

**INDIANA MATERNAL AND CHILD HEALTH TITLE V BLOCK GRANT**  
**Indiana State Department of Health**  
**Title V – Maternal and Child Health Block Grant**  
**FY 2010 Application/FY 2008 Report**  
**Advisory Panel Summary**

**Purpose**

Title V Maternal and Child Health (MCH) Block Grant funds are to be used to improve the health status of women, infants, children, adolescents and children with special health care needs in the State of Indiana. Although MCH programs are available to all women, infants and children and many other programs are available to families with children, emphasis is placed on women of childbearing age, low-income populations and those who do not have access to health care.

**Mission**

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

ISDH has also developed the following priority health initiatives:

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

The ISDH's vision for the future is one in which health is viewed as more than the delivery of health care and public health services. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

### **State Summary Profile**

Indiana's FY 2010 Title V Block Grant allocation is estimated at \$11,779,106.00. Federal mandates that at least 30% of the grant be spent on preventative and primary care services for children and at least 30% of the grant be spent on services for children with special health care needs (CSHCN).

The Indiana State Department of Health administers the Title V grant through Maternal and Child Health (MCH), a division of the [Human Health and Operational Services Commission \(HHOSC\)](#). MCH administered programs include: Prenatal Substance Use Prevention Program, Indiana Perinatal Network, SIDS, Preventive and Primary Child Health Care, Indiana RESPECT (Reducing Early Sex and Pregnancy by Educating Children and Teens), Family Care Coordination, Prenatal Care Services, Prenatal Care Coordination, Adolescent Health Centers, Family Planning Services, the Genomics/Newborn Screening Program which includes Early Hearing Detection and Intervention (EHD) Newborn Hearing Stick Program, and Sickle Cell Program. MCH also administers Children's Special Health Care Services (CSHCS), the state program for children with special health care needs, and Oral Health Services. Title V also supports programs administered within ISDH including: Indiana Childhood Lead Poisoning Prevention Program, Injury Prevention, and Nutrition and Physical Activity. MCH collaborates with many other programs within ISDH such as WIC and Office of Primary Care.

During FY '08 MCH used the Title V grant to fund 7 family planning projects, 5 genetics centers, 9 infant health projects, 14 prenatal care clinics, 11 child health projects, 3 school-based adolescent health grantees, 1 high risk infant follow-up program, 25 prenatal care coordination programs, 5 Prenatal Substance Use Prevention Programs, and 10 family care coordination programs.

(2007 Data Has Been Used When 2008 Data Was Unavailable)

### **Priority Health Needs for the MCH population, 2006-2011**

1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality racial and ethnic disparities in pregnancy outcomes.
2. To reduce barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families.
3. To build and strengthen systems of family support, education and involvement to empower families to improve health behaviors.

4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects.
5. To decrease tobacco use in Indiana.
6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs.
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity.
8. To reduce obesity in Indiana.
9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana.
10. To improve racial and ethnic disparities in women of childbearing age, mothers, and children's health outcomes.

### **National "Core" Performance Measures**

1. The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
2. The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)
3. The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
4. The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN survey)
5. Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN survey)
6. The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life, including adult health care, work, and independence. (CSHCN Survey)
7. Percent of 19 to 35 month olds who have received a full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of births (per 1,000) for teenagers aged 15 through 17 years.
9. Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
11. The percent of mothers who breastfeed their infants at 6 months of age.
12. Percentage of newborns who have been screened for hearing before hospital discharge.
13. Percent of children without health insurance.

14. Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85<sup>th</sup> percentile.
15. Percentage of women who smoke in the last three months of pregnancy.
16. The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
17. Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

### **State “Core” Performance Measures**

1. The number of data sets, including the NBS, UNHS, Lead, IBDPR, Immunizations, CSHCS, and First Steps Data, that are completely integrated into the Indiana Child Health Data Set.
2. The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old.
3. The percent of live births to mothers who smoke.
4. The percent of black women (15 through 44) with a live birth whose prenatal visits were adequate
5. The percentage of children age 0 to 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter
6. The proportion of births occurring within 18 months of a previous birth to the same birth mother.
7. Number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities
8. The percentage of high school students who are overweight or at risk

### **MCH Performance Measures Including Performance for FY 2008, Current Status of Activities for FY 2009, and Plans for FY 2010**

**PERFORMANCE MEASURE # 1** The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

FY 2008 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Status: Met - 100% Maintained

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- Newborns whose screens were invalid, abnormal, or positive received follow-up.
- All infants with confirmed positive results were referred to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the CSHCS programs.
- NBS continued to provide in-service training to Public Health Nurses, midwives, hospitals, and birthing centers.
- NBS began to develop the NBS Data mart in the Operational Data Store to allow more efficient and effective tracking and follow-up of babies who received a positive heel-stick for certain conditions.
- NBS added Cystic Fibrosis to the NBS panel on January 1, 2008
- The NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

b. FY 2009 Current Activities

FY 2009 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Activities to impact this performance objective include:

- NBS is continuing to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.
- NBS is continuing to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the Children's Special Health Care Services (CSHCS) programs.
- NBS is continuing to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. An updated presentation for Public Health Nurses is near completion for implementation online.
- NBS is continuing to develop the NBS Data mart in the Operational Data Store. This system will allow more efficient and effective tracking of all babies ensuring all receive a valid screen and appropriate follow-up.

- The NBS Director participated in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

c. FY 2010 Planned Activities

FY 2010 Performance Objective: Maintain at 100% the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

Activities that will impact this Performance Objective include:

- NBS will continue to follow-up on all invalid, abnormal, and positive test results until they are complete and negative or the babies are receiving treatment.
- NBS will continue to refer infants with confirmed positive results to the Genetics, Endocrinology or Metabolic Clinics at Indiana University Medical Center (IUMC), Sickle Cell clinics, First Steps, and the Children's Special Health Care Services (CSHCS) programs.
- NBS will continue to provide in-service training to Public Health Nurses, hospitals, and midwives, and birthing centers. An updated presentation for Public Health Nurses is near completion for implementation online.
- NBS will begin pilot testing of the NBS (Heel stick) Data mart in the Operational Data Store. This system will allow more efficient and effective tracking of all babies ensuring all receive a valid screen and appropriate follow-up.
- The NBS Director will continue to participate in the Region IV Genetics Collaborative and on the screening subcommittee of the Indiana Genetics Advisory Committee.

**PERFORMANCE MEASURE # 2** The percent of children with special health care needs age 0 to 18 years whose family's partner in all levels of decision-making and are satisfied with the services they receive.

FY 2008 Performance Objective: The percent of children with special health care needs ages 0 to 18, whose families partnered in decision-making at all levels, who were satisfied with the services they received, was determined based on the National Survey of Children with Special Health Care Needs (NS-CSHCN) data, for which FY 07 results are not yet available.

Status: 59.3 % per 2005/2006 CSHCN Chart book.(Based on provisional data)

a. FY 2008 Accomplishments

Activities that impacted this performance objective included:

- The Community Integrated Systems of Service Advisory Committee ( C.I.S.S.) was developed in February 2008, to create a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community –based and culturally competent.
- The C.I.S.S. sub-committee titled “Family/Professional Partnerships”; whose focus is to enhance systems of care for CYSHCN that enables families to partner in decision-making at all levels, and be satisfied with the services they receive continued its work.
- CSHCS updated their English and Spanish versions of the CSHCS Program Brochure and created program Fact Sheets for marketing use.
- CSHCS finalized its review and update of the CSHCS Participants Manual and Transition Manual. Both manuals were reviewed by parents and the manuals were mailed to all participants.
- CSHCS developed/tested a new CSHCS application for the program.
- CSHCS mailed a Summer and Winter newsletter to all participants.
- CSHCS updated the CSHCS Program website to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters. Links to other resources for families were created that allowed accessibility to resource information as needed by participants and their families.
- CSHCS participated as an Exhibitor at 6 Conferences throughout the state for CYSHCN and provided training on the CSHCS program to local agencies that work with CYSHCN.
- CSHCS continued its grant funding to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities. FY 2008 activities included the following:
  1. Parent to parent contact through the telephone was available to families for questions related to health care coverage, education, early intervention, community

resources, training and other issues. During FY 08 a total of 3,440 new families and professionals were served by ASK staff. In addition, 7,514 families and professionals were contacted through ASK's follow-up protocols throughout the year.

2. ASK connected on a monthly basis with pediatric residents who are being trained at Indiana University. Residents were taught about community resources and the importance of sharing this information with families who they will be seeing in practice.

3. ASK offered trainings to families and professionals about special education and health care financing. Scholarships were available to families who could not afford to attend the trainings.

4. ASK produced a monthly e-newsletter that was sent out to more than 1,000 families and professionals each month. The e-newsletter contains information pertinent to both professionals and families.

5. ASK sent out CHSHCS program applications from its office during the grant cycle.

- Medical Director worked with ISDH Disaster Preparedness to assure needs of CSHCN was included.
- CSHCS participated in 9 statewide Roadshows with members of the Indiana State Transition Team where we presented information about the CSHCS program.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of children with special health care needs ages 0 to 18, whose families partner in decision-making at all levels, who were satisfied with the services they receive, will remain at 64% based upon NS-CSHCN data.

Activities to impact this performance objective include:

- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) continued its monthly meetings to work on improving access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community-based and culturally competent.
- The C.I.S.S. Advisory Committee sub-committee titled "Family/Professional Partnerships"; whose focus was to enhance systems of care for CYSHCN that enabled families to partner in decision-making at all levels, and be satisfied with the services they received worked to identify Indiana's strengths and needs around this topic and identified activities and made recommendations to coordinate the development,

implementation and evaluation of a State Integrated Community Services Plan to achieve community-based service systems around Family/Professional Partnerships. This information was used to apply for HRSA/MCHB State Implementation Grant for Systems of Services for Children and Youth with Special Health Care Needs (CYSHCN) which was submitted March 2009 with award notifications May 2009.

- CSHCS produced and mailed a CSHCS Summer Newsletters to all participants.
- CSHCS continued to keep the CSHCS Program website updated to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters. Links to other resources for families were created that allowed accessibility to resource information as needed by participants and their families.
- CSHCS was not able to provide the updated CSHCS Program Brochures to all CSHCS providers, parent support agencies and other community-based systems that care/support CYSHCN due to budget restraints.
- CSHCS continued to provide Developmental Calendars, Transition Resources-including the CSHCS Transition Manual and Health Care financing options to all its participants.
- CSHCS continued its grant funding to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families by providing information, peer support and education and building partnerships with professionals and communities. FY 2009 activities included the following:
  1. Parent to parent contact through the telephone was available to families for questions related to health care coverage, education, early intervention, community resources, training and other issues. During FY 09 (report period is for 6 months only July 1, 2008-January 1, 2009) a total of 1,690 new families and professionals were served by ASK staff. In addition, 5,237 families and professionals were contacted through ASK's follow-up protocols throughout the year.
  2. ASK worked with Integrated Community Services (I.G.S.) Program to collect information from families and from professionals about their understanding of a medical home. Following this survey, ASK assisted the I.C.S program in identifying steps to take toward furthering the medical home concept in Indiana.
  3. ASK participated with the Indiana State Department of Health on advisory committees to special projects, insuring that the family perspective was always present throughout the planning processes.
  4. ASK continued to send an e-newsletter with readership reaching over 1200 during the year.

- CSHCS participated in statewide trainings, conferences and exhibitions to promote the CSHCS program.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: The percent of children with special health care needs ages 0 to 18, whose families partner in decision-making at all levels, who were satisfied with the services they receive, will remain at 64% based upon NS-CSHCN data.

Activities that will impact this Performance Objective include:

- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work on improving access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community – based and culturally competent. May 2009, the CISS Advisory Committee will receive notification of awards for the Improving Systems of Services for CYSHCN grant application that was submitted March 2009. If Indiana receives the grant award the CISS Advisory Committee will move forward with the focus activities outlined in the grant, Medical Home Learning Collaborative, Transition to Adult Healthcare and Work and building the capacity of the CISS Advisory Committee that will take on the responsibility of providing oversight to initiatives for CYSHCN and their families throughout the state.
- The C.I.S.S. Advisory sub-committee titled “Family/Professional Partnerships”; whose focus is to enhance systems of care for CYSHCN that enabled families to partner in decision-making at all levels, and be satisfied with the services they received will continue its work to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve community-based service systems around Family/Professional Partnerships.
- CSHCS will produce and mail a Summer and Winter CSHCS Newsletter to all participants and professionals involved with the program.
- CSHCS will provide the updated CSHCS Program Brochures to all CSHCS providers, parent support agencies and other community-based systems that care/support CYSHCN.
- CSHCS will continue to provide Developmental Calendars, Transition Resources-including the CSHCS Transition Manual and Health Care financing options to all its participants.
- CSHCS will continue to keep the CSHCS Program website updated to include up-to-date informational materials, program guidelines, and copies of the programs updated brochures, manuals, application and newsletters. Links to other resources for families

were created that allowed accessibility to resource information as needed by participants and their families.

- ASK will continue to receive grant funding from CSHCS at a reduced amount due to budget restraints. ASK will continue its work with families and professionals served through its staff and programs.
- ASK will work with CSHCS to educate families and professionals about Medical Home.
- ASK will participate with the Indiana State Department of Health on advisory committees to special projects, insuring that the family perspective is always present throughout the planning processes.
- ASK will continue to send an e-newsletter and anticipates that readership will reach over 1200 during the coming year.
- CSHCS will continue to participate in statewide conferences and exhibitions to promote the CSHCS program.

**PERFORMANCE MEASURE # 3** The percent of children with special health care needs age 0-18 who receives coordinated, ongoing, comprehensive care within a medical home.

FY 2008 Performance Objective: The percent of CSHCN in Indiana who have a "Medical Home will be 54.6 %.

Status: 54.6% per 2005-2006 NC-CSHN data. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this performance objective included:

- MCSHC developed and distributed an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH and Indiana Family Helpline (IFHL) programs.
- ASK continued to provide on a monthly basis to pediatric residents who are being trained at Indiana University information about community resources and the importance of sharing this information with families who they will be seeing in practice.
- ASK participated on the Community Integrated Service Systems (CISS) Advisory Committee and also had representation on three of the subcommittees of this project.

Initial work was begun to develop surveys for medical professionals and for families about medical home.

- MCSHC continued its work to select or develop a brochure for physicians about the medical home concept.
- MCSHC convened The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) in February 2008, to create a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community-based and culturally competent.
- The C.I.S.S. “Medical Home” sub-committee made recommendations to coordinate for Indiana the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the goal of coordinated, ongoing, comprehensive care within a Medical Home.
- MCSHC began an In-house Care Coordination System in April 2008. The Care Coordinators linked the participants to a Primary Care Physician (PCP), provided the families with “Tools” to help them prepare for medical visits and educated CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of CSHCN in Indiana who have a "Medical Home" will be maintained at 54.6% in FY 2009.

Activities to impact this performance objective include:

- MCSHC will continue to distribute an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs.
- ASK will continue to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in practice.
- CSHCS will continue to facilitate the Community Integrated Systems of Services (C.I.S.S.) Advisory Committee and have ASK participate on the Medical Home

subcommittee of this project to further the plan for spreading the medical home concept more broadly in Indiana.

- CSHCS worked with ASK to collect information from families about their understanding of a medical home. Following the survey, ASK assisted the Integrated Community Services Program in identifying steps to take toward furthering the medical home concept in Indiana.
- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community – based and culturally competent.
- The C.I.S.S. sub-committee titled “Medical Home” made recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana. This information was used to develop the grant application for Improving Systems of Care for CYSHCN that was submitted March 2009. If awarded one of the grants objectives is to focus on a Medical Home Learning Collaborative.
- MCSHC will continue to develop the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: The percent of CSHCN in Indiana who have a "Medical Home" will be maintained at 54.6% in FY 2010.

Activities that will impact this performance objective include:

- MCSHC will continue to distribute an educational brochure for parents regarding Medical Homes to include in mailings to consumers from the CSHCS, MCH, NBS and Indiana Family Helpline (IFHL) programs.
- ASK will continue to connect on a monthly basis with pediatric residents who are being trained at Indiana University. Residents are taught about community resources and the importance of sharing this information with families who they will be seeing in practice.

- CSHCS will continue to facilitate the Community Integrated Systems of Services (C.I.S.S.) advisory committee and have ASK participate on the Medical Home subcommittee of this project to further the plan for spreading the medical home concept more broadly in Indiana.
- CSHCS will work with ASK to collect information from professionals about their understanding of a medical home. Following this survey, ASK will assist CSHCS in identifying steps to take toward furthering the medical home concept to professionals in Indiana.
- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue its work to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community – based and culturally competent.
- The C.I.S.S. sub-committee titled “Medical Home” made recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve Medical Home implementation in Indiana. This information was used to develop the grant application for Improving Systems of Care for CYSHCN that was submitted March 2009. If awarded one of the grants objectives are to focus on a Medical Home Learning Collaborative and this sub-committee will provide oversight on this topic.
- MCSHC will continue to develop the In-house Care Coordination System. The Care Coordinators will continue to link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.

**PERFORMANCE MEASURE # 4** Percent of Children with Special Health Care Needs, age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

FY 2008 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be maintained at 67% in FY 2008.

Status: 61.8% in 2007 (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- Actual figures, based upon information in the Agency Claims and Administrative Processing System (ACAPS), of participants in Indiana's CSHCS program who have either private or public health insurance is 90.95%. Of that total percentage, 48.88% of participants have some kind of private health insurance and 42.07% have Medicaid.
- CSHCS tracked insurance utilization in ACAPS. This activity allowed for denial of claims for which other insurance coverage is available.
- CSHCS monitored the activities and progress of the Health Insurance for Indiana Families Committee, a group of state leaders charged with developing no-or low-cost options to provider services for the uninsured.
- CSHCS monitored the activities and progress of Covering Kids & Families (CKF), a national initiative funded by the Robert Wood Johnson Foundation to increase the number of children and adults who benefit from federal and state health care coverage programs.
- The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. As a part of this grant, ASK staff members spoke with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and helped families navigate through the complex systems.
- ASK offered trainings to families and professionals that outline the various public health insurance programs. Follow-up with an ASK Parent Liaison helped families determine which of these programs will serve their children the best. ASK staff spoke with 2,416 families in Indiana about health insurance options.
- ASK provided training to approximately 80 participants on Understanding Public Health Insurance Options.
- CSHCS program sent all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be increased to 69% in FY 2009.

Status: Insurance information for FY 09 indicates the CSHCS program has exceeded that percentage of participants who carry private or public health information. For 2008, 90.95 % of participants had other insurance or Medicaid.

Activities to impact this Performance Objective Include:

- CSHCS updated the ACAPS system to utilize insurance information for processing electronic pharmacy claims. Electronic Coordination of Benefits (COB) processing of pharmacy claims has been accomplished and we are currently working on electronic COB processing for medical claims.
- CSHCS reviewed and followed-up on system reports that were created to identify coordination and benefit issues for electronic pharmacy claims.
- CSHCS sent information to providers which clarified our reimbursement methodology as it relates to other insurance and the maximum allowable payment. A provider bulletin has been sent to providers.
- CSHCS updated both the Provider and Participant Manual.
- The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. As a part of this grant, ASK staff members speak with families about a variety of health insurance options (such as private, public, Medicaid Waivers, Children's Special Health Care Services, SSI, etc.) and can help families navigate through these complex systems.
- ASK offered trainings to families and professionals that outlined the various public health insurance programs. Follow-up with an ASK Parent Liaison can help families determine which of these programs will serve their children the best.
- ASK serves as Indiana's Family to Family Health Information and Education Center (F2FHIC). As Indiana's F2FHIC, ASK has the opportunity to meet quarterly with stakeholders from the state, community and families. The purpose of the F2FHIC is to create health care change in the state.
- ASK currently has representation on the C.I.S.S. subcommittee addressing uninsured and underinsured children in our state.
- ASK has revised its public health insurance training. The curriculum will be publicized and offered to both families and professionals with a "menu" of topics that the requesting party can select from to allow for the training to be customized.
- CSHCS program continued to send all participants age 17 years and up information on insurance options to apply for as they age off Hoosier Healthwise and their parent's healthcare policies.
- The C.I.S.S. Committee sub-committee "Access to Adequate Health Insurance" whose focus is to enhance systems of care for CYSHCN around the issues of

adequate health insurance made recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the above goal. This information was used in the Improving Systems of Services for CYSHCN grant that was submitted March 2009.

- The CSHCS program became a “Registered Agency” with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will increase to 70% in FY 2010.

Activities that will impact this Performance Objective include:

- CSHCS will be posting the Provider manual on the CSHCS website.
- CSHCS will complete the electronic COB process for medical claims which will allow medical claims to be processed more quickly.
- CSHCS will continue to review and follow-up on system reports that were created to identify coordination of benefit issues for electronic pharmacy claims.
- ASK will continue to serve on the CISS subcommittee addressing uninsured and underinsured children and will work with the committee to develop a plan of action related to this topic.
- The new ASK public health insurance training curriculum will be publicized and offered to both families and professionals in the coming year. The new curriculum will feature a “menu” of topics that the requesting party can select from so that the training can be customized.
- CSHCS program will continue to send all participants age 17 years and up information on Insurance options to apply for as they age off Hoosier Healthwise and their parent’s healthcare policies.
- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue to work to support and develop services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community –based and culturally competent.
- The (C.I.S.S.) sub-committee titled “Access to Adequate Health Insurance” will complete recommendations to coordinate the development, implementation and

evaluation of a State Integrated Community Services Plan to achieve the adequate health insurance.

- The CSHCS program will continue as a “Registered Agency” with the Division of Family Resources (DFR) to allow access to their Web Portal to verify participants Medicaid/HHW status.

**PERFORMANCE MEASURE # 5** The percent of children with special health care needs age 0 to 18 whose families report that community-based service systems are organized so they use them easily.

FY 2008 Performance Objective: 80% of families with CSHCN age 0 to 18 will report the community-based service systems are organized so they can use them easily.

Status: 94.3 % per the 2005-2006 NS-CSHCN. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- The Indiana State Department of Health granted funds to About Special Kids (ASK), a parent to parent organization that supports children with special needs and their families. ASK is supported, in part by CSHCS. ASK assists families navigating the complex systems of community resources in the following ways:
  1. ASK has an online resource directory that highlights local, statewide, and national resources specifically for children with special health care needs. The directory is searchable by topic area, county and by keyword and can be accessed at any time through the internet. There were over 50,000 hits on this site.
  2. ASK works one on one with families who need assistance navigating through the complex system of community resources. This one on one assistance comes from the ASK Parent Liaison staff who guide each individual to the resources that are appropriate for their families. There were over 10,000 families served. (These were new families and follow ups with previously identified families.)
  3. With funding assistance from the Indiana State Department of Health, ASK developed community resource pads and a community resource poster that has been distributed to health care settings, and through various information fairs throughout the state. Key community resources were selected for listing on these materials and they were made “user-friendly” so that they could easily be utilized.
- MCSHC maintained an 800 Family Help Line with V/TDD capabilities and bilingual support and referred families to community-based services.

- CSHCS provided community based-training to First Steps providers and The Division of Family Resources (DFR) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.
- CSHCS continued to reimburse families for in-state and out-of-state transportation for CSHCS participants to medical facilities for services.
- CSHCS provided outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.
- To facilitate receipt of CSHCS applications, CSHCS promoted Single Points of Entry (SPOE) early intervention sites, and used local Offices of Family Resources to take CSHCS applications.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: 82% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

Activities to impact this Performance Objective include:

- MCSHC began an In-house Care Coordination System in April 2008. The Care Coordinators assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.
- CSHCS continued its funding and collaborating with About Special Kids (ASK) and its statewide network of family-to-family peer support.
- ASK has continued to add resources and to update resources in its directory and during this year, added a for profit component to the directory (previously, the directory only included nonprofit resources). In this section, for profit companies, who are specifically addressing the needs of children with special health care needs, are listed for a fee. A disclaimer is offered to families so that they know that the organization does not endorse any specific for profit entities.
- ASK has helped over 12,000 families access appropriate community resources during this grant year.
- With funding assistance from the Indiana State Department of Health, ASK continues to update the Marion County community resource pads and also the statewide

community resource poster that has been distributed to health care settings, and through various information fairs throughout the state. Key community resources were selected for listing on these materials and they were made “user-friendly” so that they could easily be utilized.

- MCSHC convened The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) in February 2008, that created a statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community-based and culturally competent.
- The C.I.S.S. Committee sub-committee titled “Organization of Community Services for Easy Use By families” (whose focus is to enhance systems of care for CYSHCN around the issues of community-based service systems that are organized so families can use them easily) will make recommendations to coordinate the development, implementation and evaluation of a State Integrated Community Services Plan to achieve the above goal.
- MCSHC maintains an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.
- CSHCS provides current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.
- CSHCS continues to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.
- CSHCS provides outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.
- CSHCS promotes Single Points of Entry (SPOE) early intervention sites, and uses local Offices of Family Resources to take CSHCS applications.
- CSHCS continues using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.
- CSHCS publishes a bi-yearly (Summer and Winter) newsletter which includes informative articles and any program updates that affect participants (i.e., policy changes, new mileage reimbursement rates, etc.).

- CSHCS will begin to evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to study how well they assist families in using community based services.

c. FY 2010 Planned Activities

FY 2010 Performance Objective: 84% of families with CSHCN age 0 to 18 will report the community-based services systems are organized so they can use them easily.

Activities that will impact this Performance Objective include:

- MCSHC will continue to develop the In-house Care Coordination System. The Care Coordinators will continue to assess the participants and their families needs and make appropriate referrals, link the participants to a Primary Care Physician (PCP), provide the families with “Tools” to help them prepare for medical visits and educate CSHCS participants and their families on the Medical Home Concept where families and physicians work together to identify and access all the medical and non-medical services needed to help children and their families reach their maximum potential.
- CSHCS will continue to fund and collaborate with About Special Kids (ASK) and its statewide network of family-to-family peer support.
- ASK will continue to update existing resources in its online directory and will add new resources as they become available.
- ASK will continue to serve families on a one on one basis and will continue to provide follow-up to these families to insure that they are accessing the appropriate resources.
- ASK will continue to seek funding to update additional counties’ community resource cards.
- The Community Integrated Systems of Service Advisory Committee (C.I.S.S.) will continue working with the statewide Advisory Committee of governmental and state agencies, community level providers, children and youth with special health care needs and their families working together to improve access to quality, comprehensive, coordinated community-based systems of services for Children and Youth with Special Health Care Needs (CYSHCN) and their families that are family-centered, community –based and culturally competent.
- The C.I.S.S. sub-committee titled “Organization of Community Services for Easy Use By families” (whose focus is to enhance systems of care for CYSHCN around the issues of community-based service systems that are organized so families can use them easily) will continue its work and make recommendations to coordinate the development, implementation and evaluation of the State Integrated Community Services Plan to achieve the above goal.

- MCSHC will maintain an 800 Family Help Line with V/TDD capabilities and bilingual support and refer families to community-based services.
- CSHCS will provide current community based-training to First Steps providers and Division of Family and Children (DFC) providers to promote systems development, and to improve the organization and delivery of services to children with special health care needs.
- CSHCS will continue to reimburse families for in-state and out-of-state transportation of participants to medical facilities for services.
- CSHCS will provide outreach to Neonatal Intensive Care Units (NICU), and maintains and provide lists of primary care physicians participating in the CSHCS program.
- CSHCS will continue to promote Single Points of Entry (SPOE) early intervention sites and local Offices of Family Resources to take CSHCS applications.
- CSHCS will continue using a customer service representative on an "as needed" basis to take applications in specialty care centers, and maintains an information and application site at Riley Hospital for Children.
- CSHCS will continue to publish a bi-yearly (Summer and Winter) newsletter which includes informative articles and any program updates that affect participants (i.e., policy changes, new mileage reimbursement rates, etc.).
- CSHCS will continue to evaluate currently funded Children with Special Health Care Needs (CSHCN) programs to study how well they assist families in using community based services.

**PERFORMANCE MEASURE # 6** The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work and independence.

FY 2008 Performance Objective: 8% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life

Status: 41.1 % (2005-2006 NS-CSHCN). (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- Children's Special Health Care Services (CSHCS) continued to distribute the Transition Manual to 100% of CSHCS participants ages 14 years and older. CSHCS distributed the Transition Manual at health and transitional fairs that it attended as an exhibitor.
- CSHCS staff continued to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CYSHCN) to adult life.
- CSHCS published a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems on numerous topics including Transition.
- CSHCS and The Center for Youth and Adults with Conditions of Childhood (CYACC) Transition Clinic continued to develop transition assistance for clients and training for providers.
- CSHCS worked with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.
- The CYACC Transition Project worked with health care providers statewide on transitioning youth with special health care needs to adult care.
- Materials and tools developed at the CYACC transition clinic continued to be distributed to other providers.
- The CISS Advisory Committee established a Transition sub-committee whose focus was to evaluate Indiana's strengths and needs around transition and identify objectives and activities to improve the areas of identified need.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: 41% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life.

Activities to impact this Performance Objective include:

- CSHCS will continue to distribute the Transition Manual to 100% of CSHCS participants ages 14 years and older.
- CSHCS will continue to distribute the Transition Manual at health and transitional fairs that it attends as an exhibitor.

- CSHCS staff will continue to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.
- CSHCS will continue to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.
- CSHCS and CYACC Transition Clinic will continue to develop transition assistance for clients and training for providers.
- CSHCS will continue to work with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.
- The CYACC Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.
- Materials and tools developed at the CYSHCN transition clinic will continue to be distributed to other providers.
- The CISS Advisory Committees Transition sub-committee will continue its focus to evaluate Indiana's strengths and needs around transition and identify objectives and activities to improve the areas of identified need.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: 41% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life.

Activities that will impact this Performance Objective include:

- CSHCS will continue to distribute the Transition Manual to 100% of the CSHCS participants ages 14 years and older.
- CSHCS will continue to distribute the Transition Manual at health and transitional fairs that it attends as an exhibitor.
- CSHCS staff will continue to receive ongoing training and updates regarding transitioning Children and Youth with Special Health Care Needs (CSYHCN) to adult life.
- CSHCS will continue to publish a bi-yearly newsletter to CSHCN families and participants with listings for community resources and support systems.

- CSHCS and CYACC Transition Clinic will continue to develop transition assistance for clients and training for providers.
- CSHCS will continue to work with interagency initiatives (Indiana's State Transition Team, Department of Education 290 Group and CYACC Advisory Board) regarding transition for disabled individuals from school to work or youth to adult health services.
- The CYACC Transition Project will work with health care providers statewide on transitioning youth with special health care needs to adult care.
- Materials and tools developed at the CYSHCN transition clinic will continue to be distributed to other providers.
- The CISS Advisory Committees Transition sub-committee will begin its work on improving systems for CYSHCN as they transition to adult healthcare, work and independence. Planned activities to accomplish this goal will be to contract with CYACC to develop and provide tools, resources and Educational Office Visits (EOV) to build partnerships with community physicians and/or their healthcare teams to assist in meeting the transition needs of CYSHCN in their practices.

**PERFORMANCE MEASURE # 7** Percent of 19 to 35 month olds who have received the full schedule of age-appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae, and Hepatitis B as measured by the National Immunization Survey (NIS) conducted by the Centers for Disease Control and Prevention (CDC).

FY 2008 Performance Objective: The percent of 19 to 35 month olds who have received the full schedule of age-appropriate immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae, and Hepatitis B (4:3:1:3:3) will increase to 84% in 2008.

Status: 2007 NIS data (which were published in 2008) show 76.8% of children 19-35 months of age had received the 4:3:1:3:3 immunization series. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- The Immunization Program provided vaccines to Maternal and Child Health (MCH) sites enrolled in the Vaccines for Children (VFC) program.

- The Immunization Program conducted VFC and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.
- MCH worked with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.
- MCH Health Systems Development staff attended the Indiana Immunization Coalition and participated in its activities.
- The legislature increased cigarette tax by 44 cents, a portion of which was used to buy vaccines.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of 19 to 35 month olds who have received the full schedule of age-appropriate immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae, Hepatitis B, and Varicella (4:3:1:3:3:1) will increase to 74% in 2009.

Activities to impact this Performance Objective include:

- The Immunization Program continues to provide vaccines to Maternal and Child Health (MCH) sites enrolled in the Vaccines for Children (VFC) program.
- The Immunization Program continues to conduct VFC and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled MCH sites to assess implementation of VFC policies.
- MCH continues to work with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.
- MCH Health Systems Development staff continues to attend the Indiana Immunization Coalition and participate in its activities.
- MCH continues to work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: The percent of 19 to 35 month olds who have received the full schedule of age-appropriate immunizations for Measles, Mumps, Rubella, Polio,

Diphtheria, Tetanus, Pertussis, Haemophilus Influenzae, Hepatitis B, and Varicella (4:3:1:3:3:1) will increase to 75% in 2010.

Activities that will impact this Performance Objective include:

- The Immunization Program will conduct Vaccines for Children (VFC) and Assessment, Feedback, Incentives, eXchange (AFIX) visits at selected VFC-enrolled Maternal and Child Health (MCH) sites to assess implementation of VFC policies.
- MCH will work with the Immunization Program to increase the number of sites using the Children and Hoosiers Immunization Registry (CHIRP) reminder/recall feature.
- MCH will coordinate with the Immunization Program to provide educational opportunities for WIC program staff.
- MCH Health Systems Development staff will attend the Indiana Immunization Coalition and participate in its activities.
- MCH will work with the Immunization Program to increase the number of MCH sites enrolled as VFC and/or CHIRP providers.

**PERFORMANCE MEASURE # 8** The rate of birth (per 1,000) to teenagers aged 15-17 years.

FY 2008 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 18.9 in FY 2008.

Status: The birth rate per 1,000 females for ages 15-17 was 20.2 for 2007. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- The state adolescent health coordinator (SAHC) submitted an application for receipt of federal Abstinence Education Grant Program funds to support Indiana RESPECT for fiscal years 2009-2013. The application was approved.
- The SAHC provided training on program adaptation and a training on evaluation to Indiana RESPECT grantees. These trainings were conducted with a partner organization, Health Care Education and Training, Inc. (HCET).
- Due to state restrictions on marketing, the media campaign for Indiana RESPECT was not prominent the second half of FY08. However, Indiana RESPECT did continue to disseminate educational materials at community events such as Indiana

Black Expo Minority Health Fair and Fiesta Indianapolis and do mailings of educational materials to those requesting such information. .

- The MCSHC Division funded five school-based clinics which were a source of prenatal care coordination and/or on-site referral for prenatal care coordination for any pregnant student who comes to the clinic, and for support for “at risk” youth. MCSHC continued its Free Pregnancy Test program to provide counseling and referrals to healthcare providers, or provide abstinence or family planning information to sexually active teens with negative pregnancy test.
- The SAHC continued to facilitate the Indiana Coalition to Improve Adolescent Health. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.
- The SAHC promoted the 2008 National Day to Prevent Teen Pregnancy. Materials regarding the National Day and Indiana RESPECT were sent out to all middle schools, high schools, private schools in Indiana; to current and past Indiana RESPECT grantees; and to school-based clinics throughout the state. A press release about the National Day was released by the Indiana State Department of Health.
- The SAHC attended the Healthy Teen Network’s Annual Conference in November 2007, including a pre-conference training on science-based approaches to prevent teen pregnancy. The SAHC attended the Association of Maternal and Children’s Health Programs in March 2008. Several of the breakout sessions were specific to issues in adolescent health and included data and information on teen sexual behaviors and pregnancy.
- The SAHC currently is a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy, STD’s, and HIV among adolescents and translate this research into user-friendly materials to disseminate to the field.
- The SAHC assisted with the administration of the 2007 Youth Risk Behavior Survey (YRBS) and prepared the fact sheet for adolescent sexual behaviors for the release of Indiana data in December 2007.
- The SAHC was part of the planning committee for the first ISDH youth summit held in the state held in March 2008. The summit offered breakout sessions to students on healthy relationship and evaluating one’s relationships.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 18.8 in FY 2009.

Activities to impact this Performance Objective include:

- The state adolescent health coordinator (SAHC) will submit all necessary documentation and paperwork to ensure continuation of federal Abstinence Education Block Grant funds through fiscal year 2013. (Grant application was approved for fiscal years 2009-2013).
- The SAHC will oversee the FY2010-2011 Indiana RESPECT community grant program application and review process. SAHC will update the grant application for and hold a technical assistance meeting for all interested applicants to provide instruction on writing the grant and to clarify or answer questions regarding the application components.
- The SAHC will continue to monitor the progress and effectiveness of the statewide abstinence media campaign and continue to disseminate educational materials to community-based grantees, teens, parents, and other youth-serving organizations. SAHC will ensure that the Indiana RESPECT website will be redesigned and launched by July 2009.
- The SAHC will partner with other divisions within the Indiana State Department of Health to assist in the administration of the 2009 Youth Risk Behavior Survey (YRBS).
- The SAHC will continue to lead the Indiana Coalition to Improve Adolescent Health. The coalition released the state's first adolescent health plan in May 2009. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.
- MCHSC is funding three school-based adolescent health clinics that may provide either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student. SAHC is the liaison for the clinics and will provide any technical assistance or educational materials, as requested. The Free Pregnancy Test Program (FPT) through the MCHSC will continue to be available.
- The SAHC currently is a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy, STD's, and HIV among adolescents and translate this research into user-friendly materials to disseminate to the field.
- The SAHC promoted the 2009 National Day to Prevent Teen Pregnancy by ensuring a press release from the Indiana State Department of Health and coordinating announcements regarding the National Day to be sent to all school superintendents and principals throughout the state with the help of the Indiana Department of Education.

- SAHC attended a sexual health summit for adolescents in April 2009.

c. FY 2010 Planned Activities

FY 2010 Performance Objective: The birth rate for teenagers aged 15-17 years will decrease to 18.8 in FY 2010.

Activities that will impact this Performance Objective include:

- The SAHC will submit all necessary documentation and paperwork to ensure continuation of federal Abstinence Education Block Grant funds through fiscal year 2013, should these program funds still be available to states. (Grant application was approved for fiscal years 2009-2013).
- The SAHC will continue to oversee Indiana RESPECT grantees supported with state funds. The SAHC will provide training as necessary to the grantees on topics such as science-based approaches to teen pregnancy prevention and data collection and evaluation.
- The SAHC will continue to monitor all aspects of the media campaign for Indiana RESPECT, including the placement of TV advertisements, website advertisements, hits to Indiana RESPECT's website, dissemination of education materials, and a presence at community events. The SAHC will ensure quarterly updates to the website in order to keep the site updated with new information that will encourage visitors to return to the site.
- MCHSC will fund three school-based adolescent health clinics that may provide either prenatal care coordination on-site or referral for prenatal care coordination for any pregnant student. SAHC is the liaison for the clinics and will provide any technical assistance or educational materials, as requested. The Free Pregnancy Test Program (FPT) through the MCHSC will continue to be available.
- The SAHC continued to facilitate the Indiana Coalition to Improve Adolescent Health. One of the priorities of the coalition is to address risky sexual behaviors among adolescents.
- The SAHC will promote the 2009 National Day to Prevent Teen Pregnancy. The SAHC will work internally with other programs at the Indiana State Department of Health and collaborate with the Indiana Department of Education to share information regarding this initiative with schools, teachers, community members, and grantees of Indiana RESPECT.
- The SAHC will participate in conferences, online trainings and Webinars that provide training on teen pregnancy prevention programs and updates on the latest research related to pregnancy prevention among teens.

- The SAHC, if given the opportunity, will continue to serve as a member of the Program Review Panel for the National Campaign to Prevent Teen and Unplanned Pregnancy. This panel works to identify and consolidate research on science-based practices to prevent teen pregnancy, STD's, and HIV among adolescents and translate this research into user-friendly materials to disseminate to the field.
- The SAHC will assist with the dissemination of data from the 2009 Youth Risk Behavior Survey (YRBS) and prepare the fact sheet for adolescent sexual behaviors.

**PERFORMANCE MEASURE # 9** Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

FY 2008 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 48% in FY 2008.

Status: Unable to determine due to staff transition no Oral Health Services (OHS) survey of third graders in selected schools occurred.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- OHS promoted community-based dental sealant programs, and collaborated with the IU School of Dentistry Community Dentistry's sealant placement program, St Mary's Mobile Unit, Smile Indiana Mobile Program and the Marion County Smile Mobile Program.
- OHS encourages dental providers to participate in Hoosier Healthwise and use sealants with Hoosier Healthwise clients to help eliminate disparities in preventive services rendered.
- OHS met quarterly with the members of the Oral Health Task Force (OHTF) and collaborated with these community experts on drafting the State Oral Health Plan, which will increase dental services to the underserved.
- OHS coordinated a 16-page oral health insert titled, Healthy Mouth Healthy Life which was included in the November 2008 issue of Indianapolis Women magazine. This insert provided relevant information for the consumer on the importance of good oral health. Oral health information related to oral health during pregnancy, early child care and the beneficial use of sealants was provided. This magazine had a circulation of more than 200,000.

- OHS met quarterly with the Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory work group on oral health issues.
- OHS distributed oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish and provides educational training presentations when requested.
- OHS collaborated with Indiana University School of Dentistry and Indiana University School of Public and Environmental Affairs, Center for Health Policy and received a HRSA grant to identify key state oral health priorities.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 48% in FY 2009.

Activities to impact this Performance Objective include:

- OHS will utilize grant dollars to enhance and support sealant projects already in existence in Title V schools by current dental mobile providers.
- OHS will promote community-based dental sealant programs, among existing programs and will continue to collaborate with the IU School of Dentistry Community Dentistry's sealant placement program to develop specific pilot school programs to help increase sealant placement to third graders.
- OHS will utilize grant dollars to develop specific sealant projects in rural schools to begin in FY2010.
- OHS will encourage dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.
- OHS will continue to consult with Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory work group on oral health issues by attending quarterly meetings or as needed to accomplish the business at hand.
- OHS will promote the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry, and all Dental Hygiene Programs (5) and to current practitioners throughout the state.
- OHS will continue to provide oral health brochures for distribution to MCSHC, WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish.

- OHS will collaborate with partners such as the IU School of Dentistry, Indiana Dental Association, Indiana Dental Hygienists Association, Indiana Rural Health Association, Indiana Primary Health Care Association and other partners in the state to develop an Indiana Oral Health State Plan that will benefit the underserved, underinsured, working poor as well as dental professionals.
- OHS will help communities gain designation as a Dental HPSA and collaborate with ISDH Primary Care Director to accomplish this.
- OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

#### c. FY 2010 Planned Activities

Activities that will impact this Performance Objective include:

- OHS will seek grant dollars or other funding to enhance and support sealant projects already in existence in Title V schools by current dental mobile providers.
- OHS will promote community-based dental sealant programs, among existing programs and will continue to collaborate with the IU School of Dentistry Community Dentistry's sealant placement program to develop specific pilot school programs to help increase sealant placement to third graders.
- OHS will encourage dental providers to participate in Hoosier Healthwise (Medicaid) and use sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.
- OHS will continue to consult with Office of Medicaid and Policy Planning (OMPP) and the Dental Advisory work group on oral health issues by attending quarterly meetings or as needed to accomplish the business at hand.
- OHS will promote the use of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry, and all Dental Hygiene Programs (5) and to current practitioners throughout the state.
- OHS will collaborate with partners such as the IU School of Dentistry, Indiana Dental Association, Indiana Dental Hygienists Association, Indiana Rural Health Association, Indiana Primary Health Care Association and other partners in the state to develop an Indiana Oral Health State Plan that will benefit the underserved, underinsured, working poor as well as dental professionals.
- OHS will seek out funding that can be utilized to help communities gain designation as a Dental HPSA.

- OHS will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHC).

**PERFORMANCE MEASURE # 10** The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children.

FY 2008 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease to 3 in 2008.

Status: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children were 3.2 in 2007. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- ISDH funded a part-time injury epidemiologist for the ISDH Injury Prevention Program.
- ISDH coordinated periodic meetings of the Injury Prevention Advisory Council.
- ISDH continued work on the updated version of “Injuries in Indiana” data report, which has an entire section which focuses on motor vehicle crashes and issues related to adolescent driving.
- ISDH coordinated information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the current development of an Indiana Adolescent Health Plan.
- ISDH promoted automobile safety through participation in relevant local/state programs.
- Planned activities for 2009

b. FY 2009 Current Activities

FY 2009 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease to 2.8 in 2009.

Activities to impact this Performance Objective include.

- ISDH continues to fund a part-time epidemiologist for the ISDH Injury Prevention Program through August 31, 2009.

- ISDH continues to coordinate periodic meetings of the Injury Prevention Advisory Council.
- ISDH completed the work on the updated version of “Injuries in Indiana” data report that has an entire section which focuses on motor vehicle crashes and issues related to adolescent driving.
- ISDH will coordinate information on preventing deaths and injuries from teen motor vehicle crashes as one topic area in the current development of an Indiana Adolescent Health Plan.
- ISDH is promoting automotive safety through participation in relevant local/state programs.

c. Planned Activities FY 2010

FY 2010 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease to 2.6 in 2010.

Activities that will impact this Performance Objective include.

- ISDH will continue to work with the Injury Prevention Advisory Council to ensure information is shared with internal and external partners concerning programs and activities involving injury prevention.
- ISDH will continue to coordinate information on preventing deaths and injuries from teen motor vehicle crashes as a topic area in the future update of the Indiana Adolescent Health Plan.
- ISDH will continue to promote automobile safety through participation in relevant local/state programs.

**PERFORMANCE MEASURE # 11** Percentage of mothers who breastfeed their infants at 6 months of age.

FY 2008 Performance Objective: The percentage of mothers who breastfeed their infants at 6 months of age will be 35% in FY 2007.

Status: 34.6% in 2007 (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- A new State Breastfeeding Coordinator (SBC) was hired in January 2008 to work with local coalitions around the state and facilitate communication between the Indiana Breastfeeding Alliance and the local coalitions. She began the work of supporting and helping form coalitions around the state.
- A new law was passed by the state legislature, SEA 219, which requires all state agencies and businesses with 25 or more employees to make reasonable accommodations for employees who need to pump breastmilk for their baby during the workday. The employer must provide a private spot to pump other than a bathroom stall, either a refrigerator or allowance for employee's own personal cold storage device for storage of pumped milk and ability to pump whenever employee is away from their assigned duties.
- Indiana was one of ten states chosen in January 2008 to pilot HRSA's The Business Case for Breastfeeding (BCBF), a worksite lactation program. With the passage of SEA 219, the SBC kept very busy traveling the state, meeting with businesses and local coalitions, many by request, to consult, using the HRSA materials about the importance and means of providing the accommodations required by the new law.
- The annual coalition conference was held May 2008 with representatives of sixteen coalitions from around the state attending. The graphic pieces of the Breastfeeding Media Campaign were presented, with printer-ready versions distributed to coalitions around the state via disk and internet download in time for use with World Breastfeeding Week, August 1–7. HRSA's The Business Case for Breastfeeding also was presented and materials handed out for use by the coalitions in their communities.
- The American Academy of Pediatrics Indiana Chapter Breastfeeding Coordinator was elected to the Academy of Breastfeeding Medicine Board of Directors in 2008 and has been nominated to the Executive Committee of the American Academy of Pediatrics Section on Breastfeeding. She is also an active member of the IBFA and conducted physician trainings around the state. Additionally, she has co-authored at least two breastfeeding related articles which were published in professional peer-reviewed journals in 2008, based on activities and cases within the state.
- A fourth Milk Depot was opened at a WIC site in Lafayette to collect milk donations for the Indiana Mothers Milk Bank (IMMB). The First Lady of Indiana, Cherie Daniels, was the keynote speaker at this well-publicized event.

\*\*2006 Provisional Data was used due to the CDC not yet posting 2006 final data for use in making a better projection.

## b. FY 2009 Current Activities

FY 2009 Performance Objective: The percentage of mothers who breastfeed their infants at 6 months of age will be 35% in FY 2008.

Activities to impact this Performance Objective include:

- The SBC has continued actively working with local coalitions all over the state, increasing the number of coalitions 400%, from 8 to 32, a number that is still increasing. Additionally, she conducted much training at the local level, for local coalitions wishing to utilize The Business Case for Breastfeeding and has served as the resource for all related questions and issues in the state. She has exhibited at numerous local and state conferences and meetings, including the state meetings of the Society for Human Resource Managers, and the American College of Obstetrician/Gynecologists (ACOG).
- IPN established an 800 number 'Workplace Lactation Line', for questions regarding the new workplace lactation law, some of which have come from childcare providers, as well as businesses and employee. This allowed for problem-solving issues as they arose.
- IPN held a training opportunity in November 2008, in accordance with HRSA specifications, for individuals wishing to actively assist with HRSA's Business Case for Breastfeeding program to outreach to employers and employees.
- The Indiana Perinatal Network received the 2008 STAR Community/Philanthropic Award, a leading statewide honor for associations and not-for-profits, for its Breastfeeding Promotion Initiative.
- The Indiana Breastfeeding Alliance (IBFA) formalized bylaws and elected new officers. A new action list was developed at the February 2009 meeting and steps are being taken to increase both membership and collaborative efforts at the state level with the intent of pursuing insurance coverage of lactation services and supplies, and formalizing a registry of International Board Certified Lactation Consultants (IBCLCs) in the state. The IBFA also officially recognized the International Breastfeeding Symbol and is making plans to use it on their materials and to promote its use to the public, for example, at public facilities where a designated space is available for mothers to breastfeed or pump their milk.
- IPN has updated its website, including an expanded section on breastfeeding information, links and resources. The SBC is also sending out a monthly Breastfeeding Update e-newsletter.
- The Indiana Black Breastfeeding Coalition (IBBC) continues to 'promote, empower, embrace, and encourage mothers, fathers, infants, and family members in the African American community through community outreach, education, and advocacy for

breastfeeding and the use of human milk'. Additionally, a second IBBC has been formed in northern Indiana.

- WIC is providing a five day Lactation Specialist Course, open to WIC staff and non WIC community partners. Those attending all session's and passing an exam will receive a LSC certification.
- WIC is planning six opportunities to attend 'WIC: Building Bridges/Connecting Bridges' at Indiana Hospitals in 2009, and will host an Advanced Lactation Day for Lactation Consultants interested in the newest breastfeeding research.
- The ISDH Division of Nutrition and Physical Activity received a large grant from the CDC, in which one of the six target areas is to increase breastfeeding support. Their implementation of the grant, called The Indiana Healthy Weight Initiative, has drawn broad community support. They have partnered with the IBFA and the Indiana Mothers Milk Bank to develop breastfeeding support strategies in keeping with their grant guidelines, and using the Call to Action to Promote Breastfeeding in Indiana, developed by the IBFA in 2005.

#### c. FY 2010 Planned Activities

Activities that will impact this Performance Objective include:

- The SBC will continue to build and support local coalitions around the state, serving as the liaison between the IBFA and the local coalitions. She will also continue to educate local communities about the BCBF and to advance the other objectives of the IBFA, as well as to inform the IBFA of issues in the state that require action or discussion.
- The two IBBCs will continue to strengthen their coalitions and expand their work in the African-American community to improve breastfeeding promotion and support.
- The IBFA will continue to collaborate with the IN Healthy Weight Initiative to devise strategies for improving breastfeeding support in the state.
- The SBC will continue to work collaboratively with IPN, the IBFA, and individual coalitions to implement and promote The Business Case for Breastfeeding.
- The IBFA is working this year toward getting insurance coverage of lactation consultation and supplies, and to create a registry of International Board Certified Lactation Consultants in the state.
- The IBFA will continue to seek new members and collaborative partners and will complete an update of the Call to Action to Promote Breastfeeding in Indiana.

**PERFORMANCE MEASURE # 12** Percentage of newborns who have been screened for hearing impairment before hospital discharge.

FY 2008 Performance Objective: Improve universal newborn hearing screens to 98.8% in FY 2008.

Status: The data used for this objective refers to the most recent data that the Early Hearing Detection and Intervention (EHDI) program reported on the Centers for Disease Control (CDC) Annual Survey in February 2009. For Calendar Year 2007, 98.1% of newborns were screened prior to hospital discharge. Screening rates for Calendar Year 2008 cannot be reported at this time due to a transition currently underway with our new EHDI Alert Response System (EARS) data management system.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- Trained 89 birthing hospitals on EARS, a web-based program that allows hospitals to immediately report children who have referred from Universal Newborn Hearing Screening (UNHS) to the ISDH EHDI program.
- Provided 4 trainings and scheduled an additional 6 visits to physicians and physician resident groups to provide information regarding screening and follow-up for babies.
- Provided 13 trainings to audiologists and other direct service early intervention providers, early intervention intake and service coordinators, and hospital screening personnel.
- Contacted three large birthing practices and/or facilities which serve large Amish populations to begin assisting these communities in completing UNHS screenings.
- Developed a Memorandum of Understanding (MOU) that will allow loaner hearing screening to be placed in facilities outside of ISDH.
- Posted two reminders about the IBDPR reporting requirement to in-state electronic newsletters that reach physicians (i.e. Indiana chapters of the American Academy of Pediatrics and the American Academy of Family Practitioners).
- Developed a toolkit for First Steps (Part C) Early Intervention personnel to use with parents of children undergoing the EHDI process.

b. FY 2009 Current Activities

FY 2009 Performance Objective: Improve universal newborn hearing screens to 98.4% in FY 2009.

Activities to impact this Performance Objective include:

- Continue to work with individual hospitals to encourage timely and complete reporting of their children. EHDI has nearly completed a transition to a new data management system (EARS).
- Continue to visit hospitals in their respective regions of the state to provide education and assist with issues related to screening, follow-up and reporting.
- Continue to provide educational presentations to hospitals, public health nurses (PHN), students, physicians, audiologists, early interventionists, and other interested parties regarding EHDI goals, objectives and processes.
- Continue efforts to educate physicians regarding follow-up results of referred children from UNHS.
- Continue to work with public health nurses at local health departments to promote awareness of EHDI and the importance of follow-up.
- Participate in training at least one midwife facility, which sees a large Amish population, in the next few months.
- Continue to refine MCH reporting mechanisms through EARS and the Indiana Data System (IDS). The IDS allows sharing of information from Vital Records.
- Continue partnership with Indiana Hands & Voices to provide family education and support opportunities.
- ISDH Vital Records information will be shared with EARS, thereby providing EHDI staff with information from all children born within the state including those children born at home.
- Continue to work with Level 1 centers and with centers interested in Level 1 status to maximize services for young infants and babies.

c. FY 2010 Planned Activities

FY 2010 Performance Objective: Improve universal newborn hearing screening to 98.6 % in FY 2010.

Activities that will impact this Performance Objective include:

- EHDI will lead our state's involvement in a learning collaborative through the National Institute on Child Health Care Quality (NICHQ) (funded by the Health Services and Resources Administration [HRSA]) to improve UNHS and EHDI follow-up.

- EHDI will initiate a new parent-to-parent mentor program, “Guide By Your Side,” in partnership with Indiana Hands & Voices.
- A physician’s toolkit will be completed and given to providers of children who have been identified with a hearing loss through the EHDI program.
- EHDI will continue to train hospitals on updates related to newborn hearing screening, follow-up and the EARS data management system.
- EHDI will provide comprehensive performance data to individual birthing facilities, commendations and recommendations to improve rate of screening and referrals to the medical home, early intervention, and the EHDI program.
- EHDI will train the fourteen birthing hospitals not yet trained on the EARS system.
- EHDI will assist at least two nurse/midwife facilities in obtaining screening equipment.
- EHDI will continue to target midwifery facilities for implementation of UNHS.
- EHDI will work with the Indiana University Laboratory (which receive heel stick cards for babies), to look at discrepancies between electronic reporting screening results via the heel stick card versus hospital screening program reporting in the EARS system.
- EHDI will provide two large trainings to audiologists on audiology procedures and related content areas to increase the skills, knowledge base and number of providers who serve very young babies and children.
- EHDI, in partnership with the Indiana Chapter of Hands & Voices, will update the Indiana Family Resource Guide for Families with Children with Hearing Loss, and translate the guide into Spanish.
- EHDI staff will develop a specialized Parent Toolkit for parents of children identified with unilateral or mild hearing loss.
- EHDI staff will work with the Region IV Genetics Collaborative EHDI subcommittee to complete protocols for referring children for genetic counseling and genetic workup.

**PERFORMANCE MEASURE # 13** Percent of children without health insurance.

Performance Objective: To decrease the percent of children without insurance to 8.5% in FY 2008.

Status: Met at 8.0% \*\* (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- The MCHB funded project, the Indiana Early Childhood Comprehensive System Program continued to include strategies to increase the percentage of children on child care voucher programs who have health insurance.
- The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program continued to provide service information to families via a website. The website will be expanded to include more information.
- MCSHC grantees continued to serve as enrollment sites for Hoosier Healthwise and/or referred clients to local Hoosier Healthwise enrollment sites.
- The Indiana Family Helpline continued to provide referrals and screens clients for Hoosier Healthwise eligibility.
- MCSHC continued to require all grantees providing primary care to children to be Medicaid providers.
- MCSHC Family Care Coordination grantees continued to facilitate children into Hoosier Healthwise.
- The MCSHC Director continued to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.
- MCSHC staff continued to participate in the Department of Family Resources Partnership subcommittee.

\*\* Note: Projected percentage based on Ann E. Casey “Kid’s Count” data book. Figures improved consecutive years. Projection as steady (2006 actual). Final figure will be provided when available.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: To decrease the percent of children without insurance to 8 % in FY 2009.

Activities to impact this Performance Objective include:

- The MCHB funded project, the Indiana Early Childhood Comprehensive System Program continues to include strategies to increase the percentage of children on child care voucher programs who have health insurance.

- The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program continues to provide service information to families via a website. The website will be expanded to include more information.
- MCSHC grantees continue to serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.
- The Indiana Family Helpline continues to provide referrals and screens clients for Hoosier Healthwise eligibility.
- MCSHC continues to require all grantees providing primary care to children to be Medicaid providers.
- MCSHC Family Care Coordination grantees continue to facilitate children into Hoosier Healthwise. Emphasis on doing so will be increased.
- The MCSHC Director continues to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.
- MCSHC staff continues to participate in the Department of Family Resources Partnership subcommittee.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: To decrease the percent of children without insurance to 7.5 % in FY 2010.

Activities that will impact this Performance Objective include:

- The MCHB funded project, the Indiana Early Childhood Comprehensive System Program will continue to include strategies to increase the percentage of children on child care voucher programs who have health insurance.
- The MCSHC Sunny Start - Healthy Bodies, Healthy Minds program will continue to provide service information to families via a website. The website will be expanded to include more information.
- MCSHC grantees will continue to serve as enrollment sites for Hoosier Healthwise or will refer clients to local Hoosier Healthwise enrollment sites.
- The Indiana Family Helpline will continue to provide referrals and screens clients for Hoosier Healthwise eligibility.

- MCSHC will continue to require all grantees providing primary care to children to be Medicaid providers.
- MCSHC Family Care Coordination grantees will continue to facilitate children into Hoosier Healthwise. Emphasis on doing so will be increased.
- The MCSHC Director will continue to serve on the Board of Covering Kids & Families, Advocating Health Coverage for Indiana Families and to participate on the Hospital & Health Center subcommittee.
- MCSHC staff will continue to participate in the Department of Family Resources Partnership subcommittee.

**PERFORMANCE MEASURE # 14** Percentage of children ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85<sup>th</sup> percentile

FY 2008 Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be 31%.

**Status:** The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile was 29.8% in 2007. (Based on Provisional Data)

#### a. FY 2008 Accomplishment

##### Activities that impacted this Performance Objective included:

- WIC health professionals **screened** all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals also **screened** all children for “Overweight” (BMI equal to or > 95%) and “At Risk for Overweight” (BMI 85% to < 95%) status using height for weight BMI.
- WIC health professionals **assessed** WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHCS clinics also **assessed** children’s diets for nutrition and eating habits that would impact growth patterns.
- When appropriate WIC are **provided** counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. When appropriate, MCSHCS clinics **provided** guidelines on healthy eating habits and physical activity to families and children.
- WIC **displayed** posters/bulletin boards on physical activity, nutrition and healthy eating. MCSHCS clinics **displayed** posters and **created** bulletin boards communicating information on physical activity, nutrition and healthy eating habits.

- WIC provided educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics provided educational information (handouts/fliers) on healthy eating and physical activity.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be < 31%.

Activities to impact this Performance Objective include:

- WIC health professionals are screening all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for Overweight/BMI 85% to < 95%). MCSHS health care professionals are also screening all participants for “Overweight” (BMI equal to or > 95%) and “At Risk for Overweight” (BMI 85% to < 95%) status using height for weight BMI.
- WIC health professionals are assessing WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHCS clinics are assessing children’s diets for nutrition and eating habits that would impact growth patterns.
- When appropriate WIC are providing counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCSHCS clinics are providing guidelines on healthy eating habits and physical activity to families and children.
- WIC is displaying posters/bulletin boards on physical activity, nutrition and healthy eating. MCSHCS clinics is displaying posters and creating bulletin boards communicating information on physical activity, nutrition and healthy eating habits.
- WIC are providing educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics are providing educational information (handouts/fliers) on healthy eating and physical activity.

#### c. FY 2010 Planned Activities

FY 2009 Performance Objective: The percentage of children, age 2 to 5 years, receiving WIC services with a Body Mass Index at or above the 85th percentile will be < 31%.

Activities that will impact this Performance Objective include:

- WIC health professionals will screen all applicants for Risk Factor 113 (Overweight/BMI equal or > 95%) and Risk Factor 114 (At Risk for

Overweight/BMI 85% to < 95%). MCSHS health care professionals will also screen all participants for “Overweight” (BMI equal to or > 95%) and “At Risk for Overweight” (BMI 85% to < 95%) status using height for weight BMI.

- WIC health professionals will assess WIC eligible children's' diets for nutrition and feeding practices that would affect growth patterns. MCSHCS clinics will assess children’s diets for nutrition and eating habits that would impact growth patterns.
- When appropriate WIC will provide counseling to families of WIC eligible children that will include physical activity ideas and healthy eating information. Where appropriate, MCSHCS clinics will provide guidelines on healthy eating habits and physical activity to families and children.
- WIC will provide educational materials (books, handouts, videos) on healthy eating and physical activity. MCSHCS clinics will provide educational information (handouts/fliers) on healthy eating and physical activity.

**PERFORMANCE MEASURE # 15** Percentage of women who smoke in the last three months of pregnancy.

FY 2008 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be **15.3%** in FY 2008.

Status: Provisional data from the 2007 Electronic Birth Certificate shows 15.7% of pregnant women were smoking in third trimester.\*\*

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective include:

- ISDH continued to facilitate a legislative commission on prenatal smoking, alcohol, and drug use to develop a strategic plan. Meetings were held bi-monthly. An interim report was submitted to the legislature mid-year. Efforts are ongoing to pursue funding and implementation of the recommendations.
- The ISDH Prenatal Substance Use Prevention Program (PSUPP) identified 4,850 high risk, chemically dependent pregnant women and provided counseling and intervention. They also began collaborating with Indiana Access to Recovery, a program to assist substance users in getting the professional help they need to quit. This program includes pregnant women as one of their target groups.
- PSUPP/MCSHC continued their collaboration with ITPC to have greater impact on smoking cessation with pregnant women. The Indiana Tobacco Quit Line expanded its follow-up to pregnant women who now receive 10 calls instead of five calls.

- PSUPP and all MCSHCS-funded prenatal clinics incorporate education of women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.
- A training of physician representatives of all 3 MCO's on smoking cessation, evidence based assessment tools, the 5A's, 5R's and the Indiana Tobacco Quitline was completed in the Spring by Clarian Tobacco Control Center, a member of the Indiana Coalition to Prevent Smoking in Pregnancy (CPSP).
- All ITPC County Coalitions have been trained in the ACOG prenatal provider office training model and are replicating the in-office training in 80 counties. These community-based networks are also implementing strategies based on the Clinical Practice Guideline for Treating Tobacco Use and Dependence, such as establishing cessation networks and changing policies throughout the community.
- MCSHC worked with Indiana Perinatal Network (IPN) and IN ACOG to disseminate information on prenatal smoking cessation. On 3/20/2008 a Smoking Cessation Panel Discussion was conducted at the IPN State Forum: Controversies and Innovations in Perinatal Health. 120 persons attended the Forum.
- MCSHC informed all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW and Quitline materials promoting the Quit Line were made available to all funded prenatal projects
- MCSHC continued to participate on the OMPP Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients to decrease NICU admissions due to complications from prenatal smoking. Each MCO was expected to refer pregnant women to the Indiana tobacco Quitline and each MCO developed a smoking cessation program.
- MCSHC continued as a partner in the Coalition to Promote Smokefree Pregnancies with ITPC, Clarian, American Lung Association, and other agency members. The coalition collaborated to write a grant to ITPC to provide media campaigns targeted to women of child bearing age in all counties with a prenatal smoking rate of  $\geq 29$ . The grant was awarded July 1, 2008. Clarian Tobacco Control Center is serving as the fiscal agent for the grant.

\*\*The Indiana birth certificate was changed in 2007 to conform to new national standards in the US Birth Certificate set in 2003. This affected many variables, including maternal smoking. The data, therefore, may not be strictly comparable to data of prior years.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.5% in FY 2009

Activities to impact this Performance Objective include:

- ISDH continues to facilitate the legislative PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan. Dr. Nocon, the Commission Chair, presented information on assessment of, and brief intervention for, pregnant women at the Indiana ACOG conference 3/09.
- All MCSHC Title V-funded prenatal services are mandated to address Federal Performance Measure 8. Mandated activities include: 1) 100% of clients will be asked if they smoke or are exposed to second hand smoke at time of enrollment and smoking status documented in chart, 2) All clients who state they are smoking at time of enrollment will be assessed using the stages of change model\* and documented in chart, 3) All clients who state they are smoking at time of enrollment will be monitored at each visit for smoking status, 4) 100% of pregnant women will receive information on the hazards of smoking during pregnancy, 5) All patients smoking at time of enrollment will be enrolled in a cessation/treatment program or referred to a program if not available on site.
- A prenatal smoking cessation training webinar on assessment and brief intervention has been completed (April, 09) and placed on the MCH website. All funded prenatal projects must access the webinar and complete the pre/post test by August 31, 2009.
- MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine further training needs.
- The ISDH Prenatal Substance Use Prevention Program (PSUPP) continues to; 1) identify high risk, chemically dependent pregnant women and provide counseling and intervention, 2) distribute informational items about the impact of substance use among pregnant women to the public, 3) provide support groups for women in substance use cessation in 3 clinics, 4) educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy, 5) expand reach where and when possible, 6) collaborate with ATR.
- MCSHC continues as a partner in the Coalition to Promote Smoke free Pregnancies. The coalition has worked together to develop media messages. The Medicaid Managed Care Organizations (MCO's) were invited to participate and they identified counties they wanted media messages to be released in based on their numbers of pregnant women enrolled. Each of the MCO's was asked for \$1,500 to implement the media messages in their counties but they have refused to date. The Coalitions reapplied and have been granted a second year of the grant to provide media messages to women in counties with high smoking rates.
- MCH continues to participate on the Office of Medicaid Policy and Planning Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients. To date the three Medicaid Managed Care Organizations have not

successfully increased referrals to the Indiana Tobacco Quitline. They were informed they needed to send out a bulletin to their providers encouraging them to use the Quitline. The Neonatal Outcomes committee completed a Notification of Pregnancy (NOP) assessment form that will be completed by all prenatal care Medicaid providers at the first prenatal care visit. Included on the form is an assessment of smoking status, readiness to quit and reminder of referral to the Quitline. The NOP will go into effect July 1, 2009.

- MCH has worked closely with OMPP to share prenatal outcomes data. In March, 2009, linked Medicaid/vital records revealed that smoking among Medicaid pregnant women was significantly higher than for the state. Results show that 78 of 92 counties had a smoking rate of 30-49% among pregnant women on Medicaid. MCH will look at ways to impact smoking among the Medicaid population. The state Prenatal Care Coordination program is being restructured to include smoking cessation as a service.
- MCSHC is working with Indiana Perinatal Network to dedicate the May 2009 issue of the Perinatal Perspectives IPN Newsletter to prenatal smoking.
- Baby First Packets continue to be sent to Prenatal IFHL callers, which includes information on smoking cessation.

#### c. FY 2010 Planned Activities

**FY 2010 Performance Objective: The percentage of women who smoke in the last three months of pregnancy will be 15.3% in FY 2010**

#### **Activities that will impact this Performance Objective include:**

- Baby First Packets will be sent to Prenatal IFHL callers that includes information on smoking cessation
- MCH will continue to participate in the Coalition to Prevent Smoking in Pregnancy to reach out to health care providers and women of childbearing age in counties with high smoking rates to decrease prematurity, low birthweight, and exposure to second smoke among infants and children.
- MCH will analyze prenatal smoking data through monthly data from the Notification of Pregnancy form and cessation outcomes of the new Prenatal Care Coordination program, Indiana Healthy Beginnings for success and training needs.
- MCH will continue to work with the Office of Medicaid Policy and Planning and the Medicaid Managed Care Organizations to decrease smoking among pregnant women on Medicaid.

- MCH will continue to work with the Indiana Perinatal Network to provide prenatal smoking education to prenatal health care providers through forums and newsletters.
- The PSUPP program will continue to collaborate with ATR to refer pregnant substance-using women to providers for needed services.
- The Provider Resource List will be maintained and updated for public use.

**PERFORMANCE MEASURE # 16** The rate per 100,000 of suicide deaths among youths aged 15-19.

FY 2008 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.7 in FY 2008.

Negotiated Performance Measure for Indiana Suicide Prevention Coalition ISPC: 50% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

Status: 7.2% in 2007 (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- The Office of Primary Care has funded a full time Administrative Coordinator for the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional Coalitions.
- ISDH completed an updated data report on Suicide in Indiana, to be published electronically through the ISDH Program website.
- ISDH continued its collaboration with the Indiana Suicide Prevention Coalition (ISPC) to implement the State Suicide Prevention Plan. Planned Coalition activities supporting goals in the Plan include **Promoting importance of suicide prevention to interested organizations:** Providing PowerPoint presentations on suicide prevention at conferences and meetings; target audiences include: DOC, Juvenile Justice, physicians, social services, employers, schools, colleges and universities, mental health/social workers, senior community providers.

b. FY 2009 Current Activities

FY 2009 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.6 in FY 2009.

Negotiated Performance Measure for ISPC: 60% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

Activities to impact this Performance Objective include:

- Disseminating suicide prevention materials to a variety of audiences by mail and at events
- Organize members and local suicide prevention councils/coalitions to implement statewide awareness activities for National Suicide Prevention Week
- Write editorial and organize press release for National Suicide Prevention Week
- Respond to media requests for interviews concerning suicide prevention.
- Provide technical assistance to individuals and organizations regarding suicide prevention, intervention and postvention.
- Provide technical assistance to existing Indiana suicide prevention councils/coalitions.
- Encourage the development of new regional/local suicide prevention councils.
- Send information on evidence-based suicide prevention/intervention training and programs to:
  1. Community health centers
  2. Schools and colleges
  3. Employers
  4. Correctional facilities
  5. Senior community providers
  6. Health care providers
  7. Clergy
- Provide suicide prevention training (QPR, safeTALK) to interested organizations and groups.
- Provide suicide intervention training (ASIST) to interested organizations and groups.
- Manage the Indiana Suicide Prevention Coalition.
  1. Continue to diversify Coalition membership
  2. Orient new members to Coalition
  3. Maintain website
  4. Maintain Coalition directory
  5. Maintain repository of suicide prevention resources

6. Plan and implement bimonthly Coalition meetings
  7. Keep Coalition members up-to-date regarding the latest news and resources in suicide prevention, intervention, and postvention
  8. Represent suicide prevention at meetings, work groups, coalitions, and press conferences
  9. Manage and grow the statewide Suicide Prevention Email List
  10. Build speakers bureau
  11. Maintain database on Coalition member's knowledge and expertise
  12. Facilitate communication with regional councils and between members
  13. Provide technical assistance upon request
- Identify the cost and availability of billboard advertisements, including appropriate messaging, for reducing stigma surrounding suicide for use by regional councils.
  - Finalize the updated Indiana Department of Education "Student Suicide" Manual.
  - Collaborate with the Indiana Department of Education to design and pilot workshop to disseminate the new "Student Suicide" Manual.
  - Partner with Indiana Partnership to Prevent Violent Injury and Death to:
    1. Distribute Harvard University's "Means Matter" Report to targeted audiences.
    2. Distribute information on "Counseling on Access to Lethal Means" (CALM) training to targeted audiences.
  - Summarize and present lessons learned from 2007 telephone survey to the four regions in Indiana where it was conducted

**c. FY 2010 Planned Activities**

FY 2010 Performance Objective: The rate of suicide deaths among youths aged 15-19 will decrease to 7.6 in FY 2009.

Activities that will impact this Performance Objective include:

Negotiated Performance Measure for ISPC: 70% of Indiana counties with K-12 students will be involved in awareness and prevention education and/or activities.

- If funds allow, ISDH may continue to fund the Indiana Suicide Prevention Coalition. The Coalition functions as an "umbrella" organization for 12 regional Coalitions.
- ISDH may continue to collaborate with the Indiana Suicide Prevention Coalition to implement the State Suicide Prevention Plan. Planned Coalition activities supporting goals in the Plan include:

- Partner with NAMI to design and or implement an anti-stigma campaign in two cities (CC)
- Distribute SPRC/SPAN Emergency Department brochures to ERs around the state
- Create an e-network of survivor support group providers in Indiana
- Create information packet of survivor resources for survivor support groups based on needs identified in DMHA funded Survivor Survey conducted in 2007
- Promote QPR-T and/or American Association of Suicidology (AAS) & Suicide Prevention Resource Center's (SPRC) Assessing and Managing Suicide Risk clinician training to:
  1. Mental health clinicians
  2. Physicians
  3. Social workers (in social services, correctional facilities, foster care systems, etc)
- Distribute responsible reporting guidelines to media
- Encourage the inclusion of suicide risk assessment into pre-service training of the following providers:
  1. Mental health workers
  2. Health care providers
  3. Clergy
  4. Education professionals
  5. Correctional personnel
- Create and distribute list of media outlets for press releases and public service announcements to regional/county level suicide prevention councils/coalitions.

**PERFORMANCE MEASURE # 17** Percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates.

FY 2008 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 82% in CY 2008.

Status: 77.4% in 2007 (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this performance objective included:

- MCSHC, in collaboration with Indiana Perinatal Network (IPN) completed the update of the Hospital Levels of Care 9/30/08. The document was published and disseminated to providers and is placed on the IPN website. A state map shows the location of the 2 IIIC NICUS, 17 IIIB NICUS, and 2 level 111A NICUS. Most of the Level III NICUs are concentrated within 4 counties.
- The Indiana Prenatal Care Guidelines update was completed September 30, 2008 and includes when to transport mothers and infants. They can be found on the IPN website.
- An in depth analysis of birth data by hospitals lead to the report Hospital Level and Delivery Volume and Neonatal Mortality among Very Low Birth Weight Infants which was completed by MCH and published on the MCH website October, 2008.
- MCSHC continued to attend monthly meetings of the Office of Medicaid Policy and Planning Quality Strategy Prenatal Workgroup. The group continues to address prenatal smoking and access to care.
- A PCEP (Prenatal Continuing Education Program) training was hosted by St. Vincent hospital in Marion County, and included Vigo County and Franklin County hospitals. The training was completed June, 08.

b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 83% in CY 2009.

Activities to impact this performance objective include:

- Further assessment of the Hospital Level and Delivery Volume and Neonatal Mortality among Very Low Birth Weight Infants report shows that VLBW infants born at level I hospitals were more likely to be less than 500 grams and less than 24 weeks of gestation and were less likely to be a multiple birth or cesarean delivery than those born at level III hospitals. The strongest predictor of delivery outside level III hospitals was the mother's county of residency, usually rural and not in close proximity to a Level III hospital and resulted in the highest neonatal mortality rate. Results of this study suggest that increased use of hospitals with level III neonatal care might reduce neonatal mortality among VLBW infants. Indiana needs to boost its efforts in increasing the delivery of VLBW infants in subspecialty hospitals. These results will be used in setting up the PCEP Train-The-Trainer initiative.
- An MOU with a sub-specialty hospital will be obtained to provide a PCEP train-the trainer program with the sub-specialty hospital being trained to train feeder hospitals on appropriate

assessment, care and transport. This will serve as a pilot to implementing this program statewide in 2010. The IPN PCEP coordinator working on an MOU with one Level III hospital in the third quarter to develop an updated training curriculum using PCEP and new educational tools and curriculum, and host coordinator workshops with staff from two Level II or I hospitals. This process will be replicated in 2010 until all hospitals have been included

- MCSHC will work with Lake County hospitals to assess competency levels, how to do an equipment inventory, how to build a perinatal network. This was sidelined due to loss of the Lake County perinatal manager that was spearheading this and a decrease in funding to the IPN PCEP coordinator.
- Due to unusually high black infant mortality rates in St. Joseph (30.1) and Allen (31.1), a PPOR analysis will be conducted to identify areas of excess deaths to guide future activities and resources.
- MCH worked closely with the Office of Medicaid Policy and Planning to share birth data by race and county. The finalized 2007 linked Medicaid singleton birth data was released March, 09 and shared with MCOs, and IPN and March of Dimes.
- An in depth analysis of prematurity and low birthweight is being done by MCH looking at all maternal factors, incidence of inductions and cesareans by hospital, county, day and time. This data along with the 2007 Medicaid data will become the basis of the state Perinatal Initiative to reduce prematurity, low birthweight and neonatal deaths. MCH is partnering with Indiana March of Dimes, Indiana Perinatal Network, Anthem Healthcare, the Women's Center of Excellence, Purdue University/ISDH Multi-State Learning Collaborative and others to prepare for a Perinatal Initiative summit, in the fourth quarter, to bring state and local stakeholders together to develop a state plan to address low birthweight and prematurity using a multi-prong approach that will include preconception and interconception care, access to and quality prenatal care, smoking cessation, decreased scheduled inductions and cesareans, social determinants that impact perinatal health.
- An updated assessment of the state's perinatal system and status will be completed with assistance from IPN, regional perinatal networks, and others.
- Efforts are underway to expand the state perinatal network membership and reach out to regions of the state to share educational and allow for greater participation in quarterly State Perinatal Advisory board meetings.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: The percent of very low birthweight infant delivered at facilities for high-risk deliveries and neonates will be increased to 88% in CY 2010.

Activities that will impact this Performance Objective include:

- An MOU with another sub-specialty hospital will be completed to provide a PCEP train-the-trainer program with the sub-specialty hospital being trained to train feeder hospitals on appropriate assessment, care and transport.
- The Perinatal Initiative will have a state plan and a report will be completed.
- Training of prenatal care providers on universal screening for alcohol, tobacco and other drugs and brief interventions will be completed by the fourth quarter.
- MCH will continue to work closely with the Office of Medicaid Policy and Planning to share data and implement initiative to decrease neonatal mortality.

**PERFORMANCE MEASURE # 18** Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

FY 2008 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.3%.

Status: 76.5 % in 2007 (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- MCSHC in collaboration with the Indiana Perinatal Network (IPN) and Indiana ACOG completed and published the IPN Prenatal Care Guide (standards) to include preconception/interconception care on the IPN website September 30, 2008.
- MCSHC continued to disseminate the Baby First educational materials statewide through the Indiana Family Helpline. 15 Baby First educational packets at a time were distributed prenatal care providers, agencies and one packet was sent to each individual that requested one of packets from the Indiana Family Helpline.
- MCSHC will continue dissemination of the Baby First educational materials statewide through the Indiana Family Helpline. 15 Baby First educational packets were initially sent to each prenatal care coordinator in the state, agencies and individuals have requested the packets from the Indiana Family Helpline and IPN.
- Funding of prenatal care coordination projects throughout the state will continue to provide outreach, case finding, referral, advocacy, and education of at risk pregnant women. MCSHC funded 22 PNCC projects in 2008.
- County data books, including entrance into prenatal care have been published on the ISDH website and shared with local communities in counties with significant access problems.

- Vital Records data on time of entrance into prenatal care was shared with the State Perinatal Advisory Board, was published in a Perinatal Perspectives Newsletter and was shared with counties with access to care problems will receive technical assistance from MCSHC to identify barriers and plans to improve access.

b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.5%.

Activities to impact this Performance Objective include:

- Funding of prenatal care coordination projects throughout the state will continue to provide outreach, case finding, referral, advocacy, and education of at risk pregnant women. MCH has restructured the prenatal care coordination (PNCC) program to update standards and redefine services offered. The new program is now called Indiana Healthy Beginnings. Operational guidelines for working with Medicaid and the managed care organizations (MCOs) have been developed, as well as, standards, forms, and training. The changes will be finalized and published on the Indiana Medicaid website in July, 08, [indianamedicaid.com](http://indianamedicaid.com). Regional trainings of providers will begin in the 4<sup>th</sup> quarter. The Office of Medicaid Policy and Planning has been very cooperative and supportive and our PNCC program and is holding the MCOs accountable for collaborating with PNCCs around the state.
- County data books, including entrance into prenatal care continues to be updated as new data is available on the ISDH website and shared with local communities in counties with significant access problems. 2006 data is all that is available. The website will be updated with 2007 data when it becomes available.
- Title V funded prenatal and PNCC projects are mandated in 2009 and 2010 to provide neighborhood outreach through the MCH free pregnancy program, enroll women with positive pregnancy tests, identify another project specific outreach activity, and identify another project activity to increase enrollment in the first trimester. Projects will report results quarterly.
- Vital Records data on time of entrance into prenatal care was shared with the State Perinatal Advisory Board, was published in a Perinatal Perspectives Newsletter and was shared with counties with access to care problems will receive technical assistance from MCSHC to identify barriers and plans to improve access. Data shows that entrance into prenatal care is decreasing across the state and for all races. The Perinatal Advisory Board will begin to look at assessment of decreasing available OB providers and hospital closings.

- IPN hosted a second “Controversies and Innovations in Perinatal Health”, State Perinatal Forum March 25-26, 2009 with a focus on access to care. A panel of physicians and hospital administrators looked at the accessibility of prenatal care in rural and non urban counties. Model programs were presented in break out sessions.
- Implement the Early Start program in at least one of the counties with poor access to prenatal care due to systems barriers. This was not done due to lack of Title V funding.
- After collaboration of ISDH, IPN, Title X and the Office of Medicaid Policy & Planning (OMPP) decided to reinstate the plan for presumptive eligibility. MCH has been working closely with OMPP on this and PE will go into effect statewide July 1, 2009. In addition MCH has worked with OMPP and MCOs to develop a Notification of Pregnancy (NOP) form. Data to be collected includes history, current pregnancy, health risks, BMI, substance use, psychosocial status indicators, and more. The NOP will be completed by the physician on all Medicaid eligible women at the time of the first prenatal visit. Data from this web based form will be sent to EDS within three business days of prenatal care visit. OMPP will provide ISDH monthly NOP data on all forms completed.
- Target 1 emergency department in 1 Priority County to implement the ER protocol to refer all pregnant women in the ER to PNCC and a MCH funded prenatal clinic or CHC. Lake County MCH Network in collaboration with Methodist Hospital, Gary has developed a referral form, protocol and resource guide for ER staff seeing pregnant women.
- MCH is partnering with Indiana March of Dimes, Indiana Perinatal Network, Anthem Healthcare, the Women’s Center of Excellence, Purdue University/ISDH Multi-state Learning Collaborative and others to prepare for a Perinatal Initiative summit to bring state and local stakeholders together to develop a state plan to address low birthweight and prematurity using a multi-prong approach that will include preconception and interconception care, access to and quality prenatal care, smoking cessation, decreased scheduled inductions and cesareans, social determinants that impact perinatal health. The summit will occur in the fourth quarter.

#### c. FY 2010 Planned Activities

FY 2009 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 81.5% in 2009.

Activities that will impact this Performance Objective include:

- Title V funded prenatal and PNCC projects are mandated in 2009 and 2010 to provide neighborhood outreach through the MCH free pregnancy program, enroll women with positive pregnancy tests, identify another project specific outreach activity, and

identify another project activity to increase enrollment in the first trimester. Projects will report results quarterly.

- Explore incorporating community based doulas into Healthy Families Indiana to facilitate early identification of repeat pregnancies and assistance and follow-up of mothers through the pregnancy.
- Continue work with stakeholders on the MCH Perinatal Initiative.
- Work with Purdue to assess PPOR in 5 counties and present results during county meetings.

**State Performance Measure # 1** The number of data sets, including the NBS, UNHS, Lead, IBDPR, Immunizations, CSHCS, and First Steps Data, that are completely integrated into the Indiana Child Health Data Set.

FY 2008 Performance Objective: At least one additional data set will be integrated into the Indiana Child Health Data Set. This was the objective under the old definition. Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data measures will be completely integrated/linked into the Indiana Child Health Data Set, with at least two additional data measures under way in final development and testing.

Status: Met Performance Objective – integrated one additional data set into the Indiana Child Health Data Set.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- The Indiana Child Health Data Set (ICDS), formerly known as the Operations Data Store (ODS) development team, coordinated by the Data Integration Steering Committee (DISC), continued to develop and test input and output from various sources, most importantly the Vital Records Electronic Birth Certificate (EBC), and Electronic Death Certificate (EDC). Implementation is being staged. The significant change in the data fields on the birth certificate enabled us to obtain verified data rather than estimates for the Health Status Indicator related to Medicaid versus non-Medicaid population.
- Universal Newborn Hearing Screening, Lead, Indiana Birth Defects and Problems Registry, Immunizations, Children’s Special Health Care Services, and First Steps Data continued to be developed for integration into the ICDS when completed.
- The integration of the EHDI portion of Newborn Screening, and the Indiana Birth Defects and Problems Registry into the Indiana Child Health Data Set for initial use was completed.

- The integration work and testing of First Steps data continued.
- The use of verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations continued.

b. FY 2009 Current Activities

FY 2009 Performance Objective: At least one additional data set will be integrated into the Indiana Child Health Data Set. This was the objective under the old definition. Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data measures will be completely integrated/linked into the Indiana Child Health Data Set, with at least two additional data measures under way in final development and testing.

Activities to impact this Performance Objective include:

- The integration of the EHDI portion of Newborn Screening, and the Indiana Birth Defects and Problems Registry into the Indiana Child Health Data Set for initial use was completed.
- The integration work and testing of First Steps data began.
- The use of verified data from the new Electronic Birth Certificate (EBC) for Health Status Capacity Indicators (HSCIs) related to Medicaid versus non-Medicaid populations began.

c. FY 2010 Planned Activities

FY 2010 Performance Objective: At least one additional data set will be integrated into the Indiana Child Health Data Set. This was the objective under the old definition. Using the revised data access measures as a guide to be consistent with National performance measures, at least two new data measures will be completely integrated/linked into the Indiana Child Health Data Set, with at least two additional data measures under way in final development and testing.

Activities that will impact this Performance Objective include:

- The Newborn Heel Stick Screening data mart development and implementation will continue.
- The Lead program integration/linkage evaluation along with the CHIRP data evaluation for integration/linkage will continue.

- The Children’s Special Health Care Services and The First Steps Data will continue the process of integration into the Indiana Child Health Data Set.

**State Performance Measure # 2** The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old.

FY 2008 Performance Objective: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will drop to 27.0.

Status: The rate per 10,000 for diagnosed asthma hospitalizations among children less than five years old was 22.9 in 2007. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- The Asthma Program worked with the Ad Council and the Indiana State Department of Health’s Office of Public Affairs to encourage all radio and TV stations throughout Indiana to play localized National Asthma Campaign PSA’s during Asthma Awareness Month (May). The Asthma Program and Indiana Joint Asthma Coalition [InJAC] have also printed educational materials and delivered to libraries, community health centers, Medicaid providers, Head Start programs and rural health clinics in at least 15% of the state’s counties. An email was sent in March to school administrators and other school personnel (statewide) to consider planning an activity for Asthma Awareness Month.
- In May 2008, the Asthma Program held a statewide contest to further raise awareness of asthma for Asthma Awareness Month. The contest had an Indianapolis 500 theme and encouraged children to complete activities (coloring, word search, and word scramble based on age) to identify common asthma triggers. Approximately 300 contest entries were received. Contest winners received autographed merchandise from Indy 500 drivers, tickets to the Indy 500 qualifying days, Wal-Mart gift cards, Indianapolis Indians tickets, Children’s Museum tickets, and more. The Program also participated in the 500 Festival Kid’s Day to reach families during Asthma Awareness Month.
- The Asthma Program highlighted the 5-Star Recognition Program for child care settings and data on asthma among children in the *Breathe In, Breathe Out* newsletter. The 5-Star program helps regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma. The newsletter is available online at <http://www.in.gov/isdh/17279.htm>.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective 1: The rate per 10,000 of hospitalizations due to asthma among children less than five years old will drop to 23.0.

Activities to impact this Performance Objective include:

- In April 2009, the Asthma Program (along with the Indiana Joint Asthma Coalition) launched statewide asthma training for child care providers. Asthma training is being provided free of charge to any child care provider in the state requesting the training. Training is delivered by the Child Care Health Consultants within the Bureau of Child Care, Family and Social Services Administration. Participants receive a folder of materials to reinforce training messages, a poster with steps to take during an asthma emergency, and cleaning spray bottle with messages on how cleaning can remove asthma triggers.
- The Asthma Program and InJAC are working with the Indiana State Department of Health Maternal and Child Health Services Program to review the medical guidelines for asthma for the Children's Special Health Care Services (CSHCS).
- The Asthma Program is working with the Indiana Tobacco and Prevention and Cessation Head Start Advisory Group on a toolkit to help Head Start centers address children's exposure to environmental tobacco smoke (ETS) and reduce smoking among staff and parents.
- The Asthma Program received an award from the American Academy of Pediatrics, Richmond Center of Excellence to support a visiting lecturer for two days to address secondhand smoke and children's health. On May 20<sup>th</sup> and 21<sup>st</sup>, Dr. Jonathan P. Winickoff will present to pediatricians, health leaders and local tobacco coalitions to share methods for reducing children's exposure to secondhand smoke.
- The Asthma Program is promoting the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma. The State Asthma Program continues to dedicate one staff to participate on the review committee for the 5-Star Recognition Program.

#### c. FY 2010 Planned Activities

Activities that will impact this Performance Objective include:

- The Asthma Program will continue to promote the asthma training for child care providers developed by the program and InJAC. The Asthma Program will also be responsible for distributing follow-up materials to participants.

- The Asthma Program and InJAC will develop online asthma training for child care providers to compliment existing in-person trainings. Upon completion of the online training, participants will receive a folder of materials to reinforce training messages, a poster with steps to take during an asthma emergency, and cleaning spray bottle with messages on how cleaning can remove asthma triggers.
- Data from the Children’s Call-Back Survey of the Behavioral Risk Factor Surveillance System will be reported. This will be the first time Indiana is able to provide detailed information on asthma among children, such as medication use, environmental exposures, and asthma-related absenteeism.
- In August 2009, the Asthma Program and InJAC will launch a continuing medical education (CME) online training for health care providers. The training is specific to understanding the key points and key differences of the updated Expert Panel Report: 3 (EPR: 3) Guidelines for the Diagnosis and Management of Asthma.
- The Asthma Program and InJAC will provide information to participating providers in the CSHCS program to ensure their awareness of the key points and key differences in Expert Panel Report:3 (EPR:3) Guidelines for the Diagnosis and Management of Asthma.
- The Asthma Program will promote the 5-Star Recognition Program to help regulated early care settings identify and reduce exposure to environmental hazards that affect health, including asthma. The State Asthma Program will also dedicate one staff to participate on the review committee for the 5-Star Recognition Program.

**State Performance Measure # 3** The percent of live births to mothers who smoke.

FY 2008 Performance Objective: The percent of live births to mothers who smoke will decrease to 16.0% in CY 2008.

Status: 18.7% in 2007 (Based on Provisional Data) \*\*

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- ISDH continued to facilitate a legislative commission on prenatal smoking, alcohol, and drug use to develop a strategic plan. Meetings were held bi-monthly. An interim report was submitted to the legislature mid-year. Efforts are ongoing to pursue funding and implementation of the recommendations.
- The ISDH Prenatal Substance Use Prevention Program (PSUPP) screened 4,850 pregnant women, identifying the high risk, chemically dependent, and providing counseling and intervention/referral. They also began collaborating with Indiana

Access to Recovery (ATR), a program that assists substance users in getting the professional help needed to quit. Pregnant women are one of their target groups.

- PSUPP/MCSHC continued their collaboration with ITPC to have greater impact on smoking cessation with pregnant women. The Indiana Tobacco Quit Line expanded its follow-up program for pregnant women who now receive ten calls instead of five.
- PSUPP, and all MCSHCS-funded prenatal clinics, incorporate education of women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy. PSUPP gave 574 educational talks for providers and the public and participated in 134 community/health fairs and conferences in their communities.
- A training of physician representatives of all 3 MCO's on smoking cessation, evidence based assessment tools, the 5A's, 5R's and the Indiana Tobacco Quitline was completed in the Spring by Clarian Tobacco Control Center, a member of the Indiana Coalition to Prevent Smoking in Pregnancy (CPSP).
- All ITPC County Coalitions have been trained in the ACOG prenatal provider office training model and are replicating the in-office training in 80 counties. These community-based networks are also implementing strategies based on the Clinical Practice Guideline for Treating Tobacco Use and Dependence, such as establishing cessation networks and changing policies throughout the community.
- MCSHC worked with Indiana Perinatal Network (IPN) and IN ACOG to disseminate information on prenatal smoking cessation. On 3/20/2008 a Smoking Cessation Panel Discussion was conducted at the IPN State Forum: Controversies and Innovations in Perinatal Health. 120 persons attended the Forum.
- MCSHC informed all funded projects to refer pregnant women to the Quit Now program at 1-800-QUIT-NOW, and Quitline materials promoting the Quit Line were made available to all funded prenatal projects
- MCSHC continued to participate on the OMPP Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients to decrease NICU admissions due to complications from prenatal smoking. Each MCO was expected to refer pregnant women to the Indiana tobacco Quitline and each MCO developed a smoking cessation program.
- MCSHC continued as a partner in the Coalition to Promote Smokefree Pregnancies with ITPC, Clarian, American Lung Association, and other agency members. The coalition collaborated to write a grant to ITPC to provide media campaigns targeted to women of child bearing age in all counties with a prenatal smoking rate of  $\geq 29$ . The grant was awarded July 1, 2008. Clarian Tobacco Control Center is serving as the fiscal agent for the grant.

\*\* The Indiana birth certificate was changed in 2007 to conform to new national standards in the US Birth Certificate set in 2003. This affected many variables, including maternal smoking. The data, therefore, may not be strictly comparable to data of prior years.

b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of live births to mothers who smoke will decrease to 18.5% in FY 2009.

Activities to impact this Performance Objective include:

- ISDH continues to facilitate the legislative PSAC commission on prenatal smoking, alcohol, and drug use to develop an implementation plan. Dr. Nocon the Commission Chair presented information on assessment and brief intervention in pregnant women at the Indiana ACOG conference 3/09.
- All MCSHC Title V funded prenatal services are mandated to address Federal Performance Measure 8. mandated activities include: 1) 100% of clients will be asked if they smoke or are exposed to second hand smoke at time of enrollment and smoking status documented in chart, 2) All clients who state they are smoking at time of enrollment will be assessed using the stages of change model\* and documented in chart, 3) All clients who state they are smoking at time of enrollment will be monitored at each visit for smoking status, 4) 100% of pregnant women will receive information on the hazards of smoking during pregnancy, 5) All patients smoking at time of enrollment will be enrolled in a cessation/treatment program or referred to a program if not available on site.
- A prenatal smoking cessation training webinar on assessment and brief intervention has been completed (April, 2009) and placed on the MCH website. All funded prenatal projects must access the webinar and complete the pre-post test by August 31, 2009.
- MCSHC will analyze the rate of smoking in the third trimester on a quarterly basis to determine further training needs.
- The ISDH Prenatal Substance Use Prevention Program (PSUPP) continues to ; 1) identify high risk, chemically dependent pregnant women and provide counseling and intervention, 2) distribute informational items about the impact of substance use among pregnant women to the public, 3) provide support groups for women in substance use cessation in 3 clinics, 4) educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy, 5) expand reach where and when possible, 6) collaborate with ATR.

- PSUPP continues to participate in (134) community events, health fairs, conferences, and other public forums.
- PSUPP continues to distribute 28,000 informational items about the impact of substance use on pregnant women to the public.
- PSUPP continues to distribute 6,500 educational items to providers, including physician's offices, indicating the importance of identifying at-risk clients.
- PSUPP clinics (3) in Terre Haute, Evanville and Jeffersonville continue to provide support groups for women in substance use cessation.
- MCSHC continues as a partner in the Coalition to Promote Smokefree Pregnancies. The coalition has worked together to develop media messages. The Medicaid Managed Care Organizations (MCOs) were invited to participate and they identified counties they wanted media messages to be released in based on their numbers of pregnant women enrolled. Each of the MCOs was asked for \$1,500 to implement the media messages in their counties but they have refused to date. The Coalitions reapplied and have been granted a second year of the grant to provide media messages to women in counties with high smoking rates.
- MCH continues to participate on the Office of Medicaid Policy and Planning (OMPP) Neonatal Quality Outcomes committee to promote prenatal smoking cessation among Medicaid patients. To date the three Medicaid Managed Care Organizations have not successfully increased referrals to the Indiana Tobacco Quitline. They were informed they needed to send out a bulletin to their providers encouraging them to use the Quitline. The Neonatal Outcomes committee completed a Notification of Pregnancy (NOP) assessment form that will be completed by all prenatal care Medicaid providers at the first prenatal care visit. Included on the form is an assessment of smoking status, readiness to quit and reminder of referral to the Quitline. The NOP will go into effect July 1, 2009.
- MCH has worked closely with OMPP to share prenatal outcomes data. In March, 2009, linked Medicaid/vital records revealed that smoking among Medicaid pregnant women was significantly higher than for the state. Results show that 78 of 92 counties had a smoking rate of 30-49% among pregnant women on Medicaid. MCH will look at ways to impact smoking among the Medicaid population. The state Prenatal Care Coordination program is being restructured to include smoking cessation as a service.
- MCSHC is working with Indiana Perinatal Network to dedicate the May 2009 issue of the Perinatal Perspectives IPN Newsletter to prenatal smoking.
- Baby First Packets continue to be sent to Prenatal IFHL callers, which includes information on smoking cessation.

c. FY 2010 Planned Activities

**FY 2010: Performance Objective: The percent of live births to mothers who smoke will decrease to 18.3% in FY 2010**

Activities that will impact this Performance Objective include:

- Baby First Packets will be sent to Prenatal IFHL callers that includes information on smoking cessation
- MCH will continue to participate in the Coalition to Prevent Smoking in Pregnancy to reach out to health care providers and women of childbearing age in counties with high smoking rates to decrease prematurity, low birthweight, and exposure to second smoke among infants and children.
- MCH will analyze prenatal smoking data through monthly data from the Notification of Pregnancy form and cessation outcomes of the new Prenatal Care Coordination program, Indiana Healthy Beginnings for success and training needs.
- MCH will continue to work with the Office of Medicaid Policy and Planning and the Medicaid Managed Care Organizations to decrease smoking among pregnant women on Medicaid.
- MCH will continue to work with the Indiana Perinatal Network to provide prenatal smoking education to prenatal health care providers through forums and newsletters.
- The PSUPP program will continue to collaborate with ATR to refer pregnant substance-using women to providers for needed services.
- The Provider Resource List will be maintained and updated for public use.

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

FY 2008 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 65% in FY 2008.

Status: 58% for 2007 (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- MCSHC [provided](#) ongoing technical assistance to Allen, Elkhart, Lake, LaPorte, Marion, and St. Joseph counties to strengthen community partnerships between policymakers, health care providers, families, the general public, and others to form county coalitions to identify and solve perinatal disparity issues [through coalition meetings, conference calls, and e-mails](#).
- ISDH [provided](#) at least yearly training to county perinatal disparity coalitions on cultural competency, social determinants in perinatal disparities, life course perspective, impact on perinatal care, how to use tools to create and implement local action plans, and exploring promising approaches for effective action. [Perinatal Summit held in Lake County, Presented GIS maps and information on social determinates in St. Joseph County and Allen County, Presentation to Marion County Healthy Babies Coalition on Life Course and social determinates, met with LaPorte County and Elkhart County Health Officer and staff on their perinatal outcomes and best practice models to address outcomes in their county.](#)
- MCSHC [continued](#) to meet monthly with the Hoosier Healthwise Quality Improvement Committee, and work with OMPP through the Quality Strategy Prenatal Workgroup to reduce disparity issues in prenatal care [through accessible early entry into prenatal care](#).
- MCSHC will publish best practice models of care to improve access to prenatal care and reduce disparity outcomes on the ISDH website. Pilot projects will be encouraged in the disparity counties. [Information on Community Based Doula's, Centering pregnancy, Baby First Advocates, Faith based mentoring programs, How to Have a Healthy Baby](#) were shared with all targeted counties and can be found on the Indiana Perinatal Network at [indianaperinatal.org](http://indianaperinatal.org)
- The National Office of Minority Health media campaign "Know What to Do for Life" will be initiated in at least one of the disparity counties. [This media campaign has been replaced by A Healthy Baby Begins with You campaign and was implemented in Marion, Lake, St. Joseph, and Vanderburgh Counties as well as at Black Expo.](#)
- IPN and MCSHC [addressed](#) perinatal disparities by sponsoring a booth at the Indiana Black Expo Black and Minority Health Fair [in July, 08](#).
- Indiana School of Nursing is [providing](#) ongoing evaluation of the community based Doula program. MCSHC will assess the feasibility of replication based on outcomes and cost. [Outcomes so far look promising. Additional funding will be sought to replicate the project.](#)

## b. FY 2009 Current Activities

FY 2009 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 66% in FY 2009.

Activities to impact this Performance Objective include:

- To increase the percent of black women with adequate prenatal care in 2009, prenatal projects applying for Title V funding for 2009 and 2010 were mandated to: 1) increase the number of black women entering prenatal care in the 1<sup>st</sup> trimester through a community/neighborhood outreach plan to include African American churches, 2) provide reminder/recalls for all scheduled appointments for black pregnant women, 3) identify and refer all high risk pregnant women to an appropriate high-risk provider and to prenatal care coordination. Projects will be monitored and technical assistance will be given those projects in need. In addition, all of the disparity counties will facilitate “Baby Showers”, and “Grandmothers Teas” that will include outreach, and education to the African American community. [These new requirements took effect October 1, 2008.](#)
- The Office of Minority Health media campaign *A Healthy Baby Begins with You* will continue to be implemented in the disparity counties as well as at Black Expo. Three regional trainings on “Matters of Heart” from Indiana Access will be implemented to encourage providers in the disparity counties to take a learners stance when working with minority patients and will encourage providers to ask at the beginning of the visit what are your concerns today rather than waiting until the end of the visit and asking do you have any other concerns? Follow-up with cultural competency training will be available for providers that express an interest in further training.
- FIMR will continue in three Indiana Counties with a focus on disparity deaths. [The FIMR in St. Joseph County was not refunded due to lack of funds and ongoing turnover of staff.](#)
- MCH presented Unnatural Causes videos and disparity information during “Lunch and Learns” every Wednesday in September.
- Three Indiana Counties have 2006 Black infant mortality rates over 30/1,000 (St. Joseph, Allen, Delaware). MCSHC has presented an analysis of birth outcomes and infants deaths in each county and will continue to work with county coalitions and county minority coalitions to address these third world statistics.

c. FY 2010 Planned Activities

FY 2010 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 66.5% in FY 2009.

Activities that will impact this Performance Objective include:

- Three Indiana Counties have Black infant mortality rates over 30/1,000 (St. Joseph, Allen, Delaware). MCSHC has presented an analysis of birth outcomes and infants deaths in each county and will continue to work with county coalitions and county minority coalitions to address these third world statistics.
- The Office of Minority Health media campaign *A Healthy Baby Begins with You* will continue to be implemented in the disparity counties as well as at Black Expo
- Collaborate with Minority Health Coalitions in St. Joseph, Allen, Marion, Delaware, Lake, and Vanderburgh Counties to conduct a series of community conversations in Black neighborhoods to show the unnatural causes videos, provide education and empower residents to plan neighborhood activities.
- Work with hospitals to show the Unnatural Causes videos and life course perspective at grand rounds.

**State Performance Measure # 5** The percentage of children age 0 to 7 years with blood lead levels equal to or greater than 10 Micrograms per deciliter.

FY 2008 Performance Objective: During FY 2008 the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will be maintained at 1.6%.

Status: Met Performance Objective - In FY 2008, 77,408 children were tested. Of the children tested, 636 had a confirmed elevated blood lead level equal to or greater than ten (10) micrograms per deciliter of blood. The percentage of confirmed elevated children was .82%.

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- Training was conducted on the administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING. Over 325 people were trained through twenty-seven (27) training sessions. These training sessions included regional trainings, one on one training with local health department staff and the annual Indiana Lead-Safe and Healthy Homes Conference.

- The Indiana Lead and Healthy Homes Program held its annual training to assist local entities in applying for HUD lead hazard control grant funds on March 18, 2008. Thirty-nine individuals representing communities from all over the State attended.
- One new HUD grant totally approximately three million dollars was awarded in Indiana in the fall of 2007.
- The Program changed its name to the Indiana Lead and Healthy Homes Program to more accurately reflect the mission of the program.
- ILHHP established a Memorandum of Understanding with the Indiana Department of Environmental Management (IDEM) to administer the Lead-Based Paint regulations (326 IAC 29), including: abatement notification, training provider accreditation, monitoring and lead professional licensing. Concurrently, IHLLP was awarded EPA grant funds for the purpose of the program which is assisting in efforts in the primary prevention of lead poisoning among children.
- The Attorney General, State Health Commissioner and the Indiana General Assembly worked together to create and pass comprehensive lead legislation (SEA 143). This legislation addressed:
  1. Lead in consumer products
  2. Training of retail employees selling paint or painting products
  3. Laboratories not reporting complete and accurate information on children being tested for lead poisoning
- ILHHP increased efforts to improve the screening rate of Medicaid recipient children. Information on MCO screening rates is made available in a formal data exchange between ILHHP and Medicaid. Contract incentives were added for MCOs to improve screening rates. MCOs implemented contracts for filter paper testing.

b. FY 2009 Current Activities

Status: By the end of FY 2009, a currently projected 78,000 children will be tested. Of the children tested, ILHHP projects a total of 650 will be confirmed as having an elevated blood lead level equal to or greater than ten (10) micrograms per deciliter of blood. The percentage of confirmed elevated children is projected at .83%.

Activities to impact this Performance Objective include:

- ILHHP continues efforts to improve the screening rate of Medicaid recipient children. Information on MCO screening rates is made available in a formal data exchange between ILHHP and Medicaid. Contract incentives were added for MCOs to improve screening rates. MCOs implemented contracts for filter paper testing.

- 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING will be revised to reflect current recommendations from the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) and changes due to SEA 143.
- ILHHP will work to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.
- Eight local health departments will be Medicaid providers and will be actively seeking reimbursement for all lead related services.
- ILHHP will continue to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.
- ILHHP will decrease the percent of elevated children through increased primary prevention activities including: increasing the overall number of environmental inspections and investigations, increasing the number of housing units becoming lead safe by increasing follow-up and enforcement of existing regulations, helping to increase the lead hazard remediation grants in the state, improving training and increasing the number of licensed lead professionals, improving enforcement of existing abatement regulations, and an expanded mission to include an overall healthy homes approach to environmental case management.
- ILHHP will continue in efforts to affect an increase in the percent of Medicaid screened children by encouraging Medicaid reimbursement for testing, case management, and environmental inspection.
- ILHHP will improve lead program data collection and analysis including: data collections and comparisons with other programs such as Medicaid and WIC, use of the I-LEAD web application to produce consistent and effective risk assessments and environmental follow-up, development of an enhanced database of medical and case management information.
- ILHHP will increase awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.
- Six million dollars was awarded to two local health departments in Indiana to address lead hazards through President Obama's American Recovery Act of 2009.
- Legislation to transfer the Lead-Based Paint Program from the Indiana Department of Environmental Management to the Indiana State Department of Health was introduced in the 2009 General Assembly session. SEA 202 was passed and signed into law by Governor Daniels on May 1, 2009.

### c. FY 2010 Planned Activities

FY 2010 Performance Objective: During FY 2010 the percentage of children with blood lead levels equal to or greater than 10 Micrograms per deciliter will be decreased to .80% of the total children tested. The projection for total tested is 80,000 with 640 elevated.

Activities that will impact this Performance Objective include:

- Training will be conducted on the revised administrative rule 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING. These training sessions will include regional trainings, one on one training with local health department staff and the annual Indiana Lead-Safe and Healthy Homes Conference.
- ILHHP will work to improve case management of lead poisoned children by continuing the systematic training of local health department staff in the requirements of 410 IAC 29: REPORTING, MONITORING, AND PREVENTIVE PROCEDURES FOR LEAD POISONING.
- ILHHP will work with the Indiana Lead-Safe Housing Advisory Council and the Indiana General Assembly to introduce comprehensive lead legislation focusing on retaliatory evictions for contacting local health departments and issues surrounding lead hazards in rental property.
- ILHHP will work to improve monitoring of the local responsibilities under the case management rule including environmental follow-up on lead poisoned children.
- ILHHP will decrease the percent of elevated children through increased primary prevention activities including: increasing the overall number of environmental inspections and investigations, increasing the number of housing units becoming lead safe by increasing follow-up and enforcement of existing regulations, helping to increase the lead hazard remediation grants in the state, improving training and increasing the number of licensed lead professionals, improving enforcement of existing abatement regulations, and an expanded mission to include an overall healthy homes approach to environmental case management.
- ILHHP will continue in efforts to affect an increase in the percent of Medicaid screened children by encouraging Medicaid reimbursement for testing, case management, and environmental inspection.
- ILHHP will improve lead program data collection and analysis including: data collections and comparisons with other programs such as Medicaid and WIC, use of the I-LEAD web application to produce consistent and effective risk assessments and environmental follow-up, development of an enhanced database of medical and case management information.
- ILHHP will increase awareness and outreach efforts including monitoring and disseminating product alerts from the Consumer Product Safety Commission bulletins and other sources of information regarding consumer product safety issues.

**State Performance Measure # 6** The proportion of births occurring within 18 months of a previous birth to the same birth mother.

FY 2008 Performance Measure: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 17%.

Status: In 2007, 17% of mothers had a birth that was within 18 months of previous birth. (Based on Provisional Data)

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- MCSHC staff, IPN, March of Dimes, Title X and other members of the Unintended Pregnancy committee will contact DOE to begin working with DOE to add sexuality and pregnancy prevention to the curriculum of junior high school students. The adolescent coordinator has been working with DOE to implement a curriculum. The Indiana Respect program continues to do a statewide media campaign and funds abstinence and pregnancy prevention programs in schools and in communities.
- A birth cohort data analysis was utilized to identify commonalities in the subpopulation of women who do not space births at least 18 months was completed January 2008 and is on the ISDH website.
- IPN hosted “Controversies and Innovations in Perinatal Health”, a State Perinatal Forum March 19, 2008 with a focus on Unintentional Pregnancy and birth spacing.
- Interconception messages were published in one Perinatal Perspectives newsletter, and placed on the web.
- Work with Indiana ACOG to encourage providers to provide preconception and interconception care with messages on unintended pregnancy. Indiana ACOG and Indiana AAP endorsed the consensus statement: “Best Intentions: Unplanned Pregnancies and the Well-being of Indiana Families. MCH perinatal consultant provided training to Family Practice residents taking their public health rotation at ISDH on the life course perspective fetal origins of chronic disease and why they need to “ask every woman every time” about a life plan, and interconception health, regardless of whether they are seeing the child or the mother for a routine preventative exam.

b. FY 2009 Current Activities

FY 2008 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 14% in 2009.

Activities to impact this Performance Objective include:

- Develop media messages that address interpregnancy intervals. Consultants from Title X have met with coalitions in disparity counties about developing a county level program.
- Work with the ISDH Office of Women’s Health, the Indiana Office of Medicaid Policy and Planning, Indiana Perinatal Network and the Indianapolis Women’s Center of Excellence to develop an “Every Woman Every Time” movement with provider trainings, consumer media and marketing.
- IPN hosted a second “Controversies and Innovations in Perinatal Health”, State Perinatal Forum March 25-26, 2009 with a focus on access to care. Unintended pregnancies were discussed.

c. FY 2010 Planned Activities

FY 2010 Performance Objective: The proportion of births that occur within 18 months of a previous birth to the same birth mother will be reduced to 12% in 2009.

Activities that will impact this Performance Objective include:

- IPN will work with state stakeholder to implement two (2) of the recommendations in the consensus document, Best Intentions: Unplanned Pregnancy.
- Continue to work with the ISDH Office of Women’s Health, the Indiana Office of Medicaid Policy and Planning, Indiana Perinatal Network and the Indianapolis Women’s Center of Excellence to develop an “Every Woman Every Time” movement with provider trainings, consumer media and marketing
- MCSHC and the State Perinatal Advisory Board and others will explore the best way to operationalize the concept of interconception care for health care providers and will implement at least one strategy (vitamins for the whole family- all family members take a Flintstone vitamin together – to promote healthy families and folic acid for women., Rx pads for physicians to give all to women of childbearing age in their practice with “Every Woman Every Time messages.)

**State Performance Measure # 7** Number of community/neighborhood partnerships established in 5 targeted counties to identify perinatal disparities

FY 2008 Performance Measure Objective: The number of targeted communities with such community/ neighborhood partnerships will increase from 2 to 3 in 2008.

Status: Met - Increased by 1 (one) in 2008

a. FY 2008 Accomplishments

Activities that impacted this Performance Objective included:

- MCSHC will continue to provide technical assistance and follow-up to the targeted disparity counties to help county coalitions address disparity issues. The 3 disparity summits will be followed up with a series of workshops on coalition building, cultural competence, and best practice models. Lake County had another perinatal disparity summit in February and formed a disparity coalition consisting of Hospital CEOs, physicians, health and human service providers in Lake and Porter County. The Lake County MCH Network continued to put plans into action and developed a resource guide for ER physicians seeing minority pregnant women. Three meetings with the St. Joseph Healthy Babies Coalition occurred. GIS maps and new data were shared. Three funded Prenatal Care Coordination projects in South Bend were asked to cover the census tracts identified as highest risk for preterm, low birthweight, and infant mortality. One zip code in the southern part of the county was not receiving services but had problems with smoking, low birthweight and infant mortality. As a result of the data sharing one of the PNCC teams began providing services to the southern zip code. Programs to outreach to Black pregnant women, and educational/support groups for Black women were planned. Marion County Healthy Babies Coalition were presented with FIMR data, PPOR data, and Vital Records data and identified preconception and interconception programs as the top priorities.
- The Indiana State Plan on Perinatal Disparities will be published. County disparity plans will be included. This is still in progress. All counties have not completed a disparity plan.
- A statewide summit on the Life Course Perspective and perinatal disparities will be planned. A statewide summit on the Life Course Perspective and Black perinatal disparities was held September 17<sup>th</sup>, 2008 in Hammond. Dr. Collins from Chicago and Mario Drummond from the Harlem Project were the main speakers.
- MCSHC will work with the Office of Medicaid Policy and Planning, Office Of Women's Health, Indiana Perinatal Network, Indiana Minority Health Coalition, Governor's Office Of Faith Based Initiatives, state legislators, local county coalitions, and others to develop a preconception and interconception health program. MCSHC began working with OMPP and Indiana Family Health Council (Title X), and IPN on a presumptive eligibility plan to be implemented in early 2008, and a state family planning waiver. In April, 2008 OMPP announced the Presumptive Eligibility plan was cancelled due to implementation barriers. IPN and ISDH continued to work with OMPP to show them how the PE initiative could be implemented and the state plan was reactivated.

- During the month of September (Infant Mortality Month), a series of Lunch and Learns were presented to staff at ISDH on the Life Course Perspective, Black Perinatal Disparities, and the Perinatal State Plan. Unnatural Causes videos were shown over a four week period with discussion following each video. County Coalitions were sent Federal Office of Minority Health “A Healthy Baby is Worth the Wait” educational materials to share in their counties. Talks began with March of Dimes to purchase more Unnatural Causes video for the 17 counties with minority health coalitions to show in their counties during community conversations. ISDH does not have the funds to buy the videos.
- MCSHC and ISDH Office of Minority Health (OMH) worked collaboratively to bring the national office of Minority Health media campaign “A Healthy Baby Begins with You” in 3 of the 5 disparity counties (Lake, Marion, St. Joseph, and Vanderburgh) in Indiana as part of the National Partnership for Action to End Health Disparities. MCH had a booth at Black Expo and Included infant mortality disparity issues as a part of the Indiana Black Expo.

#### b. FY 2009 Current Activities

FY 2009 Performance Objective: The number of targeted communities with such community/neighborhood partnerships will increase from 3 to 4 in 2009

Activities to impact this Performance Objective include:

- Delaware County has been added as the fourth disparity county with a Black infant mortality rate of 32. MCH consultant has attended two TA meetings in February and April to share data and GIS maps and assist in planning.
- MCSHC and ISDH Office of Minority Health (OMH) will work collaboratively to bring the national office of Minority Health media campaign “A Healthy Baby Begins with You” in 3 of the 5 disparity counties (Allen, Lake, Marion, St. Joseph, and Vanderburgh) in Indiana as part of the National Partnership for Action to End Health Disparities. The Healthy Baby Begins with You materials was disseminated to St. Joseph, Lake, Marion and Vanderburgh counties.
- Include infant mortality disparity issues as a part of the Indiana Black Expo. The focus of this year’s MCH booth at Black Expo is Children with Special Health Care Needs. But some disparity information will be available to pass out.
- Include required disparity outreach activities for all applicants of the Title V 2009-2010 MCSHC RFP. Promote collaboration with local minority health coalitions and churches. To increase the percent of black women with adequate prenatal care in 2009, prenatal projects applying for Title V funding for 2009 and 2010 are mandated to: 1) increase the number of black women entering prenatal care in the 1<sup>st</sup> trimester through a community/neighborhood outreach plan to include African American churches, 2) provide reminder/recalls for all scheduled appointments for black pregnant women, 3) identify and refer all high risk pregnant women to an appropriate

high-risk provider and to prenatal care coordination. Projects are also required to identify their own activity to address disparities using best practice models provided. Projects will be monitored and technical assistance will be given those projects in need. These new requirements took effect at the beginning of the fiscal year.

- MCSHC will continue to provide technical assistance and follow-up to the five targeted disparity counties to help county coalitions address disparity issues. Continue to assist disparity counties in completion and implementation of a county plan. MCH Consultant has attended coalition meetings in Lake, Marion, St. Joseph and Delaware counties to share updated data and state plans. MCH and Purdue will complete a PPOR analysis in the fourth quarter in St. Joseph, Allen and Elkhart counties to further define areas of need.
- Provide 5 perinatal trainings on at least 6 topics for a total of 25 trainings in disparity and focus counties. Topics will include: 1) Indiana Access Habits of the Heart – Cultural Awareness, 2) Screening and treatment for PMD, 3) relevant breastfeeding topics, including “Business Case for Breastfeeding” to promote breastfeeding among minority employees of low paying businesses, 4) Use of alcohol, tobacco and other drugs among women of child bearing age and during pregnancy, 5) a how to menu / tool kit of community-based model programs designed to decrease perinatal disparities and increase access to care. At a minimum, the following programs will be described: Centering, Baby First Advocates / MOM, Baby First Digital Tool Kit, Crib Program, community based Doula. CEU contact hours will be provided as well as CME approved hours when possible. Regional trainings on Habits of the Heart, Screening and treatment for PMD, have been scheduled.
- Increase outreach among priority counties to bring in new IPN members, form/expand local perinatal networks/coalitions to utilize current infrastructure in improving perinatal outcomes. Explore use of videoconferencing to include more members in quarterly State Perinatal Advisory Board Meetings. IPN is marketing to prospective members at county meetings and trainings around the state.

#### c. FY 2010 Planned Activities

FY 2010 Performance Objective: The number of targeted communities with community/neighborhood partnerships will increase from 4 to 5 in 2010.

Activities that will impact this Performance Objective include:

- Collaborate with local minority health coalitions in the targeted counties to facilitate community conversations in which Unnatural Causes videos are shown and discussed. This will serve as a beginning of neighborhood empowerment and action.
- Share PPOR results with St. Joseph, Allen and Elkhart counties and use to spearhead action on disparity plans.
- Show Unnatural Causes videos during hospital grand rounds at hospitals interested.

- Collaborate with Purdue University to implement the Multi-State Learning Collaborative process in identified disparity counties.

**State Performance Measure # 8** The percentage of high school students who are overweight or at risk.

FY2009 Performance Objective: By the end of fiscal year 2010, Indiana's public health infrastructure for addressing childhood obesity will be strengthened, as evidenced by the creation of a statewide task force for obesity prevention, a state plan for achieving and maintaining a healthy weight, and the implementation, evaluation, and promotion of this plan.

Status: Currently, the Indiana State Department of Health (ISDH) Division of Nutrition and Physical Activity (DNPA) and a statewide task force are working together to address obesity through the Indiana Healthy Weight Initiative. Comprised of more than 120 individuals representing more than 74 organizations with an interest in preventing obesity, the Indiana Healthy Weight Initiative Task Force has started to develop Indiana's state plan for obesity prevention among children and adults. This group's efforts will focus primarily on developing goals, objectives, and policy and environmental change strategies for achieving and maintaining a healthy weight among a variety of settings, including childcare, schools, worksites, and communities at-large. Facilitating breastfeeding will be a major strategy for promoting maternal and child obesity prevention.

\*The 2009 performance measure differs from that of 2007 due to organizational changes within the ISDH and to leadership belief that enhancing the public health infrastructure is an essential first step in obesity prevention efforts, without which achieving and maintaining reduced BMIs among the state's population won't be feasible.

a. FY 2008 Accomplishments

**FY 2008 Performance Objective:** The percentage of high school students who are overweight or at risk will decrease by 3% (from the 2007 Youth Risk Behavior Surveillance (YRBS) baseline of 13.8% overweight and 15.3% at risk of overweight) over the next five years.

Activities that impacted this Performance Objective included:

- MCSHC funded Bowen Research Center to develop two resource guides to assist with statewide obesity prevention efforts. The first guide identified existing data from several different sources such as the Behavioral Risk Factor Surveillance System (BRFSS) and the YRBS. The second guide featured needs assessment methods that could be implemented by communities to inform the development of community level obesity prevention programs.

- Presentations on this material have been made on the following dates: 12/7/08, 2/1/08, 3/19/08, 4/1/08 and 4/9/08. In addition to MCH management staff and other high level ISDH program directors; this information has been shared with medical residents and key partners and stakeholders at the Indiana Perinatal Network Annual Meeting.
- A registered dietitian for the [Community Nutrition and Obesity Prevention Division \(the former name of the DNPA\)](#) was hired in September 2007 to lead the state in its efforts to promote fruit and vegetable consumption. Indiana became licensed to use the Fruit & Veggies—More Matters logo in February 2008. Due to a focus on compiling a draft obesity prevention plan and the subsequent [management transitions within](#) the division, outlined activities such as providing training the trainer sessions, developing an educational tool kit and releasing an email campaign to all MCH clinics were not completed. New direction for the program [was developed in](#) 2008-2009 FY.
- School height and weight collection guidelines were distributed through the Indiana Department of Education in the Coordinated School Health newsletter called *Healthy Connections*. Food demonstrations through the INDY COOKS program [were](#) not held.
- MCSHC funded the Body Talk program developed and implemented by the Ruth Lilly Health Education Center. The program is designed to increase middle school student's awareness of nutrition, physical activity and body image.
- Of the activities listed by the former program, a health worksite program and emergency food supplies [were](#) not be provided to MCH clinics by the DNPA.

#### b. FY2009 Current Activities

FY 2009 Performance Objective: [By the end of fiscal year 2010, Indiana's public health infrastructure for addressing childhood obesity will be strengthened, as evidenced by the creation of a statewide task force for obesity prevention, a state plan for achieving and maintaining a healthy weight, and the implementation, evaluation, and promotion of this plan.](#)

Activities to impact this Performance Objective include:

- [The DNPA has formed a statewide task force of obesity prevention partners as part of the Indiana Healthy Weight Initiative. Individuals who represent larger organizations that have a statewide reach, such as the Indiana School Boards Association, the Indiana School Nurses Association, the Indiana Restaurant Association, and the Hoosier Beverage Association, and who have a stake in the health of Indiana residents were invited to be on the task force. Members from the MCH division within ISDH are also actively involved on the task force.](#)

- As of May 8, 2009, the DNPA has held two meetings with the Indiana Healthy Weight Initiative Task Force. At the first meeting, over 50 task force members learned the rationale behind and the importance of addressing six priority target areas for obesity prevention: increase physical activity; increase fruit and vegetable consumption; increase breastfeeding initiation, duration, and exclusivity; decrease sugar-sweetened beverage consumption; decrease television screen time; and decrease the consumption of high energy dense foods. After increased recruiting efforts, over 100 people attended the second task force meeting to learn about Indiana's obesity prevention efforts related to specific settings.
- Two more full task force meetings and multiple workgroup meetings will be held during fiscal year 2009. These meetings will address topics related to completing the state plan, including writing a problem statement; developing goals, objectives, and action strategies; and disseminating the plan.
- MCH and the Coalition to Improve Adolescent Health are completing a state plan for addressing adolescent health issues. Addressing childhood obesity is a major portion of this plan, and one in which DNPA has provided significant input as to the goals and strategies that should be recommended.
- ISDH supported a legislative proposal brought before the Indiana General Assembly that would require school-based BMI collection in grades 3, 5, and 7. However, after being approved by the Senate, the proposal failed to make it out of the House committee. DNPA is engaged in efforts to increase the evidence-base to support such a proposal, including the pilot testing of BMI collection in 10 schools.
- The DNPA has continued to support the expansion of coordinated school health programs. The DNPA is partnering Covering Kids & Families, Inc. of Indiana and the Indiana School Health Network to finalize a contract that will provide one full-time staff person dedicated to assisting schools in complying with state and federal mandates and other strategies to improve school health. The contract is currently in the state government approval process.
- DNPA has collaborated with the Indiana Department of Education (IDOE). Representatives from IDOE have participated in the Indiana Healthy Weight Initiative Task Force. Additionally, DNPA staff members have supported the Healthy Hoosier School Award, which is the result of a joint effort between the IDOE and Indiana Action for Healthy Kids. DNPA and IDOE have continued to provide support and assistance for the implementation of the Coordinated School Health Model through a training program called MICHIANA II.
- DNPA has encouraged schools and communities to implement the *We Can!*™ Program. *We Can!*™, or "Ways to Enhance Children's Activity & Nutrition", is a national program designed to help children maintain a healthy weight by practicing three important behaviors: improved food choices, increased physical activity and

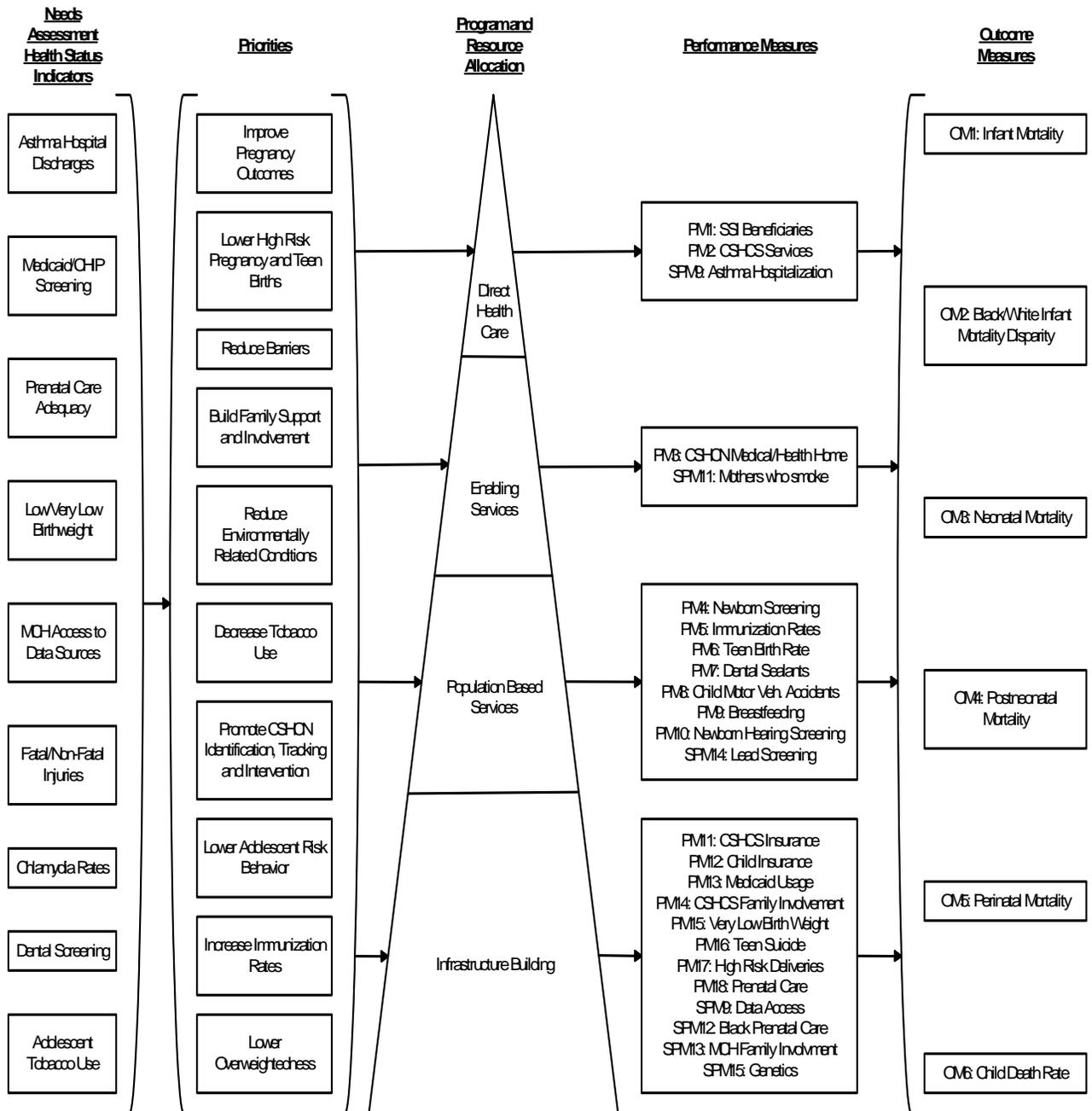
reduced screen time. Additional information about this program can be found at [www.nhlbi.nih.gov/health/public/heart/obesity/wecan](http://www.nhlbi.nih.gov/health/public/heart/obesity/wecan).

c. FY2010 Planned Activities

Activities that will impact this Performance Objective include:

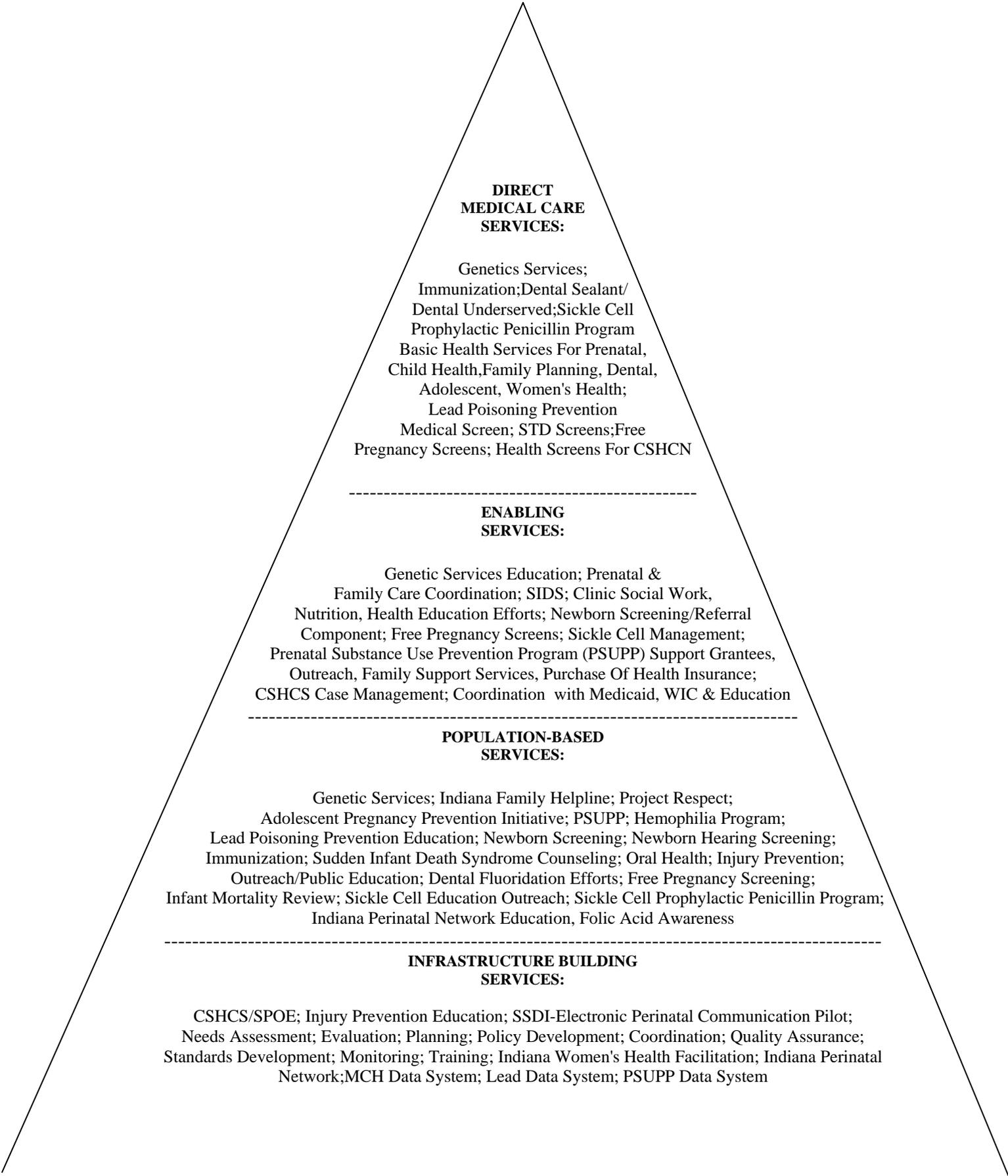
- The Indiana Healthy Weight Initiative Task Force and the DNPA will continue to develop a state plan for obesity prevention that addresses issues related to childcare and school settings and to specific populations, including childbearing women.
- By the end of June 2010, the Indiana Healthy Weight Initiative and the DNPA will complete, publish, and disseminate a state plan for obesity prevention.
- In addition to completing the state plan by June 2010, the Indiana Healthy Weight Initiative and the DNPA will complete related implementation, evaluation, and marketing plans.
- DNPA and MCH will work together to administer the YRBS. The sample of high schools will be drawn in summer 2009, but surveys will not actually be administered until fall 2009. Once the data are returned to ISDH, the two divisions will work together to disseminate the data and promote policies and programs based on the results.
- DNPA, MCH, and the Indiana Healthy Weight Initiative Task Force will investigate strategies for the using MCH adolescent clinics as a pilot setting for obesity prevention interventions.

**Figure 3: TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM**



As part of this system, all services provided by MCHS are organized in pyramidal structure as shown in Figure 2.

**FIGURE 2:  
CORE PUBLIC HEALTH SERVICES**



### Selected Health Status Indicators

2006	1999	2000	2001	2002	2003	2004	2005	2006
The Percent of Women (15 through 44) with a live birth during the reporting year whose prenatal visits are considered adequate.	75.2%	72.4%	74.1%	73.5%	72.9%	72.3%	71.1%	69.4%
The Percent of Live Births weighing less than 2,500 grams.	7.8%	7.4%	7.6%	7.3%	7.9%	6.6%	6.9%	8.2%
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.	10.0	11.4	11.5	9.0	9.6	11.6	11.3	11.29
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.	18.5	21.7	23.8	23.8	23.7	26.6	26.2	26.9
The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.	4.6	5.7	7.1	7.1	7.0	8.2	8.4	8.5

### Selected Performance Measures

	1999	2000	2001	2002	2003	2004	2005	2006
Percent of newborns in IN with a confirmed case of selected genetic condition/s who received appropriate follow-up.*	99.3%	99.9%	99.4%	99.6%	99.8%	100%	100%	100%
Percent of children through age 2 who have completed immunizations.	78.9	79.3%	78.5%	78.5%	79.3%	79%	81.4% +/- 6.5	83.2% ^
The Rate of Births (per 1,000) for teenagers aged 15 through 17 years.	27.4	26.6	23.7	22.5	21.5	20.9	20.5	20.8
Percentage of mothers who breastfeed their infants 6 months after hospital discharge.**	56.3%	59.8%	62.6%	64.9%	63.2%	66.4%	30.2% +/-5	34.6% ^
Percent of newborns screened for hearing impairment before hospital discharge.	56.6%	95%	98%	99.6%	99.8%	97.9%	98.5%	97.8%
Percent of children without health insurance.	11.8%	7.8%	7.8%	7.6%	7.6%	8.9%	9.1%	9.1% ^
The rate (per 100,000) of suicide deaths among youths aged 15-19.	8.1	8.7	9.0	9.1	6.6	8.1	6.9	7.3
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	79.5%	79.4%	78.8%	80.5%	80.6%	78.5%	78.9%	77.6%
Percent of live births to mothers who smoke.***	20.9%	20.2%	20.2%	19.1%	18.5%	17.9%	17.3%	17.28 %
The percent of black women (15 through 44) with a live birth whose prenatal care visits were adequate.	63.5%	60.2%	63.2%	61.6%	61.6%	61.3%	60.0%	57.3%

### Selected Outcome Measures

	1999	2000	2001	2002	2003	2004	2005	2006
The infant mortality rate per 1,000 live births.	7.8	7.7	7.5	7.6	7.4	8.1	8.1	7.8
The ratio of the black infant mortality rate to the white infant mortality rate.	2.5	2.4	1.9	2.4	2.5	2.5	2.4	2.8
The perinatal mortality rate per 1,000 live births + fetal deaths.	6.9	7.4	7.1	11.4	10.6	6.9	10.8	6.7 ^
The child death rate per 100,000 children aged 1-14.	27.5	25.5	21.8	22.6	19.3	23.5	24.5	23.7

\* PM changed FY2004; \*\* PM changed FY2005; \*\*\* PM changed FY2006 to “smoked in last trimester”, as the new EBC includes that information; ^ Preliminary data; +/- variance for 95% confidence level.

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