Identify and promote evidence-based continuing medical education/continuing education (CME/CE) programs that address obesity prevention, assessment, and treatment.*†	SP10. Professional associations representing health professionals, individual health care providers, colleges and universities

* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

TERTIARY PREVENTION

TERTIARY PREVENTION			
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources)		
	Health Communications		
	Community Interventions		
	Other	<p>TP1. Decrease the percentage of adults who are obese from 30% to 27% by 2016. (Source: Indiana BRFSS)*</p> <p>TP2. Decrease the percentage of high school students who are obese from 13% to 12% by 2016. (Source: Indiana YRBS)*</p> <p>TP3. Decrease the prevalence of chronic disease risks, including:</p> <ul style="list-style-type: none"> - High cholesterol - High blood pressure - Heart disease - Cancer (for which obesity is a risk factor) - Diabetes 	<p>TP 1-3. Implementation of the State Obesity Prevention Plan, Indiana Cancer Control Plan, State Strategic Plan for Indiana’s Adolescents, other Indiana-specific chronic disease strategic plans (as they become available), and other selected evidence-based interventions that are successful in practice.</p> <p>TP 1-3. Maintain and enhance state and local infrastructure to implement priority nutrition, physical activity, obesity and other chronic disease policies and environmental changes across all settings and special populations.</p> <p>TP 1-3. Educate on the need for adequate funding and resources for nutrition, physical activity, obesity and other chronic disease interventions.</p> <p>TP 1-3. Maintain a surveillance system and evaluation activities to monitor and track progress.</p>

* Taken from *Indiana’s Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

Increase Hoosiers at a Healthy Weight

Priority: To reduce the prevalence of obesity in Indiana

TERTIARY PREVENTION

	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Access to Care	Systems Change (Policy/Resources)	TP4. By 2015, develop and disseminate a protocol for use by health care providers to integrate obesity prevention into office practice. (Currently do not have baseline data; Source: inventory of opportunities most used by local health care professionals and health educators)*	TP4. Provide training and technical assistance to health care providers and office staff to ensure the effective integration of obesity prevention into office practice.*†
	Health Communications		
	Community Interventions		
	Other		

Listing of Acronyms

AAP: American Academy of Pediatrics

AAFP: American Academy of Family Physicians

BRFSS: Behavioral Risk Factor Surveillance System

CACFP: Child and Adult Care Food Program

CDC: Centers for Disease Control and Prevention

CSHAC: Coordinated School Health Advisory Council

ERC: ISDH Epidemiology Resource Center

FSSA: Indiana Family and Social Services Administration

IACCRR: Indiana Association for Child Care Resource and Referral

ICC: Indiana Cancer Consortium

ICIAH: Indiana Coalition to Improve Adolescent Health

Indiana AEYC: Indiana Association for the Education of Young Children

IDA: Indiana Dietetic Association

IDOA: Indiana Department of Administration

IDOE: Indiana Department of Education

IHA: Indiana Hospital Association

IHWI: Indiana Healthy Weight Initiative

INDOT: Indiana Department of Transportation

IPN: Indiana Perinatal Network

IRA: Indiana Restaurant Association

ISDH: Indiana State Department of Health

MPO: Metropolitan Planning Organization

SRTS: Safe Routes to School

YRBS: Youth Risk Behavior Survey

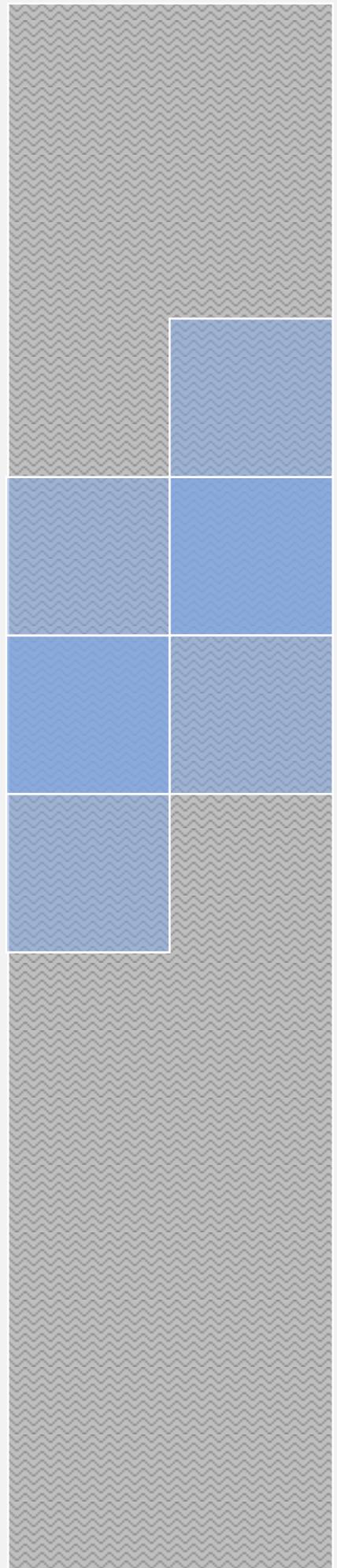
* Taken from *Indiana's Comprehensive Nutrition and Physical Activity Plan, 2010-2020 (the State Obesity Plan)*.

† A key strategy or strategies taken from a longer list of comprehensive strategies in the State Obesity Plan.

INDIANA STATE HEALTH IMPROVEMENT PLAN
Partnering for the Public's Health

**HEALTH PRIORITY:
DECREASE TOBACCO USAGE**

GOAL: Decrease tobacco use among all Hoosiers



Decrease Tobacco Usage

Indiana's Tobacco Burden

Tobacco use is the single most preventable cause of death and disease in the United States. Annually cigarette smoking causes nearly 440,000 deaths in the United States, more deaths than alcohol, AIDS, car accidents, illegal drugs, murders and suicides, combined.ⁱ

The impact of tobacco on Indiana is staggering. Each year over 9,700 Hoosier adults die from their own smoking and 194,000 Hoosiers are living with a tobacco-related illness or chronic disease.ⁱⁱ An estimated additional 1,200 adult nonsmokers die each year due to exposure to secondhand smoke, and 160,000 youth in Indiana now under the age of 18 will prematurely die from a smoking related disease.ⁱⁱⁱ

Average Number of Annual Smoking-attributable Deaths:

- Cancers – 3,978
- CVD – 3,127 (Stroke or cerebrovascular disease – 400 and is included in the CVD total)
- Respiratory Diseases – 2,623

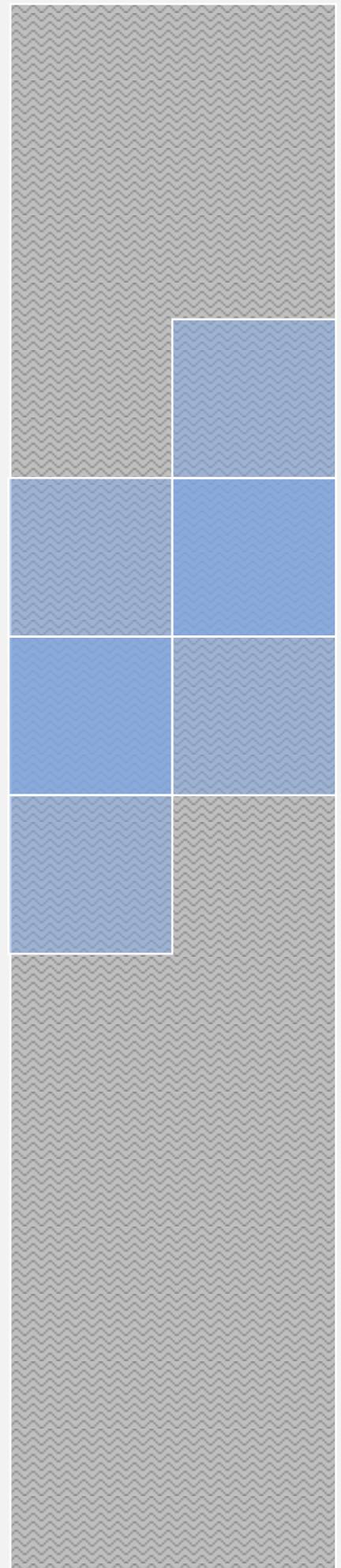
Total annual smoking-attributable mortality: 9,728^{iv}

Annual deaths attributed to secondhand smoke: 1,240^v

Hundreds more die from other tobacco-related causes, such as fires caused by smoking (more than 1,000 deaths annually nationwide^{vi}), and smokeless tobacco use.

What Tobacco Costs Indiana Each Year:

- Health care costs related to smoking in Indiana: over \$2 billion^{vii}
- Health care costs related to secondhand smoke in Indiana: \$390 million^{viii}
 - Total loss of life attributable to smoking: \$282.5 million
 - Total loss of life attributable to secondhand smoke: \$107.8 million
- For every pack of cigarettes sold in Indiana, Hoosiers spend \$7.57 in health care costs related to smoking.
- Medicaid expenditures directly related to tobacco: \$487 million^{ix}
- Indiana residents' state and federal tax burden from smoking-caused expenditures: \$566/ household^x
- Smoking-caused productivity losses in Indiana: \$2.6 billion^{xi}
- Annual smoking-related economic costs (including smoking-attributable medical expenditures and smoking-attributable neonatal medical expenditures) total \$3,391 per smoker.^{xii}



Decrease Tobacco Usage

Amounts do not include health costs caused by smoking-caused fires, smokeless tobacco use, or cigar and pipe smoking.

Tobacco Industry Influence in Indiana:

Test Marketing of New Tobacco Products:

Beginning in July 2007, RJ Reynolds introduced Camel Snus in Central Indiana as one of seven cities to receive the product. Philip Morris followed in March 2008 and released Marlboro Snus into the Indianapolis market. Tourney Snus (Vector Group Ltd of Liggett) and Grand Prix (Vector Group Ltd of Liggett) are also being marketed here. While Central Indiana has been the focus of these test markets, ongoing surveillance of the marketing and sales of the products indicate these products are moving further out into the state.

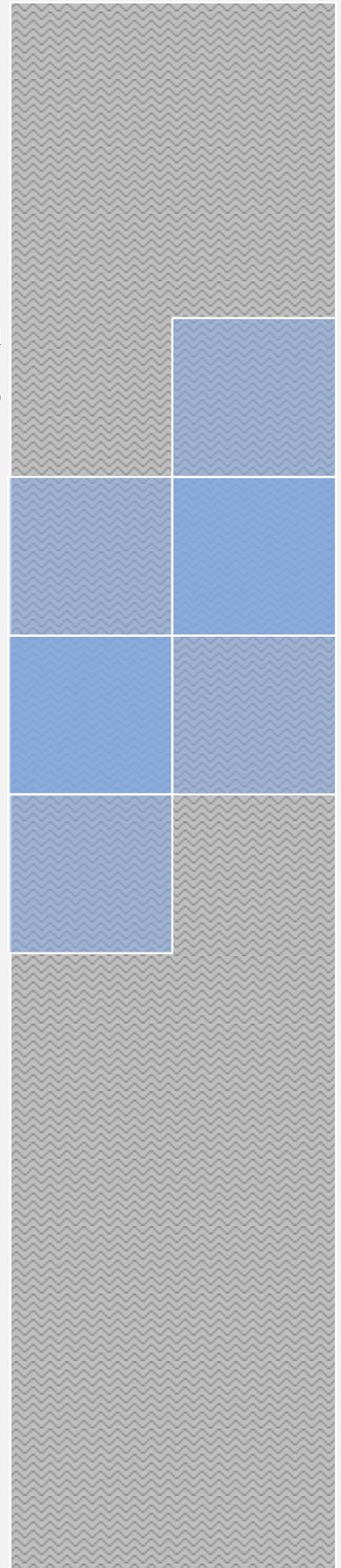
The introduction of snus products is of particular concern for Indiana employers who have spent considerable resources to motivate smokers to quit. Snus products are marketed as an alternative for smokers when they cannot smoke, thus leading to dual tobacco use. Therefore the effort of employers to reduce the percentage of tobacco-using workers is undermined.

In 2009, R.J. Reynolds introduced dissolvable tobacco products in the central Indiana area. These products called “dissolvables” are spitless, smokeless tobacco that can be dissolved in the mouth. They resemble breath mints, breath strips and toothpicks. At the time, the products were only being tested in three U.S. cities. The potential harm from these products is of much concern and has caused the Indiana Poison Center to issue a warning to parents and health care providers about the potential health impacts of a child ingesting this product.

Spending on tobacco prevention in Indiana vs. Tobacco Company Marketing Expenditures:

The U.S. Centers for Disease Control and Prevention (CDC) recommends that Indiana spend \$78.8 million a year to have an effective, comprehensive tobacco prevention program. Indiana currently allocates \$9.2 million a year for tobacco prevention and cessation. This is 11.7% of the CDC's recommendation and ranks Indiana 28th among the states in the funding of tobacco prevention programs.^{xiii} Indiana's spending on tobacco prevention amounts to 1.5% of the estimated \$599 million in tobacco-generated revenue the state collects each year from settlement payments and tobacco taxes.^{xiv}

Tobacco companies spend approximately \$426.2 million annually for marketing in Indiana. That is over 40 times what Indiana spends on tobacco prevention each year. Annual tobacco industry marketing expenditures nationwide total approximately \$12.8 billion.^{xv}



Decrease Tobacco Usage

Indiana Adult & Youth Smoking Rates:

Indiana's adult smoking rate is 23.1%, which is a statistically significant decrease from the 2001 adult smoking rate of 27.4%. Still, over 1.1 million adults in Indiana smoke cigarettes. Indiana ranks high among states in adult smoking prevalence, and is higher than the U.S. rate of 17.9%. Indiana smoking rates for men remain higher than those for Indiana women. Hoosier smoking rates by gender are also higher than the national rates.^{xvi}

Smoking among high school students in Indiana is at 18.3%, a drop from 31.6% in 2000. This decrease in the smoking rate among high school students equates to approximately 49,000 less youth smokers. Four percent of middle school students in Indiana are current smokers. This is a 59% decline from 2000, when approximately one in every ten middle school students smoked cigarettes.^{xvii}

Indiana's Tobacco Policies:

The current Indiana state cigarette excise tax is 99.5 cents/pack. Nationally, the average state tobacco tax is \$1.45, with taxes ranging from 17 cents to \$4.35/pack.

Approximately 34% of all Hoosiers are protected from secondhand smoke by a local smoke-free air law that covers workplaces and restaurants. Only 11% of Indiana residents are protected by a local law that covers workplaces, restaurants, and bars.^{xviii} At a national level, 79.4% are covered by a smoke-free air law that covers most public places and workplaces, including restaurants. Nearly half, or 47.8%, of the nation is covered by a comprehensive smoke-free air law which covers all workplaces, restaurants, and bars.^{xix}

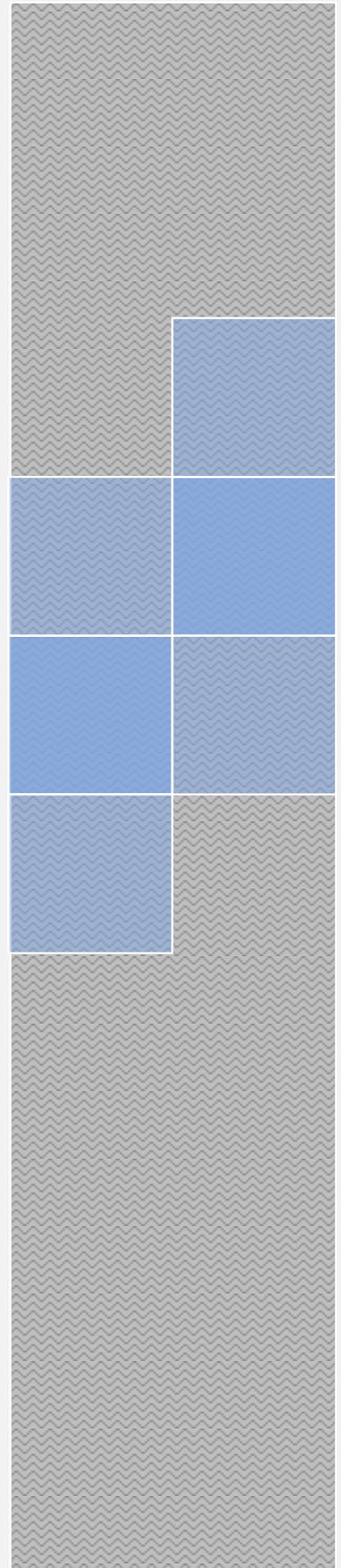
The Changing Landscape & New Opportunities in Tobacco Control:

Regulation of Tobacco Products:

On June 22, 2009, President Barack Obama signed the Family Smoking Prevention and Tobacco Control Act. This historic legislation grants authority to regulate tobacco products to the U.S. Food and Drug Administration. Powerful opportunities to advance the regulation of tobacco products exist at state and local levels, opportunities which Indiana's tobacco control commission must take advantage of to stay in front of the increasingly aggressive tactics of the tobacco industry.

Conclusion:

Tobacco use, if left unchecked, will almost certainly cause immeasurable harm to the physical health of children and adults, while damaging our country's fiscal health. To prevent these unnecessary health effects, as well



Decrease Tobacco Usage

as loss of productivity and premature death, it is imperative that the federal, state, and local governments continue to work to prevent tobacco use among young people. Tobacco control programs are at the heart of public health recommendations for national health reform, as the number one recommendation is to invest in population-based and community-based prevention, education and outreach programs that have been proven to prevent disease and injury and improve the social determinants of health. Tobacco control has years of evidence-based research behind it.

ⁱ Centers for Disease Control and Prevention. [Article title]. *MMWR* 2008;57:[inclusive page numbers].

ⁱⁱ CDC, “Cigarette Smoking-Attributable Morbidity – United States, 2000,” *MMWR* 52(35): 842-844, September 5, 2003.

ⁱⁱⁱ CDC, *State Data Highlights 2006*. See also, CDC—Projected Smoking-Related Deaths Among Youth—United States, *MMWR* 45(44):971-974, November 11, 1996, <http://www.cdc.gov/mmwr/preview/mmwrhtml/00044348.htm>

^{iv} CDC Smoking-Attributable Mortality, Morbidity, and Economic Costs (SAMMEC): Adult SAMMEC and Maternal and Child Health (MCH) SAMMEC software: <http://www.cdc.gov/tobacco/sammec>

^v Zollinger, T., Saywell, R., Muegge, C., Przybylski, M. Estimating the Economic Impact of Secondhand Smoke on Indiana in 2007. Bowen Research Center – Indiana University School of Medicine, June 2008.

^{vi} Karter, Michael Jr. “Fire Loss in the United States 2007.” National Fire Protection Association. National Fire Protection Association. <http://www.nfpa.org/assets/files/pdf/os.fireloss.pdf> August 2010;

^{vii} CDC, *Data Highlights 2006* [and underlying CDC data/estimates]. CDC’s STATE System average annual smoking attributable productivity losses from 1997-2001 (1999 estimates updated to 2004 dollars); CDC, —Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States 2000-2004,¹ *MMWR* 57(45):1226-1228, November 14, 2008, <http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf>.

^{viii} Zollinger, T., Saywell, R., Muegge, C., Przybylski, M. Estimating the Economic Impact of Secondhand Smoke on Indiana in 2007. Bowen Research Center – Indiana University School of Medicine, June 2008.

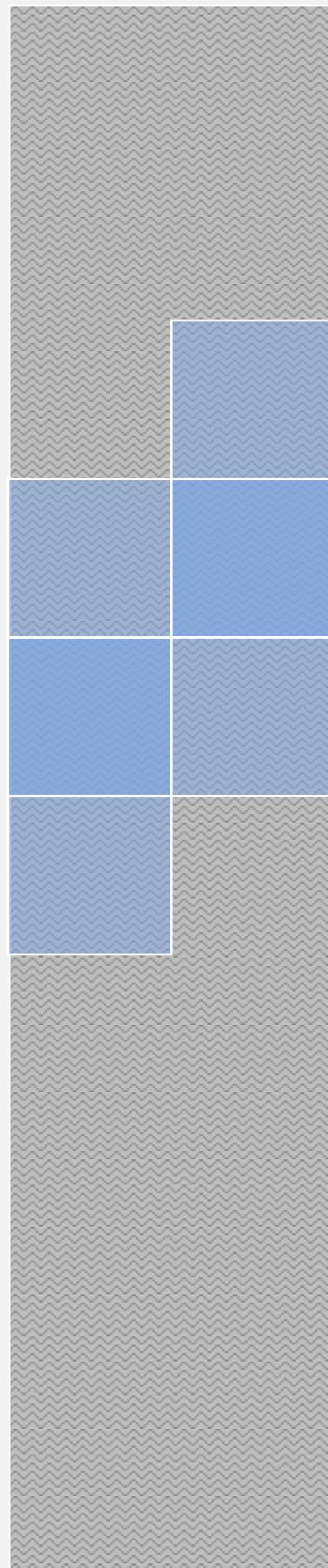
^{ix} Miller, L. et al., “State Estimates of Medicaid Expenditures Attributable to Cigarette Smoking, Fiscal Year 1993,” *Public Health Reports* 113: 140-151, March/April 1998; Orleans, CT, et al., “Helping Pregnant Smokers Quit: Meeting the Challenge in the Next Decade”, *Tobacco Control* 9(Supplemental III): 6-11, 2000.

^x Orzechowski & Walker, *Tax Burden on Tobacco 2009*, state agencies. U.S. General Accounting Office (GAO). Federal Smoking Medicaid Costs are federal expenditures within the state to cover the federal share of in-state Medicaid expenditures caused by smoking. Other Federal Smoking-Caused Costs are estimated amounts that each state’s taxpayers pay to cover their share of total non-Medicaid federal nationwide smoking-caused expenditures. Taxpayer’s burden equals the cost to taxpayers in each state to cover all smoking-caused state government health expenditures and their share of payments to cover all smoking-caused federal government health expenditures. No non-health costs included in tax burden other than smoking-caused Social Security Survivors Insurance (SSSI) payments.

^{xi} CDC, “Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Productivity Losses—United States 2000-2004,” *MMWR* 57(45): 1226-1228, November 14, 2008, <http://www.cdc.gov/mmwr/PDF/wk/mm5745.pdf>

^{xii} CDC, “Annual Smoking-Attributable Mortality, Years of Potential Life Lost, and Economic Costs – United States, 1995-1999,” *MMWR* 51(41): 300-3, April 12, 2002, <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5114a2.htm>.

^{xiii} CDC, *Best Practices for Comprehensive Tobacco Control*, October 2007



Decrease Tobacco Usage

^{xiv} Campaign for Tobacco-Free Kids, et al., *A Decade of Broken Promises: The 1998 State Tobacco Settlement 12 Years Later*, November 17, 2010, <http://tobaccofreekids.org/reports/settlements>.

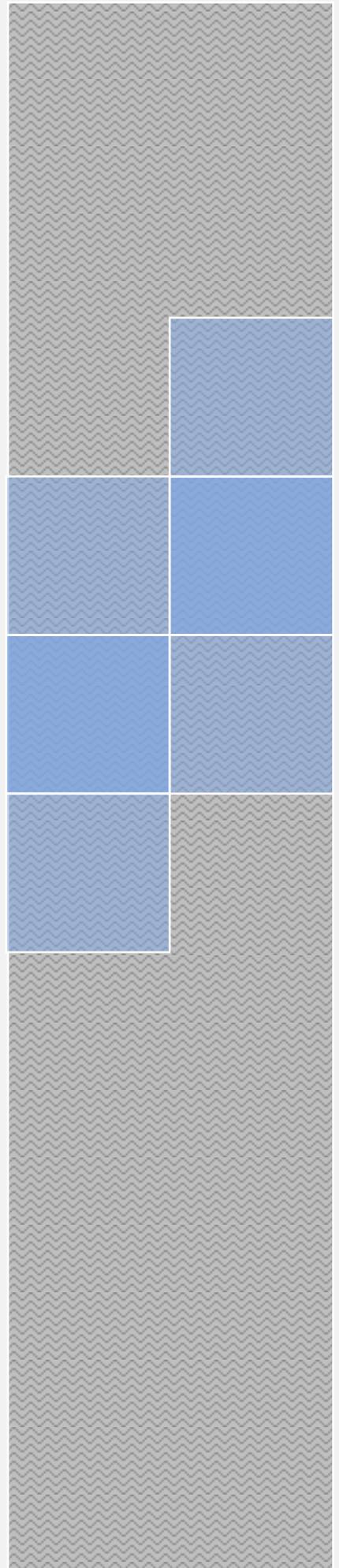
^{xv} U.S. Federal Trade Commission (FTC), *Cigarette Report for 2006*, 2009, <http://ftc.gov/os/2009/08/090812cigarettereport.pdf>

^{xvi} 2001 & 2008 Behavioral Risk Factor Surveillance System

^{xii} 2000-2008 Indiana Youth Tobacco Survey

^{xiii} ITPC Policy Tracking

^{xix} Americans for Nonsmokers' Rights overview list: <http://www.no-smoke.org/pdf/mediaordlist.pdf>



Decrease Tobacco Usage

Priority: Reduce the tobacco use burden on Indiana Adapted from the 2015 Indiana Tobacco Control Strategic Plan (2009)

PRIMARY PREVENTION

		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources)	<p>Increase to 100% Indiana’s population that is protected by secondhand smoke by law. (8.7% in 2010, ITPC policy tracking/U.S. Census)</p> <p>Increase Indiana’s cigarette tax to \$2.00 (99.5 cents in 2010, IN Dept. of Revenue)</p> <p>Increase tax on other tobacco products to 45% of the wholesale price. (24% of wholesale price in 2010, IN Dept. of Revenue)</p>	<p>Implement smoke free air policy at all levels from schools and hospital campuses to state and community laws.</p> <p>Educate on the public health benefits of high tobacco prices (cigarette taxes and taxes on other tobacco products).</p>	<p>Indiana tobacco control plan partners, including but not limited to:</p> <p>Indiana Campaign for Smoke-free Air</p> <p>Hoosier Faith and Health Coalition</p> <p>Indiana Cancer Consortium</p>
	Health Communications	<p>Increase confirmed awareness of countermarketing campaigns to 67%. (53% in 2008, IN Adult Tobacco Survey)</p> <p>Increase to 75% of adults that think secondhand smoke is the <u>serious</u> health hazard. (57% in 2008, IN Adult Tobacco Survey)</p> <p>Increase to 85% of adults that think smokeless tobacco products are <u>as harmful</u> as cigarettes. (71% in 2008, IN Adult Tobacco Survey)</p>	<p>Conduct mass media countermarketing campaigns under the brands Quit Now Indiana and Voice (ages 12-17); campaigns include paid and earned and social media</p>	<p>Indiana State Department of Health, Tobacco Prevention and Cessation</p>

Decrease Tobacco Usage

Priority: Reduce the tobacco use burden on Indiana Adapted from the 2015 Indiana Tobacco Control Strategic Plan (2009)

PRIMARY PREVENTION

PRIMARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Health Promotion	Community Interventions	<p>Decrease high school youth smoking rates to 17%. (18% in 2008, IN Youth Tobacco Survey)</p> <p>Decrease adult smoking to 18%. (23% in 2009, Behavior Risk Factor Surveillance Survey)</p> <p>Decrease smoking during pregnancy rate to 12% (18.5% in 2007, IN Natality Report)-SEE ALSO MCH PLAN</p>	<p>Provide funding, technical assistance and training to community based coalitions, one per county, with a specific tobacco control work plan.</p> <p>Provide funding, technical assistance and training local minority-based coalitions, reaching 95% of the minority population in the state, with a specific tobacco control work plan.</p> <p>Support youth mobilization to increase anti-tobacco attitudes through the Voice youth movement and hub support structure.</p>	Indiana State Department of Health, Tobacco Prevention and Cessation
	Other	<p>Decrease cigarette consumption to no more than 425 million packs per year. (453 million in SFY 2010, IN Dept. of Revenue)</p> <p>Increase to 100% the counties with a funded local tobacco control coalition. (70% of the counties in 2009-2011, ITPC Community Program)</p>	<p>Maintain and enhance state and local infrastructure to implement robust tobacco control interventions, including training and technical assistance.</p> <p>Educate on the need for adequate state funding for tobacco control interventions.</p> <p>Monitor the tobacco industry marketing tactics.</p> <p>Support surveillance and evaluation tools to monitor tobacco use indicators.</p> <p>Education for state and local policymakers to understand the more cost-effective population based interventions.</p>	<p>Indiana State Department of Health, Tobacco Prevention and Cessation</p> <p>Indiana tobacco control plan partners, including but not limited to:</p> <p>Indiana Campaign for Smoke-free Air, Hoosier Faith and Health Coalition, Indiana Cancer Consortium</p>

Decrease Tobacco Usage

Priority: Reduce the tobacco use burden on Indiana Adapted from the 2015 Indiana Tobacco Control Strategic Plan (2009)

PRIMARY PREVENTION

PRIMARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Access to Care	Systems Change (Policy/Resources)	<p>Increase to 90% the smokers that report physician advised them to quit using tobacco. (70.5% in 2008, IN Adult Tobacco Survey)</p>	<p>Implement cessation systems changes at all public health and health care setting to ask, advise and refer.</p> <p>Increase and promote health care benefits/health insurance coverage for evidence-based tobacco treatments that are provided by employers.</p> <p>Increase and promote health care coverage for evidence-based tobacco treatments provided by the state Medicaid program.</p>	<p>Indiana State Department of Health, Tobacco Prevention and Cessation</p> <p>Indiana Tobacco Quitline</p> <p>Quit Now Indiana Preferred Networks</p> <p>Indiana tobacco control plan partners</p>
	Health Communications	<p>Increase to 67% the smokers that are aware of the Indiana Tobacco Quitline (ITQL). (49% in 2008, IN Adult Tobacco Survey)</p>	<p>Promote a message of quitting and support available through the Indiana Tobacco Quitline (ITQL) and avoidance of secondhand smoke.</p>	<p>Indiana Tobacco Prevention and Cessation Agency</p> <p>Quit Now Indiana Preferred Networks</p>
	Interventions	<p>Increase to 65% of smokers making a quit attempt.(50% in 2008, IN Adult Tobacco Survey)</p> <p>Increase annual calls to the ITQL. (19,000 calls in SFY 2010, ITQL Service reports-ITPC)</p> <p>Increase the utilization of tobacco treatment among Medicaid members. (unknown; OMPP)</p>	<p>Provide quit coaching through the Indiana Tobacco Quitline (ITQL).</p> <p>Implement cessation systems changes at all levels of health care delivery to ask, advise, and refer.</p>	<p>Indiana State Department of Health, Tobacco Prevention and Cessation</p> <p>Indiana Tobacco Quitline</p> <p>Quit Now Indiana Preferred Networks</p> <p>Indiana tobacco control plan partners, including the Indiana Medicaid Program</p>
	Other		<p>Direct a portion of tobacco taxes to fund tobacco control interventions.</p>	

Decrease Tobacco Usage

Priority: Reduce the tobacco use burden on Indiana Adapted from the 2015 Indiana Tobacco Control Strategic Plan (2009)

SECONDARY PREVENTION			
	Outcomes	Activities	Responsible Partner(s)
Health Promotion	Systems Change (Policy/Resources)		
	Health Communications		
	Community Interventions		
	Other		
Access to Care	Systems Change (Policy/Resources)	<p>Increase to 90% the smokers that report physician advised them to quit using tobacco. (70.5% in 2008; IN Adult Tobacco Survey)</p> <p>Implement cessation systems changes at all public health and health care setting to ask, advise and refer.</p> <p>Increase and promote health care benefits/health insurance coverage for evidence based tobacco treatments that are provided by employers.</p> <p>Increase and promote health care coverage for evidence based tobacco treatments provided by the state Medicaid program.</p>	<p>Indiana State Department of Health, Tobacco Prevention and Cessation</p> <p>Indiana Tobacco Quitline</p> <p>Quit Now Indiana Preferred Networks</p> <p>Indiana tobacco control plan partners, including the Indiana Medicaid Program</p>
	Health Communications	<p>Increase to 67% the smokers that are aware of the Indiana Tobacco Quitline (ITQL). (49% in 2008; IN Adult Tobacco Survey)</p>	<p>Indiana State Department of Health, Tobacco Prevention and Cessation</p> <p>Quit Now Indiana Preferred Networks</p>
	Interventions	<p>Increase to 65% of smokers making a quit attempt. (50% in 2008, IN Adult Tobacco Survey)</p> <p>Increase annual calls to the ITQL. (19,000 calls in SFY 2010, ITPC Service Reports-ITPC)</p> <p>Increase the utilization of tobacco treatment among Medicaid members. (unknown, OMPP)</p>	<p>Provide quit coaching through the Indiana Tobacco Quitline (ITQL).</p> <p>Implement cessation systems changes at all levels of health care delivery to ask, advise, and refer.</p> <p>Indiana State Department of Health, Tobacco Prevention and Cessation</p> <p>Indiana Tobacco Quitline</p> <p>Quit Now Indiana Preferred Networks</p> <p>Indiana tobacco control plan partners, including the Indiana Medicaid Program</p>
	Other		

Decrease Tobacco Usage

Priority: Reduce the tobacco use burden on Indiana Adapted from the 2015 Indiana Tobacco Control Strategic Plan (2009)

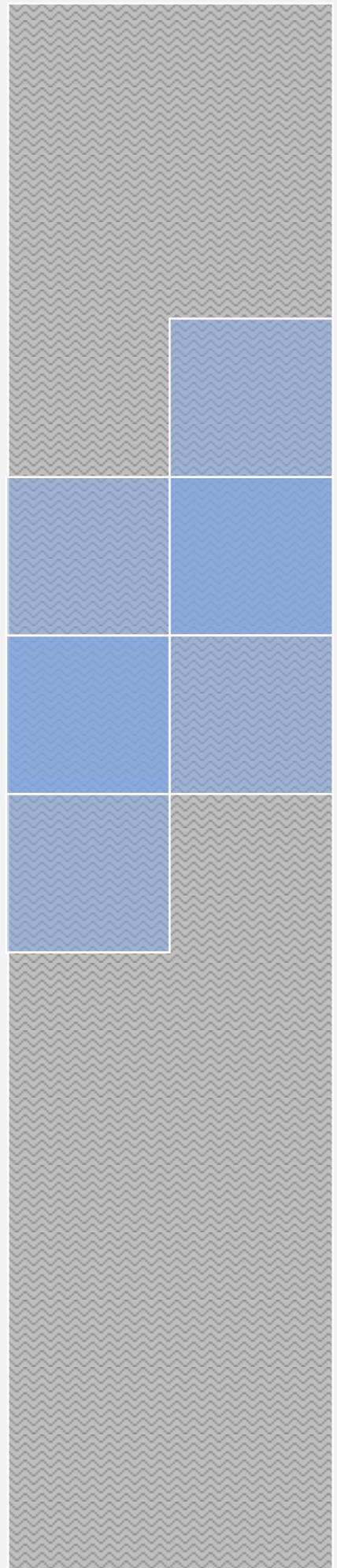
TERTIARY PREVENTION

		Outcomes	Activities	Responsible Partners(s)
Health Promotion	Systems Change (Policy/Resources)	Decrease asthma episodes. (TBD) Decrease heart attack admissions. (TBD) Decrease rates of cancer. (TBD)	Implement smoke free air policy to ensure smoke free air environments that are necessary to reduce asthma episodes and heart attacks, and other implications related to chronic diseases.	Indiana tobacco control plan partners, including but not limited to: Indiana Campaign for Smoke-free Air
	Health Communications			
	Community Interventions			
	Other			
Access to Care	Systems Change (Policy/Resources)	Increase to 90% the smokers that report physician advised them to quit using tobacco. (70.5% in 2008, IN Adult Tobacco Survey)	Implement cessation systems changes at all public health and health care setting to ask, advise and refer. Increase and promote health care benefits/health insurance coverage for evidence-based tobacco treatments that are provided by employers. Increase and promote health care coverage for evidence-based tobacco treatments provided by the state Medicaid program.	Indiana State Department of Health, Tobacco Prevention and Cessation Indiana Tobacco Quitline Quit Now Indiana Preferred Networks Indiana tobacco control plan partners, including the Indiana Medicaid Program
	Health Communications	Increase to 67% the smokers that are aware of the Indiana Tobacco Quitline (ITQL). (49% in 2008, IN Adult Tobacco Survey)		Indiana State Department of Health, Tobacco Prevention and Cessation Quit Now Indiana Preferred Networks
	Interventions	Increase to 65% of smokers making a quit attempt. (50% in 2008, IN Adult Tobacco Survey) Increase annual calls to the ITQL. (19,000 calls in SFY 2010, ITQL Service Reports-ITPC) Increase the utilization of tobacco treatment among Medicaid members. (unknown, OMPP)	Provide quit coaching through the Indiana Tobacco Quitline (ITQL). Implement cessation systems changes at all levels of health care delivery to ask, advise, and refer.	Indiana State Department of Health, Tobacco Prevention and Cessation Indiana Tobacco Quitline Quit Now Indiana Preferred Networks Indiana tobacco control plan partners, including the Indiana Medicaid Program
	Other			

INDIANA STATE HEALTH IMPROVEMENT PLAN
Partnering for the Public's Health

**HEALTH PRIORITY:
REDUCE INFANT MORTALITY**

GOAL: Decrease total preterm birth rates by 15% by 2015 from 12.7 in 2007 to 10.8 by 2015.



Reduce Infant Mortality

Prematurity is the leading cause of death among newborn babies. Being born premature is also a serious health risk for a baby. Some babies will require special care and spend weeks or months hospitalized in a neonatal intensive care unit (NICU). Those who survive may face lifelong problems such as intellectual disabilities, cerebral palsy, breathing and respiratory problems, vision and hearing loss, and feeding and digestive problems.

In 2008, the March of Dimes (MOD) announced that Indiana had a failing grade on its premature birth report card due to a number of perinatal indicators including late preterm births. The consistent escalation of Indiana's preterm rate has created major concerns in the public health community and prompted a Maternal and Child Health (MCH) investigation into the patterns of preterm births and the potential contributing factors.

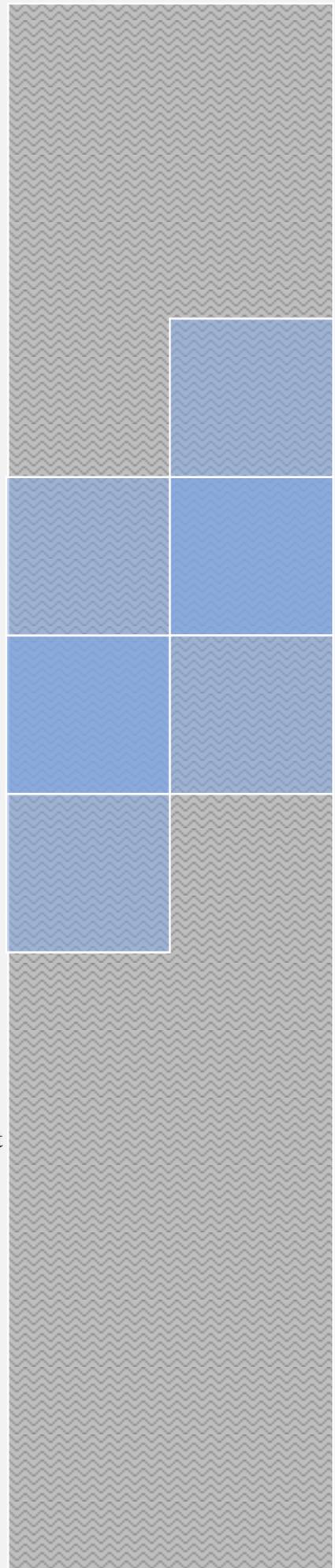
In September, 2009 MCH released results for the study *Trends in Preterm Birth, Cesarean Delivery, and Induction of Labor in Indiana: Statistics from the Live Birth Data, 1990-2006*. The purpose of this report was to study the patterns and trends in rates of preterm births, cesarean delivery, and induction of labor in Indiana between 1990 and 2006 and to explore the relationship of rising preterm rates with cesarean delivery and induction of labor.

Over the last two decades, there has been a marked shift in the gestational age distribution of Indiana live births towards earlier ages between 1990 and 2006. During this period, very preterm (less than 32 weeks) and moderately preterm (32-33 weeks) births have increased modestly (by 16 and 15 percent, respectively) whereas late preterm (34-36 weeks) and near term (37-38 weeks) births have risen sharply (by 38 and 63 percent, respectively). In contrast, births at 40 weeks or more have noticeably declined.

Cesarean delivery accounted for 29.3% of all births in 2006, up by 48% since the lowest rate of 19.8% in 1997. The upward trend in cesarean rates between 1997 and 2006 was evident across all gestational ages with the largest increases for late preterm and near term births. Primary cesarean rates in Indiana doubled (1997-2006) even for singleton full term vertex position births to women with no indicated medical risk factors (birth weight <4000g, no concurrent illness, no complications of labor and delivery). By 2007, the primary Cesarean section rate was 20.1%.

Rate of induction of labor almost tripled in Indiana from 9.3% in 1990 to 26.9% in 2006, surpassing the national rates after mid 1990's. The upward trend in induction rates was sharper for term and late preterm births compared to very and moderately preterm and post-term.

Infant Mortality (death within the first year of life) is much more prevalent in the Black non-Hispanic / Latino population than in the White non-

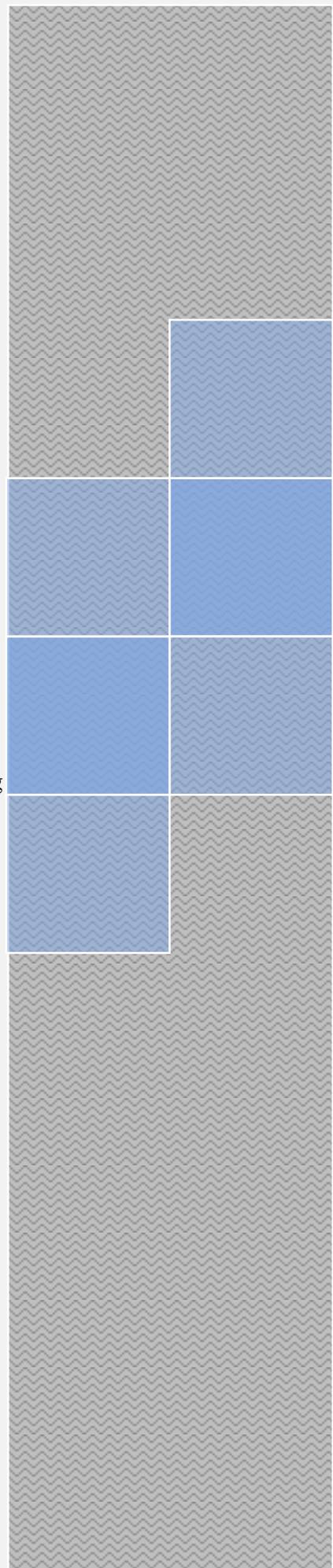


Reduce Infant Mortality

Hispanic/Latino or Hispanic/Latino population. The Infant Mortality Rate for Black non-Hispanic/Latino population is consistently higher each year than the state average, and even in 2007 when the Black non-Hispanic/Latino rate dropped from 18.1 to 15.7, it was still over twice as high as the White non-Hispanic / Latino rate in 2007. The percentage of Black women receiving prenatal care in the first trimester decreased from 68.2% in 2003 to 65.6 % in 2006. The Black premature birth rate in Indiana between 2000 and 2005 has consistently increased, and is at a much higher percentage than the total premature percentage. From 2000 through 2002, the Black premature birth percentage was 18.1, before increasing to 18.5 between 2003 through 2005. The Black low birth weight percentages have steadily increased every year from 13.3% in 2003 up to 14.4% in 2007.

Indiana has seen a decreasing trend in smoking during pregnancy from 19.1% in 2002 to 17.3% in 2006. However, 17.3% smoking in pregnant women is still too high and not acceptable. Fifty-one percent of all pregnant women in Indiana are on Medicaid at time of birth. Smoking rates among pregnant women on Medicaid have been found to be 1.5 times that for pregnant women not on Medicaid. In 2009, ISDH linked Medicaid patient data to 2007 vital record data. Results showed that an average of 27.7% of all women delivering a live baby on Medicaid smoked during pregnancy in 2007, compared to 17.3% for all pregnant women in Indiana. What was even more alarming was that for pregnant women on Medicaid 68 of 92 counties had a smoking rates of 30% or greater and 13 counties had smoking rates of 40-49%. MCH will collaborate with the Office Medicaid Policy and Planning (OMPP), Medicaid Managed Care Organizations, the Tobacco Prevention and Cessation Commission at the Indian State Department of Health, Indiana Tobacco Quitline, and other state and local partners to decrease smoking among pregnant women on Medicaid and all pregnant women.

In 2009 and 2010, Indiana received a grade of D on the March of Dimes Premature Birth Report Card. In fall 2010, ISDH Maternal and Child Health Division called together a group of health care providers, hospitals, health professional organizations and concerned organizations to coordinate statewide systems and approaches to improve perinatal health outcomes. Focus areas include implementing preconception and interconception care, reducing perinatal smoking, instituting more standardized levels of obstetric and neonatal care and reducing prematurity.



Reduce Infant Mortality

Priority: Decrease percentage of preterm births in Indiana

PRIMARY PREVENTION

		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources)	Completed perinatal state plan to guide state and local interventions.	Complete a perinatal state plan to guide state and local interventions that will reduce preterm births at all levels by creating policy that leads to system change, change in provider practice, and change in patient knowledge and practice.	Indiana State Department of Health (Maternal Child Health) (ISDH-MCH), Indiana Perinatal Network (INP), Indian Chapter March of Dimes (MOD), Indiana University National Center of Excellence in Women’s Health (IUNCEWH) with Indiana Chapter American College of Obstetricians and Gynecologists (InACOG), Indiana Chapter American Academy of Pediatrics (InAAP), Office of Medicaid Policy and Planning (OMPP) , Indiana Chapter Association of Women’s Health Obstetric, Neonatal Nurses (InAWHONN), and other partners.
		Committees organized and working on ongoing basis.	Committees working on 1) provider education, 2) public and consumer education, 3) identification of data sources, and evaluation of interventions, 4) creation of policy, standards, tools to drive system change and improve birth outcomes.	
	Health Communications	Decreased induction rates from 31% in 2007 to 21% in 2012. Decreased primary Cesarean section rates from 20.1% in 2007 to 14% in 2012.	Increase the awareness and knowledge of prenatal health care providers on the effects of prematurity due to scheduled induction and Cesarean on the mother and newborn through various educational methods.	ISDH-MCH, IPN, MOD, IUCEWH, InACOG, InAAP, InAWHONN, Managed Care Organizations (MCOs), Health Systems and hospitals, and other partners.
	Community Interventions	Decreased induction rates from 31% in 2007 to 21% in 2012. Decreased primary Cesarean section rates from 20.1% in 2007 to 14% in 2012.	Develop standards and tools to facilitate practice change at the hospital level.	ISDH-MCH, IPN, MOD, IUCEWH, InACOG, InAAP, InAWHONN, Managed Care Organizations (MCOs), Health Systems and hospitals, and other partners.
	Other			

Reduce Infant Mortality

Priority: Decrease percentage of preterm births in Indiana

PRIMARY PREVENTION			
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Access to Care	Systems Change (Policy/Resources)		
	Health Communications		
	Interventions		
	Other	Increased percentage of African-American pregnant women who have adequate prenatal care visits from 55.3% in 2007 to 62% in 2012.	

Reduce Infant Mortality

Priority: Decrease percentage of preterm births in Indiana

SECONDARY PREVENTION				
	Outcomes	Activities	Responsible Partner(s)	
Health Promotion	Systems Change (Policy/Resources)			
	Health Communications	Increased public awareness of all aspects of prematurity, including causes of early and late preterm delivery, induction and/or Cesarean delivery with no medical reason, brain development of the fetus, the long term effects of prematurity on the newborn.	Develop media messages that are culturally appropriate, literacy level appropriate and are targeted to state and local audiences.	
	Community Interventions	Decrease the proportion of pregnant women on Medicaid who smoke during pregnancy by 0.5% each year from a baseline of 27.7% in 2007.	Continue OMPP Neonatal Quality Committee that provides advice and collaborative efforts to decrease smoking in pregnancy. The Indiana Tobacco Quitline provides up to 10 tobacco cessation counseling sessions for all pregnant women who contact the Quitline for help. This service is available to all pregnant women including those on Medicaid or other insurance, and women who are uninsured.	OMPP, ISDH-MCH, MCOs, Indiana State Department of Health, Tobacco Prevention and Cessation
	Other			

Reduce Infant Mortality

Priority: Decrease percentage of preterm births in Indiana

SECONDARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Access to Care	Systems Change (Policy/Resources)			
	Health Communications	<p>Proportion of pregnant women on Medicaid who smoke during pregnancy decreased by 0.5% each year from a baseline of 27.7% in 2007.</p> <p>Percentage of women who smoke in the last three months of pregnancy decreased from 17.5% in 2007 to 15.5% in 2012.</p>	<p>Provide training and materials to prenatal Medicaid providers through each MCO to promote the use of evidenced-based screening and referral to the Indiana Tobacco Quitline.</p> <p>Members of the Indiana Preventing Smoke-free Pregnancies in Indiana training subcommittee will continue to provide regional trainings for health care providers working with pregnant women.</p> <p>Promote “text4baby” as another way to reach pregnant women and new mothers with smoking messages.</p>	ISDH-MCH, IPN, IUNCEWH, PSPI, Indiana State Department of Health, Tobacco Prevention and Cessation
	Interventions		<p>Promote tobacco treatment services, including promotion of the Indiana Tobacco Quitline and access to health care providers through policy implementation and quality improvement measures.</p>	ISDH-MCH, IPN, IUNCEWH, PSPI, Indiana State Department of Health, Tobacco Prevention and Cessation
	Other			

Reduce Infant Mortality

Priority: Decrease percentage of preterm births in Indiana

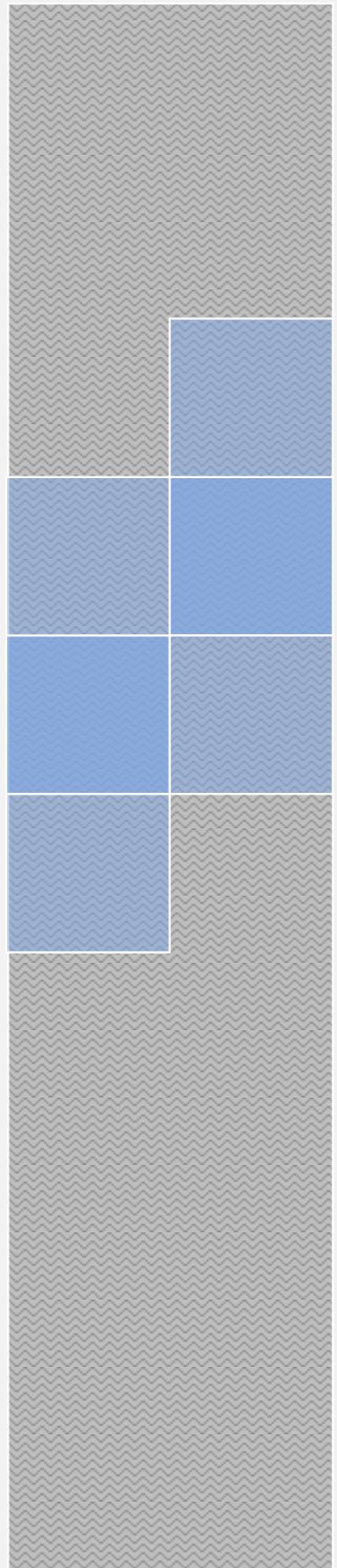
TERTIARY PREVENTION

		Outcomes	Activities	Responsible Partners(s)
Health Promotion	Systems Change (Policy/Resources)	<p>Ongoing surveillance on prevalence of smoking among pregnant women on Medicaid.</p> <p>Prenatal smoking data briefs created and disseminated to prenatal care provider, local health departments, and community policy leaders.</p>	<p>Assess counties with the highest smoking rates and the lowest smoking rates to identify what works and what does not work to decrease smoking among low income pregnant women on Medicaid.</p> <p>Conduct ongoing assessment of prenatal smoking data using monthly Notice of Pregnancy data; vital records, Title V funded project quarterly reports, by county, race, Medicaid versus Non- Medicaid.</p>	ISDH-MCH, OMPP, Indiana State Department of Health, Tobacco Prevention and Cessation
	Health Communications			
	Community Interventions			
	Other			
Access to Care	Systems Change (Policy/Resources)			
	Health Communications			
	Interventions			
	Other			

INDIANA STATE HEALTH IMPROVEMENT PLAN
Partnering for the Public's Health

**HEALTH PRIORITY:
ASSURE FOOD SAFETY**

GOAL: Reduce infections/intoxications associated with foodborne illness (FBI) outbreaks due to pathogens commonly transmitted through food.



Assure Food Safety

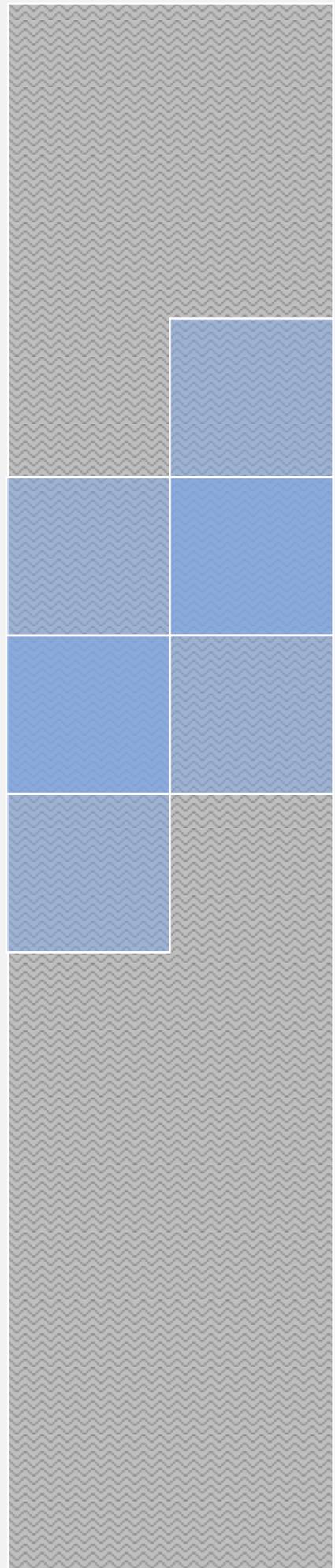
In the United States, about 48 million people (1 in 6 Americans) get sick, 128,000 are hospitalized, and 3,000 die each year from foodborne diseases, according to recent data from the Centers for Disease Control and Prevention. This is a significant public health burden that is largely preventable.

The United States Food and Drug Administration (FDA) Food Safety Modernization Act (FSMA), signed into law by President Obama on January 4, 2011, enables FDA to better protect public health by strengthening the food safety system. It enables FDA to focus more on preventing food safety problems rather than relying primarily on reacting to problems after they occur. The law also provides FDA with new enforcement authorities designed to achieve higher rates of compliance with prevention- and risk-based food safety standards and to better respond to and contain problems when they do occur. The law also gives FDA important new tools to hold imported foods to the same standards as domestic foods and directs FDA to build an integrated national food safety system in partnership with State and local authorities. The FSMA will impact the State and local food safety professionals by relying on them to help implement the FSMA.

Among the key findings of the FSMA Food Safety Working Group created by President Obama was the need to modernize statutes that require effective sanitation and preventive controls in food establishments. An increasingly globalized food supply chain, the aging of our population, increases in the number of immunocompromised and immunosuppressed individuals, and the trend toward greater consumption of foods prepared outside the home demand sustained vigilance by industry and the regulatory community, from the Federal, State, and local level, to promote food safety in retail and foodservice establishments.

Healthy People 2020 identifies food safety as important. According to Healthy People 2020, foodborne illness is a preventable and underreported public health problem. It presents a major challenge to both general and at-risk populations. Each year, millions of illnesses in the United States can be attributed to contaminated foods. Children younger than age 4 have the highest incidence of laboratory-confirmed infections from:

- *Campylobacter* species
- *Cryptosporidium* species
- *Salmonella* species
- Shiga toxin-producing *Escherichia coli* O157
- *Shigella* species
- *Yersinia* species



Assure Food Safety

People older than age 50 are at greater risk for hospitalizations and death from intestinal pathogens commonly transmitted through foods. Safer food promises healthier and longer lives, reduced health care costs, and a more resilient food industry.

Many factors determine the safety of the Nation's food supply. Improper handling, preparation, and storage practices may result in cases of foodborne illness. This can happen in processing and retail establishments and in the home.

Fewer consumers grow and prepare their own food, preferring instead either to use convenience foods purchased in supermarkets that can quickly be prepared or assembled, or to eat in restaurants. This gives them less control over the foods they eat.

The processing and retail food industries continue to be challenged by:

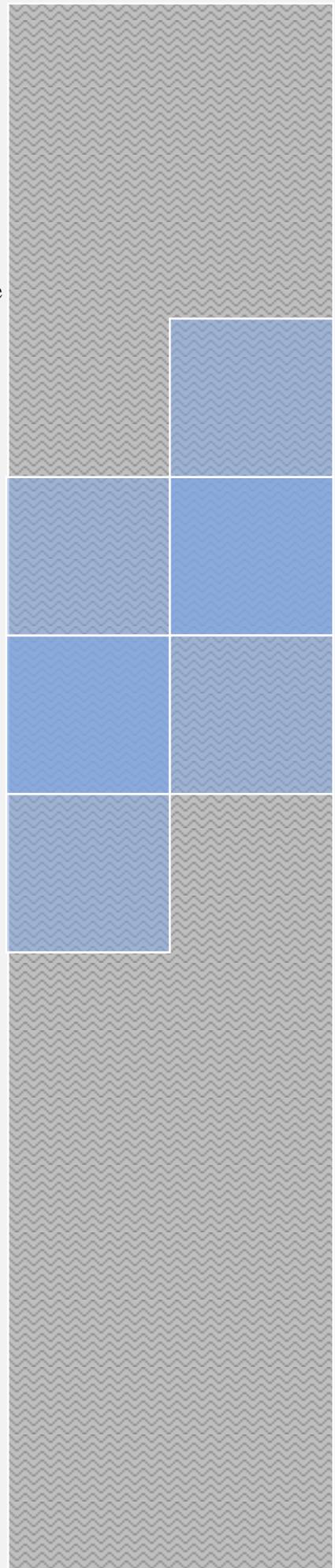
- Large employee populations that have high rates of turnover.
- Nonuniform systems for training and certifying workers.
- Ability to rapidly traceback/traceforward food items of interest.

In addition, changes in production practices and new sources of food, such as imports, introduce new risks.

Food hazards can enter the food supply at any point from farm to table. Many foodborne hazards cannot be detected in food when it is purchased or consumed. These hazards include microbial pathogens and chemical contaminants. In addition, a food itself can cause severe adverse reactions. In the United States, food allergy is an important problem, especially among children under age 18.

Implementation of the Food Code also supported many of the food safety objectives of Healthy People 2010, the comprehensive, nationwide set of health promotion and disease prevention objectives designed to serve as a 10-year strategy for improving health in the United States. Healthy People 2020's objectives include:

- Reduce infections caused by key pathogens transmitted commonly through food.
- Reduce the number of outbreak-associated infections due to *Shiga* toxin-producing *E. coli* O157, or *Campylobacter*, *Listeria*, or *Salmonella* species associated with food commodity groups.
- Prevent an increase in the proportion of nontyphoidal *Salmonella* and *Campylobacter jejuni* isolates from humans that are resistant to antimicrobial drugs.
- Reduce severe allergic reactions to food among adults with a food allergy diagnosis.



Assure Food Safety

- Increase the proportion of consumers who follow key food safety practices. *Shigella* species
- (Developmental) Improve food safety practices associated with foodborne illness in foodservice and retail establishments.

Source: *Healthy People 2020, Food Safety Topic and Objective*, Accessed March 31, 2011, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=14>

Indiana Specific Enteric Illness Data

Enteric illnesses are prevalent yet are underreported in Indiana, as well as across the U.S. The table below describes confirmed cases of various enteric illnesses from 2007 to 2009.

Condition	2007	2008	2009	Average
Botulism	3	1	0	1
Campylobacteriosis	489	686	616	597
Cryptosporidium	149	203	278	210
Cyclosporidium	2	2	1	2
Giardiasis*	NR	NR	314	N/A
Hepatitis A	28	20	19	22
Hepatitis E	1	2	2	2
Hemolytic Uremic Syndrome (HUS)	16	1	7	8
Listeriosis	18	10	10	13
Salmonellosis	675	641	572	629
Shiga-toxin producing <i>E. coli</i> (STEC)	105	96	64	88
Shigellosis	296	607	77	327
Typhoid Fever	2	1	1	1
Vibriosis	3	5	3	4
Yersiniosis	14	9	7	10

*Giardiasis was made a newly reportable disease December 12, 2008 with the release of the updated 410 IAC 1-2.3 Communicable Disease Reporting Rule for Physicians, Hospitals, and laboratories.

These enteric illnesses are identified by passive surveillance through identification by laboratory diagnosis or epidemiologic linkage. Indiana State Department of Health's (ISDH) current system is to follow-up with every reported case. Interviews are conducted by the local health department (LHD) in the county of residence to collect demographic, clinical, risk factor, and other pertinent information using a standardized questionnaire that is specific to the etiologic agent causing illness. These interviews are

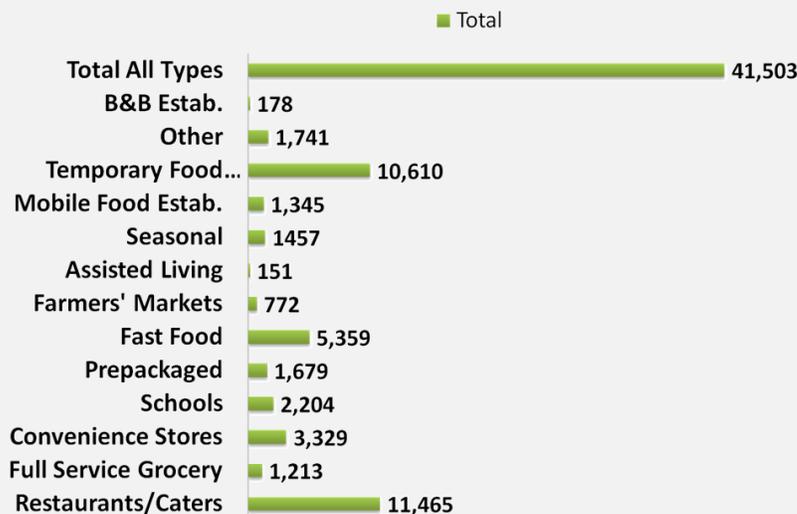
Assure Food Safety

not dependent on serotype or PFGE results but are conducted upon initial notification. Information collected from LHD case interviews, reference laboratories, and the ISDH laboratory (serotype and confirmatory testing) is entered into the Indiana National Electronic Disease Surveillance System (INEDSS) for review by the Enteric Epidemiologist. Local clusters with common risk factors or serotypes are identified at this time.

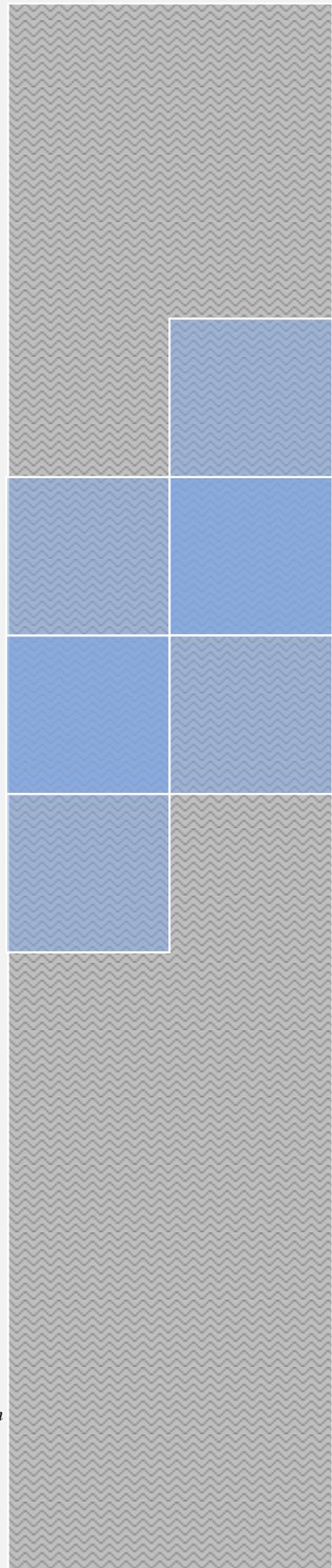
In addition to passive surveillance activities, ISDH also conducts outbreak investigations for enteric illnesses. Improvements in molecular laboratory testing methods of enteric bacteria have made it easier to identify foodborne disease outbreaks at a State and National level. In 2009, ISDH reported 10 confirmed cases of *listeriosis*, 572 confirmed cases of *salmonellosis*, and 62 confirmed cases of *Shiga*-toxin producing *E. coli* (STEC) infections. These numbers do not include the suspect, probable, or lost-to follow-up/unconfirmed cases which still required time and resources to investigate. In 2009, ISDH also investigated and reported to National Outbreak Reporting System (NORS) 31 clusters of foodborne illness caused by *Listeria monocytogenes*, *Salmonella* spp., and STEC identified by either Pulse Field Gel Electrophoresis (PFGE) or traditional epidemiologic methods. These clusters contributed a total of 67 cases of illness to ISDH's 2009 surveillance numbers and required additional time and resources of State and local Public Health professionals to investigate.

The United States Food and Drug Administration (FDA) recommend 280-320 inspections per full-time employee (FTE). This equals roughly 150 establishments per FTE if 2 inspections occur each day per year on average.

Food Establishments Served by LHD's
n= 92

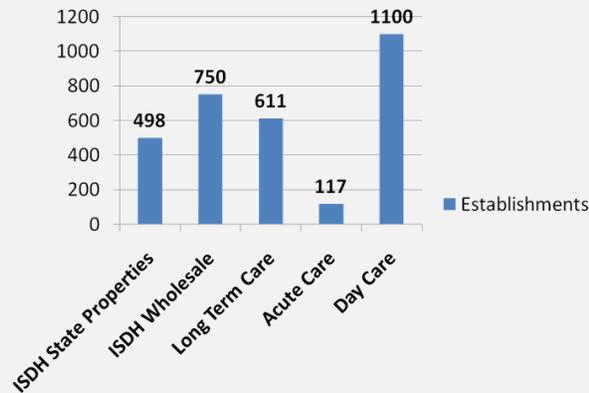


Source: 2010 Food Protection Survey, Indiana State Department of Health, Food Protection Program



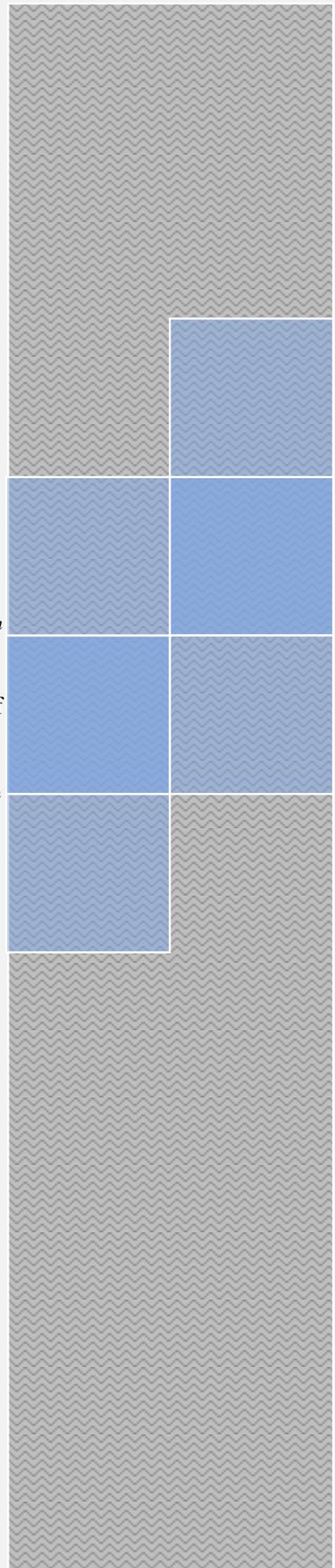
Assure Food Safety

Food Establishments Served by State Agencies



Source: 2010 Food Protection Survey, Indiana State Department of Health, Food Protection Program

Based on the number of food establishments in Indiana, the overall numbers of food safety inspection officers (FSIO), the numerous activities required of FSIOs other than inspections and the dwindling public resources, it is evident that Indiana must move to a comprehensive system of risk-based inspections to offer to best possible protection to the public. This will be one of the overriding objectives of the Food Safety Priority of the Indiana State Health Improvement Plan.



Assure Food Safety

Priority: Food Safety

PRIMARY PREVENTION

PRIMARY PREVENTION			
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Collaborate with the Indiana State Department of Health (ISDH), Indiana State Board of Animal Health (BOAH), Indiana State Egg Board (ISEB), & local health departments (LHDs) to increase inspection effectiveness based on risk.	Utilize LHD survey to educate on staffing needs based on FDA Voluntary Program Standards recommended levels.	ISDH, BOAH, ISEB, LHDs
	Will conduct and/or continue the self-assessment process for determination of standards compliance.	Achieve minimum staffing requirements recommended by the FDA Voluntary Program Standards.	ISDH
	ISDH Food Protection Inspection Staff be standardized by a FDA or ISDH standardized staff.	Meet FDA Voluntary Program Standards.	ISDH
	Develop and implement direct data entry of inspection data to support near real-time data reporting. Increase transmission of data to ISDH. Promote CodePal by presenting at food safety groups such as IEHA and other LHD training opportunities.	Begin using CodePal for inspection data at ISDH in the 1 st year. Educate LHDs on CodePal to utilize the software. Educate 5 LHDs with majority of food establishments by end of year 2. Create linkages to LHDs with their own systems by end of year 3. Continue to educate and promote software to create state-wide data system of 75% of food establishments by end of year 5.	ISDH, LHDs
	Develop and implement a field data entry and exchange system for near real time data access used to identify food safety issues relative to the commerce of shell eggs.	This information will be used to quickly and effectively assist with retail recall activities in the event of a shell egg related FBI outbreak.	ISEB
	Implement guidance from the Indiana Food Safety & Defense Task Force to improve FBI prevention based on workgroup recommendations.	Indiana Food Safety & Defense Task Force workgroups develop recommendations to improve FBI prevention. Create formalized structure and strategic plans for the Task Force that challenges the Task Force to address more food safety and defense issues. Create workgroups like the charter workgroup and licensing proposal workgroup. Create a communications workgroup.	Task Force Members

Systems Change
(Policy/Resources)

Assure Food Safety

Priority: Food Safety

PRIMARY PREVENTION

PRIMARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Health Promotion	Systems Change (Policy/Resources)	Increase level of technical knowledge of good manufacturing practices of Food Safety Inspection Officer's (FSIOs), dairy, meat, egg, and feed inspectors.	Onsite trainings from U.S. Food & Drug Administration (FDA), United States Department of Agriculture (USDA), etc. Utilize FDA Office of Regulatory Affairs University (ORAU).	ISDH, BOAH, ISEB, Indiana State Chemist
		Provide and require ongoing training for ISDH food protection staff based off of continuing education requirements.	Establish continuing education requirements.	ISDH
		Increase information sharing between agencies and the food and agriculture industry.	Establish the Indiana Food Safety & Defense Task Force communications workgroup, web resources, video conferencing and through FoodSHIELD.	ISDH, BOAH, ISEB, Indiana State Chemist, LHDs, food industry, agriculture industry, Task Force
		Reduce <i>Listeria monocytogenes</i> in ready-to-eat meat products by 10%.	Routine/intensified product and environmental sampling in meat plants.	BOAH
		Increase routine surveillance sampling at food establishments by 10%.	Collect food and environmental samples when conducting a risk-based inspection.	ISDH
		Maintain 100% compliance implementing <i>Salmonella</i> , Shiga toxin-producing <i>E. coli</i> (STEC) reduction/elimination systems on beef carcasses at slaughter.	Daily in-plant regulatory oversight and verification audits.	BOAH
		Reduction of raw milk consumption through pet food and cow share activities to reduce cases of FBI attributable to raw milk consumption.	Media/educational campaign utilizing CDC information, education for lawmakers and public to encourage a change in raw milk consumption habits.	BOAH, ISDH, State Chemist, Indiana State Department of Agriculture (ISDA)
		Increase the amount of surveillance safety testing for manufactured dairy products by 10%.	Collect 10% additional number of samples from current baseline.	BOAH

Assure Food Safety

Priority: Food Safety

PRIMARY PREVENTION

		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Health Communications	<p>Assess level of FBI prevention oversight and education based on the five key public health interventions in the food industry to include:</p> <ul style="list-style-type: none"> • Demonstration of knowledge • Employee health controls • Controlling hands as a vehicle of contamination • Time/temperature parameters for controlling pathogens • Consumer Advisory 	<p>FBI prevention education for consumers and industry.</p> <p>ISDH website.</p> <p>ISDH data collection and communication tool.</p> <p>Promotion of the FDA Voluntary National Retail Food Regulatory Program Standards for regulatory programs trained by FDA and ISDH staff.</p>	ISDH, LHDs, Purdue University
	Community Interventions	<p>Increase level of FBI prevention awareness and activities by consulting training specialist(s) designated to the food industry.</p>	<p>Food industry key factors: improve FBI prevention methods. Establish food safety trainer database to share list of approved trainers with industry. Utilize Task Force to provide at least one training per year.</p>	Food industry, trade associations, ISDH
		<p>Increase effective food safety education, especially in schools, to consumers and within the food industry utilizing training specialists.</p>	<p>Develop/enhance food safety knowledge and practice using innovative systems developed for targeted food industries, especially food handlers.</p>	ISDH, public and state educational institutions and universities
		<p>Increase accessibility to the public, LHDs, other agencies, and food industry via the ISDH website.</p>	<p>Update the ISDH website frequently with current events and information pertinent to food safety. Create and update a state map with county by county information to reach staff. Create an electronic complaint form and the ability to submit plans electronically. Monitor and measure use of website.</p>	ISDH
Other				

Assure Food Safety

Priority: Food Safety

SECONDARY PREVENTION				
		Outcomes	Activities	Responsible Partner(s)
Health Promotion	Systems Change (Policy/Resources)	Identify pathogens in the food supply.	Implement surveillance sampling of targeted foods and establishments by creating requirements of submitting samples.	ISDH, BOAH, LHDs
		Identify poor food safety practices in food establishments. Ensure that food samples are collected early in outbreaks within 24-48 hrs. once a target food has been identified.	Provide pre-paid shippers for overnight shipment of samples to ISDH lab in outbreaks.	ISDH- Epi-Resource
	Health Communications	Improve food industry self-monitoring.	Provide guidance to food industry about increased surveillance for allergens and pathogens. Increase food and environmental sampling and testing to check for food allergens and pathogens.	ISDH, BOAH, LHDs, food industry
	Community Interventions	Require food establishments to conduct market withdrawal or recall if pathogen is found during routine monitoring. As an agency, work with the industry to remove pathogens and resume normal operations.	Notify affected food establishment if pathogen is found. Recall effectiveness checks.	ISDH, BOAH, State Chemist, LHDs
	Other	Increase media alerts concerning potential risks found in surveillance sample findings.	Using news media tools, such as print, internet, social media, and email.	ISDH, BOAH, State Chemist, LHDs, food industry
		The food industry will report appropriate adverse events in the Federal Reportable Food Registry as required by law.	Educate and train on the Federal Reportable Food Registry.	ISDH, BOAH, LHDs, food industry

Assure Food Safety

Priority: Food Safety

TERTIARY PREVENTION

TERTIARY PREVENTION				
	Outcomes	Activities	Responsible Partners(s)	
Health Promotion	Systems Change (Policy/Resources)	Reduce the amount of time between identification of an outbreak and notification with health care providers during a FBI outbreak.	Notify hospitals and physicians about FBI using the Indiana Health Alert Network (IHAN) and email distribution lists both internal and through field staff.	ISDH, LHDs
		Improve information sharing between epidemiology, environmental, and laboratory.	Have all-inclusive discussions when a current FBI is suspect or occurring. Promote information sharing and educate on roles via Epi-Ready training.	ISDH, LHDs, healthcare providers
		Increase response to suspect FBI cases by having a dedicated rapid response team for FBI outbreaks.	Establish an environmental and epidemiology investigative team with laboratory support by actively pursuing the Outbreak Sentinel Grant.	ISDH, BOAH, LHDs
		Improve notification system of FBI to regulatory staff.	Notify staff through "For Official Use Only" information that a FBI outbreak is suspect.	ISDH, BOAH
		Conduct food defense investigations if intentional contamination is suspected.	Work with involved parties to help prevent future contamination and raise awareness of food defense.	ISDH, BOAH, law enforcement, food industry
	Health Communications	Food industry will take immediate necessary mitigation steps to stop FBI outbreak or enforcement options will follow.	Enforcement options, including: <ul style="list-style-type: none"> • Embargo • Recalls • Civil Penalties • Hearings • Cease and Desist 	ISDH, BOAH, LHDs
		To reduce the reoccurrence of a similar issue, offer education and assistance.	Provide educational opportunities based off of specific incidences. Offer guidance for the industry to recover.	ISDH, BOAH, LHDs
	Community Interventions	Require food industry to mitigate problem and establish permanent controls for prevention.	Recovery and mitigation assistance.	Food industry, ISDH, BOAH, LHDs
	Other			

Assure Food Safety

Priority: Food Safety

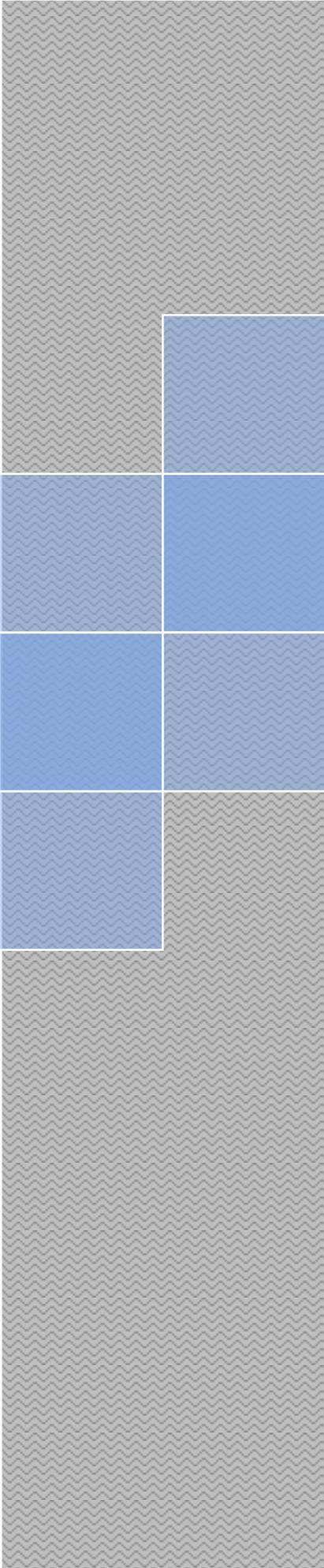
TERTIARY PREVENTION

TERTIARY PREVENTION				
	Outcomes	Activities	Responsible Partners(s)	
Access to Care	Systems Change (Policy/Resources)	Implementation of enhanced notification system for FBI. Regularly scheduled outbreak meetings.	Enhance existing alert systems and/or policies to incorporate this ability and function. Review distribution lists. Encourage enrollment in the IHAN system.	ISDH/LHD/CDC or other involved parties
	Health Communications	Create awareness of ill consumers.	Using IHAN or other alert mechanism for notifying health care providers, such as recalls and health advisories. Provide educational tools specific to pathogen or problem to health care providers. Utilize website and other media tools.	ISDH, LHDs, Media
	Community Interventions	Notifications to membership of health care professional organizations within 48 hours. Encourage and educate healthcare providers to conduct proper diagnostic testing to assist in the FBI investigation.	Notify the health care professional organizations about FBI outbreak. Conduct Epi-Ready training tailored for hospital and industry involvement.	ISDH, LHDs, Indiana State Medical Association, Hospitals, Long Term Care, Health care providers, Emergency Nurses Association
	Other	Improve media alerts targeted toward potential FBI outbreak cases.	Using news media tools, such as print, internet, social media, and email.	ISDH, LHDs, food industry

Reduce Healthcare Associated Infections

**HEALTH PRIORITY:
REDUCE HEALTHCARE ASSOCIATED INFECTIONS
(HAI)**

GOAL: Reduce the standardized infection ratio for healthcare associated infections in health care facilities.



Reduce Healthcare Associated Infections

Healthcare associated infections are infections that patients acquire within a healthcare setting during the course of receiving treatment for other conditions. Healthcare associated infections include:

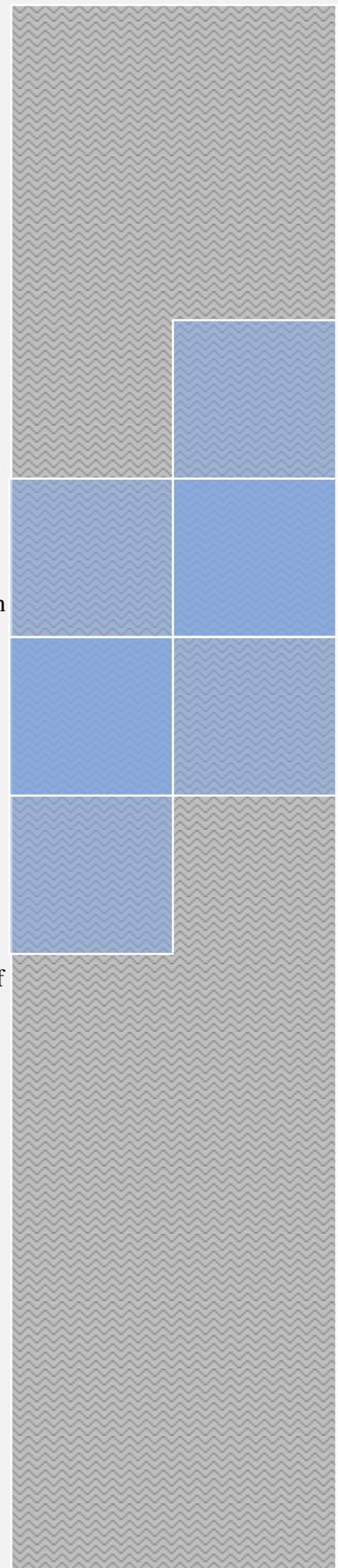
- Central line associated bloodstream infections (CLABSI)
- Catheter associated urinary tract infections (CAUTI)
- *Clostridium difficile* infection (CDI or *C diff*)
- Methicillin resistant *Staphylococcus aureus* (MRSA)
- Surgical site infections (SSI)
- Ventilator associated pneumonia (VAP)

Evidence suggests that healthcare associated infections are an increasing healthcare problem in part resulting from multi-drug resistant organisms. Studies have estimated that 5% of all admissions to an acute care setting result in a healthcare associated infection. Infections result in 99,000 deaths per year nationally. Hospital costs per infection range from \$1,000 for a catheter associated urinary tract infection to \$36,000 for a central line associated bloodstream infection resulting in excess costs of over \$28 billion per year.

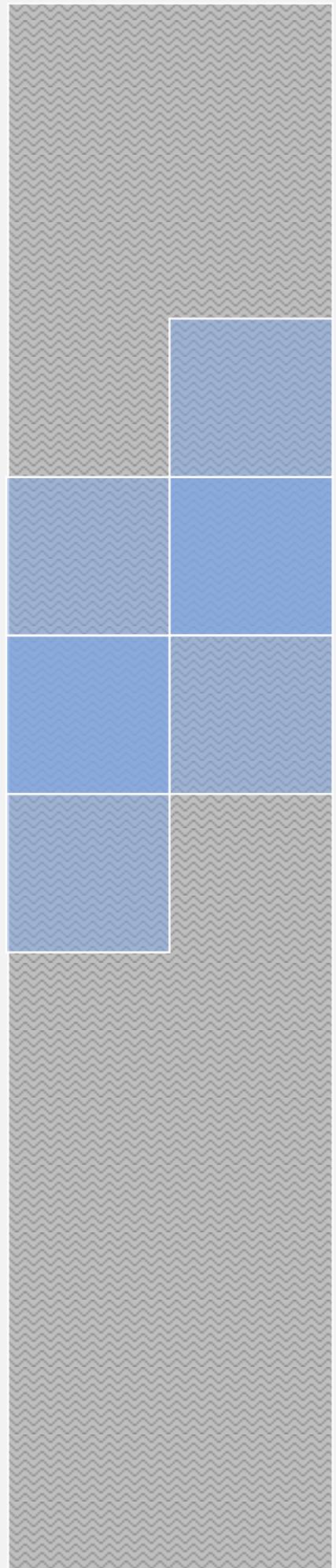
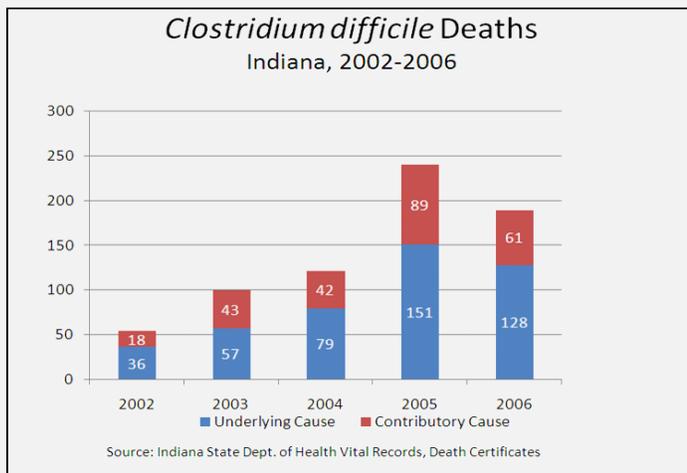
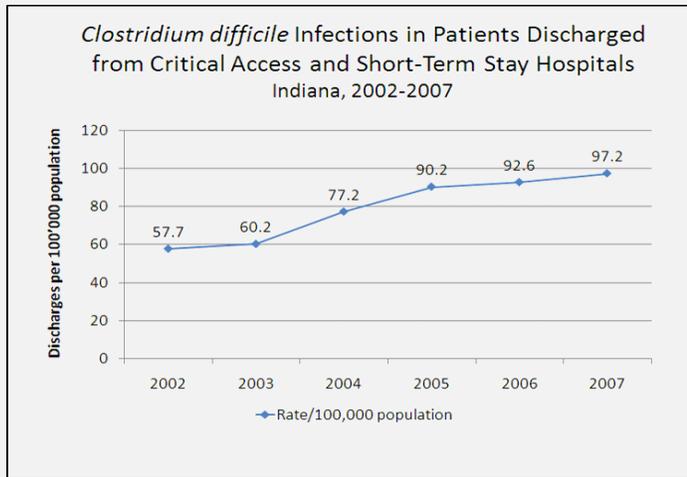
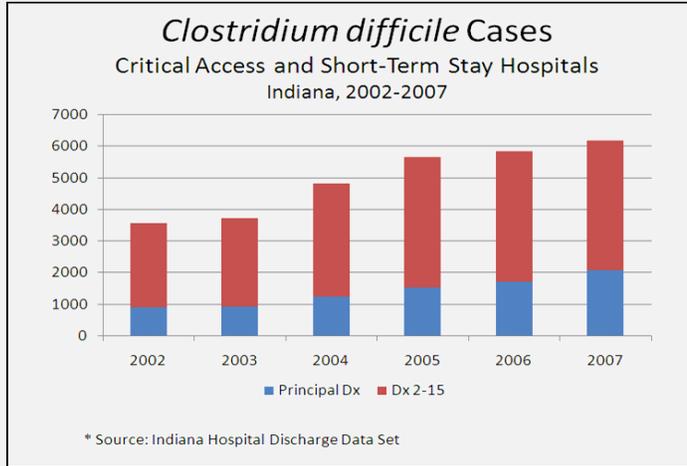
In a 2009 study of long term care facilities, one-third of long term care residents were affected by respiratory disease outbreaks. A 2008 study of Veterans healthcare facilities found a healthcare associated infection prevalence of 5.2% with 25% of residents having an indwelling medical device and therefore at increased risk for infections.

An example of increasing prevalence of infections is *Clostridium difficile*. In May of 2008, the Association of Professionals in Infection Control and Epidemiology (APIC) conducted a national prevalence study of *Clostridium difficile*. Facilities were to take one day during the month and report on their *Clostridium difficile* incidence for that day. Data showed that 13 out of every 1,000 inpatients in the survey were either infected (94.4%) or colonized (5.6%). This was 6.5 to 20 times previous estimates. Data also indicated that 69.2% were over 60 years of age and 67.6% had co-morbid conditions (renal failure, diabetes, heart failure); 10.9% had an initial episode of severe to complicated disease. 35.1% had long term care facility residence within 30 days of onset and 47.4% had hospitalization within 90 days of onset. 79.4% had antimicrobial exposure before onset.

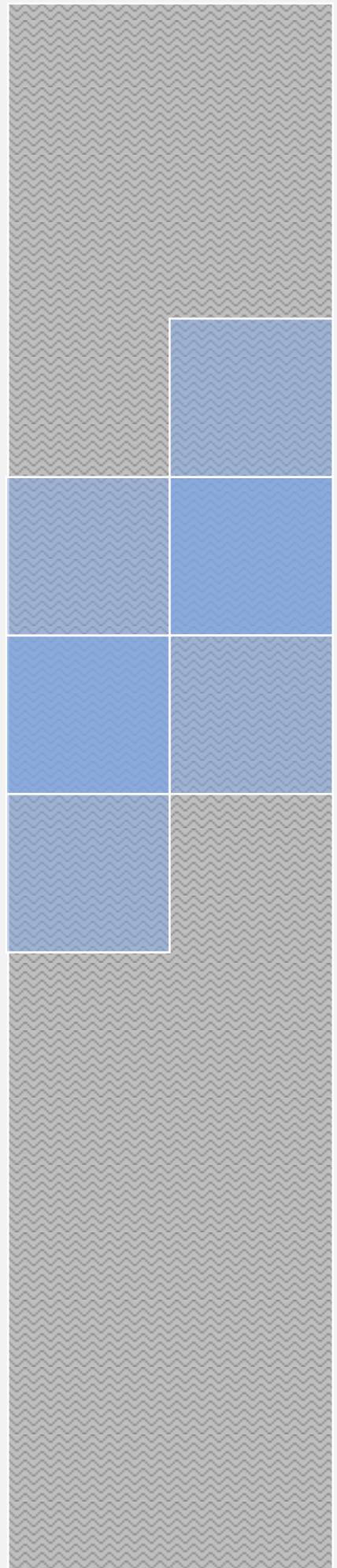
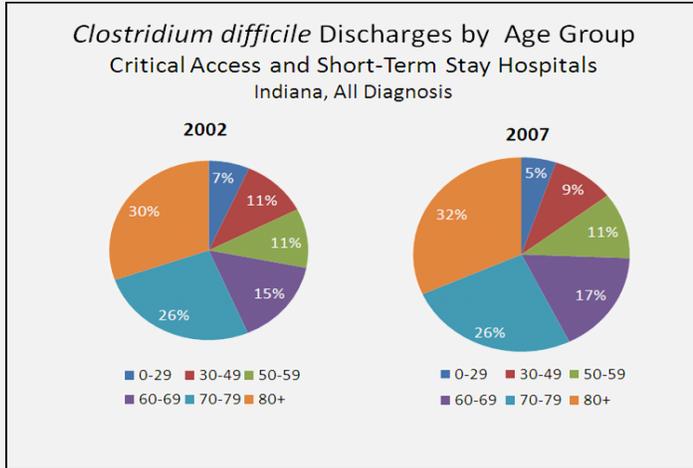
Indiana data supports the increase in reported cases of *Clostridium difficile* infections from 2002 to 2007. The following charts show *Clostridium difficile* data for Indiana:



Reduce Healthcare Associated Infections



Reduce Healthcare Associated Infections



Reduce Healthcare Associated Infections

In its *Healthy People 2020* report, the U.S. Office of Disease Prevention and Health Promotion added healthcare associated infections as a health priority. Healthcare associated infections are largely preventable. A 2003 study suggested that 6% of all healthcare associated infections are preventable with minimal infection control efforts and 32% preventable with well-organized and highly effective infection control programs. Pennsylvania and Michigan initiatives reduced central line associated bloodstream infections in ICUs by 68% and 66% through the implementation of checklists.

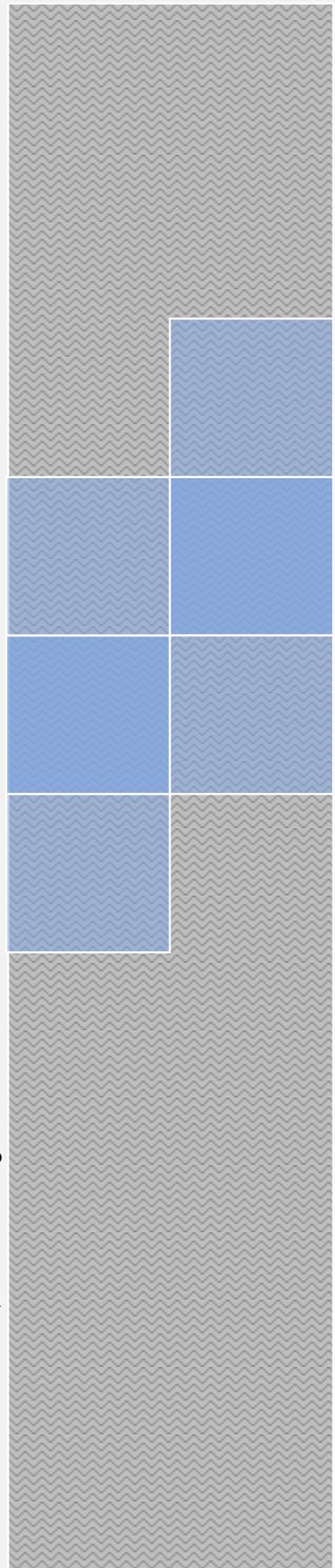
In studying causes of infection transmission, studies suggested that often healthcare facilities failed to follow fundamental prevention practices. A 2005 study found for instance that hand hygiene compliance for healthcare workers was 40-50%, compliance with time of surgical prophylaxis was 40%, and many facilities had not implemented proven prevention measures.

To address these issues, the U.S. Department of Health and Human Services (HHS) released in January 2009 an Action Plan to Prevent Healthcare Associated Infections (HAIs). The Action Plan identified key actions in the prevention of healthcare associated infections and provided states with a template for developing state prevention plans. The Action Plan recommended state implementation of infection prevention collaboratives and increased focus on tracking of infection data.

To improve the tracking of infection data, the Centers for Disease Control and Prevention (CDC) developed in 2005 a new system for monitoring healthcare associated events and processes. The National Healthcare Safety Network (NHSN) provided standardized definitions and a consistent tracking system to assist facilities and states in developing surveillance and analysis systems.

The development of NHSN resulted in increased state legislation requiring the reporting of healthcare associated infection data. By October 2009, 28 states required reporting of at least some healthcare associated infection data. Of those states, 21 states were using or planning to use NHSN as the reporting tool. Indiana does not mandate reporting of healthcare associated infections. As part of its prevention initiative, the ISDH provided training to health care facilities on NHSN and infection identification standards to prepare facilities for improved tracking of infection data.

In September 2009, CDC awarded grants to states to implement infection prevention initiatives. The Indiana State Department of Health was awarded a grant and implemented a two-year statewide initiative.



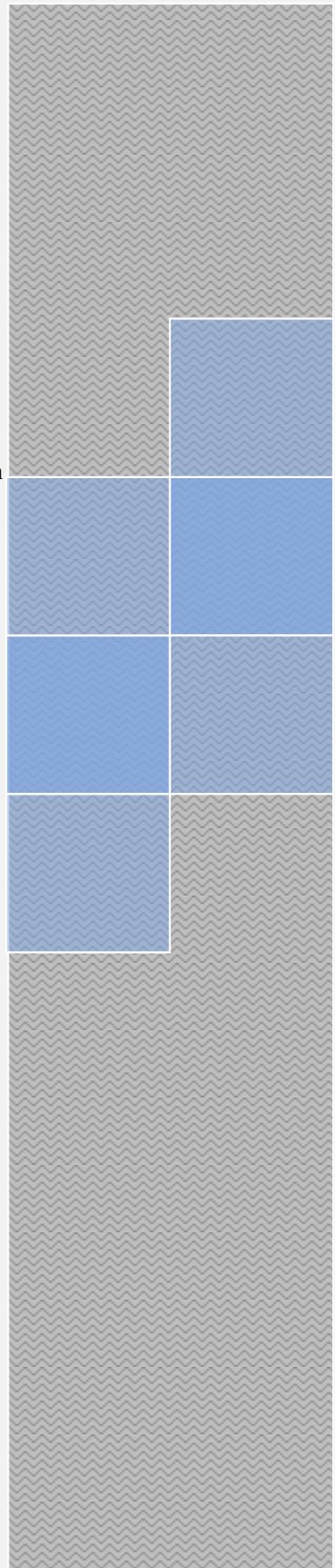
Reduce Healthcare Associated Infections

The goals of the Indiana Healthcare Associated Infection Initiative are:

- Improve the identification of healthcare associated infections by health care providers
- Reduce the number of healthcare associated infections
- Increase public and healthcare worker awareness of healthcare associated infections

Objectives of the Indiana Healthcare Associated Infection Initiative are to:

- Create a State Plan for Healthcare Associated Infections
- Develop and implement a healthcare associated infections surveillance and reporting system
- Develop and implement a healthcare associated infections prevention initiative



Reduce Healthcare Associated Infections (HAI)

Priority: Healthcare Associated Infections (HAI)

PRIMARY PREVENTION: HEALTHCARE ASSOCIATED INFECTION PREVENTION INITIATIVE

		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources)	Reduce <i>Clostridium difficile</i> infections (CDI) by at least 30% within five years as measured by the Centers for Disease Control and Prevention <i>Clostridium difficile</i> standardized infection ratio at health care facilities participating in statewide initiative.	Indiana Healthcare Associated Infection Initiative. Participation by health care facilities in a <i>Clostridium difficile</i> prevention initiative Participation by health care facilities in utilizing an environmental cleaning compliance checklist.	Indiana health care facilities; Indiana Healthcare Associated Infection Initiative Collaborative Team; Healthcare quality improvement associations, organizations, and centers; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center
		Reduce catheter associated urinary tract infections (CAUTI) by at least 25% within five years as measured by the CDC catheter associated urinary tract infections standardized infection ratio at health care facilities participating in statewide initiative.	Indiana Healthcare Associated Infection Initiative. Participation of health care facilities in a catheter associated urinary tract infection initiative. Participation by health care facilities in utilizing a catheter bundle checklist.	Indiana health care facilities; Healthcare quality improvement associations, organizations, and centers; Indiana Healthcare Associated Infection Initiative Collaborative Team; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center
		Increase hand washing compliance by healthcare workers as measured by compliance tracking by facilities participating in state initiative.	Indiana Healthcare Associated Infection Initiative. Participation by health care facilities in utilizing a hand washing evaluation tool.	Indiana health care facilities; Indiana Healthcare Associated Infection Initiative Collaborative Team; Healthcare quality improvement associations, organizations, and centers; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center
	Health Communications	Increased availability of healthcare associated infection education and training for health care providers and consumers.	Development of ISDH Healthcare Associated Infection Resource Center to be available on ISDH website. Development and use of online healthcare associated infection education modules for healthcare workers and consumers. Development of healthcare associated infection resources and toolkits. Increase certification opportunities for health care providers in infection prevention. Development of evidence-based healthcare associated infection in-service programs for health care facilities.	Indiana health care facilities; Indiana Healthcare Associated Infection Initiative Collaborative Team; Healthcare quality improvement associations, organizations, and centers; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center

Reduce Healthcare Associated Infections (HAI)

Priority: Healthcare Associated Infections (HAI)

SECONDARY PREVENTION: HEALTHCARE ASSOCIATED INFECTION SURVEILLANCE, DETECTION, REPORTING AND RESPONSE

		Outcomes	Activities	Responsible Partner(s)
Health Promotion	Systems Change (Policy/Resources)	Reduce central line associated bloodstream infections (CLABSI) by at least 25% within five years at health care facilities as measured by the Centers for Disease Control and Prevention central line associated bloodstream infection standardized infection ratio and compliance with the central line bundle.	Implement use of a central line bundle checklist at all hospitals. Participation by health care facilities in a central line associated bloodstream infection initiative.	Indiana health care facilities; Healthcare quality improvement associations, organizations, and centers; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center
	Health Communications	Adopt reporting of healthcare associated infection by health care facilities.	Adopt state standards for healthcare associated infection reporting by health care facilities beginning with hospitals and extending to other facilities and providers as the Center for Disease Control and Prevention’s National Healthcare Safety Network is adapted for other providers. Utilize healthcare associated infection data through federal reporting for improved surveillance.	ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center
		Assess current incidence of healthcare associated infections in hospitals and nursing homes.	Analyze healthcare associated infection data from the Center for Disease Control and Prevention’s National Healthcare Safety Network. Analyze healthcare associated infection data from participants in the Indiana Healthcare Associated Infection Initiative.	Indiana Healthcare Associated Infection Initiative Collaborative Team; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center
		Use of CDC National Healthcare Safety Network (NHSN) by hospitals to track healthcare associated infections utilizing National Healthcare Safety Network national standards.	Training to health care providers on the National Healthcare Safety Network and identification of healthcare associated infection. Development of state healthcare associated infection epidemiology program.	Healthcare quality improvement organizations, associations, and centers; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center

Reduce Healthcare Associated Infections (HAI)

Priority: Healthcare Associated Infections (HAI)

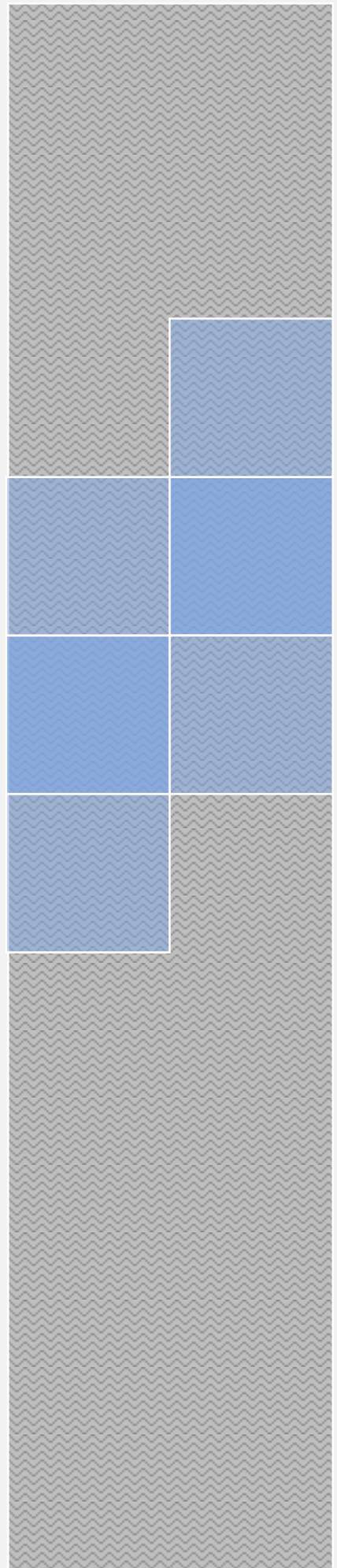
TERTIARY PREVENTION: HEALTHCARE ASSOCIATED INFECTION PROGRAM INFRASTRUCTURE

		Outcomes	Activities	Responsible Partners(s)
Health Promotion	Systems Change (Policy/Resources)	Complete an assessment and evaluation of the Indiana Healthcare Associated Infection Initiative to determine progress towards improvements and targets.	Continuation of Indiana Healthcare Associated Infection Initiative Collaborative Team to advise on infection prevention. Meetings of Indiana Healthcare Associated Infection Initiative Collaborative Team to review and advise on Indiana Plan for the Prevention of Healthcare Associated Infection.	Indiana Healthcare Associated Infection Initiative Collaborative Team; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center
		Increase number of hospitals and nursing homes participating in a regional or state patient safety coalition.	Develop regional patient safety coalitions throughout the state . Develop and implement regional care coordination and transition initiatives.	State and regional patient safety coalitions and centers; Indiana health care facilities; Healthcare quality improvement associations, organizations, and centers; ISDH Health Care Quality and Regulatory Commission; ISDH Epidemiology Resource Center

INDIANA STATE HEALTH IMPROVEMENT PLAN
Partnering for the Public's Health

**HEALTH PRIORITY:
REDUCE THE BURDEN OF HIV, STD, AND VIRAL
HEPATITIS IN INDIANA**

GOAL: To decrease the incidence of HIV, STDs, and
Viral Hepatitis in Indiana.



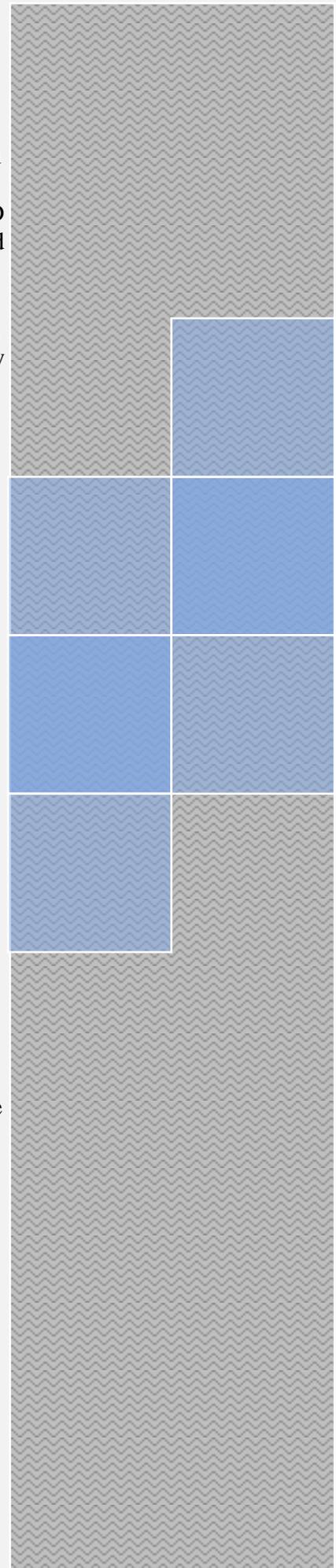
Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

The Division of HIV, STD, Viral Hepatitis, is comprised of several program areas addressing the prevention and care of these infections including: HIV Prevention, HIV Care and Medical Services, HIV Surveillance, and the STD Program. Included under these core programs are Communities of Color and Capacity Building, Training and Education, Community Planning Group, and Viral Hepatitis Prevention under the HIV Prevention Program. HIV Care and Medical Services houses the Care Coordination, Medical Services, Special Populations Support Program, and Consumer and Provider Advisory Boards. HIV Surveillance serves the Division and the community through Core Surveillance, Incidence, the Medical Monitoring Project, and the Advocacy and Responsibility Program. The Division is primarily funded via federal grants from Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMSHA) with some additional funding through the state.

In 2009, the number of newly diagnosed persons in Indiana was 489, slightly up from 2008, which had 483 newly diagnosed persons. The diagnosis rate remained relatively the same in 2009 at 7.7 slightly up from 7.6 per 100,000 people in 2008. The highest rate of new diagnosis in 2009 occurred among males between the ages of 20 to 24 years of age. Males continue to outrank females more than three times. The male diagnosis rate of 12.1/100,000 in 2009 has increased from a rate of 11.9 in 2008. The female new diagnosis rate remained constant at 3.4/100,000 in 2009 and the previous year.

More than a third of all diagnosed people are Black (41.7%), while about five out of ten people with HIV/AIDS are White (47.9%). The gap between races continues to shorten as shown by the previous year, 2008 (34.8% Black vs. 55.9% White). Blacks continue to have a rate (35.3) that is almost three times the rate of Hispanics (12.0), and more than seven times that of Whites (4.2). New diagnosis among males is predominant for all racial and ethnic groups. The rate of new diagnosis with HIV/AIDS among Black males (48.9) is especially high, compared to their Hispanic (20.0) and White (7.2) counterparts.

By the end of December 2009, a total of 9,646 persons were living with HIV/AIDS (PLWHA) in the state of Indiana, up from 9,282 people by the end of 2008. Geographically, the vast majority of people that were diagnosed in Indiana continue to reside in Indiana (91.1%). Within the state of Indiana, most PLWHA are concentrated in the urban areas of the state. The disease continues to be male dominated, with the number of diagnosed males almost four times higher than that of females. The rate of infection was at 247.1 for males and 58.2 for females per 100,000 people of the general population.



Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

The majority of PLWHA are in their middle ages, ranging from 40 to 49 years of age. Around a third of all PLWHA are Black (34.8%), while about five out of ten people with HIV/AIDS are White (55.5%). Based on the smaller number of Blacks in the general population, the prevalence rate of Blacks (579.8/100,000) is exceeding the rate of the Hispanics (201.1/100,000) and Whites (95.3/100,000). HIV/AIDS continues to affect Black males disproportionately more than their White counterparts.

The HIV, STD, Viral Hepatitis portion of the Indiana State Health Improvement Plan outlines overarching Division goals and objectives over the next five years. It is anticipated that these goals will become more refined as the Division's Strategic Plan is developed in response to the President's National HIV/AIDS Strategy.

**TABLE 2.1 ANNUAL HIV/AIDS, STD, AND HEPATITIS B & C DATA
JANUARY 1, 2009 – DECEMBER 31, 2009**

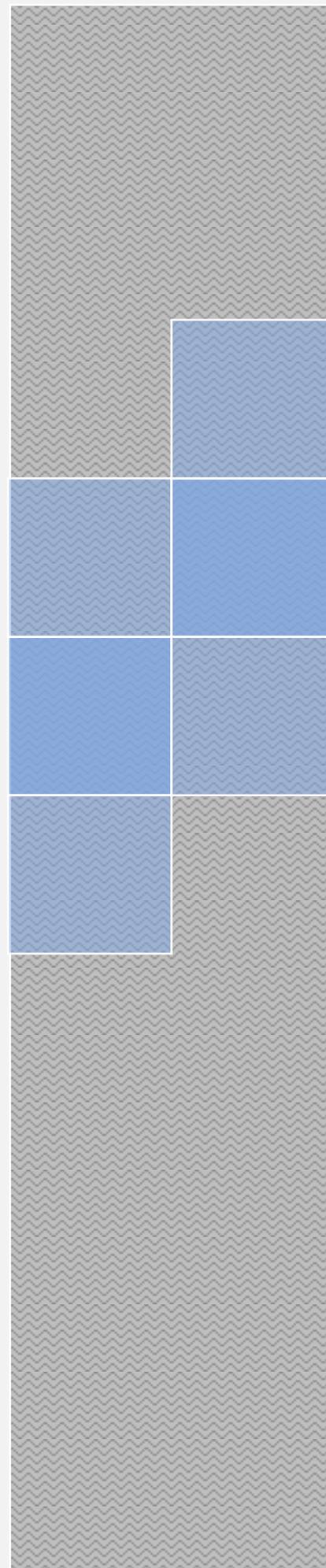
Indiana HIV/AIDS Cases	HIV Diagnosis	AIDS Diagnosis	
New Reports for 2009*	313	176	
	Persons Living with HIV (without an AIDS diagnosis)	Persons Living with AIDS	
Prevalence as of 12/31/2009**	4,267	5,379	
Indiana STD Cases	Primary/Secondary Syphilis	Gonorrhea	Chlamydia
1/01/09 – 12/31/09***	152	6,812	21,759
Indiana Hepatitis B & C Cases	Hepatitis B 1/01/09 – 12/31/09	Hepatitis C *** 1/01/09 – 12/31/09	
	63	6,101	

Source: Indiana HIV/AIDS Surveillance Database

* New Reports are broken into 2 categories: HIV at First Diagnosis represents all new reports as being diagnosed first with HIV; AIDS at First Diagnosis represents all new reports as being diagnosed first with AIDS.

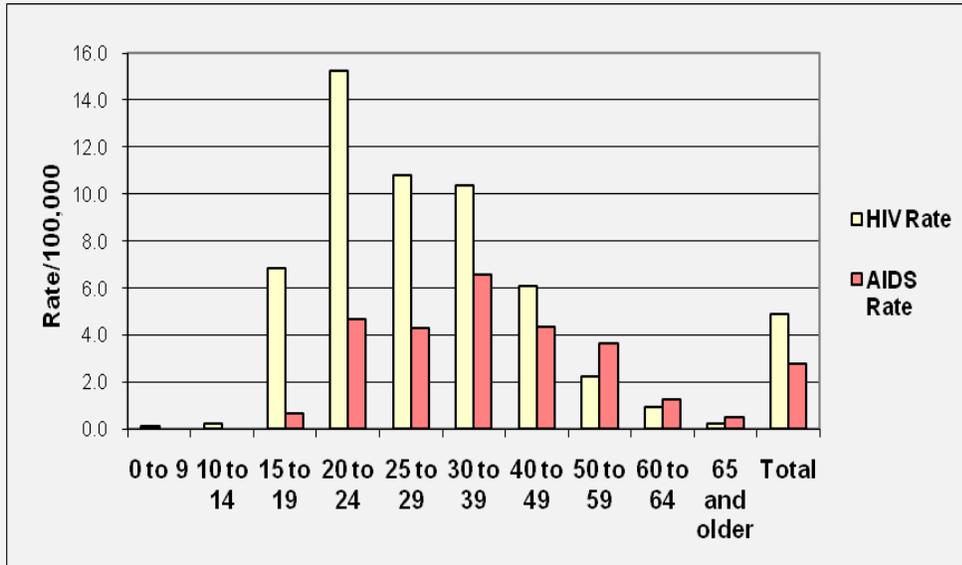
**Prevalence is the number of people who are 'living' in Indiana with HIV/AIDS, including those diagnosed in other states but living in Indiana.

***Suspected, probable, and confirmed cases based on case investigation submission.



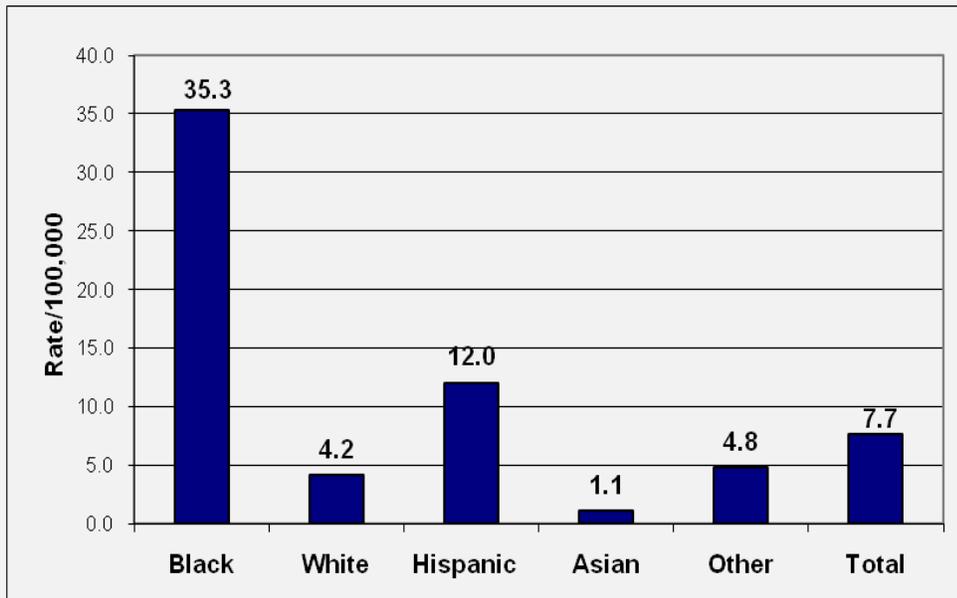
Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

FIGURE 2.1 NEW DIAGNOSIS RATES FOR HIV AND AIDS BY AGE, 2009

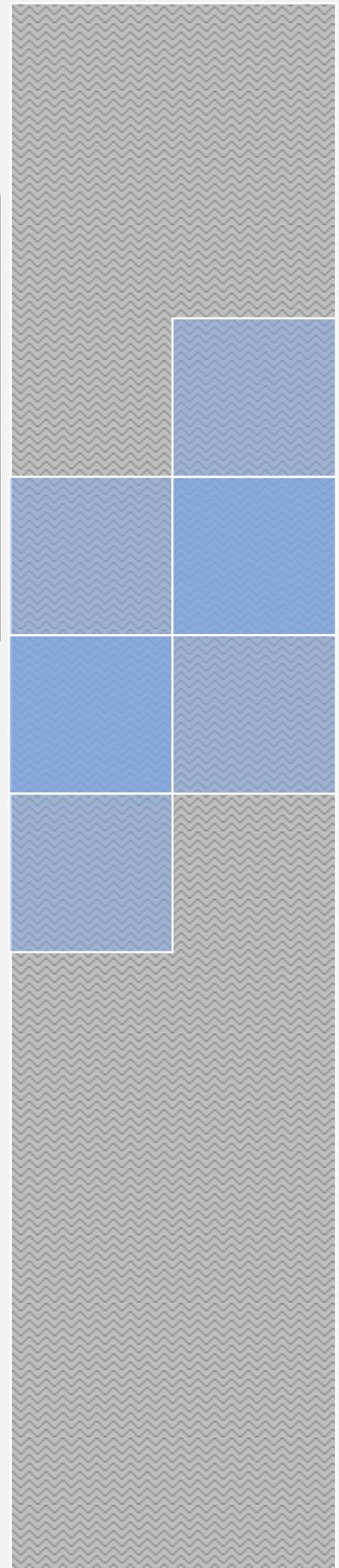


Source: Indiana HIV/AIDS Surveillance Database, Rates are based on 2008 U.S. Census Estimates

FIGURE 2.2 NEW DIAGNOSIS RATES OF HIV/AIDS BY RACE/ETHNICITY, 2009

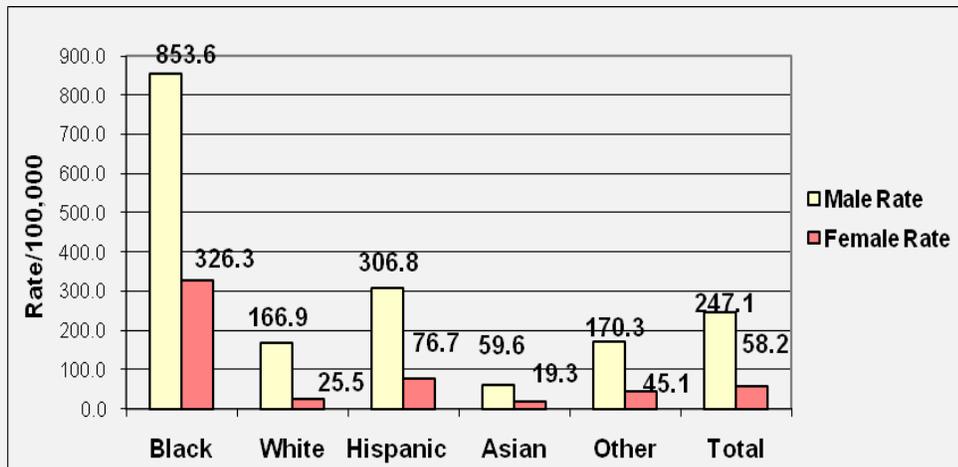


Source: Indiana HIV/AIDS Surveillance Database, Rates are based on 2008 U.S. Census Estimates

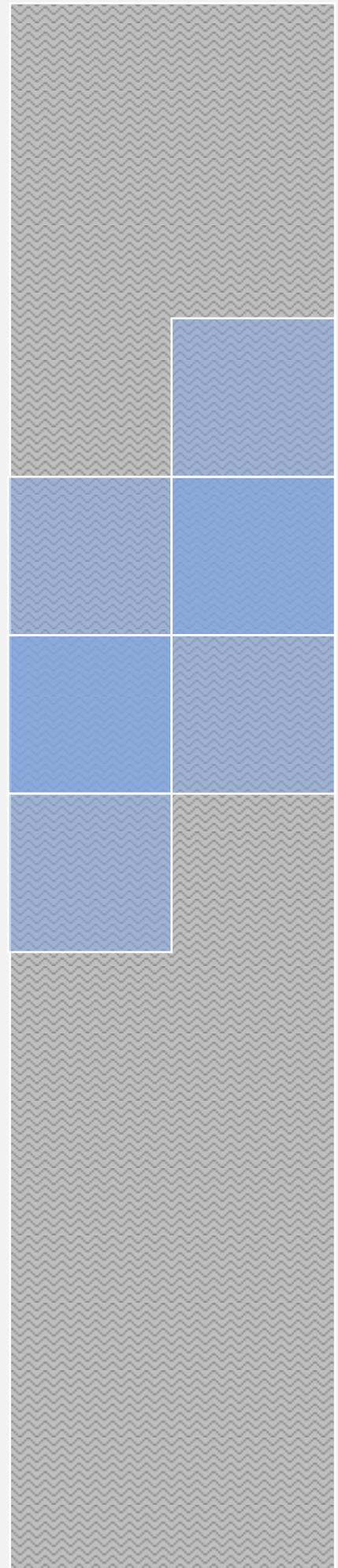


Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

FIGURE 2.3 PREVALENCE RATES OF HIV AND AIDS BY RACE/ETHNICITY & GENDER, 2009



Source: Indiana HIV/AIDS Surveillance Database, Rates are based on 2008 U.S. Census Estimates



Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

Perinatal HIV Transmission:

All infants born to an HIV-positive mother should be reported to the Indiana State Health Department, even though the final HIV status of the child is not known until later. Current Indiana law (IC 16-41-2-1) requires all health care providers to offer all pregnant women an HIV test along with their other prenatal tests. Pregnant women have the opportunity to opt-out of the HIV testing. By the end of 2009, a total of 728 children had been born to HIV positive mothers since the beginning of record keeping.

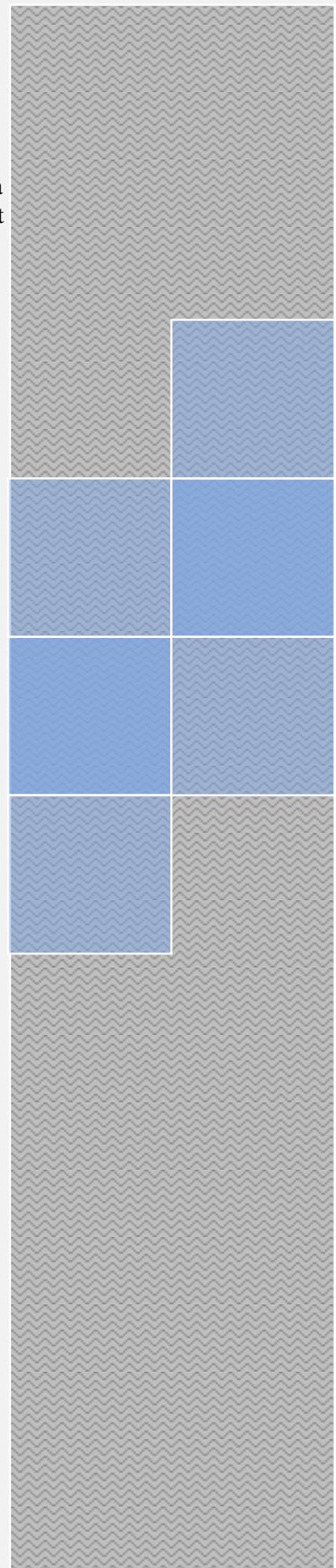
TABLE 2.2 CHILDREN BORN TO HIV INFECTED MOTHERS WHO ARE RESIDENTS OF INDIANA, CUMULATIVE 1982 THROUGH DECEMBER 31, 2009

Race	Total Exposures	Child Exposures now with HIV Disease
White	227	65
Black	373	62
Hispanic – All Races	63	6
Multiracial – Non Hispanic	62	11
Other	<5	<5
Total	728	145

Source: Indiana HIV/AIDS Surveillance Database

Exposed = Children born to HIV+ women. Laboratory testing has not yet determined their HIV status.

HIV Disease = Children born to HIV+ women. Laboratory testing has confirmed that the child is HIV+.

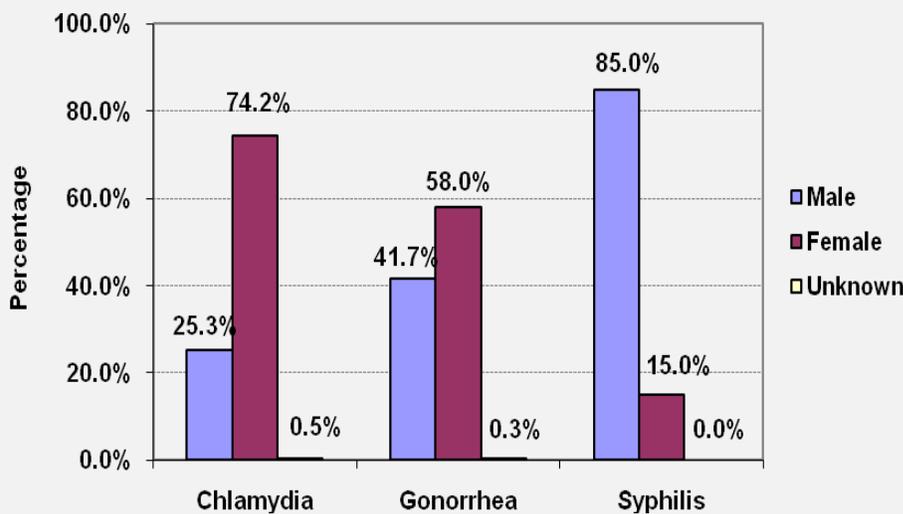


Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

STD:

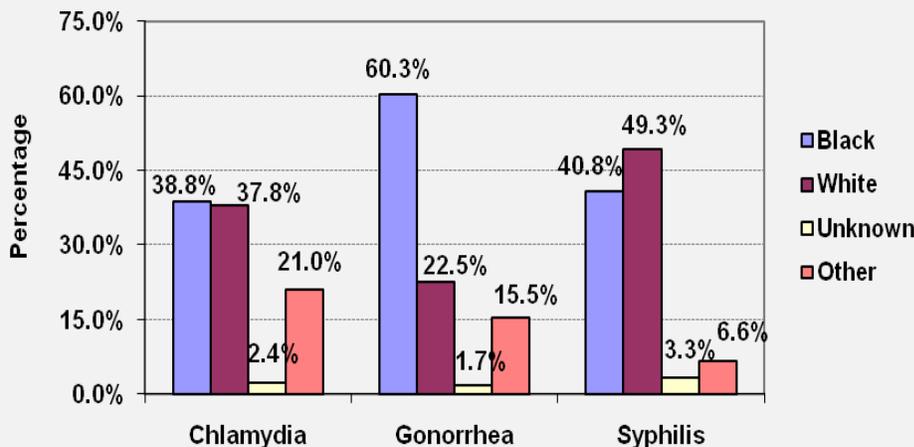
In 2009, Chlamydia continued to be the most frequently reported sexually transmitted disease (STD) in Indiana, with 21,759 reported cases, up from 21,744 cases in 2008. Gonorrhea cases were reported at 6,812 cases in 2009 and 8,489 in 2008. Primary and Secondary Syphilis was reported to be 152 in 2009, up from 140 in 2008, and 53 reported cases the year prior. Females continued to outnumber males for both Chlamydia and Gonorrhea while Syphilis is more prevalent among males. Both Blacks and Whites make up the majority of all STD cases in 2009.

FIGURE 2.4 PERCENTAGES OF STD CASES IN INDIANA BY GENDER, 2009

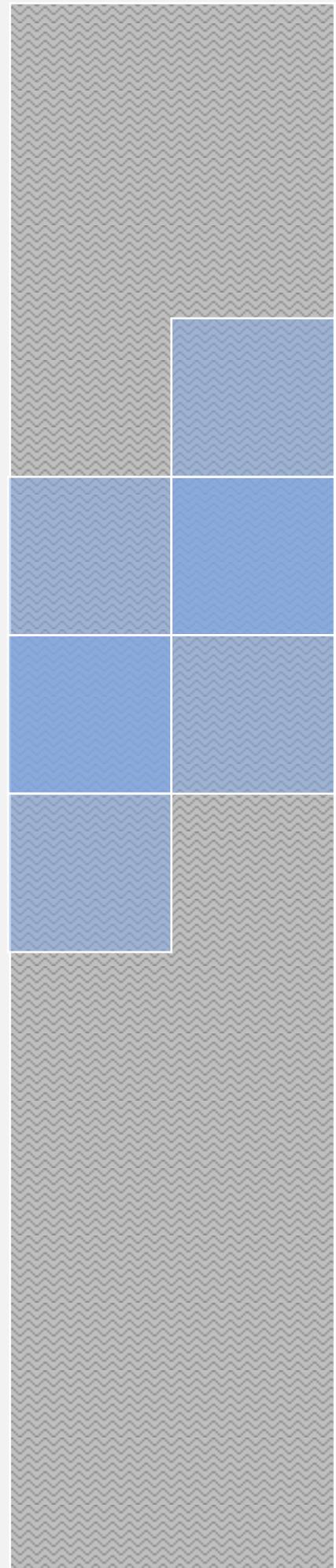


Source: Indiana STD Database, Data is considered provisional and will be updated in 2011.

FIGURE 2.5 PERCENTAGES OF STD CASES IN INDIANA BY RACE, 2009



Source: Indiana STD Database, Data is considered provisional and will be updated in 2011.



Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

Priority: Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

PRIMARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Health Promotion	Systems Change (Policy/Resources)	The Division of HIV, STD, Viral Hepatitis will complete a strategic plan for the prevention, care, surveillance, and elimination of HIV, STDs, and Viral Hepatitis.	The Division will assemble a team of staff to develop a Division-wide strategic plan based on current epidemiological data and trends, the Presidents HIV/AIDS Agenda, The NIH Viral Hepatitis and Liver Cancer Prevention National Strategy, and other appropriate tools and publications.	ISDH Division of HIV, STD, Viral Hepatitis staff members.
	Health Communications	Increase knowledge and awareness around disease etiology and the prevention of HIV, STDs, and Viral Hepatitis.	<p>Division staff and appropriate partners will provide educational messages around disease etiology and prevention including harm reduction.</p> <p>The events and opportunities for message delivery include but are not limited to: health fairs, community events, the development and dissemination of PSAs and other marketing materials and support of partner events.</p>	<p>ISDH Division of HIV, STD, Viral Hepatitis staff members</p> <p>Indiana State Department of Education</p> <p>Indiana Coalition for the Improvement of Adolescent Health</p> <p>Community partners</p>

Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

Priority: Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

PRIMARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Health Promotion	Health Communications	<p>The Division of HIV, STD, Viral Hepatitis will continue to partner with the Indiana Department of Education to ensure that scientifically accurate and age appropriate information and prevention messages are provided in Indiana schools.</p>	<p>The Division will continue to engage the Department of Education in discussions and activities that inform local school boards and schools around the delivery of scientifically appropriate information and prevention messages.</p> <p>In addition, the Division will partner with DOE and appropriate outside research entities to assess school sexual health programs to ensure they are scientific evidence based, and are found to be effective, utilizing available DOE and YRBS data.</p>	
	Community Interventions	<p>Increase knowledge and awareness of disease etiology and prevention.</p>	<p>Division staff and appropriate partners will participate in health fairs and community events where education can be provided.</p> <p>Effective Behavioral Interventions or EBIs will be provided in accordance with CDC guidance. Appropriate modifications will be utilized to ensure they adhere to CDC guidelines.</p> <p>The community based participatory model will continue utilizing the CPG, CAB, and CHSPAC groups and processes.</p>	<p>ISDH Division of HIV, STD, Viral Hepatitis staff.</p> <p>HIV Prevention and Care grantees.</p> <p>HIV Prevention Indirectly funded organizations.</p> <p>HIV Community Planning Group, Consumer Advisory Board, and Comprehensive HIV Services Provider Advisory Council.</p>
	Other	N/A	N/A	N/A

Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

Priority: Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

PRIMARY PREVENTION

				OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Access to Care	Systems Change (Policy/Resources)	<p>The Indiana One Test, Two Lives initiative will continue to provide education to medical providers and expectant mothers around the importance of prenatal HIV and hepatitis B (HBV) screening.</p> <p>The Indiana Medical Licensing Board rule will be amended to allow for the provision of Expedited Partner Therapy (EPT) when appropriate and on the discretion of the physician.</p> <p>Appropriate local health departments, community based organizations, AIDS service organizations, and community health centers will become “one-stop shops” utilizing Program Collaboration and Service Integration (PCSI) guidelines to provide prevention education and services, testing, care and referral points for HIV, STDs, and viral hepatitis.</p>	<p>Educational materials, conference presentations, a media campaign, and other interventions will be planned and implemented to ensure 100% of pregnant women are screened for HIV and HBV.</p> <p>The Division of HIV, STD, Viral Hepatitis in partnership with the Medical Director will continue to support the Medical Licensing Board in amending the current rules appropriate to this intervention.</p> <p>Division staff and national technical assistance providers will provide technical assistance and financial support when able and appropriate to entities providing these services.</p> <p>Surveillance and reporting will be streamlined as appropriate to ensure a more comprehensive picture of linked diseases.</p>	<p>ISDH Division of HIV, STD, Viral Hepatitis staff</p> <p>HIV Prevention and Care grantees</p> <p>HIV Prevention Indirectly funded organizations</p> <p>Riley Hospital for Children</p> <p>Midwest AIDS Training and Education Center (MATEC)</p> <p>Indiana Medical Licensing Board</p> <p>Riley Hospital’s Ryan White Center for Pediatric Infectious Disease</p> <p>Indiana University School of Medicine</p> <p>Indiana Perinatal Network</p> <p>Health and Hospital Corporation</p> <p>IU National Center of Excellence in Women’s Health</p>		
	Health Communications	<p>A variety of media sources will be used to inform the public of combined prevention messages and available service offerings.</p> <p>Increase the uptake of the vaccine schedule for human papillomavirus (HPV) among early adolescents and young adults to bring them in line with the national average.</p>	<p>Combined prevention messages will be developed to inform the public of disease etiology and prevention methods, and to provide information on how to access available services.</p> <p>The Division, in partnership with the Immunization Division, will educate providers and the community about the benefits of the vaccine for human papillomavirus (HPV) among early adolescents and young adults.</p>	<p>ISDH Division of HIV, STD, Viral Hepatitis staff</p> <p>ISDH Immunization Division</p> <p>ISDH Office of Public Affairs</p> <p>HIV Prevention and Care grantees</p> <p>HIV Prevention Indirectly funded sites</p>		

Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

Priority: Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

PRIMARY PREVENTION

PRIMARY PREVENTION				
	OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)	
Access to Care	Community Interventions	HIV, STD, Viral Hepatitis, and TB testing will be available at each appropriate local health department, community based organization, AIDS service organization, and community health center.	Division staff and national technical assistance providers will provide technical assistance and financial support when able and appropriate to entities providing these services.	ISDH Division of HIV, STD, Viral Hepatitis staff. HIV Prevention and Care grantees. HIV Prevention Indirectly funded organizations.
	Other	N/A	N/A	N/A

Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

Priority: Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

SECONDARY PREVENTION				
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNER(S)
Health Promotion	Systems Change (Policy/Resources)	HIV, STD, Viral Hepatitis, and TB testing will be available at each appropriate local health department, community based organization, AIDS service organization, and community health center.	Division staff and national technical assistance providers will provide technical assistance and financial support when able and appropriate to entities providing these services.	ISDH Division of HIV, STD, Viral Hepatitis staff HIV Prevention and Care grantees HIV Prevention Indirectly funded organizations
	Health Communications	Media campaign aimed at increasing awareness of routine testing for HIV and potential age based testing for viral hepatitis (based on CDC guidelines).	Prevention staff in cooperation with the Office of Public Affairs (OPA) at ISDH will work with CDC to distribute and/or develop a media campaign around routine testing.	Division of HIV, STD, Viral Hepatitis staff CDC partners OPA Media
	Community Interventions	Raise awareness among health care providers of the need for routine population, and risk based testing for HIV, STDs, Viral Hepatitis, in the health care setting.	Division staff and appropriate technical assistance providers will work to develop messages and opportunities for message dissemination to health care providers around the importance and need of routine, population, and risk based testing for HIV, STDs, and Viral Hepatitis in the health care setting.	Division of HIV, STD, Viral Hepatitis staff Appropriate technical assistance providers (MATEC, ISOM, IPCA)
	Other	N/A	N/A	N/A
Access to Care	Systems Change (Policy/Resources)	Raise awareness among health care providers of the need for routine, population, and risk based testing of HIV, STIs, Viral Hepatitis, in the health care setting.	Division staff and appropriate technical assistance providers will work to develop messages and opportunities for message dissemination to health care providers around the importance and need of routine, population, and risk based testing of HIV, STDs, and Viral Hepatitis in the health care setting.	Division of HIV, STD, Viral Hepatitis staff Appropriate technical assistance providers (MATEC, ISOM, IPCA)
	Health Communications	Provision of education around the availability of testing within the healthcare system.		
	Community Interventions	Provision of routine, population based, or risk based testing for HIV, STDs, and HIV in health care settings.	ISDH staff and appropriate partners will offer and provide greater opportunity for testing within the health care setting.	
	Other	N/A	N/A	N/A

Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

Priority: Reduce the Burden of HIV, STD, and Viral Hepatitis in Indiana

TERTIARY PREVENTION				
		OUTCOMES	ACTIVITIES	RESPONSIBLE PARTNERS(S)
Health Promotion	Systems Change (Policy/Resources)	The current process from HIV testing into care for those individuals that are newly diagnosed will be enhanced.	HIV Prevention and Care programs will continue to evaluate and refine the current referral linkage between HIV testing and HIV Care and Medical services.	Division of HIV, STD, Viral Hepatitis Staff. Appropriate HIV Testing and Care Coordination staff.
	Health Communications	N/A- Current practices will remain in place for communication related to HIV Care Coordination messages.	N/A	N/A
	Community Interventions	N/A – Current HIV Care and Medical Services interventions will continue in accordance with federal and state guidelines.	N/A	N/A
	Other			
Access to Care	Systems Change (Policy/Resources)	N/A- HIV Care and Medical Services are offered to all eligible individuals living with HIV in Indiana.	N/A	N/A
	Health Communications	N/A	N/A	N/A
	Community Interventions	The Division will support increased opportunities to facilitate hepatitis B (HBV) and hepatitis C (HCV) treatment in those with chronic infections of these diseases that are uninsured and underinsured.	The Division, in particular the Adult Viral Hepatitis Prevention Program, will support legislative action, explore grants, and otherwise support the provision of hepatitis B (HBV) and hepatitis C (HCV) treatment in those that are underinsured or uninsured.	Division of HIV, STD, Viral Hepatitis staff. Public Health and Preparedness Medical Director.
	Other	N/A	N/A	N/A

SECTION 3: SYSTEM PRIORITIES

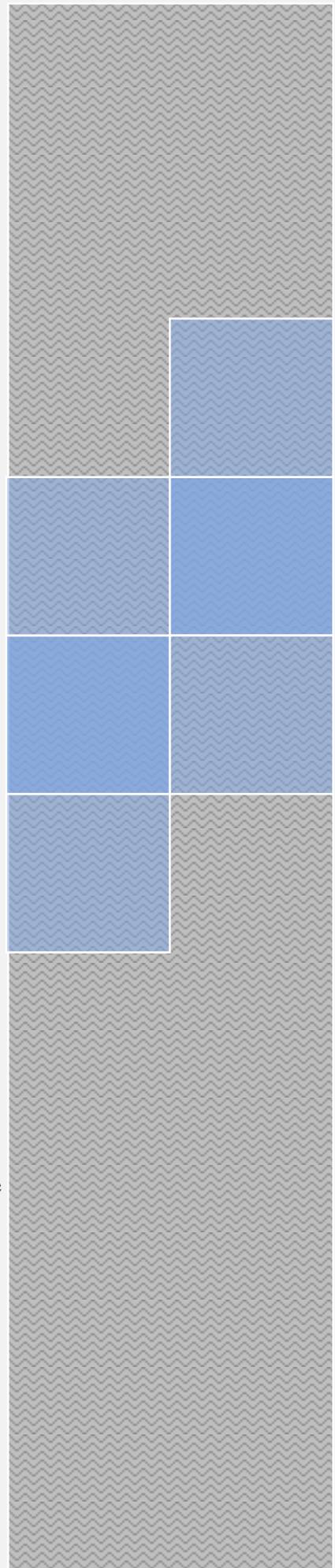
During one of its earliest meetings, the Executive Committee arrived at a consensus conclusion: the public health system of Indiana as currently constructed and funded is incapable of fully addressing the public health priorities of the State. The magnitude of these problems is simply too great for the capacity of the current system to address, despite concerted determination to do so at every level. Given this conclusion, the Executive Committee also determined by consensus that a primary focus of this plan should be public health infrastructure development to the point where the ten essential services of public health can be effectively and efficiently provided for all citizens of Indiana. Therefore, the remainder of the Plan focuses on the seven highest priority public health services.

Following are sections that address each of the System Priorities beginning with Enforcement of Laws and Regulations. For each Priority, four factors are presented 1) assessment of the priority based on specified standards, 2) current gaps described in terms of activities and participation, 3) short, medium and long-term implementation goals, and 4) prerequisite and external factors that profoundly influence the extent to which each Standard can be achieved.

The Standards and Activities were derived from a draft document published by the Public Health Accreditation Board (PHAB). Before the Standards and Activities were adopted for this plan they were vetted with groups of Indiana local public health department administrators. These groups were asked

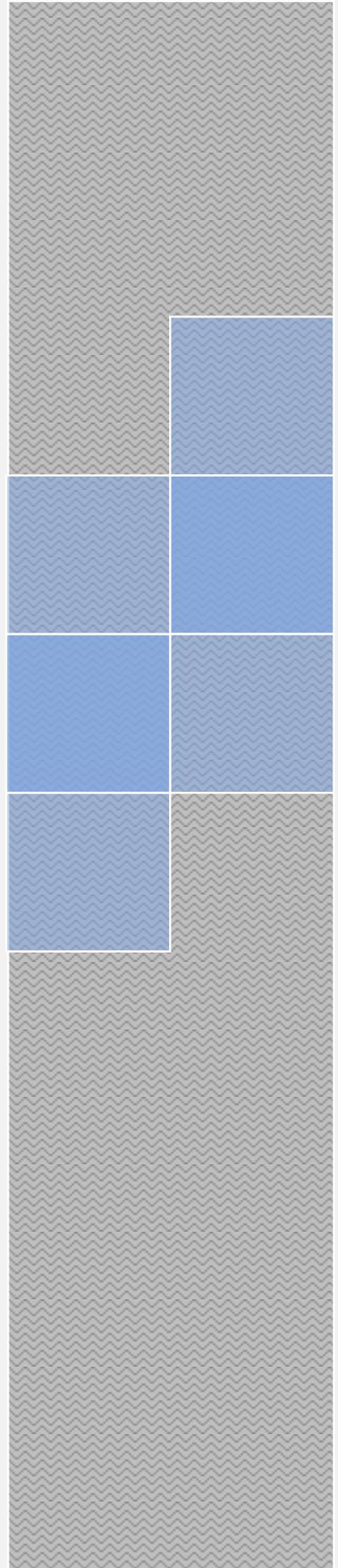
1. Do these Standards and Activities apply to Indiana?
2. If yes, should they be adopted verbatim or modified?
3. If yes, who participates in implementing them, which are reasonable and achievable short, medium and long term goals, and what prerequisites / external factors must be in place to allow attainment of each Standard.

In all cases, informants agreed that the Standards as found in the PHAB document pertained to Indiana, most in verbatim form. A very few Standards were revised to better apply to Indiana. Informants were also able to identify key participants, goals, and prerequisites/external factors for each Standard. Informants strongly emphasized, and the Executive Committee agreed, that those vital Public Health Service Standards cannot be achieved unless the resources are provided to assure that the prerequisites/external factors are adequately addressed.



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**SYSTEM PRIORITY 1:
ENFORCEMENT OF LAWS AND REGULATIONS**



ES6: Enforce Laws and Regulations That Protect Health and Ensure Safety
Maintain Up-to-Date Laws

ES-6.1

Assessment vs. Standard	Identify Gaps		Program Goal Development		
	Activities	Participation	Short	Medium	Long
Review existing laws and work with governing entities and elected officials to update as needed.	Maintain access to legal & program expertise to assist in the review of laws.	County/board attorney	Done as needed by 75% of LHDs	Done as needed by 50% of LHDs and bi-annually by 50% of LHDs	Done bi-annually by 100% of LHDs
	Evaluate the need for changes in laws.	Board of Health Local Health Officer Staff External resources			
	Inform governing entity and elected officials of needed updates of laws and make recommendations for action.	Local Health Officer Staff			
	ISDH, related state agencies and LHDs collaborate in reviewing and developing state and local laws.	ISDH staff Other state agency staff LHD staff			
			Occurs 50% of the time	Occurs 75% of the time	Occurs 100% of the time

Prerequisites/External Factors

- Availability & accessibility of resources (e.g., legal counsel)
- Knowledge of change process.
- LHO & staff possess current knowledge.
- Opportunity for public input.
- Approachable elected officials.
- Collaboration across related state agencies

ES6: Enforce Laws and Regulations That Protect Health and Ensure Safety
Educate about Public Health Laws

ES6.2

Assessment vs. Standard	Identify Gaps		Program Goal Development		
	Activities	Participation	Short	Medium	Long
Educate individuals and organizations on the meaning, purpose and benefit of public health laws and how to comply.	Maintain agency knowledge and consistent interpretation of public health laws.	Local Health Officer LHD supervisors and assigned staff Local boards of health County/board attorney Other public agencies	Done for existing law by 100% of LHDs and for new laws within 90 days of effective date	Done for existing law by 100% of LHDs and for new laws within 45 days of effective date	Done for existing law by 100% of LHDs and for new laws on effective date
	Make laws, permit/license application requirements accessible to the public.	LHD staff	80% of LHDs make easily available through a variety of mediums	90% of LHDs make easily available through a variety of mediums	100% of LHDs make easily available through a variety of mediums
	Upon request, provide public access to inspection reports & violations.	LHD staff	50% of LHDs do on request 50% do proactively	25% of LHDs do on request 75% do proactively	100% of LHDs do proactively
	Provide education to regulated entities regarding their responsibilities and methods to achieve full compliance with applicable laws.	LHD supervisors and assigned staff SHD specialists Professional and trade associations	25% of LHDs provide proactively 75% do through inspection and licensure processes	50% of LHDs provide proactively 50% do through inspection and licensure processes	100% of LHDs provide proactively

Prerequisites/External Factors

- Availability of media to enhance public awareness
- Availability and accessibility of resources (e.g., legal counsel)
- Current updated versions of state law and code
- Training of LHD staff by SHD experts/specialists
- Well prepared and knowledgeable existing and new LHD staff
- Motivation of regulated entities to know and comply

ES6: Enforce Laws and Regulations That Protect Health and Ensure Safety
Conduct Enforcement Activities

ES-6.3

Assessment vs. Standard	Identify Gaps		Program Goal Development		
	Activities	Participation	Short	Medium	Long
Conduct & monitor enforcement activities for which the agency has the authority & coordinate notification of violations with appropriate agencies.	Develop and maintain current written procedures & protocols for conducting enforcement actions.	LHD supervisors and assigned staff	50% of LHDs in compliance	75% of LHDs in compliance	100% of LHDs in compliance
	Conduct inspection activities of regulated entities according to mandated frequency &/or a risk analysis method.	LHD supervisors and assigned staff	50% of LHDs do in accordance with written protocols	75% of LHDs do in accordance with written protocols	100% of LHDs do in accordance with written protocols
	Conduct enforcement activities & follow up on complaints according to procedures & protocols for both routine & emergency situations.	LHD supervisors and assigned staff Local law enforcement County/board attorney	80% of LHDs do in accordance with written protocols	90% of LHDs do in accordance with written protocols	100% of LHDs do in accordance with written protocols
	Conduct analysis of complaints, violations & enforcement activities to determine patterns, trends, compliance & effectiveness.	LHD supervisors and assigned staff Local board of health County/board attorney Consultant experts SHD experts/specialists Federal experts /specialists	100% of LHDs conduct in profound circumstances and 30% of LHDs do as part of annual report preparation	100% of LHDs conduct in profound circumstances and 60% of LHDs do as part of annual report preparation	100% of LHDs conduct in profound circumstances and 100% of LHDs do as part of annual report preparation
	Coordinate a) notification of violations to the public when required, & b) the sharing of information about enforcement activities, analysis, results & follow-up among appropriate agencies.	LHD supervisors and assigned staff Local hospitals SHD School health services State Dept. of Education	100% of LHDs do in profound circumstances and as required by law 50% of LHDs have established notification networks for use when public health and safety is threatened	100% of LHDs do in profound circumstances and as required by law 75% of LHDs have established notification networks for use when public health and safety is threatened	100% of LHDs do in profound circumstances and as required by law 100% of LHDs have established notification networks for use when public health and safety is threatened

Prerequisites/External Factors

Availability of experts/specialists to assist

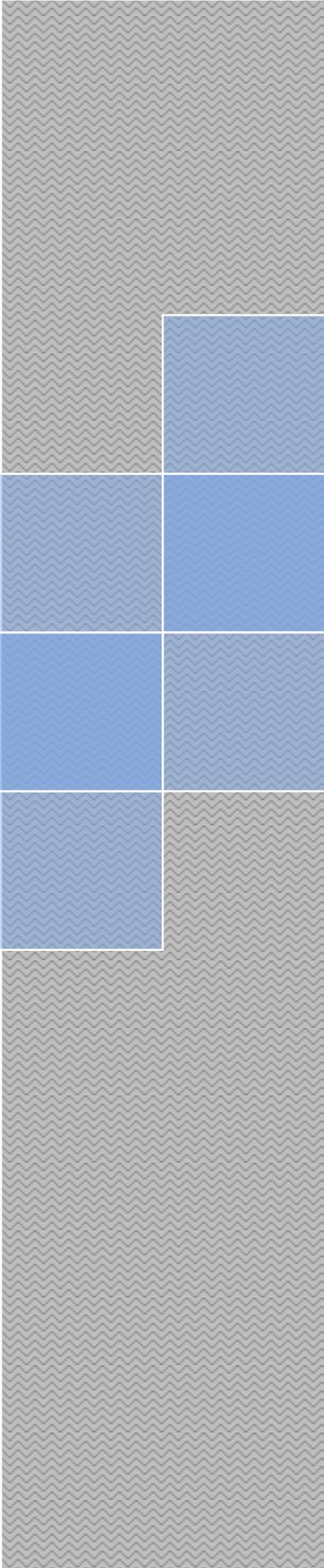
Availability of funding to maintain adequate staffing levels

Motivation of regulated agencies to comply

Established relationships with community partners and appropriate agencies

INDIANA STATE HEALTH IMPROVEMENT PLAN
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**SYSTEM PRIORITY 2:
PUBLIC HEALTH WORKFORCE DEVELOPMENT**



ES8: Maintain a Competent Public Health Workforce
Maintain a Qualified Public Health Workforce

ES-8.1

Assessment vs. Standard	Identify Gaps		Program Goal Development		
	Activities	Participation	Short	Medium	Long
Recruit, hire and retain a qualified and diverse public health workforce.	Apply recruitment and retention policies and make them available to staff.	Local health officer LHD or county HR dept. Local board of health	Done routinely for recruitment in 100% of LHDs; 50% of LHDs have formal retention policy	Done routinely for recruitment in 100% of LHDs; 75% of LHDs have formal retention policy	Done routinely for recruitment in 100% of LHDs; 100% of LHDs have retention formal policy
	Make job standards and position descriptions available to staff.	Local health officer LHD or county HR dept. LHD staff	Done routinely in 100% of LHDs	Done routinely in 100% of LHDs	Done routinely in 100% of LHDs
	Confirm that staff meet qualifications for their positions, job classifications and licensure.	Local health officer or designee LHD or county HR dept. College/university registrar	Done routinely in 100% of LHDs	Done routinely in 100% of LHDs	Done routinely in 100% of LHDs
	Establish relationships and/or collaborate with schools of public health and/or other related academic programs to promote the development of qualified workers for public health.	Local health officer LHD staff SHD staff College/university faculty Professional associations	Done routinely in 50% of LHDs SHD expand partnerships to 25% of available colleges and universities	Done routinely in 50% of LHDs and as needed by 50% of LHDs SHD expand partnerships to 50% of available colleges and universities	Done routinely in 100% of LHDs SHD expand partnerships to 75% of available colleges and universities

Prerequisites/External Factors

- Adequate funding for a professional public health workforce
- Available qualified applicants
- Resources for developing & maintaining appropriate job descriptions
- Common understanding among of possibilities and expectations LHD and college/university supervisors
- Awareness of appropriate intern activities
- Availability of interns
- Resources for managing interns
- Awareness by LHD and SHD of resources colleges and universities can provide

ES8: Maintain a Competent Public Health Workforce
Maintain a Qualified Public Health Workforce

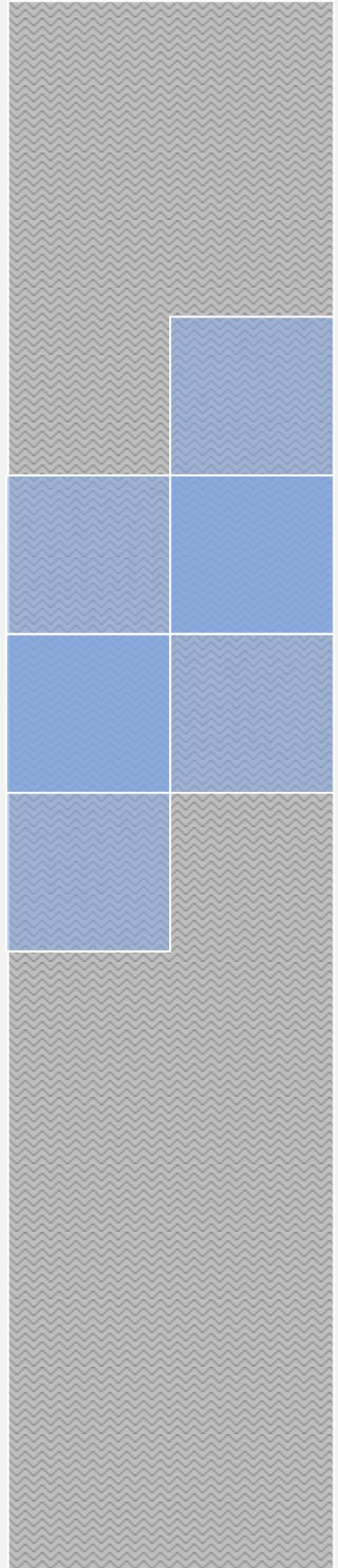
ES-8.2

Assessment vs. Standard	Identify Gaps		Program Goal Development		
	Activities	Participation	Short	Medium	Long
Assess staff competencies and address gaps by enabling organizational and individual training and development opportunities.	Complete performance evaluations and improvement/training plans.	Local health officer LHD supervisors SHD supervisors	20% of LHDs do routinely	50% of LHDs do routinely	100% of LHDs do routinely
	Implement an agency workforce development plan that addresses the training needs of the staff and development of core competencies.	LHD supervisors Local board of health	20% of LHDs do routinely	50% of LHDs do routinely	100% of LHDs do routinely
	Make provisions for staff leadership and management development activities.	Local health officer County or LHD HR dept. SHD supervisors	50% of LHDs do routinely	75% of LHDs do routinely	100% of LHDs do routinely
	State: Provide consultation and technical assistance to LHDs regarding evidence-based and/or promising practices in the development of workforce capacity, training and continuing education.	SHD Office of Public Health Performance Management	Provide to 20% of LHDs	Provide to 75% of LHDs	Provide to 100% of LHDs

Prerequisites/External Factors

- Time to conduct adequate performance reviews
- Knowledgeable supervisors and mentors available
- Funding for professional development and training/certification
- Knowledge of professional development and training resources
- Access to professional development and training resources

INDIANA STATE HEALTH IMPROVEMENT PLAN
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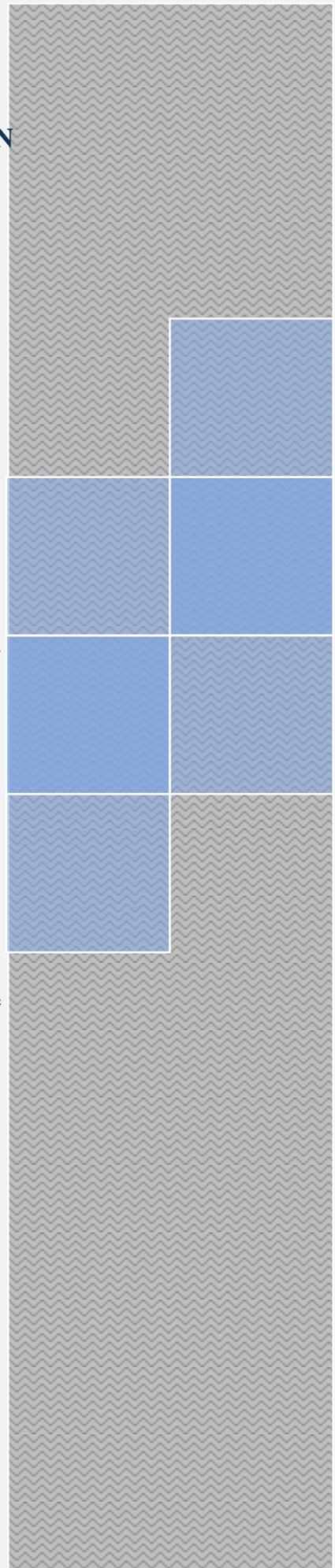
SECTION 4: IMPLEMENTATION AND EVALUATION PLAN

The public health systems priorities are based on the 10 Essential Public Health Services. Members of the Executive Planning Committee identified the areas Indiana Local Health Departments can focus on that will impact the health outcomes of their communities the most. Enforcement of Laws and Regulations and Public Health Workforce Development were the top two public health essential services targeted for development for I-SHIP. The remaining five priority areas (Data and Community Health Profiles; Diagnosing and Investigating Health Hazards; Public Health Policy Development; Informing, Educating and Empowering the Public; and Integrated Healthcare Delivery) will be developed over the next two years by the Office of Public Health Performance Management at the Indiana State Department of Health (ISDH).

Additional data is to be collected by an Accreditation Assessment Team (AAT) located at ISDH. The AAT is to conduct a public health accreditation gap analysis at the local health department level in 2011. These newly acquired data will be used as both a baseline and evaluation for the year 1 public health essential services goal development criteria. The Office of Public Health Performance Management will utilize the same methodology to develop the remaining five priority essential services. The development of the remaining services will be based on the final Public Health Accreditation Board standards and measures.

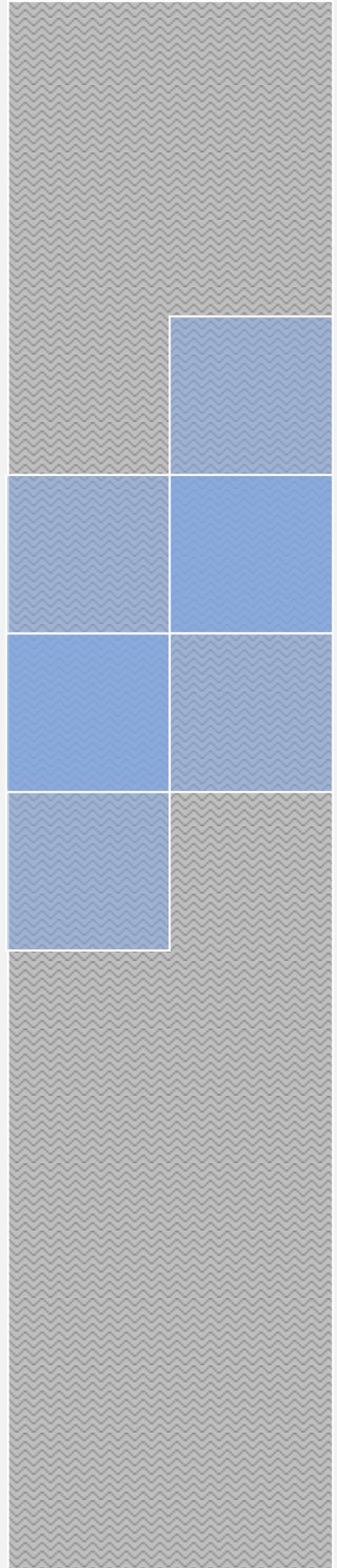
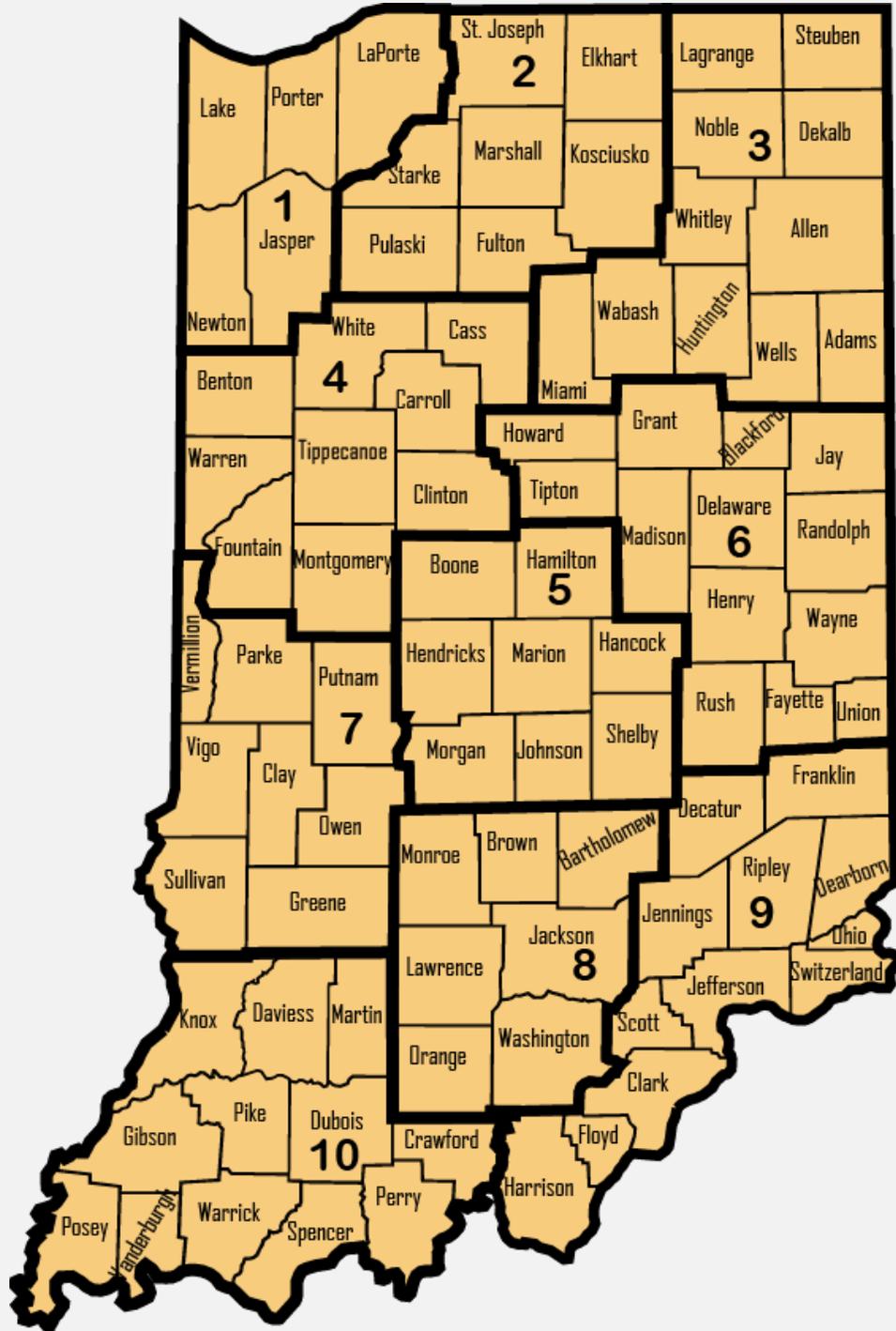
The evaluation of the System Priorities will be conducted by the Office of Public Health Performance Management. The evaluation instrument will be based on the *Local Standards & Measures Self-Assessment Tool* developed by the Public Health Accreditation Board. The *Local Standards & Measures Self-Assessment Tool* is the foundation for the public health accreditation gap analysis plan. A series of questions are asked to determine if health departments can *demonstrate*, *partially demonstrate*, or *not demonstrate* documentation requirements needed to meet each measure for accreditation. Each Assessment/Standard has an identified Domain in the public health accreditation documentation; the evaluation will connect the assessment/standard to the appropriate domain.

To evaluate the local health departments' progress toward the identified system priorities, a survey focusing on each identified Assessment/Standard will be administered at years 3 and 5 of the I-SHIP. Data will be reported in an aggregate format so no individual health department data will be identifiable.



INDIANA STATE HEALTH IMPROVEMENT PLAN
Partnering for the Public's Health

APPENDIX A INDIANA MAP AND PREPAREDNESS DISTRICTS



APPENDIX B PRIORITY TEAM PARTICIPANTS

List of participants in the SHIP – Food Safety Priority

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List of participants in the SHIP – Reduce Infant Mortality Priority

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Miranda Spitznagle, MPH
Director of Program Evaluation
Indiana State Department of Health, Tobacco Prevention and Cessation