State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (http://www.mchdata.net).

This PDF was produced by the National Center for Education in Maternal and Child Health under its cooperative agreement (MCU-119301) with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services.

1.3 Table of Contents

1.4 Overview of the State

Indiana's population in July of 1999 was estimated to be over 5.9 million (compared to 5.4 million in 1990). The state's growth in population is lower than the estimated growth rate of the nation (7.2% and 9.6% respectively), but faster than the growth rate of the 1980s. Indiana maintained its ranking as the 14th most populous state and in the 1990s was the 28th fastest growing state in the nation (with more births than deaths and more people moving into the state than out). The minority population, especially Hispanic/Latino, seems to be growing. It is anticipated that the new census figures will reflect an increase in the number of Latinos settling in Indiana. As in most states, the Census 2000 is being well marketed in Indiana. (Indiana could lose a representative in the House of Representatives.)

Indiana has 92 counties with 94 county or local health departments that are autonomous to the Indiana State Department of Health. The most urban counties are Marion, Lake, St. Joseph, Allen, Elkhart, and Vanderburgh. Many of the more rural counties are classified as Medically Underserved Areas (MUA) or Health Professional Shortage Areas (HPSA) by the federal government. Currently, hospital health care is not regionally organized nor are there official primary, secondary, and tertiary hospital designations for perinatal care.

The health of Hoosiers has improved in the last year. The United Health Group Health Status Ranking, 1999 Edition, has Indiana improving overall from 23 in 1998 to 20 in 1999. Based on 1997-1998 data from the National Center for Health Statistics, Indiana's infant mortality rate is 6.7, below the national average of 7.1. Indiana is designated as one of two states with the most dramatic improvement in infant mortality. However, minority infant mortality remains 2-3 times higher than white.

In the state of Indiana, the Title V program, which consists of Maternal and Child Health Services (MCHS) and Children's Special Health Care Services (CSHCS), provides funding for projects in all levels of the MCH Pyramid. Title V staff is directly involved in infrastructure building within the Indiana State Department of Health, among other state agencies, and among non-state agencies. Through the Title V Block Grant Federal/State Partnership, MCHS and CSHCS fund agencies to provide direct medical services for women of childbearing age and children and act as payer of last resort for primary and specialty care for children enrolled in CSHCS. These grantees/contractors also provide enabling services (like care coordination) to families with special health care needs and to families enrolled in CHSCS. The MCHS staff also create and implement population-based education on topics like tobacco use prevention and adolescent pregnancy prevention.

Title V staff interface with state physician and dental organizations, Office of Medicaid Policy and Planning (OMPP) and other managed care insurers (especially those working with the low income

population), laboratories that run the newborn screens and lead screens, not-for-profit groups that are working toward the same improved health outcomes as Title V, and other state agencies that impact the citizens of Indiana to coordinate and assure quality health care is available. Statistical monitoring of Indiana's Health Status Indicators (HSI) and health outcomes and sharing this information with the public is also a responsibility of Title V in Indiana. The State Health Commissioner's priorities—access to primary health care, rural health, minority health, tobacco use cessation, and better coordination with local health departments—continue to be emphasized.

Improved access to primary health care through expanded Medicaid coverage of the MCH population has occurred over the last decade. By July 1992 Medicaid covered pregnant women and infants under 1 year of age at $\geq$ 150% of the federal poverty guidelines; children from age 1 to age 6 at 133% of federal poverty guidelines; and children older than 6 born after May 1983 at 100% of federal poverty guidelines. Adult members of families receiving Temporary Assistance to Needy Families (TANF), is less than 27% of the federal poverty guidelines) were also eligible for Medicaid coverage. In July 1997 coverage for children at 100% of the federal poverty guidelines expanded to include children ages 13-19 years of age. In July 1998, as the first phase of the State Child Health Insurance Program (SCHIP), income eligibility for children ages 6-19 increased to 150% of the federal poverty guidelines. The SCHIP first phase eligibility expansion of Medicaid was maintained by legislation in 1999, so that all populations included in the expansion of Medicaid are currently eligible at the same 150% of the federal poverty guidelines.

With the advent of Medicaid managed care in July 1994-1997, the name of the public insurance program was changed to Hoosier Healthwise. As of January 2000, the Hoosier Healthwise public insurance program was reorganized to reflect the expanded Medicaid coverage and the SCHIP program. Hoosier Healthwise now has Package A, the Standard Plan that provides full coverage for all children 0-19 years with incomes less than 150% of the federal poverty level, pregnant women < 19 years or receiving TANF benefits, and other low-income family members receiving TANF benefits; Package B is the limited coverage for pregnant women with incomes less than 150% of the federal poverty level; and Package C is the SCHIP program for children whose family income is between 150%-200% of the federal poverty guidelines. There is also a Package D for people with disabilities and chronic disease (which was piloted in Marion County but is not active at this time) and Package E for people eligible for emergency services only like delivery coverage for undocumented pregnant women and their newborns. All participants are a part of a managed care program—either the State's primary care case management program, *Primestep*, that continues to pay fee-for-service to the physicians; or one of two a risk-based managed care programs that contract with the OMPP.

Phase II of Indiana's SCHIP, Hoosier Healthwise/Package C, was legislated in FY '99 to begin January 1, 2000 (I.C 273-1999). In addition to maintaining the expansion of the Medicaid program coverage for children younger than 19 years of age (Hoosier Healthwise/Package A) to children whose family income is $\leq$ 150% of the federal poverty guidelines and establishing Package C, the legislation established an Office of Children's Health Insurance Program. It also established the Child Health Policy Board to oversee implementation of the state-designed Package C.

Hoosier Healthwise/Package C began January 1, 2000 using the same enrollment process and sites, and managed-care providers as the Hoosier Healthwise/Package A. Package C covers preventive, primary, and acute care services for eligible children who do not have access to private insurance and whose parents agree to meet the cost-sharing requirements (ranging from $11.00 - $16.50 for one child to $16.00 - $24.75 for two or more children monthly depending on income). In Package C a premium must be paid monthly, quarterly, or annually (quarterly and annual payments are discounted by 5% and 10% respectively). Co-payments are charged for prescription drugs, ambulance transportation, and emergency room visits that do no result in hospitalization. Applicants who are eligible for this program are enrolled as soon as the first premium is paid (retroactive to the first of the month of the receipt of application). They are eligible for coverage for a full year if the premiums are paid.

Package C does not cover the following services: Medicaid rehabilitation option; nursing facility services; intermediate care facilities for the mentally retarded; case management; non-ambulance transportation; over-the-counter medications (except insulin); institutions for mental disease; and organ transplants. Children enrolled in Package C may be eligible for additional health coverage from Indiana First Steps (the early intervention program) and CSHCS.

The Child Health Policy Board consists of a Chair (appointed by the governor), the Secretary of Family and Social Services (current chair), the State Health Commissioner, the State Insurance Commissioner, the State Personnel Director, the State Budget Director, and the State Superintendent of Public Instruction. The ISDH Assistant Commissioner for Public Health Services, the MCHS Director, and the CSHCS Director provide staffing for the Health Commissioner on this Board.

This Board has an Advisory Committee for Children with Special Health Care Needs to assist them in developing policy for this target population. This Advisory Committee is co-chaired by Maureen Greer, Director of First Steps, and Wendy Gettelfinger, DNS, JD, Director of CHSCS. This group is composed of the state agency directors of mental health, special education, First Steps, and CSHCS, a specialty care pediatrician representing the American Academy of Pediatrics, the Chair of the Governor's Interagency Coordinating Council for Early Intervention; a representative for children enrolled in Hoosier

Healthwise/Packages A and C, a representative from a family advocacy group, three parents of children with special health needs, and two parents of children enrolled in Hoosier Healthwise/Packages A and C. The Advisory Committee began meeting in December 1999 and meets quarterly.

This committee is to advise and assist Child Health Policy Board in the development, coordination and evaluation of policies that have an impact on children with a focus on children with special health care needs. This committee is to seek input from families, service providers, advocacy groups, and health care specialists about state or local policies that impede the provision of quality service. They are to forward to the Child Health Policy Board relevant health policy issues that have impact on children with special health care needs. They are also to advise the Child Health Policy Board on the integration of services for children with special health care needs across programs and state agencies. To this end the Board has contracted with a consultant who will recommend options for the coordination of the eligibility determination, enrollment and claims payment processes of children's health programs. Coordination of these programs will allow the state to: (1) more effectively locate and enroll eligible children; (2) provide seamless services to families, even if the family is served by different programs and/or agencies; and (3) maximize federal, state, and local funding in order to serve as many eligible children as possible, while meeting the goals of each individual program. The CSHCS Director works with an interagency team and the consultant.

The impact of Hoosier Healthwise on the overall access to care and health of the children in Indiana remains to be seen. In December, 1999, before Package C was offered, there were 318,438 children enrolled in Hoosier Healthwise. This was more than anticipated, based on estimated number of uninsured. As of April 30, 2000, four months after Package C was introduced, 328,525 children are enrolled in Package A, and 1,799 are enrolled in Package C. During the spring the Office of Medicaid Policy and Planning (OMPP) intends to review utilization of services in the Hoosier Healthwise Program. This will reveal whether better access to payment for health care services improves access to medical and dental care and increases utilization of preventive health services as the program intended. In the spring of 2000 the Office of Child Health Insurance Program is doing a study to verify estimates of uninsured and low-income children. This should provide better estimates of numbers eligible for Packages A and C and allow for better planning.

Dentists participating in the Hoosier Healthwise/Medicaid program have increased. In January 1997, only 607 dentists provided dental care to Medicaid clients due, in part, to reimbursement cuts. During 1998 OMPP improved the reimbursement levels and the billing process for the dentists. As of December 1999, there were 1,132 dentists participating. Dental services provided to recipients increased from 11,469 in January of 1997 to 170,496 recipients in December 1999. The ISDH/MCHS Oral Health

dentists were instrumental in facilitating the improvements in reimbursements and provider participation. In spite of these improvements access to dental providers, particularly specialty care providers, may be limited in some areas.

With the expansion of Package C, OMPP anticipated a possible shortage of primary medical providers in fourteen counties initially. This was based on the anticipated number of eligible children in the county versus the number of panel slots open for each medical provider. MCHS and ISDH helped convene a provider access task force to assess the counties and develop a plan for improving the ratio for each county. Currently, plans of action have been developed for the first fourteen counties which include Hoosier Healthwise regional representatives working with MCHS Health Systems Development consultants to expand the medical provider panels or develop or expand clinic services in those counties. This task force will continue working as Package C begins to have greater impact.

Outreach for the Hoosier Healthwise child insurance program has been improved. Paid advertising is being used on radio and television. Non-profit agencies including some MCH projects have become enrollment centers for Hoosier Healthwise. No reimbursement for this service is given by OMPP at this time. MCH projects use the Combined Enrollment Form (developed for First Steps, CSHCS, and MCH), which is also accepted as an enrollment form for Hoosier Healthwise. OMPP has worked through the schools to market the insurance program.

In addition to the aforementioned roles and responsibilities of Title V staff in the expansion of public health insurance for families, since 1994 MCHS has encouraged through the application process the funded direct medical services programs to convert from preventive health care only to primary health care that can provide services within the Hoosier Healthwise system and minimize fragmentation of care. The MCHS Director participates on the Hoosier Healthwise Quality Improvement Committee which, in 2000, will address clinical quality initiative topics that include Early Periodic Screening and Diagnostic Testing, blood lead screening, children with special health care needs, prenatal care standards, diabetes, asthma, immunizations, domestic violence and access/utilization. MCHS grantees have assisted Hoosier Healthwise clients by educating them on managed care processes, eligibility criteria, and enrollment while continuing to serve uninsured clients. MCHS staff have provided feedback to OMPP on many barriers to dental and medical access from enrollment barriers to provider access.

Welfare Reform in Indiana began in 1995 before the federal legislation was enacted in 1996 and in the middle of Medicaid expansion. At the time of initial implementation of welfare reform (probably due to the need for more education of state staff as well as recipients) there was a decrease in the numbers of recipients of Medicaid and, therefore, health care access. MCHS staff assisted Family Social Services

Administration (FSSA) in educating providers and consumers on the separation of health care benefits from the eligibility for Temporary Aid to Needy Families (TANF) payments.

Indiana's welfare reform has been successful in decreasing the number of TANF recipients. In 1999 Indiana was ranked at the top of the states in the numbers of people who were no longer receiving Temporary Aid to Needy Families (TANF). Indiana was ranked number 1 in job placement in 1999; and number 6 for the number of recipients with increased earnings and job retention from quarter to quarter. Indiana received a federal bonus of 8.7 million in 1999 for its performance. The state placed 20,785 welfare recipients in jobs in 1998.

To receive TANF an applicant must have an income of less than 27% of the federal poverty guidelines. Currently, an individual/family has TANF funds cut rather drastically as the income increases—a long standing policy in place before welfare became temporary assistance in 1996. Because of this policy and low welfare payments, Indiana recipients who find work lose their grants faster than recipients in most other states.

Beginning July 1, 2000, a new policy will be implemented that will allow TANF recipients to receive the maximum allowable TANF grant until their income reaches 100% of the federal poverty guidelines. Indiana is one of ten states to have this policy. It is estimated that this will restore TANF payments to about 5,000 families and increase the number of families that succeed in the workforce. The policy will be funded by the annual federal TANF grant and will remain in place at least until the grant expires next year. These clients also continue to be eligible for Medicaid. This policy change is a result of a state study (substantiated by other states) that indicated that the earnings of most clients do not exceed the TANF payments and food stamps they lose when they go to work.

Indiana's welfare reform requires that adults applying for TANF must find work and/or participate in Indiana Manpower Placement and Comprehensive Training (IMPACT) unless the adult is responsible for a child who is 12 weeks of age or younger (December 1998). The able-bodied adults in a family may receive TANF for only 24 months, while the children may continue receiving monetary support for 60 months. (The adult support is $90 per month and is the amount withdrawn if the adult does not comply with the "Personal Responsibility Agreement".) Job searches by applicants must begin immediately upon application to TANF. In Indiana, in addition to keeping the child's immunizations up-to-date, and limiting coverage of the family to the number of children at the time of application, there is a requirement in the "Personal Responsibility Agreement" that the children be raised in a safe and secure home and applicants are prohibited from using illegal drugs or abuse other substances which would interfere with self-sufficiency.

Indiana seems to have reversed the decrease in enrollment in health benefits (Hoosier Healthwise) that occurred at the onset of welfare reform. However, lack of convenient, affordable child care for both well and sick children and convenient hours to access support services like health care and Offices of Families and Children services so that work time is not lost, continue to compromise the ability of many to remain in the job force. Also, the disparity between earned wages and the amount needed to function without assistance and transportation are among issues which must be addressed before Indiana's welfare reform can be deemed truly successful.

Focus on minority health continues to be great. Health disparities are great in all minority populations, but particularly in perinatal populations. Healthy Start projects continue to function in the two counties with the highest minority populations, Marion and Lake counties. In Marion County the Black infant mortality rate is 2.3 times more than the White infant mortality rate. In Lake County the Black infant mortality rate is 2.8 times more than the White infant mortality rate. In Marion County the Black low birthweight rate is 1.8 times higher than the White low birthweight rate. In Lake County the Black low birthweight rate is 1.6 times higher than the White low birthweight rate. In Marion County the Indiana Perinatal Network, Inc. (IPN), (an MCHS funded program) and the Health and Hospital Corporation were chosen to be a joint pilot *Friendly Access* project. *Friendly Access* is a effort by the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, the National Perinatal Association, and the Disney Institute to use the Disney management style in a public health setting—to make the health care setting more inviting. MCHS also intends to utilize some of the tools statewide.

Indiana's Health Care Professional Development Commission (created by Senate Concurrent Resolution 80-1995) revealed in the 1999 Annual Report the baseline data for racial/ethnic makeup of physicians and nurses with an active Indiana license and an Indiana practice location. Compared to 1996 Census Bureau estimates of Indiana's population racial/ethnic mix (8.1% Black/African-American, 0.88% Asian/Pacific Islander, 0.24% Native American, and 2.2% Hispanic), the physician composition is above that of the minority population as a whole in all groups but Black/African-American. The nurse composition is below in all minority groups.

In an effort to reduce provider racial/ethnicity disparity, ISDH is working with the Indiana Minority Health Coalition, Indiana University School of Medicine (IUSOM), Eli Lilly & Co., and others to promote an increase in the numbers of minorities drawn to health careers through scholarship, mentoring, early introduction of the health sciences, and additional preparation support. This should contribute to culturally competent and "friendlier" health care in Indiana.

MCHS has in the last five years encouraged all grantees (especially those in areas with large or growing minority populations) to work with local Minority Health Coalitions to develop culturally competent/sensitive staff and materials. After several delays, in 2000 an assessment of the cultural sensitivity of the grantees will be done and a plan for state-facilitated training will be developed.

During the 2000 Indiana General Assembly session (January to April of 2000), legislation to distribute the Tobacco Settlement money was passed. The distribution outlined in this session impacts positively on all of the priorities of the State Health Commissioner, as well as the health and well being of children in the state of Indiana.

The Tobacco Settlement Fund Management Legislation (SEA 108) creates the Indiana Tobacco Use Prevention and Cessation Trust Fund, an Indiana Health Care Trust Fund, a Biomedical and Technology and Basic Research Trust Fund, a local Health Department Trust Fund, an Indiana Prescription Drug Fund ($20 million), a Tobacco Farmers and Rural Community Impact Fund, and an Executive Board. Each of the trust funds is to have an advisory board to assist the Executive Board in planning and the determination of funds distribution. The Executive Board is to develop a mission statement and long range plan (5 years) for the use and distribution of the portion of the funds available. Essentially all of the tobacco settlement money is to be used for health-related services.

Dedicated allocations of money were set aside for many entities that provide services for MCH target populations. Local Health Departments are to receive $10,000 annually plus an amount based on county population and an increase in local health maintenance funds based on population (a total of $4.5 million). Hoosier Healthwise/Package C was also additionally funded by $28 million. Tobacco education, prevention, and use control received $35 million with specific amounts targeted toward minority groups. (This fund will be distributed through grants.)

The Indiana State Department of Health (ISDH) was given $15,000,000 (in addition to the $10,000,000 already appropriated from state funds) for operating expenses of community health centers and primary health care centers for children in both rural and urban settings. In addition, there was a $10,000,000 appropriation made for capital (building) costs for health centers over the next two years. This money will be distributed through the Community Health Center grant process annually. Thus, much of this money will be serving MCH target populations for primary care.

In addition to the priorities of the State Health Commissioner, the MCHS/CSHCS Directors consider the thirteen ISDH priorities developed in 1996 (that were based on a statistical analysis of health issues in the state) and the focus issues of collaborating agencies that are related to the health of MCH populations in

determining what Title V monies should support. The thirteen ISDH priorities are reflected in Title V priority needs to be delineated later.

FSSA, an agency with major MCHS collaboration, has focused on the issue of child abuse prevention in Indiana in the last decade. Title V has supported their efforts by providing funding to FSSA's Healthy Families Indiana (HFI) program. This program addresses child abuse prevention through a home visiting program.

From 1990 to1997 an average of over 200 Indiana children per year died from injuries. During that same time period, children birth to four years of age had the highest rate of death due to injuries. Unintentional injuries accounted for the highest number of deaths, followed by motor vehicle accidents. In April 2000 Prevent Child Abuse Indiana published *Keeping Kids Alive—Recommendations for Implementing a Statewide Systematic Review of Childhood Deaths*, a summary report of the Indiana Child Fatality Review Task Force. FSSA had contracted with Prevent Child Abuse Indiana to organize and facilitate this Task Force, a group composed of individuals from public and private sector agencies concerned about reducing the number of preventable child deaths. Two staff from MCH participated. This report will be reviewed by an Indiana Senate interim study committee during the summer of 2000, with anticipated proposed legislation for 2001.

Indiana is primarily a rural state with seven or eight urbanized areas or counties. The variation among counties in services available, poverty levels, racial and ethnic make-up, the focus of the local health departments, and access to health care providers is wide. A regional hospital system does not yet exist in Indiana and private physicians in general have not embraced the managed care concept, particularly within the provision of services to low income families. These challenges force Title V staff to think creatively and work cooperatively with both public and private agencies to ensure quality health care.

1.5 The State Title V Agency

"The Indiana State Department of Health serves to *promote, protect,* and *provide* for the public health of people in Indiana" is the mission statement of the agency that receives the Title V funds. The ISDH Vision Statement states that **the Indiana State Department of Health (ISDH) is committed to facilitation efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to:**

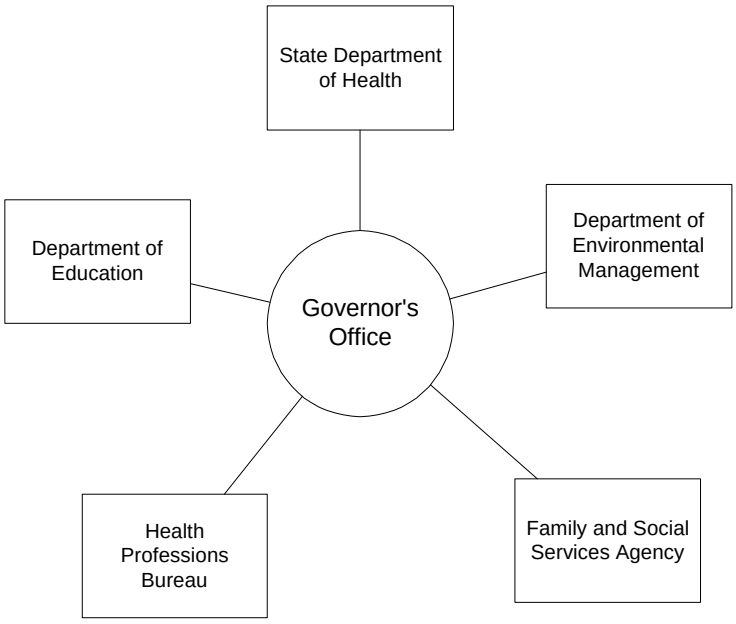
- **promote integration of public health and health care policy;**
- **strengthen partnerships with local health departments;**
- **collaborate with hospital, provider, governmental agencies, business, insurance, industry, and other health care entities;**

- **support locally-based responsibility for the health of the community.**

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. The broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of our communities in our state. Problem solving in health care will not occur in isolation but in concert with solving the social, economic, and other challenges that exist in the community.

The Indiana State Department of Health is one of several major departments in state government. The ISDH has four commissions that the Commissioner of Health and his deputy oversee. The Operational Services Commission has responsibility for the oversight of the five special institutions (Indiana School for the Deaf, Indiana School for the Blind, Indiana's Soldier and Sailor's Children's Home, Indiana Veterans' Home, and Silvercrest Children's Developmental Center), Human Resources, Laboratories, Finance, and other administration. The Information Services and Policy Commission houses Information Technology Services (ITS), Epidemiology Resource Center (ERC), External Information Services (EIS), Office of Policy, and Quality Improvement/Statistics. The Health Care Regulatory Commission oversees the regulations of Acute Care facilities, Long Term Care facilities and Consumer Protection. The Public Health Services Commission houses Title V services (MCHS and CSHCS), Supplement Nutrition Program for Women, Infants, and Children (WIC), Local Liaison Office with local health departments, Chronic/Communicable Disease, Immunization, Human Immunodeficiency Virus/Sexual Transmitted Disease (HIV/STD), Quality Improvement, Oral Health, and Primary Health Clinics. Each Commission is headed by an Assistant Commissioner.

Diagram of Indiana State Departments and Agencies of interest for Maternal and Child Health



1.5.1 State Agency Capacity

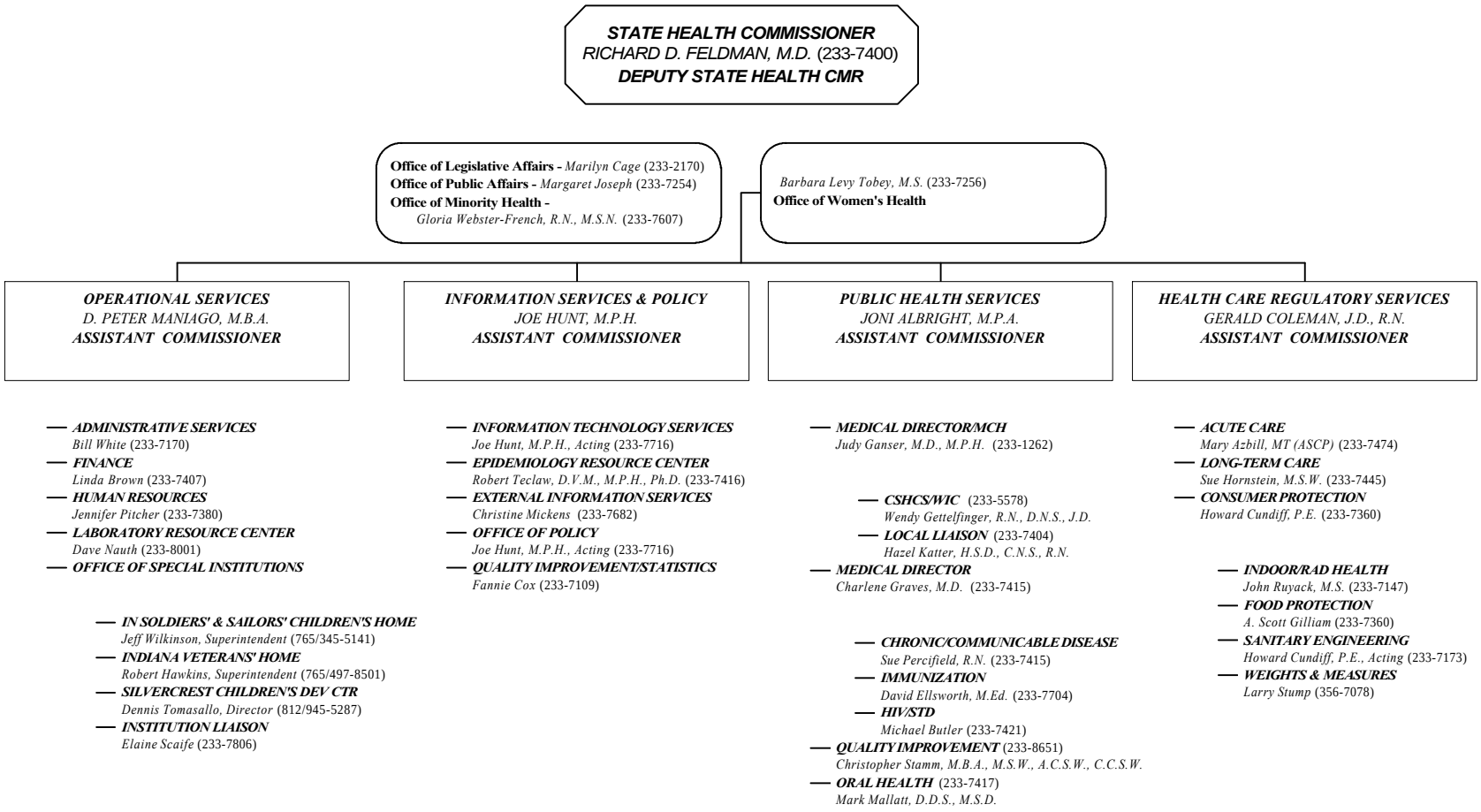
1.5.1.1 Organizational Structure

Governor Frank O'Bannon appointed the State Health Commissioner, Dr. Richard Feldman, to provide leadership to the Indiana State Department of Health upon his election in 1996. There has been a sequence of four deputy commissioners since January, 1997. The current Deputy Commissioner is Mary DePrez, who provides operational direction for ISDH. The Title V Federal-State Block Grant Partnership funded services remain in the Public Health Services Commission, directed by Assistant Commissioner Joni Albright, MPA. Judith A. Ganser, M.D., MPH, is the Director of MCHS and is Medical Director for both MCHS and CSHCS. An assistant director assists her. Wendy Gettelfinger, MSN, DNS, JD, is the Director of CSHCS and WIC. She has assistance from a program manager in each program.

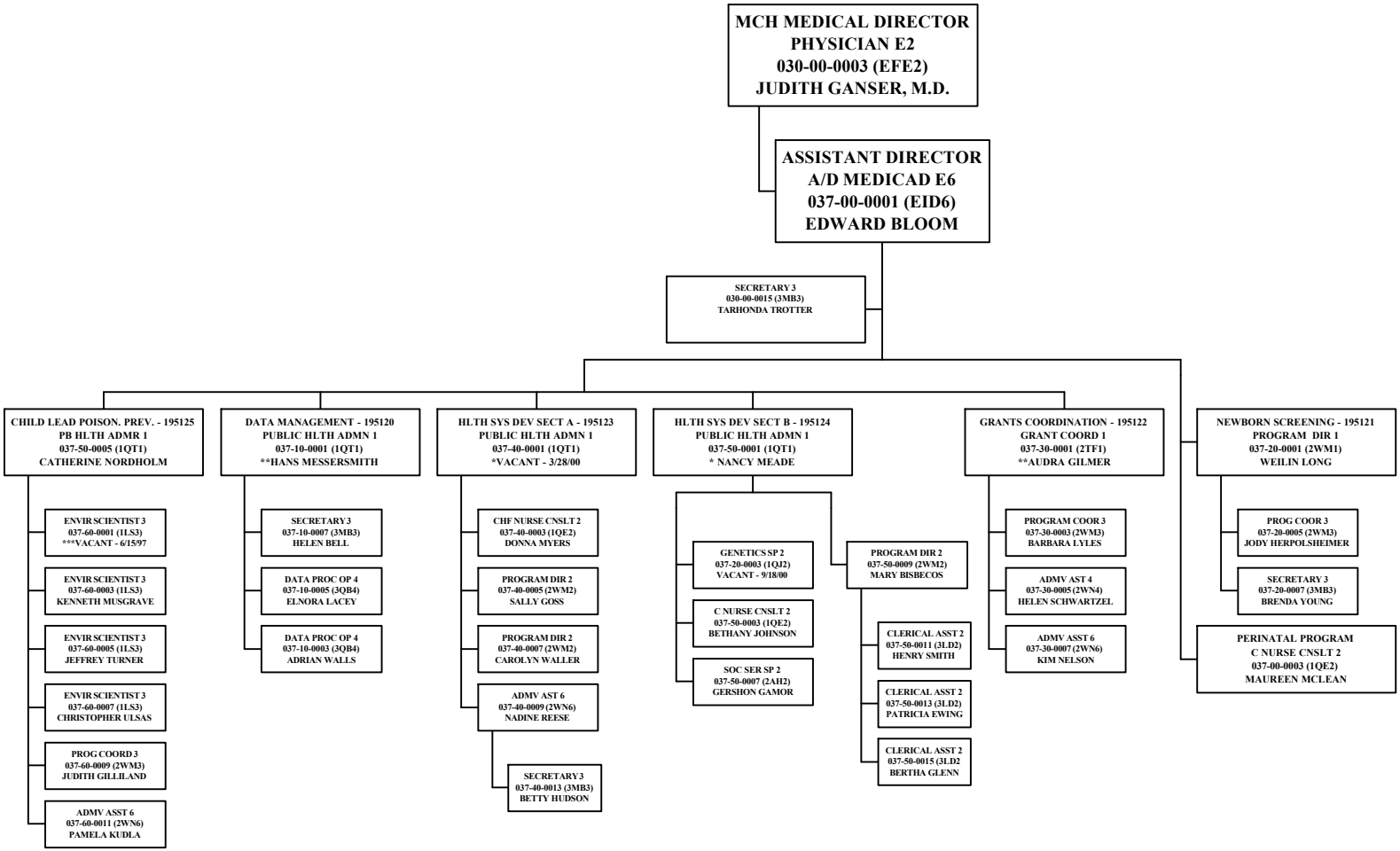
MCHS and CSHCS distribute the Title V Federal-State Block Grant Partnership budget primarily through grants to community agencies that provide direct, enabling, population-based, and infrastructure building services that will impact the federal and state performance measures. Some programs including the Indiana Family Helpline (IFHL), the Indiana Childhood Lead Poisoning Prevention Program (ICLPPP), Newborn Screening Program,

Meconium Screening for Drug-Exposed Newborns Program, Newborn Hearing Screening Program, Prenatal Substance Use Prevention Program (PSUPP) and some population-based educational campaigns e.g., the Folic Acid Awareness Campaign and the Genetics Diseases Program “Genetics and Your Practice”, are directly administered by MCHS.

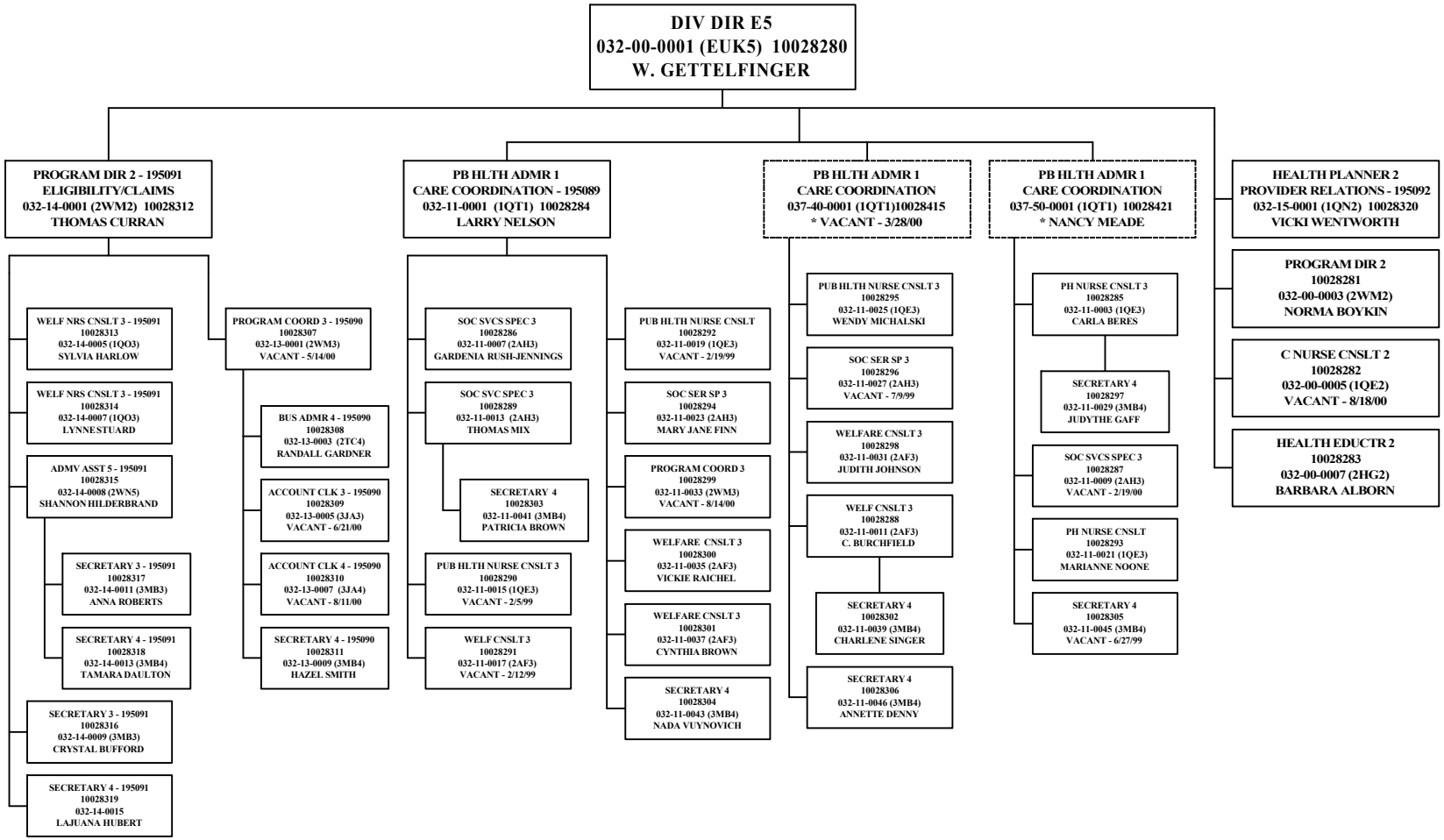
INDIANA STATE DEPARTMENT OF HEALTH



PUBLIC HEALTH SERVICES COMMISSION
MATERNAL AND CHILD HEALTH PROGRAM - 195119



PUBLIC HEALTH SERVICES COMMISSION
CHILDREN'S SPECIAL HEALTH CARE SERVICES - 195086



Both MCHS and CSHCS employ state consultants to give technical assistance and consultation to grantees providing direct medical services, direct enabling services (including care coordination), and population-based services. These consultants also monitor the grantees and participate in infrastructure building services at the state level.

During FY '99 and continuing in FY 2000, both MCHS and CSHCS have been upgrading the computer systems used to collect data on clients enrolled in both programs and to facilitate the reimbursement for CSHCS services. These systems provide statistics for this and other grant applications as well as part of the monitoring and evaluation of the grantees. Both previous systems were outdated and not Y2K compliant. Assisting with the development of the new systems continues to take a great deal of staff time.

MCHS grantees began using a paper data collection system as of October 1, 1999. While the MCHS system was ready for installation by January 2000, many grantees did not receive the new system until after the beginning of 2000. As the grantees begin to enter and transmit data, glitches within the system are being corrected and modifications are being made. Grantees have not had the opportunity to enter all enrollment and visit data to date. Until the system is running smoothly and reports on the data can be run and verified, the installation of this system will be very time consuming for many of the MCHS staff and the External Services staff funded by Title V. It is hoped that the data will be available for the FY 2000 Annual Report.

The CSHCS data system has been more problematic. However, an interim system was created so that reimbursements could continue more efficiently during the testing and transition to the new system. Much staff time has been focused on testing the new system. Implementation is being done in stages. The latest timeline for full implementation is Fall 2000. The new system should allow CSHCS access to more of the data needed for the Title V Annual Report.

<u>Programs funded by the Federal-State Block Grant partnership include the following:</u>

The Indiana Family Helpline (IFHL), established in 1987, provides direct information and referral services with advocacy assistance (if necessary) to citizens of Indiana and alerts MCHS consultants to breakdowns in health care services around the state. It is a population-based program that provides an enabling service to the general population. While originally the target populations were mothers and children, the Communication Specialists respond to any caller's request. Approximately 16,000 calls are received annually. Currently the IFHL is collaborating with Family and Social Service Administration (FSSA) to expand the marketing of the IFHL number by additional programs in FSSA. In Indiana there is interest through the private not-for-profit sector in establishing a "2-1-1" number for non-emergent social service and health information and referral calls. The ISDH/IFHL and FSSA will participate in these discussions as a unit from the state.

Currently, the IFHL Communication Specialist staff has expanded with two employees of the Indiana Perinatal Network (IPN). One of the new employees is bilingual in Spanish. The IFHL anticipates marketing services more effectively in the Latino community now that a translator is more readily available. In addition, the whole IFHL staff has learned some Spanish phrases to facilitate getting services to a growing Latino community.

The Newborn Screening Section of MCHS has expanded from the tracking and follow-up of metabolic newborn screens of the Newborn Screening Program to include the tracking of newborn hearing screens, the Newborn Hearing Screening Program, and the collection of summary data of targeted newborn meconium screens, the Meconium Screening for Drug-Exposed Newborns Program .

Newborn Screening Program has developed the infrastructure that hospitals and health departments use to report metabolic screens done on all newborns in Indiana. The Newborn Screening Program strives to assure that all infants born in Indiana are tested for 8 genetic disorders: (1) phenylketonuria (PKU) (2) galactosemia (GAL), (3) maple syrup urine disease (MSUD), (4) homocystinuria (HCU), (5) hypothyroidism, (6) hemoglobinopathies (including Sickle Cell), (7) biotinidase deficiency and (8) congenital adrenal hyperplasia. This program provides preliminary diagnosis, follow-up, management, family

counseling, and support, including equipment, supplies, formula and other materials, for all infants and individuals identified as having these conditions. Services within the program also include educational outreach to both health care professionals and the general public. The Indiana Newborn Screening Program is legislatively mandated. All infants born in Indiana are required to have blood obtained for newborn screening. The only acceptable reason for refusing the screen is an informed refusal on religious grounds. Infants normally have a screening specimen collected at least 48 hours after birth and 24 hours after protein feed. All newborn screen blood specimens, together with required medical and demographic information, are forwarded to the ISDH-designated laboratory for processing. The laboratory currently so designated is the Indiana University Medical Center Newborn Screening Laboratory (IU-NBS Laboratory). The IU-NBS Laboratory reports the results of all screens to the infant's attending physician and the birthing institution (hospital). Repeat screens are required for unacceptable screens or screens having abnormal results. If the responsible hospital or physician is unable to obtain the repeat screen, additional follow-up is initiated by the ISDH, which may include requesting assistance from local health officials. Cases are considered open until a valid screen is done with normal results, or the infant is confirmed to have one of the eight genetic conditions and is verified to be undergoing appropriate treatment/family counseling. This program works closely with the Sickle Cell Program and the Genetic Diseases Program to ensure follow-up and treatment for infants diagnosed as having one of the designated disorders. A Newborn Screening Advisory Group assists with developing recommendations for additional screens and the protocols involved. The director of this section develops contracts with laboratories to process the screens. MCHS contracts with grantees to provide intervention services for the infants with positive tests. The Program Directors for Genetics and for Sickle Cell ensure that all positive or questionable test outcomes are followed-up and have appropriate care.

Indiana's Universal Newborn Hearing Screening Program (UNHS) is designed to assure that all infants born in Indiana are given a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments. UNHS at ISDH/MCHS will track affected infants, identified at the hospitals, to collect information on the incidence of congenital hearing loss in infants born in Indiana. The hospitals and responsible physicians will refer

the parents of newborns with questionable screens to their local First Steps agency for further diagnosis, follow-up, management, and family counseling and support. MCHS through the hospital tracking will follow-up with First Steps to ensure the identified infants have gotten into care and enrolled into CSHCS and First Steps. The goal of this program is early recognition, intervention and follow-up to maximize the child's speech, language, and cognitive development. ISDH/MCHS will provide the necessary hospital and First Steps training and all collaborators will market educational outreach to both health care professionals and the public. In July, 2000 the ISDH in collaboration with the First Steps Program and the hospitals in the state will implement Universal Newborn Hearing Screening for all newborn infants as prescribed by PL 91 (1999).

Meconium Screening for Drug-Exposed Newborns Program was established in 1997 when the Indiana General Assembly passed PL 260-1997 (now PL 273-1999) requiring hospitals and physicians to submit a meconium specimen for every infant born under their care who meets the selection criterion of the program. The selection criteria, as specified in the law are the following:

- the infant's weight is less than two thousand five hundred (2,500) grams;
- the infant's head is smaller than the third percentile for the infant's gestational age; and
- there is no medical explanation for the conditions described in the above.

If the test indicates the presence of a controlled substance in the infant's meconium, the responsible physician/hospital must follow-up with the client to determine appropriate action/referrals, including a request to declare the infant a child in need of services (CHINS) as provided in Indiana law. However, the child's mother may not be prosecuted in connection with the results of the test.

In early 1999, the Indiana General Assembly, with input from the ISDH, passed PL 273-1999 that included the provision to extend the Meconium Screening Program through June 30, 2001. Additional changes in the original legislation included:

- The authority for ISDH to expand the criteria to identify infants for mandatory meconium screening (funded by the state);
- The authority for ISDH to establish guidelines to carry out this program.

- The requirement for ISDH to provide an annual update to the legislature in 2000 and 2001.

ISDH/MCHS staff wanted the authority to expand criteria for mandatory screening because of the infants screened that fit the criteria only 12% were positive; while those infants whose physicians had them screened who did not meet the criteria, 22% were positive.

The additional criteria now being used (July 1, 2000) include a history of drug use (current or past use), unexplained abruptio placentae, no or inconsistent (frequently missed appointments, hospital hopping) prenatal care, and an infant that is symptomatic of drug effects/withdrawal. Also, in August 1999 the lab criteria that determine positive results were lowered to minimize false negative screens.

Hospital/birthing center participation in this program as of December 1999 was only 40% in spite of distributing a Newborn Drug Screening Program Instruction Package to all centers. (Hospitals are to report monthly the number of infants screened and number of referrals given). Currently, ISDH staff is reviewing with hospitals specific protocols that ISDH requires them to perform. It is hoped that this reminder plus the development of a hospital "report card" with participation feedback will improve hospital reporting compliance.

Indiana Childhood Lead Poisoning Prevention Program (ICLPPP)/ Injury Prevention Section has been working at the infrastructure building level of the pyramid to implement these population-based focused programs.

The Indiana Childhood Lead Poisoning Prevention Program (ICLPPP), which MCHS began funding in 1983, provides technical assistance and consultation to the medical provider network who screen at-risk children, and to health departments, child day care field inspectors, and providers of medical and environmental follow-up services. This program works with three labs to process blood lead screens. The ICLPPP also tracks children with lead poisoning to ensure they receive care. The mission of this program is *to increase screening and follow-up care of children who most need these services;* and *to help communities pursue the most appropriate approach to the prevention of childhood lead poisoning.* In October 1999, ISDH received an

award for the innovative use of technology from the National Association of State Information Resources Executives (NASIRE) for the development of its Geographical Information Systems Lead Poisoning Prevention application. Through the NASIRE affiliation, the ICLPPP maps have been located in the Library of Congress in Washington, DC.

The MCHS Injury Prevention Program has been limited by lack of staffing. The Team Leader of this section has spent about 10% of her time in networking and building infrastructure with other agencies and organizations within the state concerned with the childhood injury issues. It is hoped that staffing for Injury Prevention will be expanded and the program improved.

A Childhood Hazards Prevention Law (IC 16-41-40) was adopted without funding naming ISDH as the implementing agency. This law expands the support for *Shaken Baby Syndrome* education to include development of an education program on consumer product safety, motor vehicle accidents, drowning, fires, falls, etc. Firearm education is not included in this mandate. MCHS is establishing a program coordinator position to develop a collaborative program to address these population-based issues.

MCHS received a one year grant in 1999 from MCHB to conduct a needs assessment. MCHS contracted with the Brain Injury Association of Indiana to identify unmet needs of Traumatic Brain Injury (TBI) survivors and their families. This association is to facilitate an infrastructure of public and private organizations, professionals, persons with TBI and their families to enhance services and produce a report on their fundings.

The Health Systems Development (HSD) Section includes subject matter experts that coordinate several MCHS programs. The HSD Section works closely with the ***Grants Coordination Section*** in contracting with grantees to implement portions of the programs.

The Indiana Adolescent Health Program's goals are to improve Indiana adolescent health status regarding six major health risks (tobacco, alcohol and other drugs, sexual activity resulting in pregnancy/HIV/STD, intentional and unintentional injuries, nutrition, and physical inactivity) and increase Indiana

adolescent access to primary health care services. The State Adolescent Health Coordinator manages the Indiana RESPECT (Indiana Reduces Early Sex and Pregnancy by Educating Children and Teens) Adolescent Pregnancy Prevention Initiative, provides programmatic consultation to four Title V funded school-based adolescent health centers, works in collaboration with other public and private entities (including the American Legacy Foundation Statewide Youth Movement Against Tobacco Use) to design, develop, and implement statewide initiatives to improve adolescent health, and will coordinate implementation of the Indiana 2001 Youth Risk Behavior Survey to be done in FY 2001.

Indiana RESPECT, Indiana's adolescent pregnancy prevention initiative uses State Adolescent Pregnancy Prevention funds ($642,782/year for State Fiscal Year 2000 and 2001) and Federal Sexual Abstinence Education Block Grant funds ($857,042/year for Federal Fiscal Year 2000 and 2001) to fund four components: (1) community grant program, (2) community grant program evaluation, (3) statewide media campaign, and (4) technical assistance/training. For the community grant program component, specific applications were distributed in May 1999 to solicit proposals for the distinct State and Federal funding programs. For FFY 2000-2001, 34 federally-funded grantees are providing programs that stress sexual abstinence until marriage. Thirty-two state-funded grantees are providing adolescent pregnancy prevention programs that stress sexual abstinence throughout the teen years. Grantees are providing these programs in a variety of youth-serving organizations including schools, faith based organizations, and community organizations.

For the evaluation component, a six-member evaluation team comprised of faculty representing four state universities has been contracted to design, develop, implement, and analyze an outcome evaluation of the community grant programs. Grantees have been invited to participate on a voluntary basis in the evaluation which will include a pre/post/delayed-post design. Implementation of the evaluation process is scheduled for Spring 2001.

For the media campaign component, Montgomery, Zukerman, and Davis, an Indianapolis advertising agency, will continue to implement and measure the effectiveness of Indiana's statewide sexual abstinence and adolescent pregnancy prevention media campaign, "Sex Can Wait—I'm Worth It." During FY

2000-2001, the media campaign will include statewide teen and parent media flights (TV, radio, billboards, print ads) scheduled for May 2000, October 2000, and May 2001. Distribution of materials, including brochures, posters, and static stickers will also continue. Free broadcast-quality copies of the media materials are provided to local communities for local campaign initiatives and local media scheduling. Awareness and recall of the media campaign will be assessed by telephone surveys completed with Indiana teens and parents after each broadcast flight of the TV and radio spots.

Healthy Pregnancy/Healthy Baby Campaign (HP/HB), initiated by MCHS in 1988, is a population-based enabling service intervention to impact high infant mortality rates and low percentages of women receiving early prenatal care. The Campaign provides agencies serving women of child bearing age free pregnancy tests to use as an outreach service for hard to reach clientele. The goals of the program have expanded. They include the initial goals of: (1) assisting pregnant women in obtaining early prenatal care, Hoosier Healthwise, and WIC; (2) encouraging women to obtain their high school diploma or GED; (3) decreasing infant mortality and morbidity and the incidence of low birthweight; and (4) assisting local communities and MCHS to assess for service gaps for planning of future programs. With the expansion of Hoosier Healthwise, HP/HB Campaign added a goal of assisting non-pregnant adolescent women into the health care system through Hoosier Healthwise enrollment. This early version of prenatal care coordination with free pregnancy testing targets the adolescent population, women without high school diplomas, and low-income women, but no woman is denied the free pregnancy test. Through this Campaign an infrastructure of agencies with a focus on child-bearing women has been develop and has provided MCHS with an ongoing database for assessment and evaluation of services offered and needed by sexually active, low income women. This program is available in 90 counties. Over 46,000 individuals are served annually. All HSD consultants provide training to agencies in their assigned regions in test procedures and protocols and log completion.

Prenatal Health Care Services are provided through grants to agencies serving pregnant women with direct prenatal medical services, such as Early Start (initial prenatal services) or full prenatal clinics, or enabling prenatal care

coordination services. The primary objective of these grants is to decrease infant mortality and low birthweight infants by providing quality, comprehensive, holistic health care to low income pregnant women in community settings. The direct medical and enabling services target pregnant women with low incomes and pregnant women who are high-risk because they reside in medically underserved areas. MCHS staff is also responsible for the training and certification of community health workers to assist prenatal care coordinators and providing consultation to the two Healthy Start Programs in Indiana.

MCHS in conjunction with the Indiana Perinatal Network has developed perinatal health standards based on ACOG and AAP recommendations. These have been distributed by both groups to both public and private health care practitioners, hospitals, and support personnel. Prenatal health education topics for population-based education efforts and local community systems changes have been gleaned from Fetal and Infant Mortality Reviews. Over the past decade, MCHS has supported five such in depth reviews and has created a mini-review format that hospitals, clinics and physicians' offices can use to determine systems gaps. The identified gaps in the systems have been developed into *Lessons Learned in Fetal and Infant Mortality Reviews,* educational pieces for professionals and consumers. These are being widely distributed through MCHS and Indiana Perinatal Network.

Prenatal Substance Use Prevention Program (PSUPP) is funded primarily through a grant from FSSA, Division of Mental Health Addictions Prevention and supplemented with Title V Federal – State Block Grant Partnership. The goal of PSUPP is to prevent birth defects, low birthweight, premature births, and other problems associated with prenatal substance use. There are three primary objectives: (1) identify high risk, chemically dependent pregnant women, provide perintal addiction prevention education, promote abstinence, provide referrals for treatment, and follow-up; (2) facilitate training and education for professionals and paraprofessionals who do not provide substance abuse treatment, but do work with women of childbearing age, on how to identify high risk, chemically dependent women; and (3) provide public education on the possible hazards to a fetus when alcohol, tobacco, and other drugs are used during pregnancy. Free posters, brochures, and other materials

are available upon request through the Indiana Family Helpline. Division of Mental Health funding supports enabling services for drug use cessation in seven grantee agencies. In addition, the PSUPP Director/HSD consultant builds professional capacity through professional training. This program also interfaces with smoking cessation efforts with MCHS prenatal services and ISDH by providing public education.

Genetic Disease Program (GDP) bridges the perinatal and child health services. The Genetics Disease Program strives to increase the awareness and understanding of genetic conditions and to ensure that all of the approximate 5,000 infants born in Indiana each year with birth defects or genetic conditions have access to genetic services. The goals of the program are to educate the families and children with genetic disorders or birth defects about the disorders and available services; educate the public and health care providers about genetic disorders and available services; minimize the psychosocial problems connected with these disorders and; promote knowledgeable decision-making about reproduction and health care through non-directive, supportive counseling. The current goals of the GDP are: (1) collaborate and coordinate with the Regional Genetic Centers (both state sponsored and private providers of genetic services) as well as local agencies, individual providers, hospitals, health departments, the Indiana Perinatal Network (IPN), and the Indiana Chapter of the March of Dimes; (2) build public health genetics capacity within ISDH; (3) increase public and professional awareness of genetics; (4) assure access to services; (5) enhance genetic data collection statewide; and (6) improve the quality of the birth defects surveillance system. MCHS funded projects offer genetic testing, evaluation and counseling, and prenatal diagnosis through support of five regional genetics projects that sponsor clinics in thirteen sites. The HSD Genetics Program Director offers consultation to these and nine (seven non-funded and two state funded) additional Genetics Centers/Programs in Indiana.

The HSD Genetics Program Director also facilitates the Folic Acid Initiative, sponsored by Title V and WIC—a population-based education effort--and *Genetics and Your Practice*, sponsored by MCHS and March of Dimes, a professional training opportunity. She is responsible for educational materials for professional and lay persons about genetics counseling, a statewide genetics

newsletter, a directory of Indiana Clinical Genetic Services overseeing implementation of the state planning grant, and convening and staffing a Genetics Advisory Committee.

For FY 2001-2002 a genetics planning grant from MCHB has been awarded to this program. The goal is to expand and integrate genetics beyond perinatal and child health, begin to interface databases to improve the quality of birth defects surveillance, and to develop a state genetics plan.

Children's Health Care Services are provided through grants to agencies that provide direct medical services or enabling services to children. Many of these grantees are community health centers or are a part of a larger health care facility. They provide direct health care services and health and safety education. MCHS, using AAP guidelines and Bright Futures, has developed Standards of Care for children 0-21 years of age.

Family Care Coordination is an enabling service provided by grantees that facilitates high-risk families into needed services. Home visiting is used in this service. One grantee, the Riley Hospital Comprehensive High-Risk Newborn Follow-up Program, provides follow-up to children and their families who are at the highest risk, medically and developmentally of morbidity or mortality. The goal is to build community-based infrastructure for these fragile children. Grantees that provide family care coordination are also used by the CSHCS program. MCHS staff is currently updating the Family Care Coordination Manual which outlines standards of care for care coordination services. This manual is used to train family care coordination grantees and CSHCS local care coordinators.

Family Planning/Women's Health Services are also provided through local grantee agencies. The Indiana Family Health Council (Indiana's Title X agency) is contracted to provide clinic monitoring and standards of care.

Infant Mortality/Special Projects Section oversees the functioning of two grantees, the IPN and the Family Preservation Program at the Indiana Women's Prison.

The Indiana Perinatal Network, Inc. is the implementation instrument for the collaborative action plan, *Indiana Perinatal Systems Strategic Plan for the 21st Century,* released in June 1996. This plan was developed through a series of regional town meetings and state task force groups. This group is involved in infrastructure building, professional and public education on perinatal health issues, and the development of quality assurance standards of care for perinatal services in Indiana. This grantee houses the Sudden Infant Death (SIDS) program and the MCHS breastfeeding Program through the IPN subcommittee. This grantee has a Board of Directors, a statewide Advisory Board for program planning, Regional Perinatal Advisory Boards, a Speakers Bureau, and a multi-media Public Education Campaign. The IPN also publishes *Indiana Perinatal News* (IPN newsletter), the *Indiana Prenatal Online Magazine* (web site), consumer information, *Clinical Practice Alerts,* critical reports, and consensus documents like the *1998 Indiana Prenatal Guide*.

Sudden Infant Death Syndrome (SIDS) Program is funded by Title V through a grant with the Indiana Perinatal Network, Inc. The funding supports a parent who facilitates the development of support groups and provides direct counseling and education. She also facilitates groups interested in providing education about SIDS. Through the program, parents of children who have died receive a condolence card, a referral to a support group in their area, and a referral to the IFHL for community resources. Some receive a visit from a public health nurse. The SIDS program also provides training and training tools for first responders (firemen, EMT staff, and police) and coroners. The "Back to Sleep" Campaign continues to be emphasized to all mothers, grandmothers and caretakers.

Indiana Womens Prison Responsible Mothers/Healthy Babies is a program established to build and preserve the mother/child/family bonds while women are in prison. The program has four major components: (1) therapeutic, education, and support groups that provide parenting skills to mothers and grandmothers; (2) a family care coordination program for pregnant women that includes parenting education and facilitation of the child's placement after birth; (3) a visitation center and day camp to provide the opportunities for parental bonding; (4) special holiday parties that can be family times.

Grants Coordination Section facilitates the contracts both within and outside ISDH. MCHS supports several programs within ISDH.

Oral Health Program focuses on education and prevention with a special emphasis on fluoridation. Oral Health staff provides technical assistance and surveillance to communities and schools with fluoridated water supplies (about 1500 site visits per year). Indiana currently has 98.6% of its citizens served by over 700 municipal water systems receiving optimally fluoridated water. Title V also supports the Division's community-based pit and fissure sealant program which was initiated in 1994. This program's objectives include (1) promoting the use of sealants throughout Indiana and working toward the national health objective to have 50% of children with sealants by Year 2010, and (2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in community dental health programs.

Indiana Poison Center continues to be funded by a contract with Clarian Health Partners, Inc. The center is designated by ISDH as the Regional Poison Information Center and operates a 24-hour phone service to assist and refer persons who have been exposed to potentially poison substances and educate those who are seeking information. CSHCS provides funding.

"Tobacco: It's Gonna Cost You" Communication Campaign was created to support Indiana's youth who have not begun to use tobacco and to keep them from initiating tobacco use. This media campaign was focused on 10 to 14 year olds in 36 mid-state counties. The multi-media campaign included a "Name the Dog" in the commercials contest. According to a Gallup evaluation study, the campaign has had a positive impact on attitudes and some behaviors of the youth—smoking initiation has been postponed. This program is also trying to obtain and verify baseline data on youth smoking behaviors.

Data Team Section provides data entry, technical support, and data analysis to MCHS staff. The team leader has coordinated the current Title V Needs Assessment process.

CSHCS State Consultant Section provides technical assistance, consultation, and systems development to grantees providing local care coordination. These

staff will also become subject matter experts in areas related to children with special health care needs. Topic areas will include asthma, transition, infant hearing impairment, family involvement, and others.

Asthma Prevention Program is the first topic area to have a point person. This program is in its infancy and currently is gathering resources, information, and contacts necessary to develop a program plan. A task force made up of MCHS, CSHCS, and ERC staff is working with an Asthma Coalition that is being organized by the Indiana Department of Environmental Management (IDEM).

Sickle Cell and Other Hemaglobinopathies Programs are funded by CSHCS but the consultant is housed in the Minority Health Office of ISDH. This program pays the public high-risk insurance premium for hemophilia CSHCS clients, provides penicillin, education, care coordination, and counseling for sickle cell clients in the state. There are four regional sites for the care coordination. This consultant also facilitates three contracts with the Indiana Hemophilia and Thrombosis Center, Inc. (IHTC). One contract funds the provision of statewide outreach to Amish persons with bleeding disorders. The program provides home visits, health care services, an annual health clinic and factor concentrate to those affected. The second contract funds a dental clinic for Amish children in northern Indiana to provide dental care, achieve optimal fluoridation, and increase awareness of oral health and disease. The third contract funds a statewide sickle cell education and practitioner assistance program. The program provides education and consultation to primary and hospital emergency room providers about current therapy for sickle cell disease complications and educational materials to health care providers and patients' families.

Statutes relevant to Title V services have been indicated throughout this document. However, one law enacted in the Indiana General Assembly in 2000 is SEA 79 which expanded the Medicaid disability medical requirement for coverage to include persons who are unable to work and have a physical or mental impairment, disease, or loss that appears reasonably certain to last for at least four years without significant improvement. This bill also eliminates the requirement that parental income is counted for blind and disabled students who are between the ages of 18 and 21 and allows verification of a qualifying

diagnosis of *mental* impairment, disease, or loss to be made by a psychologist. This may impact CSHCS clients by providing them with Medicaid coverage in addition to CSHCS supplemental coverage.

1.5.1.2 Program Capacity

MCHS provides direct preventive and primary services to pregnant women, new mothers and infants by providing grants to 26 agencies. These grantees have estimated that they will provide prenatal care services in 21 counties to approximately 5,997 pregnant women and primary/preventive health care services to 6,611 infants under one year of age in FY 2000.

MCHS supports direct preventive and primary health services to children and adolescents by providing grants to 23 agencies that provide these services in 39 counties. These grantees estimate they will serve approximately 24,350 children from 1-21 years of age in FY 2000. A total of 2,252 children and their families will receive genetics services from 5 grantees.

There are 19 grantees that provide the enabling service of family and/or prenatal care coordination either in conjunction with direct medical service or as a separate service. Family care coordination through MCHS is offered by 10 programs; prenatal care coordination is offered by 23 programs. The grantees providing family care coordination estimate they will provide services for approximately 1,341 families in FY 2000. The grantees providing prenatal care coordination are projected to serve 4,552 pregnant women.

In FY 2000 MCHS has funded 6 grantees that provide family planning services in 36 counties. These agencies will serve approximately 10,737 clients during the fiscal year. One grantee has been funded to provide women's health services in Tippecanoe County.

CSHCS has increased the number of grantees through outsourcing for local care coordination. Currently, 31 agencies are providing local care coordination in 79 counties. This covers about 95% of the CSHCS clients (based on enrolled client numbers obtained in February 2000).

MCHS-funded programs are monitored and provided technical assistance by six multidisciplinary Health Systems Development consultants supervised by two Public Health Administrator I team leaders (one position vacant). Four of these consultants have assigned counties and are responsible for providing consultation to the grantees in those counties and for facilitating to improve the health systems in those counties if necessary. Two of the consultants have specific program areas—genetics and adolescent health—that are statewide and they provide consultation to grantees and leadership in population-based programming for these topics.

The team leaders also provide MCHS expertise in infrastructure building at the state level. Due to staff shortages and Y2K computer updates, consultants have spent more time providing in-house expertise, reviewing grants and providing technical assistance to grantees than facilitating health systems development.

Newborn Screening Program, which provides training, tracking and follow-up for newborn metabolic, hearing, and meconium screens as well as administers the laboratory contract and training protocols for newborn screens, currently has a staff of three—a new program director, a secretary, and a program coordinator for newborn screening follow-up (currently vacant). The staff is assisted by the Genetics Program Director and the Prenatal Substance Use Prevention Program (PSUPP) Director—both Health Systems Development consultants.

ICLPPP has four field representatives (one vacancy) supervised by the Public Health Administrator I team leader. The staff works closely with the Indiana Department of Environmental Management and community lead task forces.

An injury prevention coordinator position is planned to be added to the MCHS ICLPPP/Injury Prevention section, which will broaden the scope of this section to include environmental conditions related to the health of children and families. MCHS contracted with the Brain Injury Association of Indiana to identify unmet needs of Traumatic Brain Injury (TBI) survivors and their families and to facilitate an infrastructure of public and private organizations, professionals, persons with TBI and their families to enhance services.

MCHS Data Analysis Section also has a new team leader and additional new duties because the External Information Services is now responsible for the functioning of the new MCHS data collection program. Data entry for short-term projects and projects done in-house will now be part of the charge of this MCHS section as well as analysis of the data collected on the new MCHS system. The team leader is assisted by a secretary, two data entry staff, and a contracted data analyst.

The Grants Coordination Section of MCHS is responsible for facilitating all contracts with MCHS and CSHCS, preparing project grant application packets, facilitating the reviews of the MCHS applications, and monitoring grant expenditures. This section makes Title V budget planning recommendations and liaisons with ISDH Finance. The section has a grants coordinator, two administrative assistants and a program coordinator. MCHS also supports one dentist (position vacant), a dental hygienist, four fluoridation staff and a secretary in the Oral Health Program.

Children's Special Health Care Services (CSHCS) has an eligibility section, a reimbursement section, and a care coordination section. Eligibility section staff review applications to determine eligibility and inform the applicant of the decision. The reimbursement section enrolls CSHCS medical and other service providers into the program, and processes the reimbursement for the services rendered by over 7,000 providers. It has been necessary in the past two years to add temporary staff to respond to increased applications due to the collaboration with First Steps and the resulting increase in claims. Implementation of the new computer system has also added to the need.

In eligibility, the program director supervises three nurses and five support staff (plus one vacancy), supplemented by two temporary employees and a contract employee. The team leader who directs the reimbursement section has 4 professional FTEs, 7 support FTEs, a vacant FTE position in each category, and 13 temporary staff. The need for temporary professional help in eligibility diminished once the backlog of applications was reduced. However, temporary employees are still needed to process and pay claims as the new computer system is implemented.

The staff of the Indiana Integrated Services for Children with Special Health Care Needs includes the director, a health educator, and a secretary. The SPRANS grant is in its final year of funding.

Eight care coordination state consultants (2 nurses, 6 social workers) are currently employed to provide consultation and technical assistance to the grantees providing local care coordination. Specific of the consultants continue to have direct service care coordination with clients. The role of the state consultant has/is changing as care coordination is being transferred to local providers. There are three support staff in CSHCS.

Of the eight state care coordination consultant positions currently filled, five state consultants have offices around the state. Support staff includes 2 FTEs and one temporary staff at the centralized location and three at the regional offices. There are 5 state consultant position vacancies.

1.5.1.3 Other Capacity

In the first half of FY 2000 MCHS staff has had some fluctuation. The vacancy left in Newborn Screening Section when the NBS director was promoted to Assistant Director was filled; the Data Analysis Director retired and was replaced; and one of the Health Systems Development Team Leader position is to be refilled. None of the new employees has previously worked in Maternal and Child Health Services.

The management team consists of the Director, Assistant Director, two HSD Teams Leaders who split their time between CSHCS and MCHS (one position is currently vacant), the Director of the Data Analysis Section, the Director of the NBS, Public Health Administrator for ICLPPP and Injury Prevention, the Grants Coordinator, and a Chief Nurse Consultant II who is liaison to grantee health systems development efforts in the area of prenatal health. The Director is a pediatrician with a Masters of Public Health. The Assistant Director with business and automation skills coordinates personnel and facility issues for MCHS, supervises the attendance of the team leaders, and coordinates the overall MCHS budget with the Finance Department of ISDH and the MCHS grants coordinator. Other professional skills and degrees within the MCHS

leadership group include a health educator with a Masters in Education, a Registered Dietitian with an MPH, a nurse with an MSN, an MSW, an MA/MPA, and an MPH student.

Two Public Health Administrator I Team Leaders supervise the Health Systems Development staff. The professional consultants include one MSN, one Ph.D., one MSW, and three MSs (one an RN and one a Certified Health Education Specialist [CHES]). One of the HSD consultants is based out of her home. This section has a support staff of one administrative assistant, one secretary, and one temporary secretary.

The IFHL staff includes the supervisor, two full time communication specialists, one data coordinator/communication specialist, two communication specialists contracted through a grantee, and two temporary support staff. This staff number will be reevaluated as the IFHL begins to market services at FSSA.

CSHCS staffing has become more stable in FY 2000. The management team includes the Director, Program Manager, Eligibility Manager, Reimbursement Manager, one FTE Care Coordination Team Leader and two split-time Care Coordination Team Leaders (one vacant), SPRANS Grant Coordinator, and CSHCS historian and computer expert. The Director is an RN with a DNS in Nursing and a JD. Other professional skills and degrees in this management group include RN/MSN, RN, RD/MPH, and several with good skills in business and management.

In addition, Title V Federal – State Block Grant Partnership supports seven professional staff, one contractual position, and one temporary support staff in Oral Health Services; one lawyer in ISDH legal department; two Information Technology Services staff plus three contractual positions in ITS; and one Epidemiology Resource Center professional.

Within MCHS and CSHCS state staff are approximately seven parents or grandparents of children with special health care needs. Two are directly involved in the management team and activities of the CSHCS and four are part of the IFHL. MCHS, through a contract with the Indiana Perinatal

Network, Inc., supports a SIDS parent who runs the SIDS program in Indiana. Of the local care coordinators contracted by CSHCS, thirteen have children or grandchildren who have special health needs. Utilization of these and other consumers of the services of MCHS and CSHCS will be emphasized in the next five years.

1.5.2 State Agency Coordination

State agency coordination continues to improve, particularly between FSSA and ISDH. Efforts to implement Hoosier Healthwise and its SCHIP expansion have provided opportunities for OMPP and ISDH/MCHS to plan together. Both of the Directors of MCHS and CSHCS staff the Child Health Policy Board and the Director of CSHCS co-chairs the Advisory Committee for Children with Special Health Care Needs. MCHS, CSHCS, and OMPP are currently updating the Memorandum of Understanding (MOU) between the agencies. This MOU will address general areas of collaboration and data interchange as well as specific issues like reimbursement for lead lab tests, IFHL outreach for FSSA services, and case management reimbursement for children with special health care needs who are eligible for both Hoosier Healthwise and CSHCS.

Currently, the Indiana Family Helpline is collaborating with FSSA to possibly consolidate some state "800" numbers by marketing the IFHL instead. Also, the two agencies together will participate in discussions with information and referral groups and United Ways in Indiana regarding a statewide "2-1-1" non-emergency social service information and referral number. This collaboration may lead to future expansion of the IFHL.

Welfare reform continues to foster collaboration. Healthy Families Indiana expansion continues with financial support from welfare savings. This program provides extra support for families affected by the reform. The IFHL provides internship training for TANF clients who are making the transition from welfare to work.

Coordination and collaboration with the Indiana Minority Health Coalition (IMHC) remains primarily through the MCHS grantee consultation. MCHS provides funding for prenatal care coordination (case management) and support services to pregnant minority women in two of the most populous counties as part of the effort to lower minority infant mortality and disparity. Through 15 local Minority Health Coalitions, IMHC provides an immunization outreach program. These local outreach efforts usually work with local health departments or MCH projects to provide the immunization and health care.

The staff of the Indiana Integrated Services for Children with Special Health Care Needs SPRANS grant, developed jointly by CSHCS and the First Steps Early Intervention Program, has been very active in coordinating the programs within Family and Social Service Administration (FSSA) (including Medicaid, Division of Families and Children, and the Bureau of Child Development) with MCHS and CSHCS within ISDH. The outcome goal of this grant is to increase access to local medical homes and coordinate community-based services for families of young children, birth to age 3, with special health care needs through collaborative linkages at the state and local levels. This project has implemented a combined enrollment form to ease access to First Steps, CSHCS, MCH and Medicaid, a health passport notebook for foster and special need children, and the inclusion of a Systems Point of Entry (First Steps) intake worker in the discharge process from neonatal intensive care units. Training efforts as part of the SPRANS grant include a four-part video package independent study program for physicians and their staff (including resource and reference manual) to train local physicians to work with special needs children, an infant mental health task force to develop provider training, and training for child care providers to care for special needs children.

MCHS continues to contract with the Indiana Family Health Council, Inc. (IFHC), a private not-for-profit agency that serves as the Title X grantee, to monitor the Title V family planning agencies. The contract also allows Title X to provide training and technical assistance to Title V family planning agencies. The Title V family planning agencies utilized the Clinic Visit Report (CVR) Data System used by Title X during the first quarter of FY 2000. This data began being entered on the MCH system after January 1, 2000.

MCHS is in the second year of funding five high-risk county health departments $20,000 per year to provide maternal and child health services they identified as lacking in their county. Starke, Martin, and Orange County are focusing on improving immunization outcomes in their county by expanding clinic hours and sites. Southern Indiana Community Health is providing prenatal and family care coordination. The Switzerland County Health Department's projects include expanded immunization hours, providing family planning services, and providing children in day care with public safety information.

Healthy Families Indiana (HFI), a child abuse prevention initiative, is available in all 92 counties from 59 sites and has expanded in FY '99 through funding made available through welfare reform. This program, a part of Healthy Families America, provides support to families with their first newborn whose hospital or prenatal screens indicate that they are at risk for child abuse. It is a voluntary program. It was initially begun through coordination of funds of FSSA, MCHS, and Indiana Criminal Justice Institute. All three agencies have continued support and there is on-going state support through TANF funds, a specialized license plate, *Kids First,* and other sources. A more formal infrastructure has been developed to provide training, technical assistance and quality assurance to HFI sites. Training for HFI is contracted through the Indiana University School of Nursing.

Due to MCHS support, HFI has included family physical health parameters as part of its goals, data collection, and evaluation. During FY '99 this program assessed 12,000 families and provided home visitation support for 8,900 families. Of the families served 99% have no reports of substantiated abuse, 90% of the children have age appropriate immunizations, and 80% of the families have a medical home.

MCHS and CSHCS continue to link with state universities through the development of the Masters of Public Health Program at Indiana University and the Center for Public Health Leadership and Education. Medical students from the Indiana University Medical School are provided with preceptors for a public health rotation. Riley Infant and Childhood Nutrition Fellows at Clarian's James Whicomb Riley Hospital for Children are provided Title V background information and field observation experience. MCHS staff also provides an internship for a genetics specialist student. MCHS staff participates in the planning of the Childhood Nutrition training program funded by an MCHB grant. The MCHS and CSHCS directors serve on the advisory board for the MCHB funded Adolescent Health Training Program, Riley Child Development Program, and Behavioral Pediatrics Program.

MCHS staff continues to assist HFI, Indiana's Children's Trust Fund (Kids First License Plate Fund), and departments within ISDH in reviewing grant applications for state and federal dollars. In FY 2000 distribution of Tobacco Trust funds will be included in these reviews.

II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

FY'99 Summary Expenditures

Component A	Services for Pregnant Women, Mothers, and Infants up to age one
Component B	Preventive and Primary Care Services for Children and Adolescents
Component C	Family Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care Needs and their families

Administrative Expenditures — Rates approved in the Rate Agreement between ISDH and DHHS are for use on grants, contracts, and other agreements with the federal government subject to the conditions in Section III. Indiana considers indirect costs to be the administrative costs of the program.

	Dollars	Percentages
Component A	$ 3,879,498	30.93%
Component B	$ 4,343,549	34.64%
Component C	$ 3,909,982	31.17%
Administrative Expenditures (Indirect Costs)	$ 409,290	3.26%
Grant Total	**$12,542,319**	**100.00%**

FY'99 Expenditures by Type of Services

I. Direct Medical Care Services

The $4,543,610 expended at this level includes all community grants which provided direct services and MCH State Supplemental funds.

II. Enabling Services

The $17,999,393 expended at this level includes all community grants which provided enabling services, Hemophilia insurance premiums, and CSHCS state funds.

III. Population Based Services

The $1,602,912 expended at this level include all community grants which provided population based services, Newborn Screening funds, Test for Drug Afflicted Babies, and Indiana RESPECT funds.

IV. Infrastructure Building Services

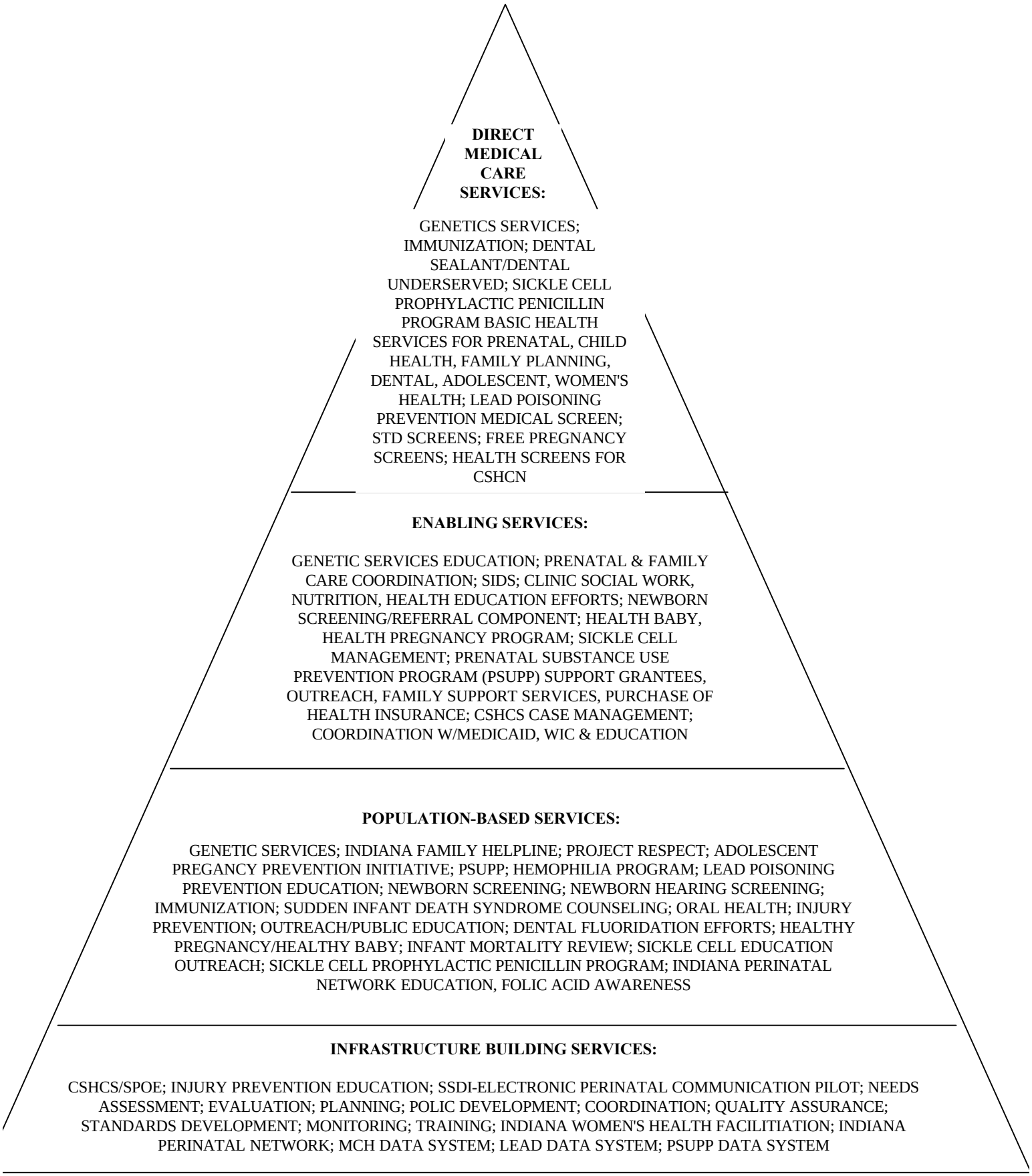
The $5,929,270 expended at this level includes salaries of all staff and other operating expenses minus insurance premiums and community grant funds.

Total FY'99 Federal-State Title V Block Grant Partnership Expenditures $30,075,185.

Indiana's year-to-year unobligated balance appears high and actual reporting year expenditures appear low. This is due to the way the information is reported [See Form 3 (SD3.1)]. The FY'99 federal funding expended is actually the sum of the FY'98 Unobligated Balance ($5,056,955) and the FY'99 Federal Allocation Expended ($7,818,170), which is $12,875,125. Indiana is fully utilizing the federal grant.

See Forms 3, 4, and 5.

FIGURE 2: CORE PUBLIC HEALTH SERVICES



2.2 Annual Number of Individuals Served

See Forms 6, 7, and 8.

2.3 State Summary Profile

During FY'99, MCHS used the Title V grant to fund 4 adolescent health centers, 7 family planning programs, 6 genetics centers, 23 prenatal care coordination programs, 15 prenatal care clinics, 19 child health project, 10 family care coordination programs, 1 feta and infant mortality review project, and 1 high risk infant follow-up program. Funds were also used to support special projects including Health Families Indiana, the IPN, grants to local health departments in underserved counties, and Prevent Child Abuse, Indiana.

FY'99 significant accomplishments include:

- Indiana Perinatal Facilitators have been working to establish local or regional advisory boards. In FY'99 there were 20 Regional Perinatal Advisory Boards that covered 62 of the 92 Indiana counties.
- The *Baby First--Right From the Start* media campaign began development in FY'98, and was implemented in January '99.
- Indiana Integrated Services, a Special Project of Regional and National Significance (SPRANS) grant continued in its second year to develop integrated services for children with special health care needs.
- Two distinct Requests-for-Proposals were developed and distributed to agencies throughout the state to fund projects for Indiana RESPECT, Indiana's adolescent pregnancy prevention initiative. For FY'98 and FY'99, 52 federally-funded grantees provided programs that stress sexual abstinence until marriage, and 29 state-funded grantees provided adolescent pregnancy prevention programs that stress sexual abstinence throughout the teen years. Grantees provided these programs in a variety of youth-serving organizations including schools, faith-based organizations, and community organizations.
- Indiana RESPECT also developed a media campaign *Sex Can Wait-I'm Worth It*. Four teen and one two-part parent media spots were developed in FY 1998 and broadcast during FY 1998 and FY 1999. Teen billboards and parent print ads were also placed in major media markets. Collateral printed materials, including teen brochures and posters and parent brochures were distributed to community grantees and the general public. Effectiveness of the media campaign was assessed by telephone surveys completed with 300 teens and parents after each quarterly broadcast of the media spots.
- Maternal and Child Health Services (MCHS) and External Information Services (EIS) continued to work with an outside vendor to develop a new Y2K-compliant data collection system. It is anticipated that this system will collect data in a user-friendly method and allow MCHS to report on Performance Measures that were previously unavailable. Children's Special Health Care Services (CSHCS) continued to work toward the upgrade of their data system. CSHCS has purchased a system that,

when completed, will handle claims payment and eligibility determination. This system will also track CSHCS-specific performance measures and provide needed data for the FY 2000 annual report.

- The Healthy Pregnancy/Healthy Baby Campaign provided over 46,000 free pregnancy tests to Indiana women. Eighty-seven percent of these women with positive pregnancy tests were referred for care in the first trimester.
- MCHS continued to collaborate with the two federally funded Healthy Start grants. On-going technical assistance is offered to the Healthy Start grants in Marion County (Indianapolis) and Northwest Indiana (Hammond, Gary, East Chicago, and Lake Station). MCHS-funded projects in these areas continue to collaborate through collocation or agreements for referrals.
- The Combined Enrollment Form has been revised for use by the Children's Special Health Care Services program, MCHS-funded providers, First Steps Early Intervention program, and Indiana Medicaid. This form has decreased duplication in enrolling clients into services.
- CSHCS continued to work toward providing community-based care coordination for clients. Twenty-seven grantees delivered care coordination services in 55 Indiana counties in FY'99.
- CSHCS continued to fund the Sickle Cell Disease Education and Practitioner Assistance Program to develop and provide statewide sickle cell education to physicians and health care practitioners.
- CSHCS continued to fund the Indiana Hemophilia and Thrombosis Center, Inc. to provide services to a large underserved and uninsured population of Amish families in northern Indiana with significant untreated dental disease. The outreach clinic provided services in Elkhart County until November, 1998 when a permanent site was opened in LaGrange County.
- CSHCS continued to fund the Hemophilia and Thrombosis Center, Inc. outreach program to Amish persons with bleeding disorders.
- MCHS continues to fund the Indiana Minority Health Coalition Nurturing Assistance to Assure Life Expectancy (NATALE) program to provide prenatal care coordination to minority pregnant mothers in Lake and Vanderburgh Counties.
- MCHS funded Parent Child Abuse, Indiana to distribute information regarding Shaken Baby Syndrome to all public and private primary health care providers throughout Indiana.

2.4 Progress on Annual Performance Measures

Data used to evaluate performance measure progress is the latest available. In the past, the state of Indiana has reported information that is available on a calendar year basis (birth information, death information, etc.), in the fiscal year following the calendar year. For example, birth information for CY 1998 was reported in the FY 1999 column on Form 11. The rationale for this reporting mechanism was that a portion of CY 1998 was in FY 1999. Also birth and death records information is usually at least two years old.

However, based on new guidance from MCHB, this year's application/report will report information that is available only for a calendar year in the fiscal year column that contains the majority of that calendar year. In other words, CY 1998 data is being reported in the FY 1998 column. Through the efforts of our staff and our needs assessment contractor, all historical information on Forms 11 and 12 has been rechecked for accuracy and is now listed in the correct column. The historical values on this year's forms should replace the previously reported information.

This change causes some difficulty in our reporting for this past fiscal year. Information which was originally going to be treated as FY 1999 information is being reported on this report as FY 1998. This causes some confusion as to which objectives should be applied to that information; FY 1998's objectives or FY 1999's. In this year's report, wherever this issue arises, the previously reported objectives for FY 1999 will be compared to the measure information for FY 1998 and noted with an asterisk (*) in the Annual Report narrative. This will allow for some continuity in reporting. On Forms 11 and 12, new objectives for the years 1999 through 2005 are reported. These objectives will be compared to the data for that year in future reports.

INFRASTRUCTURE BUILDING SERVICES

All Targeted Populations (Pregnant Women, Mothers, and Infants; Children; and Children with Special Health Care Needs)

Significant Activities:

- During FY'99, Maternal and Child Health Services (MCHS) and External Information Services (EIS) continued to work with an outside vendor to develop a new Y2K-compliant data collection system. This system will collect data in a user-friendly method and allow MCHS to report on Performance Measures that were previously unavailable. This system will be in place in early FY 2000. FY'99 data from the old data collection system is available for the FY'99 annual report.
- During FY'99, Children's Special Health Care Services (CSHCS) continued working toward the upgrade of their data system. CSHCS has purchased a system that, when implemented, will handle claims payment and eligibility determination. This system will also track CSHCN-specific performance measures and provide needed data for the FY 2000 annual report.
- During FY'99, MCHS continued to contract with the Indiana Family Health Council (IFHC), a private, not-for-profit agency serving as the grantee for Title X funds within Indiana, to monitor all Title V family planning agencies for compliance with all appropriate rules, regulations, and guidelines stated for Title X and Title V projects through a comprehensive site review at least once during a three-year period. Three comprehensive site reviews took place in FY'99. IFHC provided copies of the review reports on the Title V agencies to MCHS.

Pregnant Women, Mothers, and Infants

SP #05: Establish a Perinatal Network in Indiana as established in the Perinatal Strategic Plan.

FY'99 Performance Objective: Expand Perinatal Network Advisory Boards from 14 Regional Advisory Boards representing 33 counties to 24 Regional Advisory Boards representing 78 counties.

Status: Accomplished in part. There are now 20 Perinatal Regional Advisory Boards representing 62 counties.

Significant Activities:

- Indiana Perinatal Network, Inc. (IPN) - During FY'99 the Indiana Perinatal Advisory Board met three times. Virginia Caine M.D., and Dan Sunkel, M.D. co-chair the Board. Regional Perinatal Advisory Boards, Issues Committees, a Speakers Bureau and a "Baby First" Education Campaign Committee reported to the Board. Perinatal Facilitators as well as regional board representatives attended the State Advisory Board meetings to advise the Board on barriers to care and make recommendations to improve perinatal services. The Indiana Perinatal Facilitators worked collaboratively with the Indiana Minority Coalitions and ISDH health systems development staff in developing or working with already existing regional or county boards that address perinatal issues. These boards were encouraged to do a perinatal resource assessment of unmet needs and develop a plan of action to improve outcomes.
- Indiana's Perinatal town meetings encouraged the establishment of local or regional perinatal advisory boards. In response the Indiana Perinatal Facilitators have been working throughout Indiana to encourage the establishment of these boards. Their purpose is to act as a voice on local perinatal issues; assess needs and develop and implement community-based solutions. In FY'99 there were 20 Regional Perinatal Advisory Boards that covered 62 of the 92 Indiana counties. In counties that had high infant mortality and low birthweight rates the development of these boards was relatively easy and in some places already in place. In other counties because of limited time, money and interested providers and consumers the development of these boards was more difficult or impossible. Instead they wanted consultation, professional education, free perinatal materials or money to fund a special project.
- Indiana Perinatal Network Staff: - Planning began for a provider Continuing Education Program (PCEP) to be piloted in 3 hospitals in Vigo, Bartholomew, and Madison counties beginning in March 2000. This is a collaborative project with Clarian Health. This is a comprehensive perinatal education program for hospital staff that is designed to be self-perpetuating.
- Indiana was selected as a pilot for "Friendly Access: with IPN as the lead organization. "Friendly Access" is a national training, leadership development and research initiative designed to reshape the delivery of healthcare for mothers, infants and young children in America to achieve Disney's high standards of "Quality Service".

- IPN is working with WTLC (radio station targeting African Americans) on a 1 year "Baby First" radio campaign.
- IPN convened the Universal Newborn Hearing Screening Subcommittee of the State Perinatal Advisory Board in July 1998 to research the issue and educate legislators and others regarding the need for screening. Thanks to their efforts state legislation was passed in April 1999.
- IPN applied for and was funded to implement the MCH Provider Partnership grant in September, 1999. The long range objective is to develop strategies to ensure adequate numbers and appropriate geographic distribution of quality perinatal providers.
- Indiana Perinatal Perspectives Newsletter was published and distributed statewide 4 times during FY'99.
- Indiana Perinatal Practice Alerts were published and distributed statewide on HIV in Pregnancy and on Universal Newborn Hearing Screening.
- The first Tri-County Perinatal Outcomes report in collaboration with St. Joseph, Elkhart and Marshall counties was published and distributed statewide in March 1999. This was the first Indiana report to contain timely perinatal data for 1998. Because of it approximately 10 other health departments have installed the software in order to have timely birth/death perinatal data. Plans are being made to develop regional "Baby First Data Books".
- "Baby Keepsafe Bracelets" were developed and distributed in English and Spanish to encourage parents and caregivers to place babies on their back to sleep, not shake them, and not smoke around them.
- Indiana Women's Prison Responsible Mothers/Healthy Babies program was developed and initiated to improve perinatal outcomes for incarcerated pregnant women and their infants. In FY'99 eighty percent of the women were substance abusers and most of the pregnancies were unintended.
- Indiana Perinatal On-line Magazine http://www.cpdx.com/ipom**www.cpdx.com/ipom** continued to be developed thanks to the support of an IPN board physician who donated a free web site server and technical assistance.
- Consensus statements were developed and distributed statewide on Prenatal Care Coordination and Prenatal Care Guidelines.
- IPN collected and published the findings of an Indiana Hospital Survey on behalf of the Perinatal Network subcommittees to help formulate recommendations to improve services in June 1999. Indiana hospitals for the first time in history self declared their levels of perinatal care.
- IPN staff continued to provide consultation to Fetal Infant Mortality Review (FIMR) and Child Fatality Review teams in the state and assisted in developing new teams.

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

FY'99 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase from 78.4% in FY'98 to 78.6% in FY'99.

Status: 77%. Objective not achieved.*

Significant Activities:

- "Baby First…Right from the Start" multi-media campaign began on January 21, 1999 in central Indiana. This campaign promotes awareness of the need for prenatal care and healthy lifestyles. The messages include a call to action that urges women to call the toll-free Indiana Family Helpline for information, a "Baby First" video and education materials in English and Spanish, and other needed assistance such as food and enrollment in Medicaid and WIC
- In FY'99 the Healthy Pregnancy/Healthy Baby Campaign prenatal outreach program which identifies women early in their pregnancy and assists them into prenatal care provided free pregnancy tests, initial consultation, and technical assistance to 208 agencies in 90 counties that participated in the campaign during FY'99. The data for this program shows that during FY'99, an estimated 46,437 pregnancy tests were performed. Of the estimated 15,696 women testing positive, 87% were tested in the first trimester and 75% were referred for prenatal care. Of those referred, 33% left the test site with confirmed appointments and only 24% kept their first appointment regardless of confirmation.
- In FY'99 Indiana funded 23 agencies to provide prenatal care coordination (PNCC) services in an effort to get high-risk pregnant women into prenatal care in the first trimester.
- The Early Start Program initiates prenatal care at the time of a positive pregnancy test. Women agreeing to be enrolled in the program receive referrals, health history, risk assessment, nutrition assessment, initial prenatal labs, health education, prenatal vitamins, and prenatal care coordination. Women found to be at highest risk are referred to a physician who has agreed to see referred women within 1-2 weeks of referral. Other women are followed at least monthly until they are have to access prenatal care with a prenatal care provider. In FY'99 MCH funded two successful pilot projects. Clinics have requested the Early Start protocols to implement the program on their own.

PM 15: Percent of very low birthweight live births.

FY'99 Performance Objective: The percent of very low birthweight infants among all live births will decrease from 1.3% to 1.2%.

Status: 1.4%. Objective not achieved.*

Significant Activities:

- MCH in collaboration with IPN developed a Monthly Review of Infant Deaths and Low Birthweight tool to be used at the clinic, office level. The purpose of the tool is for clinicians to evaluate their poor pregnancy outcomes to identify causes and barriers that might have impacted the outcome and make programmatic changes to improve service delivery to prevent the same outcomes. An example of successful use of the tool by one MCH project revealed that the increasing low birthweight rate was

due to asymptomatic urinary tract infections (UTI's). A review of current policies and procedures resulted in some changes that would help educate women about UTI's, improve assessment, testing, and treatment. A review of nutritional notes revealed all seven women involved had a poor dietary history and high daily consumption rate of Mountain Dew. This resulted in a change in policy and procedure concerning nutrition assessment and education by the clinic and WIC nutritionists.

PM 17: Percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates.

FY'99 Performance Objective: None. In Indiana this performance measure can only be estimated based on hospital self reported classification and it not reliable enough to use for setting objectives.

Status: 54.3% (Based on State Perinatal Advisory Group Survey - self-reported status of hospitals.)*

- The Indiana Perinatal Advisory Group is working to insure that very low birthweight babies are delivered at appropriate facilities.

Significant Activities: *The following activities will impact all of the Infrastructure Building Performance Measures for Pregnant Women, Mothers and Infants*

- Provision of Prenatal Care Services - The goal of comprehensive prenatal health care programs is to reduce infant mortality, morbidity, low birthweight, and to increase access to early prenatal care. During FY'99, there were 15 Title V sponsored prenatal programs serving primarily low-income women and women at risk for poor birth outcomes. Those agencies served an estimated 7% of the pregnant women in the state.
- Health Systems Development - MCHS staff were available to provide consultation and technical assistance on request to agencies that provide prenatal services not receiving Title V funds. These services also target low income, high-risk women who have difficulty accessing health and other needed services.
- Healthy Pregnancy/Healthy Baby Campaign - The goal of this prenatal outreach program is to identify women early in their pregnancy and assist them into prenatal care, WIC, Medicaid enrollment and other needed services. The campaign provided free pregnancy tests, initial consultation, and technical assistance to 208 agencies in 90 counties that participated in the campaign during FY'99. The data for this program shows that during FY'99, an estimated 46,437 pregnancy tests were performed. Of the estimated 15,693 women testing positive, 87% were tested in the first trimester and 75% were referred for prenatal care. Of those referred, only 33% left the pregnancy testing site with confirmed appointments, and on follow-up, 24% kept their appointments. The need for follow-up is being stressed to the pregnancy test providers.

- Prenatal Care Coordination – Indiana funded 23 agencies to provide prenatal care coordination (PNCC) services to high-risk women. One of the objectives of the program is to get high-risk pregnant women into prenatal care in the first trimester. Managed care in Indiana continues to be a barrier to getting women into care in the first trimester. Women often have to wait up to six weeks, or more, to receive their Medicaid card. Physicians refuse to see them until their card is in hand. As a result, only 61% of the women seen by this program entered care in the first trimester. MCHS continues to work with the OMPP, IPN, and the two MCOs to assist in the development of a quality program. In FY'99, ISDH in collaboration with the above agencies released a consensus statement on PNCC and Best Practice Guidelines for prenatal care coordinators. MCHS staff continued to work with the National Association of Social Workers (NASW) to provide an up-to-date, comprehensive training and certification process for professional staff. The Community Health Worker (CHW) training and certification program continued with 190 paraprofessionals trained. Collaboration with Healthy Families Indiana resulted in the inclusion of the CHW prenatal training into the training of Healthy Family Workers as the two programs blended services to provide a seamless delivery system. MCHS staff continued to provide quarterly regional care coordination meetings on recent updates and health topics pertinent to the program.
- MCH funds prenatal care coordination to keep the women in care and free pregnancy tests through the Healthy Pregnancy/Health Baby campaign to identify women early in their pregnancy. The Fifth Annual Summary Report of the Healthy Pregnancy/Healthy Baby Campaign showed that 91% of all women who had a positive pregnancy test were in their first trimester; 84% were referred to prenatal care, 44% had confirmed appointments, but only 31% kept the first appointment.
- The Early Start Program initiates prenatal care at the time of the positive pregnancy test. Women agreeing to be enrolled in the program receive referrals, health history, risk assessment, nutrition assessment, initial prenatal labs, health education, prenatal vitamins, and prenatal care coordination. Women found to be at highest risk are referred to a physician who has agreed to participate in the Early Start Program. The physician agrees to see referred women within 1-2 weeks of referral. Other women are followed at least monthly until they are able to access prenatal care with a prenatal care provider. IN FY'99 MCHs funded two successful pilot projects, one located in a health department and one located in a large urban county hospital. Clinics have requested the Early Start protocols to implement the program on their own. As a result we should begin to see an increase in women entering care in the first trimester.
- Indiana Family Helpline – During FY'99 the Indiana Family Helpline (IFHL) number was marketed on the *Baby First – Right from the Start Campaign* of the IPN. Every prenatal caller was provided requested referrals and if pregnant was offered and sent a Baby First packet of information, including a video. The number of callers requesting information or referrals to prenatal care services was 233 and 1,234 referrals were given. There were 1,112 callers who were sent Baby First packets. The

IFHL received 712 calls requesting information on the Indiana WIC Program and 2,668 referrals were made to WIC.

- Fetal and Infant Mortality Review (FIMR) - During FY'99, 1 FIMR project was funded by MCHS. The Northwest Indiana Healthy Start project, with additional funding from MCHS, was able to expand their FIMR to reach all of Lake County. The team reviewed 57 cases in FY'99 and as a result, provided 7 recommendations aimed at reducing fetal and infant mortality to local prenatal care service providers.
- Healthy Start – Two federal Healthy Start projects continued to receive funding during FY'99. The Northwest Indiana Healthy Start, one of the 15 original sites, continued to provide prenatal care coordination to women in Gary, Hammond, East Chicago, and Lake Station. The Northwest site is in the process of seeking sustainable funding for its services. The MCHS consultant assigned to Lake County provided technical assistance from ISDH. The MCHS Medical Director remains on the Healthy Start Action Alliance (consortium). The Indianapolis site is a Phase II: Replication of the Healthy Start Adolescent Pregnancy Prevention Model. This project provided pregnancy prevention and health services for adolescents aged nine to nineteen through the development of partnerships with various local and state agencies. The Title V director and a Health Systems Development Consultant participated in the Marion County consortium and provided technical assistance as needed. The MCHS consultant also served on two consortia committees, the data committee and the pre/postnatal committee.
- Prenatal Smoking Cessation – In FY'99 MCHS developed a "train the trainer" smoking cessation program to be presented in a series of workshops around the state to reach all perinatal providers, county health departments, MCH funded clinic staff, and managed care HMO providers. Due to limited financial resources and limited staff, implementation of the training could not be realized. In addition, MCH priorities such as development of a new MCH Data System and implementation of newborn meconium screening diverted time away from smoking cessation. Collaborative conversations began with Health Care Education & Training, Inc. (HCET), the home of the Region V Training Project that was interested in providing trainings on prenatal smoking cessation throughout Region V. HCET applied for and received a grant from CDC to collaborate with Region V states to provide or assist in providing smoking cessation workshops.

Children

PM 12: Percent of children without health insurance.

FY'99 Performance Objective: To decrease the percent of children without insurance from 10.6% to 9.7% at the end of the fiscal year.

Status: 12.0%. Objective not achieved.*

PM 13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

FY'99 Performance Objective: To increase the percent of Medicaid eligible children who have received a service paid by the Medicaid program from 90% to 92% at the end of the fiscal year.

Status: 72.6%* *Objective not achieved.*

Significant Activities:

- Child Health Insurance Program (CHIP) – CHIP Phase I, expansion of Hoosier Heathwise to include all children to age 19 up to 150% of the federal poverty level, was legislatively continued. CHIP Phase II, a state designated insurance program for uninsured children to age 19 up to 200% of the federal poverty level was legislatively established to be effective January 1, 2000. A Child Health Policy Board was convened to assist with the development of Hoosier Heathwise Package C for children whose family income is between 150% and 200% of the federal poverty level. Package C is to use the Hoosier Healthwise eligibility determination system, enrollment process, provider networks, and claims payment system to the extent possible to provide this coverage. Package C eligibility requirements, in addition to those listed above, require that applicants be Indiana residents, be ineligible for Hoosier Healthwise Package A, not have access to private insurance, and agree to meet cost-sharing requirements.
- Preventive and Primary Child Health Care - The goals of comprehensive child health care programs are to decrease infant mortality and morbidity, increase immunization levels, prevent child abuse and neglect, promote good nutritional status, enhance development, and improve parenting skills. These programs offer a range of preventive and primary health services including physical exams, diagnosis and limited treatment, referral for chronic illness, vision, hearing and developmental screening, immunizations, nutritional assessment and counseling, psychosocial assessment and intervention, lead and dental screenings, and health education. The target population is all children birth through twenty-one years of age and their families, especially those who are in their preschool years, low income, or reside in medically underserved areas. In addition to Title V funds, local agencies utilize Hoosier Healthwise and other third party payments, patient fees (on a sliding fee scale), local donations, and in-kind support from a variety of individuals. There were 19 Title V sponsored comprehensive child health projects in the state during FY'99. All MCHS funded child health clinics either provide child health services to Hoosier Healthwise eligible children or facilitate the choice of a Medicaid managed care physician to provide services.
- Health Systems Development - MCHS staff continued to provide consultation and technical assistance on request to agencies that provide child health services and do not receive Title V funds. Many of these agencies target low income children and are located in geographic areas where children have difficulty accessing health services.

- Indiana Family Helpline - The IFHL continued to provide referrals to families in need of health care for children. The IFHL also continued to screen all callers for private insurance and Hoosier Healthwise and to refer clients that appeared to be eligible to Hoosier Healthwise. There were 67 IFHL callers with Hoosier Healthwise questions as the primary reason for calling in FY'99. These calls have decreased significantly with the increase in marketing of Hoosier Healthwise and the use of the 800 number for consumers.
- Family Care Coordination - Family Care Coordination for both MCHS and CSHCS has a primary objective to facilitate children into primary care and into Hoosier Healthwise, if eligible. Two hundred forty families were provided family care coordination in FY'99.

PM 16: The rate (per 100,000) of suicide deaths among youths aged 15-19.

FY'99 Performance Objective: The rate of suicide deaths among youths aged 15-19 years will decrease from 11.0 to 10.0 by the end of the fiscal year.

Status: 8.1%. Objective achieved.*

Significant Activities:

- No statewide programs to assess risk of suicide or educate on prevention of suicide among youth are in place in Indiana.
- School-based adolescent health centers perform risk assessments on students seeking mental health services. Support groups are available for teens experiencing depression and referrals are made for further services as needed. There were four Title V funded adolescent health centers during FY'99.

Children With Special Health Care Needs

SP #06: Establish a method of tracking children with chronic and disabling conditions and babies born with chronic conditions predisposed to developmental delay.

FY'99 Performance Objective: To have accessible demographic, medical diagnostic, and claims data on children with special health care needs available for the MCHS needs assessment and program planning.

*Status: * Objective not achieved. The Central Reimbursement Office (CRO) was implemented for First Steps in July 1997. Because of the difficulties in defining the Medicaid rates for payment, as mandated by Indiana State law, CSHCS was not able to participate in the project as planned. There were a number of other programmatic issues that made participation in the program problematic, if not impossible. In order to keep the concept of the CRO as it was originally planned, the decision was made to back out of the project. CSHCS dollars did, however, assist in the development and implementation of the CRO, a system that will be continued to help developmentally delayed children in Indiana receive care in the first three years of life.*

Significant Activities:

- CSHCS continued to work on the development of a new system to track children who apply for the program and provide an efficient claims processing system. The system that is currently under development will track the demographic information of all children that have applied regardless of whether they are eligible or not. The system will also be able to interface with the First Steps CRO and Indiana Medicaid to identify dually eligible children. Indiana still needs to develop a system to track all children with special needs. The pharmacy module was fully implemented in FY'99.

PM 11: Percent of Children with Special Health Care Needs (CSHCN) in the State with a source of insurance for primary and specialty care.

FY'99 Performance Objective: CSHCS enrollees who have a source of insurance for primary and specialty care will be maintained at 100% in 1999.

Status: 76% (Baseline data) Source of Numerator and Denominator: Indiana Children's Special Health Care Services (CSHCS). In previous years, this data was not easily available. Therefore, since CSHCS does provide coverage for primary and specialty care related to the condition for which the child is enrolled, this measure was reported as 100%. However, due to changes in the data system used, it is now possible to get data on the number of children who were reported as insured, either by Medicaid or by Private/Other insurance. This value does not include those children who were enrolled in CHIP, as this is not yet tracked in the new data system.

- All families are required at the time of CSHCS application to apply for Indiana Hoosier Healthwise. The implementation of the combined enrollment form has helped make this process easier for the families and the program. Families are also required to report any third party insurance that they carry that covers the eligible child. Both Hoosier Healthwise and third party insurance are required to be billed before a claim for services can be submitted to CSHCS. Through care coordination and/or a case review committee staffed with an MD, the program pursues all alternative sources of funding before expending program dollars. As additional sources become available (Early Intervention, CHIP), CSHCS will work with these programs to make sure that the appropriate dollars are expended first.

PM 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN program.

FY'99 Performance Objective:The Indiana CSHCS Program will improve parent involvement in the program by progressing from 14 to 15 points by the end of the fiscal year.

Status: 16 out of 18. Objective achieved.

Significant Activities: *The following activities will impact all of the Infrastructure Building Performance Measures for Children with Special Health Care Needs.*

- The Indiana Integrated Services Special Project of Regional and National Significance (SPRANS) grant was awarded to Indiana to develop integrated services for children with special health care needs. The objectives of the grant are:
  - Development of a replication model of the Systems Point of Entry (SPOE) and Central Reimbursement Office (CRO) for national dissemination.
  - To increase linkage to primary medical home for children with special health care needs.
  - To insure a smooth transition of special needs children with continued collaboration between the tertiary care centers and primary medical home, a SPOE coordinator will be assigned to the NICU in their community.
  - To increase the knowledge and skills of Early Intervention and Disability Providers in Infant Mental Health needs.
  - To improve access, quality, and availability of inclusive child care for children with special needs.
  - To develop a data base at a pilot site to coordinate family centered care that is accessible to, and serves as a linkage among the family, primary medical home and medical practitioners of the tertiary care center.
  - To support development of training modules for child care providers regarding inclusive child care delivery.
  - To create an Infant Mental Health state association for parents, and providers of Early Intervention services.
  - To assisted in the development of a guide for parents of children with special needs in conjunction with the Governor's initiative "Building Bright Beginnings".

Significant Activities (accomplished by this SPRANS Grant):

- Updated the Combined Enrollment Form to address new state Childhood Health Insurance Program (SCHIP) expansions to be used by CSHCS, MCH providers, First Steps, and Indiana Hoosier Healthwise throughout the state.
- Continued utilization of the Leadership team that includes four physicians who are active members of the American Academy of Pediatrics (AAP). These physicians review materials and curriculum and provide guidance, advice and communication between AAP and CSHCS. The leadership team also includes five parents of special needs children from a culturally diverse population as active members. The purpose of the team is to provide direct oversight and advice to the project and work closely with the Interagency Coordinating Council. The parent team members serve as support and technical advisors to the Project Director, and provide liaison and representation for and to their local communities on all grant activities. Quarterly meetings were held during FY'99 with the parents and professionals who are on the leadership team.

- Continued development of a four-part video package for primary physicians and their staff to raise awareness of the mission of First Steps and CSHCS.
- During FY'99, CSHCS began working with Riley Hospital for Children on a fee for services basis with an agreed upon cap on the amount to be spent. All Riley providers enrolled in Medicaid as individual providers. This change was made at the request of Riley providers but may result in reduced spending of CSHCS funds. Through this contract, CSHCS and its participants have access to a number of services offered by the state's only specialized children's hospital. Physicians and staff at the hospital are very familiar with CSHCS and refer families consistently. In FY'99, Riley completed 16% of all the applications taken statewide for program eligibility. In addition, staff from Riley has been used to assist CSHCS staff with medical directives and decisions. An additional contract was funded through Riley that included follow-up clinics for children who were discharged from the newborn intensive care unit.
- During FY'99, CSHCS funded the Indiana Hemophilia and Thrombosis Center, Inc. (IHTC). The IHTC conducted an outreach program for Amish persons with bleeding disorders in the state of Indiana. The IHTC followed 38 Amish patients with factor IX deficient hemophilia, one Amish patient with factor VIII deficient hemophilia, one Amish patient with von Willebrand's disease, and seven Amish patients with the rare PAI-1 deficiency. In addition there were approximately 28 carriers of hemophilia who required services. The IHTC Amish outreach program has three main components: an outreach nurse, an outreach clinic, and provision of factor concentrate. The IHTC employed a Mennonite nurse trained in hemophilia care who provided the Amish nursing assessment, infusion services, home infusion training, hemophilia education, and monitoring of treatment products. She worked closely with the IHTC and the Amish hemophilia population and served as a liaison between the two. The IHTC conducted an annual outreach clinic in Middlebury, Indiana, and all members of the Amish hemophilia community were invited to attend. This clinic included assessment and examination by a pediatric and adult hematologist, as well as evaluations by nurses, a social worker, a dental hygienist, a dietitian, a genetic counselor, and a physical therapist. The nurses and medical director of the IHTC made home visits without charge. As the Amish do not have medical insurance due to religious convictions, the cost of treatment with factor concentrate can be prohibitive. The IHTC assists the Amish with these costs by enrolling them in research studies when possible, investigating assistance programs, compassionate care programs, and purchasing factor concentrate for them with the grant funds.
- CSHCS continued to fund dental outreach clinics that targeted Amish families once a month in Elkhart County. One hundred eighty-eight patients were served in these clinics in FY’99. In November 1998 a permanent dental clinic targeting these families was opened to provide services four days per week in LaGrange County. In November and December 465 patients were served.

- CSHCS continues to target low income and working poor families with a financial eligibility limit of 250% of the federal poverty guidelines. In FY'99 the CSHCS Program began reimbursing Riley Hospital on a fee for service basis. Therefore CSHCS no longer assigns children to Riley Hospital. CSHCS continued to emphasize the importance of the linkage of the families to primary and specialty care throughout FY'99 to establish a primary medical home for each family.
- CSHCS Care Coordination staff continued to provide training for new providers of care coordination services to clients. This training included information on the CSHCS program, the need for prior authorization of services, and the procedure for billing.
- In FY'99, CSHCS contracted with 27 grantees to deliver community-based care coordination services for children with special health care needs. These contracts are models that are being developed by the program to evaluate the effectiveness of the delivery of care coordination by contracted local agencies as opposed to the traditional delivery system which is done by state employees. Contracted local agencies handled a smaller caseload and have a better knowledge of community resources to help families and children obtain services. Most care coordinators that are employed by the State are now serving a dual role: that of a care coordinator and that of a consultant to the local CSHCS projects. As consultants, the experience and knowledge of the state care coordinators is passed to the local care coordinators. The consultants become resources for the local projects.
- The Indiana Family Helpline refers all children that appear to be eligible for services to the CSHCS program. Sixty-five calls were received requesting information for children with special health care needs.
- In FY'99, CSHCS continued to contract with Clarian Health Partners, Inc. to support the Indiana Poison Center which is designated by ISDH as the Regional Poison Information Center. The 1998 Annual Statistical Summary indicated that 81,048 requests for assistance were received. Of these, 66,617 concerned exposures to poisons and 14,431 were callers seeking information without exposure. Children under the age of six years accounted for 56% of the poisonings managed by the center.
- During FY'99, Indiana CSHCS continued to provide funding to the Indiana Parent Information Network (IPIN) to support nine parents of children with special needs as Parent Liaisons to provide information, peer support, and education to families of children with special needs.
- A parent participated in the grant review process for the community-based care coordination grants for CSHCS.
- During 1999, CSHCS supported the printing and dissemination of more than 12,000 IPIN brochures on such topics as "Paying the Medical Bills", "COBRA" and "Vocational Rehabilitation Services for Youth with Chronic Illness".
- During 1999, IPIN disseminated 11,000 newsletters to families of children with special needs with support, in part, by CSHCS.

- Indiana Family Voices is located at IPIN and CSHCS supports the printing and postage of Family Voices information that is disseminated to more than 250 parents and professionals in Indiana every quarter.
- CSHCS supports a toll-free number to IPIN that is available both in state and out-of-state.
- With support from both CSHCS and Lilly Endowment, IPIN began developing a resource database that will be available on CD or through IPIN's website later in FY 2000. IPIN has a close working relationship with the MCH Family Helpline and they refer to each other as appropriate.
- During 1999, Parent Liaisons provided support to 1,592 families of children with special needs in the areas of: community resources (300), disability specific information (103); education (736), health care financing (143); early intervention (21), child care (89), relocation to Indiana (16), and other issues (128). (Families received follow-up calls after an initial call and, with the family's permission, receive "HAT" [How are things] calls every three months for up to one year.)
- Using the ACT! Database, IPIN matched families with each other based on a particular interest or disability. When a new support group was forming in northeast Indiana for families of children with Down Syndrome, IPIN used its database to identify and contact families in the area to share information.
- Through a letter of agreement, CSHCS permitted Parent Liaisons to serve as CSHCS care coordinators under the supervision of a Social Worker (MSW) in an Indianapolis inner city clinic. This agreement was part of a collaborative initiative called the "Indianapolis Medical Home Project", through the federal Maternal and Child Health Bureau (MCHB). Another component of this grant was to adapt an existing computer program (ACT!) for use by all CSHCS care coordinators in tracking contacts and follow-up with families of children with special needs.
- During 1999, IPIN provided 30 educational workshops to 331 parents and professionals. These workshops were supported in part by CSHCS. (Since October 1, 1999, IPIN has been working to make these workshops and other educational programs self-supporting but continues to conduct outreach to families through CSHCS care coordinators.) During FY 2000, IPIN will conduct training workshops in five different regions of the state.
- CSHCS supported IPIN staff made presentations at workshops and conferences that included, college classes, the state conferences of the Governor's Planning Council for People with Disabilities and Indiana Association for the Education of Young Children, regional meetings for First Steps (Part C) and Headstart
- Parent Liaisons participated in medical education activities that included site visits to IPIN by second and third year pediatric residents at the Indiana University Medical Center where staff explained and demonstrated the role of a Parent Liaison in supporting a medical home in private or group practice.
- With support from CSHCS, IPIN conducted regional family dinner meetings to collect information from families about services in Indiana for children with special needs. Meetings included formal

discussion and informal networking opportunities. Outreach for the meetings was conducted through CSHCS care coordinators and family leaders in each region.

- The Executive Director attended the CHIP Tri-Regional Meeting in Kansas City in 1999 and presented on the role of Parent Liaisons in supporting the medical home concept in a plenary session.
- Using the ACT! Database, IPIN identified families to attend forums, workshops and conferences that targeted a particular interest or disability.
- All CSHCS funded staff at IPIN participated on local and state planning advisory committees to represent the perspective of families of children with special health care needs. The Executive Director was a member of the Governor's Panel on the Children's Health Insurance Program and is now a member of the state mandated Children with Special Needs Advisory Committee. The Program Coordinator participates on the state First Steps (Part C) Family Support Committee and local First Steps Monitoring and Evaluation Committee. Parents Liaisons are involved in both local and state advisory committees.
- IPIN staff also worked with local and state planning committees to identify parents to participate on those committees. IPIN wrote a letter of support for Indiana's recent application for MCHB support of a planning grant for genetic services with specific reference to identifying family representatives to participate in planning and advisory committees.
- Through a CISS grant from MCHB, Healthy Child Care Indiana, IPIN facilitated the partnership between state MCH and Indiana's Bureau of Child Development in identifying and updating Indiana's child care rules and regulations specific to the health and safety of children, including children with special health care needs.

POPULATION-BASED SERVICES

All Targeted Populations (Pregnant Women, Mothers, and Infants; Children; and Children with Special Health Care Needs)

- Indiana Black Expo, the largest assembly of its kind, hosts the ISDH-sponsored Black and Minority Health Fair. In FY'99, staff volunteers distributed 1500 pamphlets regarding MCH/CSHCS programs, provided 595 blood pressure screenings, and passed out 2000 outreach posters (growth charts for children with the 1-800 number for MCH/CSHCS/WIC). The ICLPPP provided lead screening and educational materials.
- Maternal and Child Health Services, in conjunction with CSHCS and WIC, sponsored the second and third phases of a Folic Acid Awareness Campaign during FY'99. The goal of this campaign is to decrease the incidence of neural tube defects through the use of a statewide educational campaign promoting adequate folic acid consumption during preconception and the first trimester of pregnancy. The target population for the campaign is all women of childbearing age, regardless if they are contemplating pregnancy. Governor O'Bannon proclaimed October 14, 1999 as Folic Acid

Awareness Day. A Folic Acid Health Fair, The Folic Acid Way to Healthier Babies was held at the Indianapolis City Market. Education materials and foods rich in folic acid were distributed to individuals. Certified folic acid trainers from phase I of the campaign continued to educate professionals and consumers at the local level. Approximately 40 sessions regarding genetic conditions and services were provided to over 500 primary care providers. These sessions were offered as part of the "Genetics and Your Practice" education curriculum for primary care providers. A resource guide and other educational materials were provided to all participants. Letters were also sent to all pediatricians, OB/GYNS, and family practice physicians as well as agencies serving women of childbearing age informing them of the availability of materials.

- In 1999 trainers educated the prior year by the state Genetics Program Director and genetic service providers educated other professionals and consumers in their local communities on the importance of folic acid. Materials were mailed to physicians, MCH clinics, genetic clinics, and family planning clinics regarding the campaign and materials available. Posters, pamphlets, fact sheets, bookmarks, videos, stickers, green ribbons, and jar openers were provided to professionals and consumers at no cost.
- In 1999 the CSHCS funded Sickle Cell Disease Education and Practitioner Assistance Program provided sickle cell education to 170 health professionals.

Pregnant Women, Mothers and Infants

SP #02: Establish a population-based Perinatal Education System to implement the education portion of the Perinatal Strategic Plan.

FY'99 Performance Objective: Complete the central state implementation of the "Baby First…Right from the Start" media campaign and hold at least three educational sessions on perinatal health issues.

Status: Objective Achieved

Significant Activities:

- "Baby First…Right from the Start" multi-media campaign began on January 21, 1999 in Central Indiana. This campaign promotes awareness of the need for prenatal care and healthy lifestyles. The messages include a call to action that urges women to call the toll-free Indiana Family Helpline for information, a "Baby First" video and education materials in English and Spanish, and other needed assistance such as food and enrollment in Hoosier Healthwise and WIC.
- A "Baby First" Advisory Board was developed with representation from the Marion County Health Department, Marion County Healthy Start, the Minority Health Coalition, the March of Dimes, WRTV Channel 6, Eller Media, Willey and Associates, Bennett Innovations, Metro Graphics and Clarian Health Partners, Inc.
- "Baby First" wallet cards on signs and symptoms of preterm labor and fetal activity were developed in English and Spanish.

- "Baby First" consumer tape is being translated into Spanish with funding provided by the Efroymson Fund.
- Vanderburgh, Lake, and Allen counties are in the planning stage for implementation of "Baby First" media campaign.
- IPN hosted the National Perinatal Association Leadership meeting with emphasis on cultural diversity in Indianapolis in April, 1999.
- IPN cohosted the Vanderburgh County Perinatal Conference in September, 1999.
- IPN worked with ISDH to do many regional "Lessons Learned" provider education sessions around the state. Over 300 "Lessons Learned" provider education packets were distributed throughout the state that included a self study Continuing Education Unit (CEU) credit.
- SIDS has decreased 50% since the implementation of Indiana's Back to Sleep campaign. Grandparent misinformation still is a problem so the Indiana SIDS Center in collaboration with IPN developed and distributed a "Grandparent Power" educational flyer to help educate and empower grandparents regarding "Back to Sleep" and safe sleeping arrangements for the baby.

PM 06: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

FY'99 Performance Objective: The birth rate for teenagers aged 15-17 years of age at the time of birth will drop from 33.2 per 1000 in FY'98 to 32.6 per 1000 in FY'99.

Status: 28.9 per 1000. Objective achieved.*

Significant Activities:

- Indiana RESPECT - Indiana's adolescent pregnancy prevention initiative funded abstinence until-marriage education programs with federal and state match funds, and adolescent pregnancy prevention education programs with state funds beginning in FY'98. The initiative consisted of four components: a community grant program, a community grant program evaluation, a statewide media campaign, and technical assistance/training.
    - Community grant program - two distinct Requests for Proposals (RFP) were developed and distributed to agencies throughout the state to initiate the FY'98 – FY'99 community grant program. For FY'99, 52 federally-funded grantees provided sexual abstinence until marriage education using the federal 8 – point definition, and 29 state-funded grantees provided adolescent pregnancy prevention programs that stress sexual abstinence throughout the teen years. Grantees provided these programs in a variety of youth-serving organizations including schools, faith-based organizations, and community organizations.
    - A six-member evaluation team comprised of faculty representing four Indiana state universities was contracted to design, develop, implement and analyze an outcome evaluation of the community grant programs. Grantees have been invited to participate on a voluntary basis in the evaluation that will include a pre/post/delayed post design. Montgomery, Zukerman, and Davis,

(MZD) an Indianapolis advertising agency, was contracted to create, implement, and measure the effectiveness of a statewide sexual abstinence and adolescent pregnancy prevention media campaign. Focus groups with youth, parents, and youth-serving professionals were implemented to assess constituent beliefs regarding adolescent pregnancy prevention and identify effective media campaign themes and specific audience messages.

- Four teen and one two-part parent media spots with the theme *Sex Can Wait I'm Worth It* were developed in FY '98. One media spot was broadcast in FY'98. Three spots were broadcast in 6-week flights in January 1999, April 1999, and September 1999. Teen billboards and parent print ads were also placed in major media markets. Collateral printed materials, including teen brochures and posters and parent brochures were distributed to community grantees and the general public through the Indiana Family Helpline 800 number. Effectiveness of the media campaign was assessed by telephone surveys completed with 300 Indiana teens and 300 parents after each quarterly broadcast of the TV and radio spots. Teen recall of FY '99 media flights was 86% for flight number 1, 94% for flight number 2, and 95% for flight number 3.
- In November, 1998 MCHS co-sponsored with federal funds the "Saying Yes to Saying No" sexual abstinence education conference in South Bend. The conference was attended by 150 individuals.
- Primary and preventive health services are provided by four projects located in high schools in areas of need. These school-based centers provide education on adolescent sexual abstinence and pregnancy prevention.

PM 09: Percentage of mothers who breastfeed their infants at hospital discharge.

FY'98 Performance Objective: The percentage of mothers who breastfeed their infants at hospital discharge will increase from 44.6% in 1998 to 45.2% in 1999.

Status: 57.7%. Objective achieved.*

Significant Activities:

- An agreement was reached between MCHS and the Indiana WIC program to allow the WIC breastfeeding consultant to also function as the MCHS breastfeeding consultant.
- The IPN Subcommittee on Breastfeeding functions as the MCHS Breastfeeding Advisory Group and action arm.
- Breastfeeding information is provided to all prenatal clients receiving care through the MCHS funded prenatal clinics.
- The Indiana WIC Program provides breastfeeding promotion information at the prenatal certification. Further information and contacts are provided based on the health professional's assessment of clients' interest. Peer counselors are available through most WIC clinics to provide

additional support as needed. Breast pumps are provided when requested and education is provided on their use.

- All MCHS and WIC clinics are encouraged to be breastfeeding-friendly.
- The Indiana Family Helpline refers all breastfeeding questions to a local lactation consultant or peer counselor, or to an MCHS breastfeeding consultant. Sixty-eight referrals were made in CY 1999.
- In FY'99 the State WIC office distributed 10,400 Loving Support pamphlets to local agencies. Updated pamphlets were also provided to the Indiana Family Helpline to send to persons requesting information on breastfeeding. An additional 1500 pamphlets were given out at Indiana Black Expo – The ISDH sponsored Black and Minority Health Fair.
- State and local WIC agency employees were required to attend a 3 Step Training program to (1) train all breastfeeding coordinators; (2) conduct peer counselor training statewide, and (3) train all local WIC staff how to approach a WIC client about breastfeeding.

PM 04: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).

FY'99 Performance Objective: Maintain or improve on the 99+ percent of newborns with at least one completed NBS test.

Status: 99.3% Objective achieved.

Additional FY'99 Performance Objective: To maintain at 100% resident newborns known to the Indiana Newborn Screening Program who have confirmed cases of PKU, hypothyroidism or galactosemia who have received appropriate treatments in the reporting year.

Status: 100%. Objective achieved.

Significant Activities:

- Newborn Screening Program
  - The Newborn Screening Program strives to assure that all infants born in Indiana are tested for six genetic disorders: (1) phenylketonuria (PKU), (2) galactosemia (GAL), (3) maple syrup urine disease (MSUD), (4) homocystinuria (HCU), (5) hypothyroidism, and (6) hemoglobinopathies (including Sickle Cell). The 1999 Indiana Administrative Code was modified to add biotinidase deficiency and congenital adrenal hyperplasia to the six genetic diseases screens. IN FY 1999, 85,574 infants were screened, representing an estimated 99.3% of all Indiana births during the period. As a result of these screens, 65 infants were identified as having various genetic conditions requiring treatment. All infants were immediately entered in an appropriate treatment program. Another 1,310 infants were identified as having sickle cell trait or other less severe or trait genetic conditions which did

not require immediate treatment, but should be considered as part of the child's overall medical condition and may indicate a need for genetic counseling. In addition, 44 other newborns were identified as being at high risk for an abnormal condition other than those on the screening battery. These infants (primarily with possible abnormal thyroid function) were identified to their physician for additional testing as appropriate.

- Newborn Screening Advisory Task Group meetings were held. Subcommittees evaluated the screening battery and timing issues. An official request for rule change was initiated to add Congenital Adrenal Hyperplasia and Biotinidase Deficiency to the present testing panel. These two conditions were proposed and approved by the Governor to be added to the six genetic conditions screens in 1999.
- The in-service training program for hospitals' staff was redesigned and updated.
- Spanish-language versions of *Your Baby and Newborn Screening* brochure and the follow-up letters that are sent to parents were developed.
- The ISDH NBS program began monitoring the rate of infants screened prior to discharge by individual hospitals.
- Quality assurance was improved by tracking the percentage of Quantity Not Sufficient/rejected specimens by hospital.
- Hospitals submitted monthly summary reports to ISDH. Feedback was provided to hospitals regarding these reports. Biannual reports were issued rating the hospitals' compliance with ISDH rules regarding accurate and timely reporting of newborn screening data, as well as the effectiveness of their newborn screening operations including screens conducted prior to discharge and specimen rejection rates.
- Follow-up for confirmed metabolic screening cases. Immediately after diagnosis and at one year, follow-up is done to ensure that infants confirmed to have one of the newborn screening conditions are receiving appropriate treatment. 100% positive cases were transferred to the GDP to received follow-up and treatment.

- Meconium Screening – In 1997, the Indiana General Assembly passed PL 260-1997 (now PL273-1999) requiring a screening test for possible drug affliction in newborns. This law continues and hospitals and physicians are required to submit a meconium specimen for every infant who meets the selection criteria. During 1999, 1149 infants were screened. The number of newborns meeting the criteria was 228, and 28 (12%) were positive. Many hospitals are sending the screens of newborns not meeting the criteria to the same laboratory. The number not meeting the criteria and tested was 921 with 203 (22%) positive. The selection criteria will be expanded in FY 2001.

- Universal Newborn Hearing Screening Program – The ISDH is in the process of implementing Indiana's Universal Newborn Hearing Screening Program for all newborn infants. Public Law 91, passed by the 1999 Indiana General Assembly; requires hospitals and physicians to perform hearing screening for every infant born under their care. Hospitals currently conducting either universal or targeted newborn hearing screening are required to conduct universal newborn hearing screening under this program when the law becomes effective July 1, 2000. Of the 105 hospitals that deliver, 27 hospitals or birthing centers currently screen 100% of the newborns. Another 19 are doing targeted screens in transition to universal newborn hearing screening.
- Genetic Diseases Program - The Genetic Diseases Program (GDP) strives to increase awareness and understanding of genetic conditions and to ensure that all of the approximately 5,000 infants born in Indiana each year with birth defects or genetic conditions have access to genetic services. Program activities take place in fifteen Genetic Centers/Programs in the state. During FY'99 there were six MCH funded projects and two state funded projects. An additional seven centers operated without any funding from ISDH. In addition to the main clinic locations, there were nine outreach clinic locations. During FY'99, these Genetics Projects offered services to 2,820 patients. Of these, 1,228 were pregnant women, 486 were infants less than 1 year of age, 826 were individuals ages 1 to 22, and 280 were categorized as "other" types of patients.

  Activities Included:

  - Published a quarterly newsletter for professionals, *The Genetic Transcription*, which is distributed to approximately 5,500 providers. Nine editions have been distributed to date (4 in FY'99).
  - Distributed approximately 50,000 professional and consumer brochures in 1999.
  - Developed proposal to form Genetics Advisory Committee and submitted for approval.
  - Increased collaboration with March of Dimes. Collaboration involved Genetics and Your Practice, Folic Acid Campaign, birth defects surveillance, fetal alcohol syndrome and general issues regarding birth defects and genetics.
  - Developed display for the GDP and exhibited at several conferences and health fairs.
  - Developed and finalized the Death Certificate Pilot Project that will be implemented January 1, 2000. A review team consisting of the State Genetics Coordinator, the Director of Indiana University Clinical Genetic Services, and a genetic counselor for Indiana University Clinical Genetic Services is currently reviewing all infant death certificates to determine the underlying cause of death. Those infant deaths due to a congenital anomaly are to be identified and the family is to receive a letter notifying them of the availability of genetic services
  - Developed the Infant Mortality Indicator Working Group Report with other staff to highligh issues regarding infant mortality due to congenital anomalies.

- Sickle Cell Program - The Indiana Sickle Cell Anemia Program provides prevention, treatment, and professional and public education concerning sickle cell disease. In FY'99 five community-based sickle cell projects provided screening, diagnosis, counseling, support services, education, newborn screening follow-up, and CSHCS care coordination. These regionally based projects tested over 4,317 individuals. Including newborn screening referrals, these five sickle cell projects identified and provided services to 47 children and adults with the disease and 2,029 individuals with sickle cell trait. Title V funds were also utilized to provide prophylactic penicillin for nearly 75 uninsured, low-income pediatric patients.
    * The Sickle Cell Program continued to fund the Sickle Cell Disease Education and Practitioner Assistance Program to develop and provide statewide sickle cell physician and health care practitioner education. This program includes Emergency Room physician and nurse education, posters and slide presentations. The program is currently in the development stage and is expected to be completed in FY 2000.

PM 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

FY'99 Performance Objective: Maintain at 50% the number of newborns screened for hearing impairment before hospital discharge.

Status: 56.6% . Objective achieved.

Significant Activities:

- During 1999, 27 hospitals conducted universal hearing screening for newborns, and 19 hospitals conducted targeted hearing screening for high-risk newborns.
- Based on hospital survey data, approximately 40,000 newborns were screened during CY'99. No centralized reporting is required prior to statewide implementation of the new UNHS program in July, 2000.
- An ad hoc UNHS Advisory Task Group was established to assist with initial program implementation.
- An in-service training program for hospitals' staff was developed.
- Initial training for First Steps staff was developed.

Children

SP #03: To maintain a lead poisoning surveillance and intervention system in Indiana.

FY'99 Performance Objective: Facilitate the development of lead poisoning prevention task force groups in six urban counties and four suburban counties; coordinate the training of 15 local neighborhood groups to clean up lead areas in and around homes; maintain the ICLPPP database and the Environmental Health Database.

Status: Objective partially achieved. Four local Task Force Groups were developed and four local neighborhood groups were trained. In 1999, there were 28,587 children less than or equal to age six screened. There were 7.2% of all children screened with a blood lead result above or equal to 10 ug/dL and 0.9% of all children screened with a blood lead result above or equal to 20 ug/dL. Screening activities were down from 1998 to 1999 by 8.3%. In 1999, 1.3% of the Black children screened had a blood lead level above or equal to 20 ug/dl and 16.9% of the Black children screened had a blood lead level above or equal to 10ug/dL.

Significant Activities:

- There were 478 home environment inspections (either a medical case follow-up or a preventive inspection) conducted within the state for 1999.
- Website information was created and formatted, but the site has not been brought up.
- Annually, ICLPPP is a sponsor of the Indiana Black Expo Black and Minority Health Fair, maintains a booth during the Fair, and provides blood lead screening..
- The Medical Case Coordinator conducted 12 statewide training sessions for health care providers and addressed the quality of incoming data, quality of services, and updated screening information.
- ICLPPP actively participated in the Free Home Lead Assessment 2000 Project, along with the Department of Environmental Management and Governor Frank O'Bannon's office. The goal to assess 2000 homes was not reached, but approximately 1600 homes were assessed.
- All ICLPPP field staff have completed training and obtained their state license as Lead Risk Assessors and Inspectors.
- ICLPPP received a grant award from CDC for $250,000.

PM 05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.

FY'99 Performance Objective: The percent of children through age two (2) who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus, Influenza, and Hepatitis B will increase from 85% in FY'98 to 88% in FY'99.

Status: 77.5%. Objective not achieved. Although the objective was not achieved, six of nine vaccine preventable disease reduction objectives were met in 1999.*

Significant Activities:

- An MCHS staff person was assigned as liaison to the ISDH Immunization program. MCHS services staff continued to work closely with Immunization Program staff.
- Free vaccine (both VFC and 317) was provided to all MCHS sites providing immunization services for children. All funded child health programs provide immunizations on site. All family care coordination programs refer children to programs that provide immunizations.

- The Vaccines For Children (VFC) Program has been implemented in Indiana using 1,575 private providers and 195 public providers.
- All public providers receive an Operational Program Review (OPR) on immunization services each year. Providers serving over 25 children ages 19-35 months, receive a Client Assessment Software Application (CASA) each year to determine the immunization rate of children of this age group.

PM 07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

FY'99 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase from 27% in 1998 to 30% in 1999.

Status: 27%. Objective not achieved. Data not available.*

Significant Activities:

- Title V resources helped support the Oral Health Division of the Indiana State Department of Health by providing salaries for a dentist, dental hygienist, secretary, and field fluoride specialists. Indiana's Oral Health Program focuses on education and prevention with special emphasis on fluoridation. Oral Health staff provides technical assistance to communities and schools with fluoridated water supplies and conducts over 1,500 site visits annually. Indiana currently has 98.6% of the population on city water lines receiving optimally fluoridated water (700 municipal water systems).
- Title V also continued to support the Oral Health Division's community-based pit and fissure sealant program which was initiated in 1994. This program targets low-income children who might not otherwise have access to dental care. During 1999, the Sealant Assistance Program provided support for seventeen community-based sealant programs. These programs were conducted at fourteen different sites, and served ten different communities in ten counties throughout the state. As a result of these programs a total of 630 children received oral health screenings, 423 eligible children received dental sealants, and a total of 1,588 teeth were sealed.
- The consultant presented lectures about dental sealants and program planning to both dental students and dental hygiene students at the Indiana University School of Dentistry. The consultant also provided information to potential program organizers through dissemination of the Sealant Program Planning Manual and through personal consultation to assist them in planning effective community-based sealant programs in their communities.
- During FY’99 MCHS applied for and was awarded an SSDI grant to improve MCHS dental sealant data. The grant period is FY 2000 through FY 2001. Initial data will be reported in the FY 2000 Annual Report.

- Oral Health division staff continue to promote Prevent Abuse and Neglect through Dental Awareness through community education presentations at local dental societies and other organizations throughout the state. Also, the Oral Health division remains the investigative authority regarding universal precaution and infectious waste management issues.
- In FY'99 the IFHL received 5,319 or 32.6% of the total calls with a requested need for dental services. This was the number one need of callers to the Helpline. IFHL staff made 791 folow-up calls to ensure the client received services and 171 calls to dentist for the caller to get care.

PM 08: The rate of deaths to children aged 0-14 (as requested in Dr. Van Dyke's 6-2-2000 letter) caused by motor vehicle crashes per 100,000 children.

FY'99 Performance Objective: The rate of death to children aged 0-14 years caused by motor vehicle crashes per 100,000 children, will decrease from 4.9 in 1998 to 4.6 in 1999.

*Status: 5.5/100,000 *. Objective not achieved.*

Significant Activities:

- In FY'99, 10% of the Childhood Lead Poisoning Prevention Program/Injury Program Director's time was directed toward injury prevention.
- The US Consumer Product Safety Commission's Alerts were shared with all MCHS funded projects through mailings. These alerts were also shared with the ISDH Office of Public Affairs (OPA). OPA provides news releases regarding safety issues.
- Educational sections including information on safety seats or booster seats are included in the ISDH Family Care Coordination manual. This manual is given to all ISDH funded Family Care Coordinators.
- A survey was developed and sent to all state government agencies to assess injury prevention activities being provided by state government.
- A survey was sent to 17 selected states with injury prevention programs to assess injury prevention activities.
- As a result of the survey of state government agencies three meetings were held with the Governor's Council for Impaired and Dangerous Driving, the State Fire Marshal's Office, the Governor's Volunteer Action Office, and Prevent Child Abuse, Indiana (PCAI), to discuss activities in injury prevention taking place in those agencies.
- MCHS contracted with PCAI, to provide a program addressing Shaken Baby Syndrome. 3470 packets containing comprehensive information regarding Shaken Baby Syndrome were distributed to private and public primary health care providers throughout Indiana. As a result, PCAI received over 225 requests for educational materials and distributed 30,000 "Preventing Shaken Infant Syndrome" brochures and 2250 note pads of "Tips for Tears".

- A short provider survey to assess injury prevention activities was included in the PCAI provider information packet. A report on results of the survey is to be completed in FY 2000.
- The Lead Poisoning/Injury Prevention Director maintains membership and actively participates in the following organizations: Hoosier Safety Council, Department of Education's Violence Prevention Planning Committee, State Fire Marshal's Office Juvenile Firesetters Task Force, Emergency Medical Services for Children Advisory Committee, Sports Medicine Commission of the State Medical Association, and Automotive Safety for Children Program's Advisory Council.

ENABLING SERVICES

All Targeted Populations (Pregnant Women, Mothers, and Infants; Children; and Children with Special Health Care Needs)

- Healthy Families Indiana - This program has been available in all 92 counties since October 1998. There are 59 HFI sites that provided 12,000 assessments and served 8900 families in FY '99. Statistics from this program show that 99% of the families served have no reports of substantiated abuse; 90% of the children had age appropriate immunizations; 3% of the women had subsequent pregnancies during the time of service; and 80% of the families have a medical home. MCHS provided funds to initiate this service and continues to provide funds for the training of the service providers in this program. This program has received national recognition for its effectiveness and leads the nation in the number of sites available.
- Healthy Families Indiana receives funding from a variety of sources including Title V. The MCH Director and Grants Coordinator continue to participate in the HFI "Think Tank" and subcommittees.

SP #01: Establish a data collection and analysis system for Family Care Coordination (including Care Coordination for CSHCS) to evaluate the enabling effects on health outcomes of this service.

FY'99 Performance Objective: Family and Prenatal Care Coordination grantees will utilize the risking and data collection tools for one full year and the data will be evaluated to determine effectiveness of the service.

Status: Objective not achieved. The EIS department did not develop an Access data system to analyze family care coordination data. Risking and data collection tools were filled out by hand by care coordinators and mailed in to MCH. Boxes of data forms still need to entered into a system and analyzed. Due to financial and staffing problems it was decided that the prenatal care coordination program would be analyzed first.

Significant Activities:

- Development of a Y2K compatible MCH data system was begun. Both Family Care Coordination and Prenatal Care Coordination forms and tools have been built into the new data system. Care Coordinators will enter data into the computer on site and transmit to MCH monthly. Reports have been developed to retrieve data for analysis and program evaluation.
- Family Care Coordination was included in the training of all new CSHCS care coordinators.
- Title V funded 22 projects to provide Prenatal Care Coordination Services and 10 projects to provide Family Care Coordination Services in 1999.

Pregnant Women, Mothers, and Infants

- The NATALE program was funded with the Indiana Minority Health Coalition during FY'99 to provide prenatal care coordination to minority pregnant mothers in Lake and Vanderburgh Counties. These two counties have been targeted as at-risk counties with high infant mortality disparities. This program provided outreach, support, and facilitation into services to vulnerable, hard-to-reach populations in need of more intensive intervention. The program served 53 pregnant women in Lake County and 71 pregnant women in Vanderburgh County. The NATALE staff makes every effort to enroll minority mothers during the first trimester of pregnancy to ensure early entry into prenatal care. All of the NATALE clients were African American. In Lake County the NATALE program works closely with Healthy Start.

SP #04: Percent of prenatal population served by MCHS who reduced or stopped smoking.

FY'99 Performance Objective: Increase the percents of prenatal clients served by MCHS, who reduce or stop smoking during their pregnancy from 74%. In FY'98 to 75% in FY'99.

Status: 77.8%. *Objective achieved.*

Significant Activities:

- Prenatal Substance Use Prevention Program (PSUPP) (see page 22): Expansion of PSUPP was completed in 1999 with an additional 114 pregnant women screened, 11 presentations to providers working with pregnant women on substance abuse issues, 530 pieces of information on substance abuse to pregnant women, and 153 pieces of information indicating the importance of identifying at risk clients to providers.
- During FY'99, over 1,144 women receiving health services at eight PSUPP projects were screened for substance use. Over half (54%) were determined to be high risk pregnancies based on the client's significant use of tobacco , alcohol, or drugs during pregnancy.
- During FY'99, PSUPP statistics recorded that 94.1% of women in the program that used alcohol reduced consumption, 45.6% of women in the program that were tobacco users decreased tobacco use, 97.8% of women identified as using street drugs reduced their drug use, and 100.0% of women identified as using prescription or over-the-counter drugs decreased use.

- The PSUPP director provided public education regarding the potential hazards of alcohol and other drug exposures to unborn babies at community events, health fairs, conferences, and through professional presentations.
- The PSUPP director has been actively involved in the Meconium Drug Testing Program (see page 17) which was passed by the Indiana General Assembly (PL 260-1997, now 273-1999). The director is responsible for compiling data received monthly from each birthing hospital, analysis of data received from AIT Laboratories and monthly summary reports, responding to personnel from birthing hospitals regarding the law and their responsibilities, contact as necessary with AIT Laboratory regarding hospital guidelines and required data, presentations as needed regarding Meconium Screening, and trainings on Meconium collections, etc., with laboratory personnel when requested by hospitals.
- The Division of Mental Health Addictions Prevention has rescinded their guidelines on working with pregnant teenagers and PSUPP services will be provided to these teens in FY 2001.
- The ISDH continued the anti-tobacco campaign aimed at youth ages 10 – 14. This campaign includes radio and television ads and creative educational materials to youth in 36 mid Indiana counties. 969,000 households with televisions are in the area. Print materials (500,000 posters, 625,000 school folders, and 500,000 parent teacher brochures) to reinforce the ads were sent to public and private schools in the area. An evaluation conducted by Gallup indicated that:
  - 83% of the participants recalled seeing the "It's Gonna Cost You" television ads in the prior 12 months
  - 76% of those participants smoked regularly
  - 45% of the 5th and 6th graders indicated that the television ads made them think about not smoking
  - 79% could recall the theme of the television ad

  This initiative received funding from MCHS in August 1998 for a two-year period.
- The anti-tobacco curriculum *Tar Wars* funded to educate 5th grade students regarding the short term effects of tobacco use, the reasons people use tobacco, and images of tobacco companies use to market their products continued. *Tar Wars* provides an opportunity for family physicians, health care providers, school personnel and community leaders to form coalitions toward the common goal of discouraging youth tobacco use. During FY'99, the number of schools participating in the program increased from 100 to 306 and the number of students reached increased by over 1,100 to 18,000 in 77 counties. Mailings were sent to 1,637 elementary schools.
- The Indiana ASK protocol continued to be distributed and discussed during FY'99. MCH clinics used the protocol with each patient at each visit. The protocol consists of three steps: (1) ask at

each visit how the patient is exposed to tobacco smoke, (2) provide educational materials, and (3) provide referral and follow-up for reduction/cessation.

PM 03: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home."

FY'99 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health home" will maintain at 90% in FY'99.

Status: 87.8%. (Overestimate based on % with health insurance.) Accurate estimation of this measure would require primary data collection. At the present time, Indiana can determine the number of children served by the CSHCN program, but not the number of children in the State who meet the broad federal definition. Likewise, for this broad category of children, Indiana does not have a means to determine if these children have a "medical/health home" using the Academy of Pediatrics' 7 point definition of a medical home.

Significant Activities:

- CSHCS program-eligible children are linked to a primary health care provider at the time of enrollment.

DIRECT HEALTH CARE SERVICES

All Targeted Populations (Pregnant Women, Mothers, and Infants; Children; and Children with Special Health Care Needs)

Pregnant Women, Mothers and Infants

SP #07: The percent of HIV exposed infants as a result of perinatal transmission that remain HIV positive by 18 months of age.

FY'99 Performance Objective: The rate of HIV exposed infants as a result of perinatal transmission that remain HIV positive after 18 months of age will decrease from 22% 1998 to 20% in 1999.

Status: 9.1% Objective achieved. (Note: small numbers create great fluctuation in this measure from year to year. Measure is also impacted by effectiveness of efforts to determine HIV exposed infants.)*

Significant Activities:

- Disseminated information and development of educational materials.
- Worked cooperatively with hospital designated representatives to work with the medical staff and to reinforce the requirements of the law and rule.
- Educated prenatal care providers in collaboration with the hospitals about the requirements of the rule and their responsibilities
- Collaborated with other programs, specifically HIV Surveillance Program regarding HIV exposed infants.

- ISDH developed training to assist providers with HIV counseling, testing, treatment and resources for the pregnant client. Eight trainings were provided in Northern and Central Indiana.
- ISDH has maintained a relationship with a designee at every hospital with labor and delivery services and provided assistance to these designees.
- Continued to encourage hospitals to have rapid testing available.
- Distributed videos, brochures, and posters to physicians, other health care professionals, and hospitals.
- Distributed information about available community resources to physicians, other health care professionals, and hospitals.
- Worked in partnership with various professional organizations to provide information to their members through bulletins, newsletters, and exhibits at meetings, exhibited at IADP, ICOG, and had articles in IPN.
- Conducted surveys: one compared information regarding HIV testing in the patient's office medical record with information on the birth certificate; the other surveyed postpartum women regarding HIV knowledge they gained from their healthcare provider.

Children with Special Health Care Needs

PM 01: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

FY'99 Performance Measure: During FY'99 a system will be developed to determine utilization of CSHCS by dually enrolled SSI clients. Baseline data will be determined.

Status: 10.2%. Indiana now has the capacity to match SSI beneficiary records with the CSHCN Program. Data is available from the CSHCN data system that indicates if the child is concurrently enrolled in SSI. The creation of this linkage will be a programmatic objective for the CSHCN program during FY2000. The new CSHCS data system should enable Indiana to report for FY 2000.*

Significant Activities:

- The Children's Special Health Care Services (CSHCS) Program begin collecting information relative to the percentage of children receiving services from the CSHCS Program who are also receiving SSI benefits.

PM 02: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

FY'99 Performance Measure: The Indiana CSHCS Program will continue to provide 8 of the 9 services listed in PM 02.

Status: 8 out of 9 specialty and subspecialty services are provided or paid for by the CSHCS program. Home health care services can be provided at the Director's discretion, on a case-by-case basis. Some early intervention services are eligible for payment from CSHCS. CSHCS reimburses the First Steps program for these services. Objective achieved.

Significant Activities:

- The CSHCS program pays for basic primary care for enrolled clients. Specialty and subspecialty care are provided for services related to the client's eligible condition.
- During FY'99, 27 local community agencies were funded to provide care coordination to CSHCS participants within their counties. Care coordination is also provided by state care coordinators/consultants.

2.5 Progress on Outcome Measures

The most current vital statistics data available is for 1998. It is unknown whether the outcome objectives for 1999 have been achieved.

Outcome Measure #01: The infant mortality rate per 1,000 live births.

FY'99 Performance Objective: 8.1.

Status: 7.5. Objective achieved.*

MCHS is aware of Indiana's high infant mortality rate. The IPN, an alliance of individuals and community groups committed to lowering Indiana's high infant mortality rate, was established to implement the Indiana Perinatal Systems Strategic Plan, a statewide, community-based blueprint for action. The IPN, other programs and the following performance measures are felt to impact outcome measure 01:

- PM 04 (see p. 64),
- PM 15, PM 17, PM 18, and SP #05 (see pp. 49, 50, 48, 47),
- SP #01 (see p. 71),
- SP #02 (see p. 61),
- SP #04 (see p. 72).
- Enabling services such as Healthy Families Indiana (p. 71) have also been supported to lower the infant mortality rate.
- Indiana RESPECT (PM 06, p. 62) strives to delay onset of sexual activity among teens, decrease teen pregnancy, and lower infant mortality.

Outcome Measure #02: The ratio of the black infant mortality rate to the white infant mortality rate.

FY'99 Performance Objective: 2.3

Status: 2.7. Objective not achieved.*

Indiana showed progress toward reducing the disparity between Black and White infant deaths. This as been an Indiana priority since it was introduced as a state performance measure in FY'98. Fifteen percent of women in Prenatal Care last year through MCH funded projects were black, as opposed to only 11% of the total women. Ten percent of black births were in Prenatal Care last year through MCH funded projects, as opposed to only 7% of total births. The IPN, collaboration with the two Healthy Start projects in Indiana, and the relationship with the Indiana Minority Health Coalition have been priorities for MCHS. Each of these programs has as a priority reducing the health disparities between black and white infants. State performance measure #08 has been developed to impact this outcome measure. Performance measures and activities affecting this outcome measure include:

- PM 15, PM 17, PM 18, and SP #05 (see pp. 49, 50, 48, 47),
- SP #02 (see p. 61)
- MCHS participation in the Indiana Black Expo Black and Minority Health Fair (see p. 60) is intended to impact this outcome measure.
- Funding for the Indiana Minority Health Coalition's NATALE program (p. 72) is also intended to impact this outcome measure.

Outcome Measure #03: The neonatal mortality rate per 1,000 live births.

FY'99 Performance Objective: 5.4

Status: *5.1*. Objective achieved.*

Indiana has also shown progress toward reducing neonatal mortality. Performance measures and activities affecting this outcome measure include:

- SP #05, PM 18, PM 15, and PM 17 (see pp. 47, 48, 49, 50)
- SP #02 (see p. 61)
- PM 06 (see p. 62)
- PM 04 (see p. 64)
- SP #01 (see p. 71)
- SP #04 (see p. 72).

Outcome Measure #04: The postneonatal mortality rate per 1,000 live births.

FY'99 Performance Objective: 2.7

Status: 2.4. Objective achieved.*

The postneonatal mortality rate remains above the objective. Performance measures and activities affecting this outcome measure include:

- PM 09 (see p. 63)
- PM 04 (see p. 64)

- PM 05 (see p. 68)
- SP #01 (see p. 71)
- SP #04 (see p. 72)
- SP #07 (see p. 74).
- Efforts to increase family care coordination (p. 33) and continued funding for Healthy Families Indiana (p. 71) should help in the efforts to decrease postneonatal mortality.
- Increased efforts to decrease injuries in young children should also impact this outcome.

Outcome Measure #05: The perinatal mortality rate per 1,000 live births.

FY'99 Performance Objective: 11.7.

Status: *9.8*. Objective achieved.*

Progress has been made in reducing perinatal mortality. Performance measures and activities affecting this outcome measure include:

- SP #05 and PM 18 (see pp. 47, 48)
- SP #02 (see p. 61)
- SP #01 (see p. 71)
- SP #04 (see p. 72)

Outcome Measure #06: The child death rate per 100,000 children aged 1-14.

FY'99 Performance Objective: 31.3

Status: *26.2*. Objective achieved.*

Indiana has shown progress toward reducing the child death rate. Performance measures and activities affecting this outcome measure include:

- PM 12 and PM 13 (see pp. 52, 53)
- SP #06 (see p. 54)
- PM 11 (see p. 55)
- PM 04 (see p. 64)
- SP# 03 (see p. 67)
- PM 05 (see p. 68)
- PM 08 (see p. 70)
- SP# 01 (see p. 71)
- PM 03 (see p. 74)
- SP# 07 (see p. 74)
- PM 02 (see p. 75)
- PM 14 (see p. 55)

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

For the FY 2001 Indiana Block Grant Application Needs Assessment, MCHS contracted with The Lewin Group, Inc. to compile and write Sections 3.1 and 3.2

3.1.1 Needs Assessment Process

The needs assessment process used both quantitative and qualitative methods to assess the needs for direct and enabling health care, population-based, and infrastructure building services. The quantitative analysis was built on a review of MCH health status indicators. A range of data examining health risks, health-related behaviors, health status and outcomes, health service utilization and environmental risks were collected. To the extent possible, data were compiled on trends from 1994 to 1998 and localized to the county level. Qualitative input from the public and private sector, state and local agencies, and citizens and family members was gathered through a statewide teleconference in March 2000 and through key informant interviews.

A preliminary analysis of health status indicators was presented to ISDH MCHS team leaders in January 2000. Problems and issues highlighted in the data were discussed and high risk groups identified and areas of service deficiency suggested. After discussion of the preliminary data analysis, a broad list of problem areas and their precursors and interventions was drafted.

ISDH MCHS/CSHCS hosted a statewide teleconference in March 2000 to involve the public in a priority setting exercise. The statewide teleconference was attended by about 200 MCH providers, planners, and advocates from across the state. The preliminary data analysis was presented to participants along with a general discussion of MCH problems, precursors, and interventions. Teleconference participants then gathered in small groups to conduct a prioritization exercise. Participants were asked to generate specific precursors and potential interventions needed to address the problems and needs identified in their communities. The prioritization exercise sought to identify consensus for interventions needed for each MCH target population. Groups were also asked to discuss limits and opportunities for collaboration, systems change, and policy development. Each breakout group also discussed sub-populations at greater risk of MCH problems or with special needs for services. Recorders in each breakout group then reported back to the entire teleconference for further discussion and submitted written notes of the issues raised in the breakout groups.

Further public input into the needs assessment process was provided by a series of key informant interviews. Twenty-five program administrators, providers, and advocates, primarily outside of ISDH MCHS/CSHCS, were interviewed and asked about their involvement with MCH populations and services and the extent of collaboration with ISDH MCHS/CSHCS. Perspectives on the strengths and weaknesses in MCH services were sought from informants along with suggestions for greater interagency collaboration.

Using the quantitative analysis and input from the statewide teleconference and the key informant interviews, a matrix of MCH problems by prioritizing criteria was developed. Each problem in the matrix was given a score for the following criteria: severity of consequences, improving/worsening trend, extent of the problem, inclusion in Healthy People 2010 goals, consistency with state priorities, and acceptability to the public. The scores were weighted for the importance of each criterion and total scores calculated to identify the highest priority concerns.

ISDH MCHS/CSHCS team leaders used the results of the prioritization matrix to develop a final list of nine priority needs for the state. Using the priority needs as a guide, the team leaders reviewed and revised annual targets for performance measures for both state and national indicators. The state plans to conduct further work to link the needs assessment and priority setting process to resource allocation. Over the next year, additional efforts will be made to make the health status data more accessible to the public and involve greater public participation to develop methods and strategies to link priority needs with resources.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

The health of children and women of childbearing age is crucial to the growth and development of Indiana's future workers and citizenry. However, health is influenced by numerous factors. These factors include economic and social characteristics such as poverty and family composition, health-related behaviors such as smoking and diet, and patterns of health care use of preventive and primary care. This analysis examines some of the key indicators that reflect the health status, health risks, and health care access of Indiana's MCH population. It is intended to provide a broad overview of the most important characteristics of the MCH population. The profile also reviews some of the key risk factors and prevalent health problems that impact health status and opportunities for intervention.

Social Demographics of Indiana's MCH Population

In 1998, 5,899,195 persons resided in Indiana according to Census estimates. There were 1,324,439 women in the state of childbearing age (15-44), and 1,862,242 children (0-21). In 1998, 97,591 women became pregnant and 85,055 babies were born. (Table 1)

Table 1 - Indiana Population, by Race/Ethnicity, 1994-1998

	1998		1984		Pct. Change
	Number	Percent	Number	Percent	1994-1998
Total Population	5,899,195		5,750,033		2.6%
Non-Hispanic					
White	5,205,638	88.2%	5,118,723	89.0%	1.7%
Black	482,147	8.2%	459,368	8.0%	5.0%
Amer. Indian	12,978	0.2%	12,482	0.2%	4.0%
Asian	53,251	0.9%	44,003	0.8%	21.0%
Hispanic	145,181	2.5%	115,457	2.0%	25.7%
Children Ages 0-21	1,862,242		1,805,072		3.2%
Non-Hispanic					
White	1,589,758	85.4%	1,555,757	86.2%	2.2%
Black	186,339	10.0%	181,623	10.1%	2.6%
Amer. Indian	3,973	0.2%	3,965	0.2%	0.2%
Asian	19,177	1.0%	14,396	0.8%	33.2%
Hispanic	62,995	3.4%	49,331	2.7%	27.7%
Women Ages 15-44	1,324,439		1,323,537		0.1%
Non-Hispanic					
White	1,149,700	86.8%	1,162,079	87.8%	-1.1%
Black	120,950	9.1%	116,623	8.8%	3.7%
Amer. Indian	3,143	0.2%	3,127	0.2%	0.5%
Asian	14,906	1.1%	12,752	1.0%	16.9%
Hispanic	35,740	2.7%	28,956	2.2%	23.4%

SOURCE: Bureau of the Census.

Between 1994 and 1998, Indiana's total population grew by 2.6 percent. The number of children increased by a slightly higher rate, 3.2 percent, while the number of women of childbearing age rose by 0.1 percent.

Indiana's population is predominately white, non-Hispanic, but is becoming more diverse. In 1998, 88.2 percent of the total population was white, non-Hispanic. Blacks, the largest minority group, constituted 8.2 percent of the population and Hispanics made up 2.5 percent of the total. Minorities constituted a slightly larger proportion of children and women of childbearing age. Black and Hispanic children account for 10 percent and 3.4 percent, respectively, of the child

population. Among women of childbearing age, blacks are 9.1 percent and Hispanics are 2.7 percent of the total.

In recent years, the state's minority population, especially among Hispanics and Asians, has grown rapidly. The total Hispanic population grew by over 25 percent, from 115,457 to 145,181 between 1994 and 1998. Asians experienced a 21 percent growth in population over those five years, though their numbers still remain fairly small. Among the child population, these trends are even more pronounced. The number of Hispanic children jumped nearly 28 percent from 49,331 to 62,995. The Asian child population increased one-third from 14,396 to 19,177.

Overview of Births in Indiana

In 1998, 85,055 infants were born to residents of Indiana. Between 1994 and 1998, the number of births in Indiana rose slightly from 82,522. In 1998, 87.4 percent of all births were white, 10.8 percent were black, and 1.7 percent were other races. The relative proportion of births by race has been relatively constant from 1994 to 1998. Hispanics (regardless of race) constituted 4.4 percent of all births in 1998, compared to just 2.8 percent in 1994. Since most Hispanics in Indiana are white, the increase in the number of Hispanic births is mostly offset by a relative decline in the proportion of non-Hispanic white births. The increase in Hispanic births signals a need to develop and expand linguistically and culturally appropriate services for this population. (Table 2)

Table 2 - Indiana Births, by Race, Hispanic Origin, 1994-1998

		1994	1995	1996	1997	1998
All Races						
	Number	82,522	82,918	83,157	83,385	85,055
White						
	Number	72,445	73,001	73,074	73,344	74,374
	Percent	87.8%	88.0%	87.9%	88.0%	87.4%
Black						
	Number	8,938	8,752	8,746	8,739	9,216
	Percent	10.8%	10.6%	10.5%	10.5%	10.8%
Other						
	Number	1,139	1,165	1,337	1,302	1,465
	Percent	1.4%	1.4%	1.6%	1.6%	1.7%
Hispanic						
	Number	2,311	2,525	2,941	3,393	3,781
	Percent	2.8%	3.0%	3.5%	4.1%	4.4%

Note: Hispanics may be of any race.

Source: Indiana State Department of Health, Epidemiology Resource Center

Children born to unmarried parents are more likely to have lower family incomes and suffer other economic disruptions. (See Map A) Over one-third (33.6 percent) of births in Indiana were to unmarried parents in 1998. The proportion was 28.4 percent among whites and 77.3 percent among blacks. In contrast the national rates in 1997 were 32. 4 percent, 25.8 percent, and 69.4 percent for all races, whites, and blacks, respectively. Data from the 1996 linked birth and death certificate data set indicate that infants born to unmarried parents suffer an infant mortality rate 79 percent higher than infants born to married parents[1]. While this data reflects varying family formation patterns, it underscores the need for family planning services to assure that all children are born to parents ready, willing, and able to care for them.

INSERT "MAPA.JPG" HERE

Infant Mortality (Deaths during the first year after birth) (See Map B)

Infant mortality is the sentinel measure of the health of women and children. Infant mortality reflects the health of mothers before they become pregnant and during their pregnancies as well as the care and nurturing of babies during their first year of life. Though advances in prenatal diagnosis and neonatal technology have led to continuing improvements in the survival of even the sickest babies, the United States has one of the highest infant mortality rates among industrialized nations. The improvements also have come with a heavy health burden on surviving infants who suffer greater developmental and physical delays and disabilities and on society through higher health care costs.

INSERT "MAPB.JPG" HERE

In 1998, 641 infants in Indiana died before their first birthday. Indiana's infant mortality rate was 7.5 deaths per 1,000 live births. Between 1994 and 1998, the infant mortality rate fell from 8.8 to 7.5, a 14.8 percent improvement. The rate of improvement is close to reaching the Healthy People 2000 goal of 7.0 deaths per 1,000 live births and on track to meet the Healthy People 2010 goal of 5.0. (Table 3)

Table 3 - Indiana Infant and Perinatal Mortality, 1994-1998

	1994	1995	1996	1997	1998
Infant Mortality	Infant deaths per 1,000 live births				
All Races	8.8	8.3	8.7	8.1	7.5
White	7.6	7.2	7.5	7.2	6.3
Black	19.2	17.0	18.4	15.6	17.1
Black/White Ratio	2.5	2.4	2.4	2.2	2.7
Neonatal Morality	Neonatal deaths birth per 1,000 live births				

[1] Rahmanifar, A. *Indiana Infant Mortality Report 1996 Birth Cohort* (Indiana State Department of Health, September 1999).

Table 3 - Indiana Infant and Perinatal Mortality, 1994-1998

	1994	1995	1996	1997	1998
All Races	5.5	5.6	5.6	5.2	5.1
White	4.8	4.8	5.0	4.1	4.2
Black	11.7	12.5	10.7	9.7	11.8
Black/White Ratio	2.5	2.6	2.1	2.4	2.8
Postneonatal Mortality	Postneonatal deaths per 1,000 live births				
All Races	3.3	2.7	3.1	2.9	2.4
White	2.8	2.4	2.5	2.2	2.0
Black	7.5	4.6	7.7	5.8	5.3
Black/White Ratio	2.7	1.9	3.1	2.6	2.6
Perinatal Morality	Perinatal deaths per 1,000 live births + fetal deaths				
All Races	11.0	12.0	12.1	11.0	10.6
White	9.7	10.6	10.8	9.6	9.4
Black	21.1	22.4	21.2	20.9	18.3
Black/White Ratio	2.2	2.1	2.0	2.2	1.9

Source: Indiana State Department of Health, Epidemiology Resource Center

However, the state lagged behind the national infant mortality rate every year during this period. Indiana's overall infant mortality rate ranked 39th among the states in 1997. Indiana babies were more than twice as likely to die than babies born in the state with the best infant mortality rate, New Hampshire. Among neighboring states, only Illinois had a worse overall infant mortality rate.

Infants born to black women were 2.7 times as likely to die during infancy as whites in 1998. The black infant mortality rate was 17.1 deaths per 1,000 live births compared to 6.3 among whites. The black infant mortality rate fell just 10.9 percent between 1994 and 1998 compared to a drop of 17.1 percent for whites. The high rate of infant death among blacks and the continuing large racial disparity is a cause for concern and renewed emphasis on improving the birth outcomes of blacks in Indiana.

However, the infant mortality problem in Indiana is not confined to the black community. Indiana's poor ranking against other states is driven by relatively high rates of infant mortality among whites. Only 3 states had worse white infant mortality rates than Indiana in 1997 – Alabama, Arkansas, and West Virginia. Given the relatively favorable socio-economic characteristics of Indiana compared to those states, Indiana's white infant mortality is much worse than expected.

Among Indiana's 92 counties, 37 counties had over 20 infant deaths to calculate reliable infant mortality rates from 1994-1998. Just seven counties accounted for half of the state's 3,449 infant deaths from 1994-1998: Marion, Lake, Allen, St. Joseph, Vanderburgh, Elkhart, Madison. The infant mortality rates ranged widely among the counties with a low of 5.6 in Johnson County and a high of 12.7 in Scott County. However, because of the small numbers involved, only 4 counties had statistically significant rate differences from the state average (8.3). The two counties with statistically significant better rates than the state were Johnson (5.6),Tippecanoe (5.8). The two counties with worse rates were Marion (9.8) and Lake (10.8). Racial disparities were very wide at the county level. The best black infant mortality rate at the county level (Marion - 16.4) was worse than the worst white infant mortality rate at the county level (Scott - 12.7).

Neonatal Mortality (Infant deaths less than 28 days after birth)

Neonatal mortality is closely related to the health status and care of infants at birth. Congenital anomalies, disorders related to short gestation and low birthweight, and pregnancy complications are the leading causes of death for neonates. The greatest opportunities to improve neonatal mortality are in the reduction of preterm birth and low birthweight.

In 1998, Indiana's neonatal mortality rate was 5.1 deaths per 1,000 live births. Neonatal deaths accounted for 68 percent of infant deaths in the state. The neonatal mortality rate has improved more slowly than the overall infant mortality rate. Between 1994 and 1998, the neonatal mortality rate decreased from 5.5 to 5.1, a 7 percent decline. At that rate of progress, the state is not likely to reach the Healthy People 2010 neonatal mortality goal of 3.3 deaths per 1,000 live birth. The state ranked 35th among the states in neonatal mortality for all races in 1997. Indiana's white neonatal mortality rate ranked 42nd out of 48 states with measurable rates. The state's black neonatal mortality rate was 20th out of 33 states with measurable rates.

As with the overall infant mortality, blacks experienced much higher rates of neonatal mortality. The black neonatal mortality rate was 11.8 deaths per 1,000 live births in 1998, almost double the white overall infant mortality rate. Between 1994 and 1998, there was no improvement in the black neonatal mortality rate. The slight increase from 11.7 to 11.8 was not statistically significant but does indicate that little progress is being made on this front.

Postneonatal Mortality (Infant deaths between 28 weeks and 1 year after birth)

In 1998, Indiana's postneonatal mortality rate was 2.4 deaths per 1,000 live births. Postneonatal mortality represents 32 percent of all infant deaths. Between 1994 and 1998, the postneonatal mortality rate fell from 3.3 to 2.4, a 27 percent improvement. If that rate of improvement

continues, the state is likely to meet the Healthy People 2010 goal of 1.7 postneonatal death per 1,000 live births. Improvements in postneonatal mortality accounted for 69 percent of the improvement in the state's infant mortality rate between 1994 and 1998. The progress may reflect the success of the state's SIDS reduction efforts. In 1997, the state's postneonatal mortality rate ranked 36th out of 47 states with measurable rates. The white postneonatal rate ranked 34th out of 42 states and the black rate ranked 22nd out of 27 states.

The black postneonatal mortality rate in 1998 was 5.3 compared to 2.0 for whites. The black postneonatal mortality rate is subject to wide annual variation because of small numbers. Between 1994 and 1998, the black postneonatal mortality rate improved from 7.5 to 5.3, with a low recorded in 1995 of 4.6.

Perinatal Mortality (Fetal deaths after 20 weeks gestation and infant deaths under 7 days after birth)

Since infant mortality rates only consider live births, they fail to consider fetuses with health problems that are not born alive. The perinatal mortality rate includes fetal deaths and infant deaths in the first week after birth to provide a more complete picture of the perinatal population.

Indiana's perinatal mortality rate in 1999 was 10.6 deaths per 1,000 live births and fetal deaths. The 1998 rate is lower than the 1994 rate of 11.0, but rates over 12.0 were recorded in 1995 and 1996. The slight rate of progress in reducing the perinatal mortality rate means that Indiana is not likely to reach the Healthy People 2010 goal of 7.7. The black perinatal mortality rate is very high at 18.3. The black white ratio has hovered near 2, lower than the ratio for infant, neonatal and postneonatal mortality.

Low birthweight and Very Low Birthweight (Births weighing less than 2,500 grams and 1,500, respectively) (See Map C)

Low birthweight is the single greatest risk factor in infant mortality. Infants born too soon or too small are at much higher risk of death than full-term, normal weight infants. According to Indiana's 1996 linked birth and death certificate data, low birth weight and very low birthweight babies were 21.0 and 89.4 times, respectively, as likely to die as normal weight infants.

INSERT "MAPC.JPG" HERE

In 1998, 7.9 percent of Indiana babies were born at low birthweight. Between 1994 and 1998, the low birthweight rate increased 16 percent from 6.8 percent to 7.9 percent. Among whites, the rate increased from 6.2 to 7.3 percent, a 17 percent increase. The black rate rose from 12.4

percent to 13.5 percent. The worsening trends were statistically significant for all three groups. Since there has been no improvement in low birthweight, the state will not likely meet the Healthy People 2010 goal of 5 percent. (Table 4)

Table 4 - Indiana Low Birthweight and Very Low Birthweight, 1994-1998

	1994	1995	1996	1997	1998
Low Birthweight	Percent of births less than 2500 grams				
All Races	6.8	7.5	7.6	7.7	7.9
White	6.2	6.8	6.9	7.0	7.3
Black	12.4	13.0	13.8	13.6	13.5
Black/White Ratio	2.0	1.9	2.0	1.9	1.8
Very Low Birthweight	Percent of births less than 1500 grams				
All Races	1.3	1.3	1.4	1.4	1.4
White	1.1	1.1	1.2	1.2	1.2
Black	2.9	2.7	3.1	2.8	3.0
Black/White Ratio	2.6	2.5	2.6	2.3	2.5

Source: Indiana State Department of Health, Epidemiology Resource Center

The rate of very low birthweight infants has also shown a worsening trend across all race groups. In 1998, 1.4 percent of all Indiana babies were born at very low birthweight. The rates were 1.2 percent and 3.0 percent for whites and blacks, respectively. The ratios of black to white low birthweight and very low birthweight have closed slightly only because the white rates have worsened more than the black rates. Since very low birthweight is moving in the wrong direction, the state will not likely meet the Healthy People 2010 goal of 1.0 percent.

At the county level, 24 counties showed improvement in low birthweight rates from 1994 to 1998. However, none of the changes were statistically significant. At the same time, 27 counties had worsening low birthweight rates with 11 being statistically significant. The aggregate low birthweight rates for 1994-1998 ranged from a low of under 5 percent in Newton, Warren, and LaGrange Counties to over 9 percent in Marion and Crawford Counties. Seven counties accounted for half of the state's 31,340 low birthweight births from 1994-1998: Marion, Lake, Allen, St. Joseph, Vanderburgh, Elkhart, and Hamilton.

Interventions are needed to both reduce the prevalence of low birthweight and very low birthweight and improve the survival of babies born too soon and too small. Birthweight can be improved by better nutrition and prenatal care to assure greater maternal weight gain during pregnancy and reduce the chances of preterm birth. Reducing the incidence of tobacco, alcohol,

and illegal drugs during pregnancy are vital to preventing low birthweight. The survival rate of very low birthweight infants can be improved by making sure all babies are born in facilities appropriate to their level of risk. While Indiana does not have official designation of Level III hospitals, it is estimated that only 54 percent of very low birthweight infants in 1998 were born in facilities that can best care for high-risk deliveries and neonates.

WIC Participant Data

According to the CDC Pregnancy Nutrition Surveillance of pregnant women participating in the WIC program, only 45.3 percent of Indiana women were normal weight before pregnancy in 1998. In that year, 12.7 percent were overweight and 26.0 percent were very overweight. Another 16 percent were underweight or very underweight. Low maternal hematocrit/hemoglobin levels indicate potential nutritional and health risk to mothers and infants. Among women examined in the first trimester, 8.4 percent had low hematocrit/hemoglobin levels. That proportion rose to 13.1 percent in the second trimester and 35.2 percent in the third trimester. Among postpartum women, 41.0 percent had low hematocrit/hemoglobin levels.

Weight gain during pregnancy directly influences an infant's birthweight. During the course of their pregnancy, only 43.4 percent of Indiana pregnant women participating in WIC had ideal weight gain. Among WIC participants, 22.2 percent gained less than the ideal weight and 34.4 percent had greater than ideal weight gain. Infants born to women with less than ideal weight gain experienced a low birth weight rate of 14.2 percent compared to 6.4 percent among those born to women with ideal weight gain.

The Pediatric Nutrition Surveillance System provides data on the health and nutritional status of WIC participating children. In 1998, 7.9 percent of WIC participating children in Indiana exhibited low height for age (below the 5^{th} percentile) and 1.8 percent were low weight for height. Another 8.2 percent of these children were high weight for height (above the 5^{th} percentile). In that year, 20.8 percent of WIC participating children examined had low hematocrit/hemoglobin levels.

Prenatal Care Use (See Map D)

Prenatal care should begin early and continue throughout pregnancy. Prenatal care allows for the proper assessment of maternal and fetal risk, treatment for medical conditions and risk reduction, and education. Problems identified during pregnancy such as gestational diabetes and preeclampsia can be identified and mitigated before they become a danger to mother and fetus.

Regular contact with a health provider also provides important opportunities to teach good health-related behaviors such as smoking cessation and drug and alcohol abstinence.

INSERT "MAPD.JPG" HERE

Early prenatal care is defined as prenatal care that begins during the first trimester of pregnancy. Infants born to women who did not receive early prenatal care were 20 percent more likely to die than those that received early care, according to Indiana's 1996 linked birth and death data.

In 1998, 77.0 percent of Indiana babies were born to mothers who began prenatal care during the first trimester. Between 1994 and 1998, the proportion of births with early prenatal care declined slightly from 78.6 percent to 77.0 percent, a statistically significant decline of 2.0 percent. The worsening trend means that the state is not likely to reach the Healthy People 2010 goal of 95 percent of all babies born to mothers receiving early prenatal care. The national rate of early prenatal care use was 82.5 percent in 1997. (Table 5)

Table 5 - Indiana Early Prenatal Care Use, 1994-1998

	1994	1995	1996	1997	1998
	Percent				
All Races	78.6	79.4	78.1	76.7	77.0
White	80.6	81.2	80.1	78.3	78.7
Black	62.6	65.1	61.3	63.3	63.3

Source: Indiana State Department of Health, Epidemiology Resource Center

The rate of early prenatal care among whites was 78.7 percent and the rate for blacks was 63.3 percent. The white early prenatal care rate worsened between 1994 and 1998 while the black rate improved slightly. The trend for whites was statistically significant, but the black improvement was not.

At the county level, 38 counties showed improving trends from 1994-1998. However, only 4 were statistically significant. 54 counties showed worsening trends and 12 were statistically significant. Only 1 county (Dubois) had early prenatal care use above 90 percent. 23 counties reported early prenatal care rates below 75 percent over the entire five year period.

Beginning prenatal care early is not sufficient. In addition, care must continue regularly throughout pregnancy. The Adequacy of Prenatal Care Utilization Index, also known as the Kotelchuck Index, combines both the timing of entry into care and the number of prenatal care visits. Based on those two factors, the index characterizes prenatal care use as adequate plus,

adequate, intermediate, or inadequate. According to Indiana's 1996 linked birth and death data set, babies who received inadequate prenatal care were 86 percent more likely to die than those that received adequate care.

In 1998, 74.3 percent of all Indiana babies were born to mothers who received at least adequate prenatal care. In that year, 13.1 percent received inadequate or no prenatal care at all. Between 1994 and 1998, the percentage of babies with adequate or adequate plus prenatal care rose from 72.5 to 74.3. At the same time the percent with inadequate or no prenatal care worsened from 12.2 to 13.1 percent. (Table 6)

Table 6 - Indiana Adequacy of Prenatal Care, 1994-1998

	1994	1995	1996	1997	1998
All races			Percent		
Adequate plus	24.4	25.9	27.1	28.7	30.9
Adequate	48.1	47.5	46.5	45.1	43.4
Intermediate	15.4	14.6	13.8	13.2	12.5
Inadequate	11.2	11.0	11.7	12.1	12.2
No care	1.0	0.9	0.9	0.9	0.9
White					
Adequate plus	24.4	25.8	26.9	28.7	30.9
Adequate	49.9	49.1	48.2	46.7	45.0
Intermediate	15.2	14.5	13.7	13.1	12.4
Inadequate	9.8	9.9	10.4	10.9	11.0
No care	0.7	0.7	0.7	0.7	0.7
Black					
Adequate plus	25.1	27.1	28.7	29.3	30.7
Adequate	32.0	32.9	31.0	31.4	30.7
Intermediate	16.9	16.0	14.3	14.0	13.4
Inadequate	22.9	21.2	22.8	22.4	22.3
No care	3.1	2.7	3.2	2.9	2.8
Hispanic					
Adequate plus	22.0	22.6	20.7	20.5	23.2
Adequate	38.9	38.4	37.6	36.6	35.1
Intermediate	16.9	15.8	16.1	17.0	15.7
Inadequate	20.3	21.2	24.3	24.3	24.2
No care	1.8	1.9	1.3	1.6	1.7

Source: Indiana State Department of Health, Epidemiology Resource Center

Among blacks in 1998, only 61.4 percent received at least adequate prenatal care and 25.1 percent received inadequate or no care. The rates for Hispanics were 58.3 percent receiving adequate care and 25.9 percent receiving inadequate care. In contrast the rates for whites were 75.9 and 11.7 percent for adequate and inadequate care, respectively.

Trends in adequacy of prenatal care for Hispanics worsened for both the proportion receiving at least adequate care and those that received inadequate or no care. In contrast, those measures improved for blacks.

Tobacco Use and Substance Abuse (See Map E)

According to the Indiana's 1996 linked birth and death data, babies born to mothers who smoked during pregnancy were 51 percent more likely to die. In 1998, 21.3 percent of Indiana babies were born to mothers who smoked during pregnancy. The rate was higher among whites at 22.1 percent and lower among blacks at 16.3 percent. In contrast, the U.S rate of smoking during pregnancy was 13.2 for all races, 16.5 percent for whites, and 9.8 percent for blacks in 1997. At the county level, smoking rates ranged from 8.2 percent in Hamilton County to 36.1 percent in Parke County.

INSERT "MAPE.JPG" HERE

Smoking among teenaged mothers is especially worrisome because of the added risks faced by young mothers. In 1998, 29.7 percent of Indiana mothers ages 10-19 smoked during pregnancy. Among mothers ages 18-19, 32.0 percent smoked. In 1998, 25.8 percent of mother ages 15-17 smoked and 15.1 percent of mothers ages 10-14 smoked. Smoking during pregnancy was far more prevalent among white teens than among blacks. In 1998, 34.5 percent of white teen mothers smoked compared to 11.1 percent among black teen mothers. (Table 7) This is also reflective of teen smoking trends.

Table 7 - Indiana Smoking During Pregnancy, by Race and Age of Mother, 1995-1998

	1995	1996	1997	1998	Aggregate 1995-1998	Pct. Change 1995-1998
All Races						
Age 10-14	16.2	--	12.4	13.1	13.2	-19%
Age 15-17	26.1	26.0	27.3	25.8	26.3	-1%
Age 18-19	29.9	28.9	31.4	32.0	29.4	7%
Total Ages 10-19	28.2	20.1	29.7	29.7	28.8	5%
White						
Age 10-14	26.4	--	--	--	21.2	--
Age 15-17	32.0	32.0	33.2	31.4	32.2	-2%
Age 18-19	33.7	32.7	35.7	36.0	34.5	7%
Total Ages 10-19	33.0	32.3	34.7	34.5	31.5	5%
Black						
Age 10-14	--	--	--	--	3.8	--
Age 15-17	6.8	6.9	7.0	7.7	7.0	13%
Age 18-19	11.3	10.9	9.9	13.7	11.5	21%
Total Ages 10-19	9.1	8.9	8.5	11.1	9.4	22%

Table 7 - Indiana Smoking During Pregnancy, by Race and Age of Mother, 1995-1998						
	1995	1996	1997	1998	Aggregate 1995-1998	Pct. Change 1995-1998

Source: Indiana State Department of Health, Epidemiology Resource Center

Since smoking behaviors do not begin with pregnancy, tobacco use must be examined among the entire female population. According to the Indiana Behavioral Risk Factor Survey, 23 percent of all Indiana women were smokers in 1998. The rate has fallen slightly from 26 percent in 1995-96.

Efforts to reduce smoking during pregnancy should not be confined to the perinatal period. Rather, efforts to reduce tobacco use must begin with childhood and adolescence, when smoking habits are formed. According to the Indiana Prevention Resource Center Survey, tobacco use rates by Indiana youth are above the national average. In 1999, 40.5 percent of Indiana 12th graders smoked on a monthly or more frequent basis compared to the national average of 35.1 percent. The rate increased slightly from 37.3 percent in 1994. Similarly, daily cigarette use by Indiana 12th graders rose from 25.1 percent in 1994 to 27.6 percent in 1999. These trends were consistent with smoking percentages among teen women who delivered a live birth in 1998.

Trends have been more favorable among younger children who are targets of extra prevention programming by the state. Between 1994 and 1999, monthly cigarette smoking by 6th graders dropped from 10.0 percent to 7.0 percent. Daily smoking by 6th graders fell from 4.3 percent to 3.1 percent in those years. Among 9th graders, the monthly cigarette smoking rate dropped from 29.4 percent to 25.4 percent between 1994 and 1999. In that period, daily smoking decreased from 18.3 percent to 15.5 percent among 9th graders.

Smokeless tobacco use has also fallen sharply in recent years. Among Indiana 12th graders, monthly smokeless tobacco use fell from 15.5 percent to 11.2 percent from 1994 to 1999. In 1998, the national rate of monthly smokeless tobacco use was 8.8 percent. Among Indiana 9th graders, the monthly rate of smokeless tobacco use fell more than half from 13.3 percent to 6.5 percent between 1994 and 1999. During that period, the 6th grade smokeless tobacco use rate fell from 4.0 percent to 1.4 percent.

It is difficult to measure the extent of drug use during the prenatal period without universal newborn screening for drug exposure. Indiana law requires that a subset of infants born receive a meconium screen for drugs. Infants weighing less than 2500 grams and with a head

circumference smaller than the third percentile for gestational age with no other medical explanation for their condition must be screened. While not all positive meconium tests indicate drug exposure, positive test results trigger counseling and referral to appropriate support programs. From November 1998 through June 1999, the meconium screening program screened 502 specimens and identified 102 positive results. Seventy-one of the positive results were for cannabinoids, 31 were for cocaine, and 2 were for opiates. No positive results for amphetamines or PCP were found. With expansion of the screening criteria (see page 22) a better indication of the extent of drug use may be available.

Like smoking, illicit drug using behavior begins in childhood and adolescence. Among 12th graders in 1999, 8.2 percent reported daily marijuana use and 23.5 percent reported monthly use, according to the Indiana Prevention Resource Center Survey. In 1994, the daily and monthly marijuana use rates were 6.0 and 21.4 percent, respectively. The national rates of daily and monthly marijuana use were 5.6 and 22.8 percent in 1998. Between 1994 and 1999, monthly use of psychedelic drugs increased from 4.4 percent to 5.7 percent and monthly use of tranquilizers rose from 4.6 percent to 5.9 percent. Indiana's rates for monthly psychedelic and tranquilizer use were higher than the national average levels of 3.8 and 2.4 percent. Monthly cocaine use by Indiana 12th graders was 2.4 percent in 1999 (the same as the national level) compared to 2.0 percent in 1994.

Adolescent Childbearing (See Map F)

The teen birth rate for women ages 15-17 decreased 18 percent between 1994 and 1998. The 1998 teen birth rate was 28.9 births per 1,000 girls ages 15-17. Indiana's teen birth rate compares favorably to the 1997 national rate of 32.1 births per 1,000 women ages 15-17. (Table 8)

Table 8 - Indiana Teen Birth Rates, 1994-1998

	Ages 10-14	Ages 15-17	Ages 18-19
		Births per 1,000 Women	
1994	1.9	35.1	91.0
1995	1.1	36.2	92.5
1996	1	32.7	90.9
1997	0.8	32.1	87.5
1998	0.8	28.9	89.4
Change 1994-1998	-58%	-18%	-2%

Source: Indiana State Department of Health, Epidemiology Resource

Table 8 - Indiana Teen Birth Rates, 1994-1998

	Ages 10-14	Ages 15-17	Ages 18-19
		Births per 1,000 Women	
Center			

A broader measure of adolescent childbearing is the proportion of all births to women under 20. In 1998, 13.8 percent of Indiana babies had teen mothers. The proportion for whites was 12.4 percent. The black rate was twice as high at 25.6 percent. The national proportion of births to teens in 1997 was 12.7 percent for all races. The rates for whites and blacks was 11.2 percent and 22.2 percent, respectively.

INSERT "MAPF.JPG" HERE

According to Indiana's 1996 linked birth and death data, infants born to mothers younger than 20 were 81 percent more likely to die than those born to older women. The greater health risk of adolescent childbearing coupled with the social consequences of early childbearing makes this an area of serious concern.

Breastfeeding

Breastfeeding is the best form of nutrition for babies. It confers immunities to the infants, bonds mother and child, and improves maternal health by reducing postpartum bleeding. In 1998, 55.9 percent of Indiana infants were breastfed at hospital discharge. The rate varied widely among the races. The rate was 58 percent among whites and 36.6 percent among blacks. Among the low-income and nutritionally-at-risk Indiana infants who participate in the WIC program, 45.2 percent were breastfed in federal fiscal year 1999. The average duration of breastfeeding for those infants was 12.5 weeks. The Healthy People 2010 goal is that at least 75 percent of all infants be breastfed in the early postpartum period.

HIV and AIDS

HIV transmitted from mother to infant during the perinatal period is a cause of morbidity and mortality that can be prevented or alleviated with proper behavioral and chemoprophylactic precautions. Up to the end of 1998, 211 cumulative cases were reported of infants born to mothers with HIV in Indiana. Of that number, the HIV status of 59 is still undetermined, 29 are infected with HIV, 31 have AIDS and 92 are HIV negative. Among the state's female population, 511 women were reported with HIV for a point prevalence of 17 per 100,000 women. 253 women had AIDS for a point prevalence rate of 8.3 per 100,000 population.

Chlamydia and Sexually Transmitted Diseases (See Map G, H, I)

Sexually transmitted diseases reflect risky behaviors among sexually active adolescents and adults. The highest rates of STD are among adolescents. Yet, societal taboos about sexual activity inhibit youth from seeking health education and screening needed to identify, treat, and ultimately prevent sexually transmitted diseases. While many STDs appear asymptomatic or mild, their consequences on maternal and child health are severe. Chlamydia is the most prevalent STD in the nation. It is the leading cause of pelvic inflammatory disease which is the most common cause of ectopic pregnancy.

INSERT "MAPG.JPG" HERE

INSERT "MAPH.JPG" HERE

INSERT "MAPI.JPG" HERE

In 1998, the rate of reported cases of chlamydia among Indiana women ages 15 to 19 was 19.5 per 1,000. Among women ages 20-44, the rate was 4.1 cases per 1,000. Between 1994 and 1998, the chlamydia rate has improved slightly for teenage girls, but it has worsened for older women. However, these trends are greatly affected by the screening rates for the disease and may not indicate underlying changes in the disease prevalence. (Table 9)

Table 9 - Indiana Chlamydia Rates, 1994-1998

	1994	1995	1996	1997	1998
	Cases per 1,000 Women				
Women Ages 15-19	20.0	16.7	19.4	17.7	19.5
Women Ages 20-44	3.5	3.3	3.4	3.5	4.1

Source: Indiana State Department of Health, Epidemiology Resource Center

Immunizations and Vaccine Preventable Diseases

Immunizations are one of the most effective and cost-effective of all health interventions. Immunization rates are considered a key indicator of children's access to health services. Though cases of preventable disease have been very low, maintaining high rates of immunization is the only way to prevent future outbreaks of disease.

According to the National Immunization Survey, the percentage of 19-35 month old children fully immunized was 77.5 percent in Indiana in 1998. In Marion County, the rate was 78.2 percent. Full vaccination is defined as 4 doses of polio vaccines, 3 doses of diphtheria, tetanus, and pertussis vaccine, 1 dose of measles containing vaccine, and 3 doses of Hib vaccine. Between 1994 and 1998, the immunization rate has fluctuated without showing a clear improving trend.

The state remains far from the Healthy People 2010 goal of vaccinating 90 percent of all two year olds. (Table 10)

Table 10A - Percent of 19-35 Month Old Children Fully Immunized

	Indiana	Marion County
1998	77.5	78.2
1997	72	81
1996	70	72
1995	75	75
1994	70	78

Source: Centers for Disease Control, National Immunization Survey

Table 10B - Indiana Vaccine Preventable Disease Cases, 1998

	Cases
Pertussis	185
Hib	6
Mumps	7
Measles	3
Polio	1
Rubella	0
Tetanus	1
Diphtheria	0
Hepatitis B	101

Source: Indiana State Department of Health, Epidemiology Resource Center

The actual number cases of vaccine preventable diseases in Indiana are quite low. In 1998, the state experienced an outbreak of pertussis centered in LaGrange County. However at least one case of pertussis was reported in 37 other counties. Seventy-nine cases were among infants causing 52 to become hospitalized. Over the 1990s, the incidence of pertussis in Indiana has increased slowly.

Child Lead Poisoning

Children are severely affected by lead levels in the blood. Even low levels of lead can affect learning, behavior and development. High levels can cause disability and death. The national goal is to reduce the incidence to zero for children under five years old. Children most at risk of lead poisoning include those in low-income families and those living in urban areas and in pre-1950 housing. However, no estimates of the total number of children in Indiana with abnormal blood lead levels are available.

Indiana's Childhood Lead Poisoning Prevention Program has screened more than 185,500 children ages 0-6 for blood lead levels since 1994. In 1999, the program screened 28,587 children and identified 2,070 (7.2 percent) with elevated lead levels. Medicaid-enrolled children are considered a high-risk group for lead poisoning, yet few receive the blood lead tests they are entitled. The Childhood Lead Poisoning Prevention Program found that only 25.3 percent of Medicaid children ages 6 and younger received a lead screening paid for by Medicaid between 1994 and 1995. Efforts to educate families and providers about the need to screen more at-risk preschoolers is needed.

Child Mortality

In 1998, 306 children ages 1-14 died in Indiana. Motor vehicle crashes accounted for 67 of those deaths and other unintentional injuries resulted in 78. Cancer caused 32 deaths and congenital anomalies accounted for 16. The mortality rate for this age group fell from 30.3 to 26.2 deaths per 100,000 population between 1994 and 1998. The high proportion of child deaths caused by unintentional injuries underscores a need for special attention to child safety. (Table 11)

Table 11 - Motor Vehicle Deaths (Ages 15-24)

Number	266	266	260	285	273
Rate per 100,000	31.4	31.5	31.1	34.2	32.6
Suicide (Ages 15-19)					
Number	55	45	48	32	36
Rate	13.2	10.6	11.1	7.3	8.1

Source: Indiana State Department of Health, Epidemiology Resource Center

Among older children, motor vehicle safety is paramount in saving lives. Motor vehicle crashes resulted in 247 deaths among children and youth ages 15-24. Another significant cause of childhood morality is suicide. In 1998, 36 Indiana adolescents aged 15-19 took their own lives, a

rate of 8.1 deaths per 100,000 persons. The number of suicides for this age group has declined steadily between 1994 and 1998, though they may fluctuate widely because of small numbers. Nearly all cases of youth suicide have documented substance abuse or behavioral health disorders. Thus, suicide can be viewed as a barometer of youth drug use and mental health. The actual number of suicides is only a small part of the picture, as the number of suicide attempts is estimated to be 10 times higher.

Homicide is another major cause of death of older teens and young adults. Among youth ages 15 to 24, homicide was the second leading cause of death. Homicide accounted for 134 deaths in that age group for a mortality rate of 16 deaths per 100,000 persons. Among black youth, homicide accounted for more deaths than all other causes combined. Homicide deaths accounted for 107 of the 187 deaths recorded among black youth. Though 92 of the homicide deaths were among black males, homicide was also the leading cause of death for black females ages 15 to 24.

Injury Control

All young children should use safety seats and all older children should use safety belts. According to the 1997 Indiana Behavioral Risk Factor Surveillance System (BRFSS), only 74 percent of adults with children ages 5 to 15 reported that their children always use safety belts. Only 91 percent of parents of children ages 4 and younger reported that their children always use a safety seat.

In 1997, 38 percent of Indiana adults reported that they did not always wear a seat belt. Among younger drivers ages 18 to 24, a majority (52 percent) said they did not always use seat belts. Since the survey, Indiana began allowing law enforcement officers to stop a vehicle to determine compliance with Indiana's mandatory seat belt law. Thus, current seat belt use may be higher.

The 1997 Indiana BRFSS also asked adults with children ages 5 to 15 about their children's use of bicycle helmets. Only 14 percent reported that their child always wore a helmet and 48 percent said they never wore a helmet.

Diet, Exercise, and Obesity

Healthy lifestyles have a direct bearing on the wellness of Indiana's population. Data from the Indiana Behavioral Risk Factor Surveillance System (BRFSS) shows the need to improve health-related behaviors in the state. The National Academy of Sciences, the U.S. Department of Agriculture, the U.S. Department of Health and Human Services and the National Cancer Institute have determined that a minimum number of five servings of fruits and vegetables per

day are needed to maintain good health. In 1998, the Indiana BRFSS found that only 21.5 percent of the state's adults consumed the recommended servings of fruits and vegetables. Even moderate levels of regular exercise can result in significant health improvements. Yet, 56 percent of Indiana adults live a sedentary lifestyle and exercise for 20 minutes fewer than 3 times a week in 1998. One consequence of poor diets and inactivity is obesity. Only a minority of Indiana adults are normal weight according to National Institutes of Health body mass index guidelines. In 1998, 35.6 percent were overweight and 19.5 percent were obese. The state ranked 13th highest among the states in the proportion of overweight adults.

Cancer Screening

Cancer is the cause of death of one in four deaths in Indiana. Early diagnosis of breast and cervical cancer greatly reduces the mortality rate of these diseases. The National Cancer Institute recommends that women age 18 and older, or as soon as they become sexually active, get an annual Pap test and pelvic exam (After three consecutive normal exams, the Pap test may be performed less frequently at the discretion of the physician). In 1998, 19.1 percent of Indiana women over 18 had a Pap smear within the past three years. The state ranked 5th highest among the states in the proportion of adult women without a recent smear.

The American Cancer Society recommends a baseline mammogram at age 40, a mammogram every two years for women in their forties, and an annual mammogram for women age 50 and over. In 1998, 28.5 percent of Indiana women over age 50 did not have a mammogram within the past two years. Indiana ranked 14th highest in the proportion of women who did not have a recent mammogram.

3.1.2.2 and 3.1.2.3 Direct and Enabling Services

Direct care services include direct medical or clinical care for individuals (prenatal care, vaccinations, family planning) and enabling services provide linkages among direct services or support access to care (transportation, WIC, outreach, Medicaid enrollment). Estimating the direct and enabling service needs and gaps for the maternal and child health population is complex. The health system is an ever changing mix of public and private physicians, clinics, and other health facilities. While many communities may have a sufficient number of providers, not all providers are available to serve the needs of women and children, especially low-income populations. In rural communities, services may be geographically distant and otherwise difficult to access. This section provides data on the availability of public health services for the MCH population and several indicators of provider shortage and need.

State Priority Concerns

Barriers to care include financial access, cultural acceptability, and availability of services. While these factors are similar across all the targeted MCH populations, they are evidenced in different ways.

Improving birth outcomes is the central goal for pregnant women, mothers and infants. Since 1994, low birthweight rates have worsened and the state's infant mortality rates have remained among the worst in the nation. The need to improve direct and enabling health services for this population may be best evidenced by the declining proportion of infants born to mothers with early prenatal care.

Many participants in the teleconference and in key informant interviews reported that, while Medicaid coverage is available for pregnant women and infants to levels well above poverty, many low income women are uninsured and have little financial access prior to pregnancy. Consequently, they have a tenuous relationship to the health system and little experience navigating the Medicaid system. Their entry into prenatal care may be delayed as they wait for Medicaid eligibility determination and seek out an obstetrical provider. Outreach, prenatal care coordination, and Early Start clinics were not always readily available.

Once financial barriers are overcome, many encounter difficulties finding needed services. According to many public participants in the needs assessment, in rural areas of Indiana, obstetrical services may simply be unavailable in a community or require long travel distances. In urban and suburban areas, providers may be available, but unwilling to accept Medicaid patients. Transportation to care was a frequently cited problem too.

Personal barriers such as understanding the importance of prenatal care and comfort with health institutions also play a role. Language barriers and cultural beliefs may hamper the most appropriate use of services. The growing number of Hispanic births in Indiana underscores a need for culturally competent services. In addition, some women have high risks such as tobacco, alcohol, and drug use that require specialized services.

Removing these barriers requires continued investment in direct services to increase the accessibility of preventive and primary care, including genetic services and family planning, for all pregnant women, mothers, and infants. In addition, support for prenatal and family care coordination to overcome systemic and personal barriers to care continues to be essential.

Low income and medically underserved children face many of the same barriers to care as pregnant women and infants. Thus, support for preventive and primary care for pediatric services is needed. Two areas most commonly cited by teleconference participants and key informants requiring direct and enabling service were immunizations and lead poisoning prevention.

As children become older, their health concerns change dramatically. Risky behaviors become a more central concern. High rates of sexually transmitted disease and adolescent childbearing indicate a need to further expand and target direct and enabling services to this population, according to need assessment informants. A continued strong investment and high priority for reducing risky behaviors and teenage pregnancy is essential. Direct and enabling service needs in this area include counseling and mental health services for adolescents.

Because of the complexity of their health needs, effective enabling services are critical for children with special health needs. For many children with special health care needs, their care requires a constant juggling of providers and service systems. According to parent informants, care coordination is essential to navigating the system. They credit ISDH/CSHCS care coordinators with identifying and resolving many of the financial access and availability of service issues they encounter.

Financial Barriers to Care

Financial barriers to care reflect both low family incomes and a lack of insurance coverage to pay for needed care. Indiana has a lower poverty rate than the national average. However, uninsured rates are comparable to the rest of the nation indicating that a higher proportion of the state's uninsured population are near-poor, working families.

According to the Census Current Population Survey, in 1998, Indiana's poverty rate was 9.4 percent compared to a national average of 12.7 percent. Indiana's poverty rate was 8.6 percent in 1996-1998 compared to the national rate of 13.2 percent for the nation as a whole. Indiana's poverty rate has steadily decreased in recent years and it has fallen faster than the national rate. In 1992-1994, the state's poverty rate was 12.6 percent. (Table 12)

Table 12 - Indiana Poverty Rate, 1992-1998

	Indiana	U.S.
1998		
All Persons	9.4%	12.7%

Table 12 - Indiana Poverty Rate, 1992-1998

	Indiana	U.S.
Persons <18	12.0%	18.9%
1996-1998	8.6%	13.2%
1995-1997	8.6%	13.6%
1994-1996	10.3%	14.0%
1993-1995	11.8%	14.5%
1992-1994	12.6%	14.8%

SOURCE: Bureau of the Census, March 1993-1999 Current Population Survey.

Children are more likely to be poor than the general population. Among persons under 18 in 1998, the Census estimates that 181,000 or 12.0 percent of Indiana's children were poor. In contrast, the national poverty rate for persons under 18 was 18.7 percent. The Census also published state-level estimates of the number of low-income children (defined as those with family incomes below 200 percent of the poverty level). In 1996-1998, an estimated 471,000 Indiana children, 30.0 percent of the state's total, fell below 200 percent of poverty. The number of low-income children has fallen even more dramatically than the overall poverty rate. In 1993-1995, 721,000 Indiana children (42.8 percent) were low income. (Table 13)

Table 13 - Indiana Low Income, Uninsured Children Ages 0-19, 1993-1998

	All Incomes	<200% Poverty	Low-income and Uninsured
1996-1998	1,576,000	471,000	123,000
Percent		30.0%	7.7%
1995-1997	1,536,000	491,000	121,000
Percent		32.1%	7.8%

1994-1996	1,595,000	618,000	121,000	
Percent		38.2%		7.6%
1993-1995	1,673,000	721,000	131,000	
Percent		42.8%		7.9%

SOURCE: Bureau of the Census, March 1994-1999 Current Population Survey.

According to the March 1999 Current Population Survey conducted by the Census, 232,000 children in Indiana under age 18 were completely uninsured throughout 1998. That represents 15 percent of the total population under 18, the same as the national rate. In 1998, 85 percent of Indiana children had private insurance for at least part of the year and 12 percent had public coverage at some point during the year. Indiana children were far less likely than children nationally to have some public coverage – 12 percent versus 23 percent. Among all persons under 65, 14 percent were uninsured (393,000) throughout 1998, lower than the national rate of 18 percent. Only 8 percent of the total non-elderly population received public insurance coverage at any point during the year while 84 percent had private coverage at some point in time. (Table 14)

Table 14 - Indiana Insurance Coverage, 1998

	Total	Private Insurance	Public Coverage	Uninsured
Persons <65		**Indiana**		
Number	5,165,000	4,333,000	393,000	832,000
Percent		84%	8%	14%
Persons <18				

Number	1,513,000	1,280,000	175,000	232,000
Percent		85%	12%	15%
Persons <65		**U.S.**		
Number	238,665,000	195,087,000	34,704,000	43,578,000
Percent		82%	15%	18%
Persons <18				
Number	71,338,000	60,610,000	16,184,000	10,728,000
Percent		85%	23%	15%

SOURCE: Bureau of the Census, March 1999 Current Population Survey.

The Census estimates that an average of 123,000 low-income children ages 0-19 (7.7 percent of the total child population) were uninsured in 1996-1998. That represents a slight improvement from 1993-1995 when 131,000 low-income children were without health insurance (7.9 percent of the total child population).

Changes in Health Care Financing

Indiana's cash assistance programs have changed dramatically since welfare reform. The number of TANF recipients plummeted from over 218,000 in January 1994 to fewer than 109,000 in January 1999, a 50 percent drop. The maximum TANF benefit in Indiana is $288 per month for a family of three - about 24 percent of the federal poverty guideline in 2000 ($14,150 per year)). In contrast, the maximum benefit level in the median state was $377 in January 1997, according to the U.S. House of Representative Committee on Ways and Means Green Book. The total number of infants and children age 0-19 in TANF families in 1999 was 68,760. The state average of the percentage of the population receiving TANF in June of 1999 was 1.3 percent. This percent ranged by county from 4.1 percent in Lake to 0.1 percent in Kosciusko.

In contrast to the 50 percent drop in TANF enrollment in Indiana between 1994 and 1999, Hoosier Healthwise (see page 5) enrollment in Indiana was comparably stable. The number of Hoosier Healthwise enrolled children in Indiana dropped from 241,000 in July 1995 to 209,000 in July 1997. Child enrollment stabilized in 1998 and rose to reach 290,000 in July 1999. Sharper drops in Medicaid enrollment were experienced by women ages 20 to 44 whose Medicaid eligibility is closely tied to TANF. Between July 1995 and July 1998, the number of women ages 20 to 44 enrolled in Medicaid dropped more than one-third from 96,000 to 63,000. By July 1999, the figure rebounded to 76,000. Indiana's Medicaid coverage for women and children closely follows federal mandates.

Indiana's Hoosier Healthwise and SCHIP programs (see page 5) use mandatory managed care arrangements for women and children whose eligibility is based on TANF enrollment or low income. Most recipients in managed care arrangements in Indiana participate in primary care case management that reimburses providers on a fee for service basis. In addition, two managed care organizations offer risk based managed care in the state. The relatively small presence of risk-based managed care in Indiana's Medicaid program has meant the state has experienced less dramatic changes than other states.

In key informant interviews, interviewees were asked to respond to how changes in eligibility and organization of major health financing systems have affected the MCH target population. In regard to shifts in Medicaid coverage, respondents were consistent in saying that new Medicaid changes have increased the number of people who qualify for the program, as well as expanding the types of services covered, including mental health. All agree, however, that regardless of enrollment or coverage, Medicaid patients are having difficulty accessing care primarily due to the lack of providers willing to accept Medicaid payments.

In response to the creation and implementation of CHIP and how it has affected financial barriers to care and services, interviewees felt that the program was positive. There were concerns that that system may not be able to handle too many additional children, but respondents were positive about the services covered under CHIP. There was some concern, however, about not being aggressive enough in enrollment and education about the program. As with Medicaid, respondents report that some providers are not accepting CHIP patients.

Availability of Care

One of the most widely used measures of health service needs is the federal Health Professional Shortage Area (HPSA) designation. The federal government identifies HPSA using criteria such as the number of health professionals, low-income populations, and the accessibility of health services. In Indiana., 49 geographic areas and health facilities have been designated HPSAs for primary health care services. In addition, 11 areas and facilities are mental health HPSAs and 9 are dental care HPSAs.

Federal designation of Medically Underserved Areas (MUAs) is an even more restrictive definition used to target resources for federally-funded community health centers. MUAs are identified using a weighted formula that accounts for the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over. Currently, the Bureau of Primary

Health Care's Division of Shortage Designations has identified 47 counties in Indiana as MUAs in whole or in part.

Private physicians are at the center of the health delivery system in Indiana. Data from the Indiana Health Care Professional Development Commission provides some perspective on the ratio of primary care and obstetrical providers to population across Indiana. Using an ideal physician to population ratio of 1 to 1700, 66 counties have a shortage of primary care and obstetrical providers. (See Map J) These counties would need an additional 374 physicians to reach the ideal ratio. The vast majority of these counties are rural. In fact, all of Indiana's urban counties have a surplus of providers using the 1:1700 ratio. Across the state, Indiana has 394 more physicians than needed to match the 1:1700 ratio. Thus, the availability of physicians must be understood as a problem of distribution in rural and underserved communities rather than an absolute shortage of physicians. (Table 15)

Table 15 - Primary Care and Obstetrical Physician Need

	Population	Primary Care Physicians	Physician Pop. Ratio	Surplus or (Shortage)
Adams	32,697	10	3,237	(9)
Allen	305,621	179	1,712	(1)
Bartholomew	68,359	54	1,278	13
Benton	10,213	4	2,553	(2)
Blackford	14,826	6	2,316	(2)
Boone	43,221	32	1,334	7
Brown	15,690	2	7,845	(7)
Carroll	20,313	7	2,902	(5)
Cass	40,405	21	1,924	(3)
Clark	92,730	143	649	88
Clay	28,188	8	3,614	(9)
Clinton	34,245	11	3,113	(9)
Crawford	10,816	2	4,507	(4)
Daviess	30,048	11	2,757	(7)
Dearborn	44,825	46	977	20
Decatur	25,314	11	2,281	(4)
Dekalb	37,875	20	1,903	(2)
Delaware	118,369	73	1,615	4
Dubois	39,052	26	1,531	3
Elkhart	166,097	88	1,890	(10)
Fayette	26,937	15	1,808	(1)
Floyd	71,416	67	1,066	25
Fountain	19,371	7	2,980	(5)
Franklin	21,413	8	2,855	(5)
Fulton	21,323	11	1,870	(1)
Gibson	33,695	23	1,478	3

Table 15 - Primary Care and Obstetrical Physician Need

	Population	Primary Care Physicians	Physician Pop. Ratio	Surplus or (Shortage)
Grant	75,053	34	2,182	(10)
Greene	34,862	9	3,917	(12)
Hamilton	140,628	89	1,575	7
Hancock	50,906	26	1,965	(4)
Harrison	32,851	22	1,521	2
Hendricks	85,877	45	1,904	(5)
Henry	51,157	27	1,923	(3)
Howard	84,450	51	1,653	1
Huntington	37,797	21	1,791	(1)
Jackson	41,273	14	2,886	(10)
Jasper	28,079	11	2,463	(5)
Jay	22,682	11	2,140	(3)
Jefferson	31,436	23	1,373	4
Jennings	26,527	14	1,895	(2)
Johnson	101,816	47	2,166	(13)
Knox	41,293	24	1,750	(1)
Kosciusko	69,254	30	2,348	(11)
Lagrange	30,699	9	3,373	(9)
Lake	476,594	433	1,100	153
Laporte	109,481	80	1,370	15
Lawrence	46,993	28	1,709	-
Madison	135,735	68	1,987	(12)
Marion	813,172	745	1,092	267
Marshall	45,722	32	1,433	5
Martin	10,745	3	3,160	(3)
Miami	32,373	15	2,187	(4)
Monroe	106,779	66	1,620	3
Montgomery	37,253	21	1,817	(1)
Morgan	61,752	17	3,611	(19)
Newton	14,787	2	6,161	(6)
Noble	40,956	13	3,150	(11)
Ohio	5,642	1	5,642	(2)
Orange	19,935	9	2,345	(3)
Owen	19,869	3	5,844	(8)
Parke	17,344	6	2,710	(4)
Perry	19,438	13	1,495	2
Pike	13,276	4	3,319	(4)
Porter	137,006	63	2,175	(18)
Posey	26,432	7	3,776	(9)
Pulaski	13,583	5	2,515	(3)
Putnam	33,197	14	2,354	(5)
Randolph	28,816	9	3,202	(8)
Ripley	27,505	29	962	12

Table 15 - Primary Care and Obstetrical Physician Need

	Population	Primary Care Physicians	Physician Pop. Ratio	Surplus or (Shortage)
Rush	18,834	7	2,653	(4)
Scott	22,580	12	1,836	(1)
Shelby	42,993	11	3,873	(14)
Spencer	20,717	3	6,278	(9)
St. Joseph	261,678	181	1,445	27
Starke	24,003	7	3,479	(7)
Steuben	30,983	16	1,999	(3)
Sullivan	21,247	10	2,168	(3)
Switzerland	8,746	3	2,572	(2)
Tippecanoe	127,970	83	1,534	8
Tipton	17,094	7	2,408	(3)
Union	7,502	2	4,168	(3)
Vanderburgh	176,042	173	1,016	70
Vermillion	17,987	7	2,767	(4)
Vigo	108,845	80	1,369	15
Wabash	35,895	19	1,850	(2)
Warren	8,537	5	1,611	-
Warrick	48,681	26	1,909	(3)
Washington	26,959	13	2,027	(3)
Wayne	75,201	42	1,808	(3)
Wells	27,107	29	941	13
White	26,110	9	2,869	(6)
Whitley	30,046	9	3,535	(9)
Indiana	5,839,842	3,829	1,525	394

NOTE: Surplus/shortage of physicians is based on an ideal ratio of 1 physician to 1,700 population.

SOURCE: Indiana Health Care Professional Development Commission, 1998 Annual Report

Participants in the key informant interviews and the statewide teleconference reported needs for family care coordination across the MCH populations. Care coordination provides direct counseling, education, and advocacy to enable individuals and families to access the services they need. The sub-populations identified with the greatest need for family care coordination included high-risk pregnant women and children with special health needs.

INSERT "MAPJ.JPG" HERE

Among high-risk pregnant women, care coordination was cited as a high priority because of this sub-population's need for help navigating the health and social service systems. Enrolling in Medicaid, finding a prenatal care provider, and arranging for transportation are all prerequisites

to accessing prenatal care. Needs assessment participants described these challenges as particularly difficult to overcome for many high-risk pregnant women. In addition, clinical care is not sufficient to ensure a healthy birth outcome in this population. Problems in income housing, domestic violence and other areas may prevent a high-risk pregnant women from placing a high priority on health concerns. Care coordinators can ease some of these burdens and lessen the psycho-social stress faced by these women. The close contact and personal relationship developed by care coordinators with their clients also creates teaching opportunities to encourage healthy behaviors, according to several needs assessment participants.

Because of the complexity of their health needs, effective family care coordination is essential for children with special health needs. For many children with special health care needs, care requires a constant juggling of providers and service systems. Since the health conditions that affect children with special needs are often rare, many health and social service programs are ill equipped to respond the individual needs of these children. Services for these children may only be available at facilities far from a child's home. Programs targeted to the general child population may not be sensitive to the particular issues of children with special health needs. Many health and social service providers may not even know the available resources that a special needs child requires. Family care coordinators help families navigate through these systems and prepare families for the challenges they face. Families of children with special needs who participated in the needs assessment credited ISDH/CSHCS family care coordinators with identifying and resolving many of the financial access and availability of service issues they encounter.

Another measure of the availability of providers for the MCH population is the number of providers serving Hoosier Healthwise enrolled children. Data on the number of Hoosier Healthwise pediatric providers indicate that there is not an absolute shortage of providers, but a problems of distribution that limits access to certain populations. Statewide, 1500 pediatric providers participate in Hoosier Healthwise and are willing to serve 855,826 Hoosier Healthwise patient slots. That figure appears more than adequate to serve the 312,660 enrollment of children in the program. However, some counties do not have sufficient slots available for Medicaid enrolled children. According to the data, Hoosier Healthwise enrollment in 16 counties exceeds 80 percent of the available slots participating patients are willing to serve. (Table 16) (See Map K)

Table 16 - Hoosier Healthwise Pediatric Physician Participation, December 1999

	Healthwise	Available

	Participating Pediatric Providers	Healthwise Pediatric Slots	Healthwise Pediatric Enrollees	Percent of Capacity Filled
Adams	4	1,200	718	60%
Allen	78	48,003	16,568	35%
Bartholomew	16	3,350	3,571	107%
Benton	5	1,030	249	24%
Blackford	3	2,550	688	27%
Boone	8	4,000	981	25%
Brown	2	2,150	275	13%
Carroll	5	1,590	400	25%
Cass	12	5,050	2,081	41%
Clark	29	27,100	5,094	19%
Clay	11	13,575	1,520	11%
Clinton	10	1,567	1,316	84%
Crawford	1	750	640	85%
Daviess	6	2,400	1,491	62%
Dearborn	13	3,300	1,864	56%
Decatur	13	2,750	1,260	46%
Dekalb	14	2,450	1,220	50%
Delaware	31	16,274	7,994	49%
Dubois	9	2,290	1,350	59%
Elkhart	43	9,740	7,584	78%
Fayette	6	2,385	1,459	61%
Floyd	21	10,726	4,309	40%
Fountain	5	5,150	783	15%
Franklin	6	1,140	1,099	96%
Fulton	8	8,600	1,099	13%
Gibson	12	8,100	1,365	17%
Grant	17	15,200	5,123	34%
Greene	7	4,600	900	20%
Hamilton	24	6,800	2,310	34%
Hancock	8	1,104	1,121	102%
Harrison	6	1,735	1,500	86%
Hendricks	17	2,510	1,470	59%
Henry	12	4,996	2,652	53%
Howard	12	7,974	3,671	46%
Huntington	13	5,925	1,227	21%
Jackson	8	1,356	1,418	105%
Jasper	13	10,350	1,045	10%
Jay	8	2,700	1,087	40%
Jefferson	11	2,520	1,900	75%
Jennings	3	1,500	878	59%
Johnson	18	6,800	2,895	43%
Knox	11	6,800	3,061	45%
Kosciusko	27	4,753	2,333	49%
Lagrange	5	1,200	572	48%

Table 16 - Hoosier Healthwise Pediatric Physician Participation, December 1999

	Healthwise Participating Pediatric Providers	Available Healthwise Pediatric Slots	Healthwise Pediatric Enrollees	Percent of Capacity Filled
Lake	138	128,253	41,758	33%
Laporte	33	15,486	5,824	38%
Lawrence	16	10,050	3,022	30%
Madison	44	18,242	7,908	43%
Marion	198	170,476	59,905	35%
Marshall	20	4,950	1,551	31%
Martin	1	150	171	114%
Miami	7	2,015	1,858	92%
Monroe	19	10,650	5,112	48%
Montgomery	1	600	627	105%
Morgan	13	3,670	2,152	59%
Newton	7	5,000	816	16%
Noble	6	5,050	963	19%
Ohio	1	164	164	100%
Orange	7	3,050	1,150	38%
Owen	2	2,150	788	37%
Parke	3	3,000	321	11%
Perry	3	1,150	591	51%
Pike	5	4,050	621	15%
Porter	14	3,959	3,194	81%
Posey	6	7,300	1,294	18%
Pulaski	1	325	331	102%
Putnam	8	3,700	1,487	40%
Randolph	8	8,300	1,213	15%
Ripley	9	1,500	975	65%
Rush	7	1,400	707	51%
Scott	7	2,475	1,666	67%
Shelby	11	4,350	1,687	39%
Spencer	6	1,800	719	40%
St. Joseph	84	47,188	17,606	37%
Starke	8	10,600	1,583	15%
Steuben	1	800	803	100%
Sullivan	7	8,650	1,544	18%
Switzerland	1	250	134	54%
Tippecanoe	30	6,487	5,839	90%
Tipton	6	2,450	340	14%
Union	1	150	151	101%
Vanderburgh	49	23,869	12,936	54%
Vermillion	6	6,000	1,158	19%
Vigo	36	21,604	9,076	42%
Wabash	13	4,800	763	16%

Table 16 - Hoosier Healthwise Pediatric Physician Participation, December 1999

	Healthwise Participating Pediatric Providers	Available Healthwise Pediatric Slots	Healthwise Pediatric Enrollees	Percent of Capacity Filled
Warren	1	2,000	106	5%
Warrick	9	2,450	771	31%
Washington	6	1,800	1,018	57%
Wayne	14	6,085	4,824	79%
Wells	16	3,825	1,241	32%
White	9	3,710	1,201	32%
Whitley	7	3,050	728	24%
Indiana	1500	855,826	312,660	37%

SOURCE: Office of Medicaid Policy and Planning

The Indiana State Department of Health provides leadership and resources to local health departments and community-based providers, rather than operating personal health care services directly. Indiana is divided into 92 counties which contain a total of 94 local health departments. Most local health departments offer limited direct health care services. Since local health departments are autonomous, each locality determines its own priorities and program goals.

INSERT "MAPK.JPG" HERE

The public health services for the maternal and child health population vary considerable across the state. (See Map L) All 92 counties in the state have at least one site providing WIC and immunization services and 90 counties have a site providing free pregnancy tests. However, the availability of public primary care services is more limited. Only 56 counties have at least one family planning site and 52 counties have at least one child health clinic. Prenatal care sites are available in 41 counties and adolescent health clinics are located in 22 counties. In addition, 52 counties have care coordination services available through public clinics. (Table 17)

Table 17 - Public Health Services Sites, by County

	Child Health	Family Planning	Prenatal Care	Adolescent Health	Free Pregnancy Tests	Care Coordination	WIC Services	Immu-nization	Total Service Sites
Adams	1	1	1	0	2	1	2	3	4
Allen	2	3	1	1	4	1	4	3	9
Bartholomew	0	1	0	0	1	0	1	1	2
Benton	0	0	0	0	3	0	1	1	3
Blackford	0	0	0	0	0	0	1	1	2
Boone	1	0	0	0	2	1	1	1	3
Brown	1	1	0	1	2	0	1	1	2

Table 17 - Public Health Services Sites, by County

	Child Health	Family Planning	Prenatal Care	Adolescent Health	Free Pregnancy Tests	Care Coordination	WIC Services	Immu-nization	Total Service Sites
Carroll	0	1	0	1	2	1	1	1	3
Cass	1	2	1	0	2	1	2	2	4
Clark	3	0	2	1	3	2	2	2	3
Clay	0	0	0	0	1	0	3	1	4
Clinton	1	0	1	0	1	0	1	2	4
Crawford	0	1	1	0	2	2	1	2	2
Daviess	0	1	0	0	1	0	1	1	3
Dearborn	0	1	0	0	4	0	2	2	4
Decatur	1	1	0	0	3	1	1	2	3
Dekalb	1	0	0	0	1	0	1	1	2
Delaware	1	2	2	1	3	0	4	2	7
Dubois	1	1	1	1	3	1	1	1	3
Elkhart	4	3	2	2	7	4	4	5	9
Fayette	1	0	1	0	3	1	1	2	3
Floyd	0	2	1	0	2	1	1	1	3
Fountain	0	0	0	0	1	0	1	1	2
Franklin	0	0	0	0	2	0	1	2	2
Fulton	0	0	1	0	1	1	1	1	1
Gibson	0	0	0	0	1	1	1	1	2
Grant	3	2	2	0	3	1	1	2	4
Greene	0	0	0	0	1	0	1	1	3
Hamilton	1	2	1	1	3	1	2	1	5
Hancock	1	0	1	0	2	0	1	2	3
Harrison	1	1	1	0	1	0	1	1	1
Hendricks	1	2	1	1	1	1	1	1	5
Henry	0	1	1	0	2	1	2	2	5
Howard	3	3	2	1	3	1	2	3	6
Huntington	0	0	0	0	2	0	1	1	2
Jackson	0	1	1	0	3	1	1	1	3
Jasper	0	1	1	0	2	0	2	1	5
Jay	1	1	0	0	2	0	2	1	4
Jefferson	0	1	0	0	2	0	1	1	2
Jennings	1	0	1	0	1	0	1	1	2
Johnson	1	1	0	1	4	2	1	1	5
Knox	0	1	0	0	4	0	2	1	4
Kosciusko	1	1	0	0	2	1	1	1	3
Lagrange	0	0	0	0	1	0	1	1	2
Lake	10	7	7	2	17	10	21	13	42
Laporte	1	2	1	1	7	2	4	4	14
Lawrence	2	1	2	0	3	1	2	3	4
Madison	2	2	2	0	7	1	2	3	9
Marion	18	24	22	13	29	18	25	18	61
Marshall	0	3	2	0	3	0	2	1	6
Martin	0	0	0	0	0	0	1	2	3
Miami	0	0	1	0	3	1	1	1	4
Monroe	1	1	0	0	3	2	1	2	4
Montgomery	1	1	1	0	2	0	1	1	3
Morgan	1	1	0	0	1	0	2	1	4
Newton	0	0	0	0	1	0	1	1	1

Table 17 - Public Health Services Sites, by County

	Child Health	Family Planning	Prenatal Care	Adolescent Health	Free Pregnancy Tests	Care Coordination	WIC Services	Immu-nization	Total Service Sites
Noble	0	0	0	0	2	1	2	1	5
Ohio	0	0	0	0	2	1	1	1	2
Orange	0	1	0	0	2	1	1	2	3
Owen	1	1	0	1	3	1	1	2	3
Parke	1	1	0	0	1	1	1	1	2
Perry	0	1	1	0	2	0	1	1	2
Pike	0	1	0	0	2	2	2	1	4
Porter	2	3	0	0	5	3	4	2	9
Posey	1	0	0	0	2	0	1	1	2
Pulaski	0	0	0	0	2	1	1	1	3
Putnam	1	1	0	1	1	1	1	2	2
Randolph	1	0	0	0	2	0	2	1	3
Ripley	0	0	0	0	2	1	2	2	4
Rush	1	0	1	0	1	1	1	2	2
Scott	1	1	0	0	3	0	2	1	4
Shelby	1	1	0	0	1	1	1	1	4
Spencer	1	1	0	1	1	1	2	1	4
St. Joseph	6	5	5	2	4	3	7	6	19
Starke	2	1	2	2	2	2	1	3	4
Steuben	1	0	2	0	2	0	1	2	3
Sullivan	0	0	0	0	1	0	1	1	2
Switzerland	0	1	0	0	1	0	1	1	2
Tippecanoe	1	3	1	1	3	2	2	2	6
Tipton	0	0	0	0	1	0	1	1	2
Union	0	0	0	0	1	1	1	1	2
Vanderburgh	8	3	4	8	13	5	6	9	20
Vermillion	0	0	0	0	2	0	2	1	3
Vigo	2	2	1	0	5	1	2	2	7
Wabash	1	0	1	0	1	1	2	2	4
Warren	0	1	0	0	1	0	1	1	3
Warrick	1	1	0	0	2	1	1	2	3
Washington	0	1	0	0	2	1	1	1	3
Wayne	1	2	1	1	4	1	2	3	4
Wells	1	0	1	0	2	0	1	2	3
White	0	0	0	0	1	0	1	1	2
Whitley	1	0	0	0	1	0	1	1	1
Counties With Service Sites	52	56	41	22	90	52	92	92	92

Source: Indiana State Department of Health Maternal and Child Health Services Division

The Indiana State Department of Health funded 30 community health centers in 1999-2000 to provide primary and preventive health services to medically underserved populations. These centers serve all patients, regardless of their ability to pay, and are located in communities where few other providers are available to serve at-risk populations. The federal Bureau of Primary

Health Care also funds 9 of the community health centers in Indiana. In addition, 51 rural health clinics have been designated in Indiana. Rural health clinics must be located in HPSAs and receive enhanced Medicaid and Medicare reimbursement.

INSERT "MAPL.JPG" HERE

In addition to primary care providers, other health professionals -- nurses, nutritionists and dieticians, medical social workers, audiologists and speech/language therapists, and occupational and physical therapists -- play a critical role in the delivery of care to the MCH population. The following data are from the Indiana Health Care Professional Development Commission:

- Dieticians -- As of May 1999, there were 1,018 dietitians in Indiana with a current certification. Of these, 928 (91 percent) had a mailing address in Indiana, for a statewide dietitian to population ratio of 1:6,294 or 16 per 100,000 population.

- Registered Nurses -- As of May 1999, there were 76,737 registered nurses with a current Indiana license. Of these, 62,518 (81 percent) had a mailing address in Indiana, for a statewide RN to population ratio of 1:93, or 1,075 per 100,000.

- Nurse Midwives -- As of May 1999, there were 42 Nurse Midwives with a current Indiana license. Of these, 37 (88 percent) had a mailing address in Indiana and the other 5 (12 percent) had a mailing address in one of the neighbor states of Illinois, Michigan or Ohio.

- Advance Practice Nurses/Certified Nurse Midwives – As of May 1999, there were 31 APN-Certified Nurse Midwives with a current Indiana license. Of these, 29 (94 percent) had a mailing address in Indiana, and the remaining 2 (6 percent) had a mailing address in one of the neighbor states of Kentucky or Michigan.

- Advance Practice Nurses/Nurse Practitioners -- As of May 1999, there were 638 APN-Nurse Practitioners with a current Indiana license. Of these, 539 (93 percent) had a mailing address in Indiana, for a statewide APN-NP to population ratio of 1:9,154, or 11 per 100,000.

- Social workers -- As of May 1999, there were 3,387 LSW and 3,775 LCSW social workers with a current Indiana license. Of these, 2,953 (92 percent) have a mailing address in Indiana, making for a statewide SW to population ratio of 1:1,978, or 51 per 100,000. In addition, there were 3,569 clinical social workers with a current Indiana license. Of these,

3,098 (87 percent) have a mailing address in Indiana, for a statewide LSW to population ratio of 1:1,885, or 84 per 100,000.

- Audiologists – As of May 1999, there were 340 audiologists with a current Indiana license. Of these, 275 (80.9 percent) had a mailing address in Indiana, for a statewide audiologist to population ratio of 1:21,238, or 5 per 100,000

- Occupational Therapists – As of May 1999, there were 1,996 occupational therapists with a current Indiana license. Of these, 1,490 had a mailing address in Indiana, for a statewide OT to population ratio of 1:2,926, or 34 per 100,000 population

- Physical Therapists – As of May 1999, there were 4,477 Physical Therapists with a current Indiana license. Of these, 2,593 (57.9 percent) had a mailing address in Indiana, for a statewide PT to population ratio of 1:2,252, or 44 per 100,000.

- Speech Pathologists -- As of May 1999, there were 1,668 speech pathologists with a current Indiana license. Of these, 1,347 (81 percent) have an Indiana mailing address, for a statewide speech pathologist to population ratio of 1:3,501, or 29 per 100,000.

3.1.2.4 Population-Based Services

Direct and enabling services are targeted for individuals with specific barriers to care that can be met through provision of needed health services. However, many health needs and risks are widely spread throughout the maternal and child health population and require broad-based screening, education, and awareness to promote better health knowledge and behavior.

Need for Population-Based Services

Outreach and education messages must be disseminated widely throughout the population. All targeted MCH populations require resources for information and referral. Indiana operates the Indiana Family Helpline to assist callers with identifying and reaching health and social service providers.

For pregnant women, infants, and children, newborn screening services are critically important population-based services. Since children with hearing impairments and metabolic disorders can only be effectively identified if all children are screened for problems, these screening activities

must be population based. Since congenital anomalies are leading causes of infant mortality, early identification of genetic and metabolic disorders can lead to substantial reductions in morbidity and mortality.

Specific population-based service needs identified in key informant interviews and through the statewide teleconference focused on public education and outreach. Many respondents identified the importance of the Healthy Pregnancy/Health Baby Campaign. The Campaign provides free pregnancy tests and initial counseling to women throughout the state. It offers a teaching opportunity about family planning and encourages early entry into prenatal care.

Increasing awareness and understanding about perinatal health issues was frequently raised by informants to the needs assessment. For example, BRFSS data indicate that only 21.5 percent of Indiana adults consume the recommended servings of fruit and vegetables. Since leafy green vegetables are a crucial source of folate, these diet patterns indicate a high likelihood of poor folic acid intake. Thus, public education about the link between folic acid consumption and neural tube defects are needed to reach all women of childbearing age, regardless of pregnancy status. Perhaps there is a need for additional folic acid education and access to Registered Dieticians or Public Health Nutritionists. Other broad based public education messages for perinatal populations identified by respondents include the importance of prenatal care and SIDS risk-reduction.

For the child population, population-based services identified in the needs assessment include immunizations, lead poisoning prevention, and tobacco control. Immunization education and outreach is critical because of vaccination rates remain far below national targets. According to the National Immunization Survey, the percentage of 19-35 month old children fully immunized was 77.5 percent in Indiana in 1998. In addition, Indiana has experienced continuing outbreaks of pertussis throughout the 1990s. Lead poisoning prevention education is a necessary population-based service because lead exposure risks are not confined to medically underserved children. All children living in pre-1950s housing are at risk and parents need to be informed and the importance of getting their children screened. Thirty-four percent of housing units in Indiana were built prior to 1950. Smoking rates in Indiana are comparatively high and over 21 percent of infants in Indiana were born to mothers who smoked during pregnancy. Since smoking begins in childhood, education about tobacco abstinence must begin in early childhood and be reinforced through adolescence.

Participants in the needs assessment process cited a wide breadth and depth of public education materials, brochures, and campaigns to educate and inform Indiana residents about maternal and child health issues. However, they also characterized public understanding of these issues as relatively weak. Many suggested the need for more sophisticated mass media campaigns to address many MCH problems. Several commentators cited new anti-tobacco media campaigns as a model for other public health-oriented messages.

Description of Population-based Services

Indiana MCHS/CSHCS directly manages a number of population-based services aimed at disease prevention, health promotion, and outreach. In general, these services are available to the entire MCH population across Indiana.

The Indiana Family Helpline (IFHL), established in 1987, provides direct information and referral services with advocacy assistance (if necessary) to citizens of Indiana and alerts MCHS consultants to breakdowns in health care services around the state. It is a population-based program that provides an enabling service to the general population. While originally the target populations were mothers and children, the Communication Specialists respond to any caller's request. Approximately 16,000 calls are received annually. Currently the IFHL is collaborating with Family and Social Service Administration (FSSA) to expand the marketing of the IFHL number by additional programs in FSSA. In Indiana there is interest through the private not-for-profit sector in establishing a "2-1-1" number for non-emergent social service and health information and referral calls. THE ISDH/IFHL and FSSA will participate in these discussions as a unit from the state.

Newborn Screening Program has developed the infrastructure that hospitals and health departments use to report metabolic screens done on all newborns in Indiana. This program provides preliminary diagnosis, follow-up, management, family counseling, and support, including equipment, supplies, formula and other materials, for all infants and individuals identified as having these conditions. Services within the program also include educational outreach to both health care professionals and the general public. The Indiana Newborn Screening Program is legislatively mandated. All infants born in Indiana are required to have blood obtained for newborn screening. The only acceptable reason for refusing the screen is an informed refusal on religious grounds. This program works closely with the Sickle Cell Program and the Genetic Diseases Program to ensure follow-up and treatment for infants diagnosed as having one of the designated disorders. A Newborn Screening Advisory Group assists with developing recommendations for additional screens and the protocols involved.

Indiana's Universal Newborn Hearing Screening Program (UNHS) is designed to assure that all infants born in Indiana are given a physiologic hearing screening examination at the earliest feasible time for the detection of hearing impairments. UNHS at ISDH/MCHS will track affected infants, identified at the hospitals, to collect information on the incidence of congenital hearing loss in infants born in Indiana. The hospitals and responsible physicians will refer the parents of newborns with questionable screens to their local First Steps agency for further diagnosis, follow-up, management, and family counseling and support. MCHS through the hospital tracking will follow-up with First Steps to ensure the identified infants have gotten into care and enrolled into CSHCS and First Steps. The goal of this program is early recognition, intervention and follow-up to maximize the child's speech, language, and cognitive development. ISDH/MCHS will provide the necessary hospital and First Steps training and all collaborators will market educational outreach to both health care professionals and the public. In July, 2000 the ISDH in collaboration with the First Steps Program and the hospitals in the state will implement Universal Newborn Hearing Screening for all newborn infants as prescribed by PL 91 (1999).

Meconium Screening for Drug-Exposed Newborns Program was established in 1997 when the Indiana General Assembly passed PL 206-1997 (now PL 273-1999) requiring hospitals and physicians to submit a meconium specimen for every infant born under their care who meets the selection criterion of the program. If the test indicates the presence of a controlled substance in the infant's meconium, the responsible physician/hospital must follow-up with the client to determine appropriate action/referrals, including a request to declare the infant a child in need of services (CHINS) as provided in Indiana law. However, the child's mother may not be prosecuted in connection with the results of the test.

The Indiana Childhood Lead Poisoning Prevention Program (ICLPPP), which MCHS began funding in 1983, provides technical assistance and consultation to the medical provider network who screen at-risk children, and to health departments, child day care field inspectors, and providers of medical and environmental follow-up services. This program works with three to laboratories process blood lead screens. The ICLPPP also tracks children with lead poisoning to ensure they get care. The mission of this program is to increase screening and follow-up care of children who most need these services; and to help communities pursue the most appropriate approach to the prevention of childhood lead poisoning. The staff woks closely with the Indiana Department of Environmental Management and community lead task forces.

The MCHS Injury Prevention Program implements Indiana's Childhood Hazards Prevention Law (IC 16-41-40). This law expands the support for *Shaken Baby Syndrome* education to include development of an education program on consumer product safety, motor vehicle accidents, drowning, fires, falls, etc. Firearm education is not included in this mandate. In addition, MCHS contracted with the Brain Injury Association of Indiana to identify unmet needs of Traumatic Brain Injury (TBI) survivors and their families. This association is to facilitate an infrastructure of public and private organizations, professionals, persons with TBI and their families to enhance services.

The Sudden Infant Death Syndrome (SIDS) Program is funded by Title V through a grant with the Indiana Perinatal Network, Inc. The funding supports a parent who facilitates the development of support groups and provides direct counseling and education. She also facilitates groups interested in providing education about SIDS. Through the program, parents of children who have died of SIDS receive a condolence card, a referral to a support group in their area, a referral to the IFHL for community resources and some receive visit from a public health nurse. The SIDS program also provides training and training tools for first responders (firemen, EMT staff, and police) and coroners. The "Back to Sleep" Campaign continues to be emphasized to all parents, grandparents and caretakers.

The Genetic Disease Program strives to increase the awareness and understanding of genetic conditions and to ensure that all of the approximate 5,000 infants born in Indiana each year with birth defects or genetic conditions have access to genetic services. The current goals of the GDP are: (1) collaborate and coordinate with the Regional Genetic Centers (both state sponsored and private providers of genetic services) as well as local agencies, individual providers, hospitals, health departments, the Indiana Perinatal Network (IPN), and the Indiana Chapter of the March of Dimes; (2) build public health genetics capacity within ISDH; (3) increase public and professional awareness of genetics; (4) assure access to services; (5) enhance genetic data collection statewide; and (6) improve the quality of the birth defects surveillance system. MCHS offers genetic testing, prenatal diagnosis, counseling through support of six regional genetics projects that sponsor clinics in thirteen sites. The HSD Genetics Consultant offers consultation to these and six additional Genetics Centers/Programs in Indiana.

The Folic Acid Awareness Campaign seeks to decrease the incidence of neural tube defects through the use of a statewide educational campaign promoting adequate folic acid consumption during preconception and the first trimester of pregnancy. The target population for the campaign is all women of childbearing age, regardless if they are contemplating pregnancy.

Governor O'Bannon proclaimed October 14, 1999 as Folic Acid Awareness Day. A Folic Acid Health Fair, The Folic Acid Way to Healthier Babies was held at the Indianapolis City Market. Education materials and foods rich in folic acid were distributed to individuals. Certified folic acid trainers from phase I of the campaign continued to educate professionals and consumers at the local level. Letters were also sent to all pediatricians, OB/GYNS, and family practice physicians as well as agencies serving women of childbearing age informing them of the availability of materials.

Oral Health Program focuses on education and prevention with a special emphasis on fluoridation. Oral Health staff provides technical assistance and surveillance to communities and schools with fluoridated water supplies (about 15000 sites visits per year). Indiana currently has 98.6% of its citizens served by over 700 municipal water systems receiving optimally fluoridated water. Title V also supports the Division's community-based pit and fissure sealant program which was initiated in 1994. This program's objectives included 1) promoting the use of sealants throughout Indiana and working toward the national health objective to have 50% of children with sealants by the year 2010, and 2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in community dental health programs.

"Tobacco: It's Gonna Cost You" Communication Campaign was created to support Indiana's youth who have not begun to use tobacco and to keep them from initiating tobacco use. This media campaign was focused on 10-14 year olds in 36 mid-state counties. The multi-media campaign included a "Name the Dog" in the commercials contest. According to a Gallup evaluation study, the campaign has had a positive impact on attitudes and some behaviors of the youth – smoking initiation has been postponed.

Sickle Cell and Other Hemaglobinopathies Programs provides education and consultation to primary and hospital emergency room providers about current therapy for sickle cell disease complications and educational materials to health care providers and patients families. In addition, the program pays the public high-risk insurance premium for hemophilia CSHCS clients, provides penicillin, education, care coordination, and counseling for sickle cell clients in the state. There are four regional sites for the care coordination.

Healthy Families Indiana (HFI) is a child abuse prevention initiative available in all 92 counties from 59 sites and has expanded in FY'99 through funding made available through welfare reform. This program, a part of Healthy Families America, provides family support to families with their first newborn whose hospital or prenatal screens indicate that they are at risk for child

abuse. It was initially begun through coordination of funds of FSSA, MCHS, and Indiana Criminal Justice Institute. All three agencies have continued support and there is on-going state support through TANF funds, a specialized license plate, *Kids First,* and other sources. Due to MCHS support, HFI has included family physical health parameters as part of its goals, data collection, and evaluation. During FY'99 this program assessed 12,000 families and provided home visitation support for 8,900 families. Of the families served 99% have no reports of substantiated abuse, 90% of the children have age appropriate immunizations, and 80% of the families have a medical home.

"Baby First…Right from the Start" multi-media campaign began on January 21, 1999 in Central Indiana. This campaign promotes awareness of the need for prenatal care and healthy lifestyles. The messages include a call to action that urges women to call the toll-free Indiana Family Helpline for information, a "Baby First" video and education materials in English and Spanish, and other needed assistance such as food and enrollment in Medicaid and WIC.

Indiana RESPECT – Indiana's adolescent pregnancy prevention initiative funded abstinence until-marriage education programs through federal and state match funds, and adolescent pregnancy prevention education programs through state funds, beginning in FY'98. The initiative consisted of four components: a community grant program, a community grant program evaluation, a statewide media campaign, and technical assistance/training. Montgomery, Zukerman, and Davis, (MZD) an Indianapolis advertising agency, was contracted to create, implement, and measure the effectiveness of a statewide sexual abstinence and adolescent pregnancy prevention media campaign. Focus groups with youth, parents, and youth-serving professionals were implemented to assess constituent beliefs regarding adolescent pregnancy prevention and identify effective media campaign themes and specific audience messages. Four teen and one two-part parent media spots with the theme Sex Can Wait I'm Worth It were developed in 1998 and broadcast during 1999. Teen billboards and parent print ads were also placed in major media markets. Collateral printed materials, including teen brochures and posters and parent brochures were distributed to community grantees and the general public. Effectiveness of the media campaign was assessed by telephone survey completed with 300 Indiana teens and 300 parents after each quarterly broadcast of the TV and radio spots. Teen recall of media flights was 86%, 94%, and 95% for flights number 1, 2, and number 3 respectively.

3.1.2.5 Infrastructure Building Services

Developing strong systems of care for the MCH population requires developing and building networks and infrastructures to monitor health services and status, sustaining collaborative relationships, setting standards of care and evaluating program effectiveness.

Coordination with Other Agencies and Organizations

Key informants were asked to identify examples of coordination and collaboration between their program and other programs or organizations working toward similar goals. Coordination was described by the respondents at a variety of levels. In some cases the coordination between agencies and organizations was described as institutional. In these instances, organizations worked together on projects or shared information and resources. In other cases, coordination was conducted through interpersonal relationships of key staff within various agencies.

A key area of interagency coordination is the combined enrollment form (application) for Title V, Medicaid and First Steps (Part H of the IDEA). Families applying for any single program automatically have their eligibility checked for the other programs. WIC programs also accept the combined enrollment form, though they use a separate online eligibility system. Medicaid agency staff report frequent and ongoing communication with MCHS and participation of MCHS in Medicaid policy committees. One area requiring ongoing discussion between Medicaid and ISDH/MCHS is reimbursement for MCHS supported clinics. Medicaid has not certified all MCHS as Medicaid primary care case managers because of issues around provider service standards. The result is that Medicaid services like EPSDT are being provided by some Title V supported clinics but not being reimbursed.

ISDH is also collaborating with First Steps (Part H of the IDEA) in the implementation and operation of the Universal Newborn Hearing Screening Program (UNHS) in Indiana. Under this program, all infants identified with a presumptive-positive hearing loss are referred to First Steps for coordination of diagnostic follow-up. Once a confirmed diagnosis of hearing loss is determined, First Steps will coordinate medical, developmental, and psychosocial interventions as appropriate to the needs and desires of the family. First Steps is to provide summary data of diagnostic and intervention services to ISDH.

ISDH/MCHS and CSHCS participate in a number of interagency task forces and advisory committees with programs from the Indiana Family and Social Services Administration and the Department of Education. FSSA programs include Medicaid, early intervention, vocational

rehabilitation, and mental health. Needs assessment participants report ongoing formal and informal relationships that facilitate collaboration between FSSA and ISDH. However, coordination efforts between the Department of Education and ISDH appear to be less developed. Further efforts to collaborate with special education programs may be desirable.

ISDH/MCHS and CSHCS maintains close relationship with major providers of health and health-related services in Indiana. The president of the Indiana Chapter of the American Academy of Pediatrics serves as a medical consultant to ISDH/CSHCS and sits on SCHIP implementation advisory committees with ISDH/MCHS. A number of programs at Riley Hospital, the major children's hospital in Indiana, are supported by grants from ISDH/MCHS and CSHCS. Provider agreements are in place with every hospital in Indiana to provide access to care for children enrolled in CSHCS. Additional agreements are in place to provide access to highly specialized services at out-of-state pediatric centers of excellence in Chicago, St. Louis, Louisville, Cincinnati, and Denver.

Service System Constructs for Children With Special Health Needs

Developing a strong system for children with special health needs involves (1) collaboration with other agencies and organizations, (2) support for communities, (3) coordination of health components of community-based health systems, and (4) coordination of health services with other services at the community level.

Early identification of children with special health needs was identified as a priority need by many participants in the needs assessment process. Specific needs discussed included genetic disease services and newborn metabolic and hearing screens. Indiana has established universal metabolic and hearing screening. The Newborn Screening Program provides follow-up, counseling, and support, including equipment, supplies, and formula, to children identified with metabolic disorders. The Genetic Diseases Program provides genetic counseling to evaluate and test for genetic disorders and help families deal with the problems associated with genetics disorders. Both programs coordinate with each other and with First Steps and CSHCS. To support community-based services, the Genetic Diseases Program supports six regional genetics centers and the Newborn Screening Program funds two additional centers.

Needs assessment participants gave the highest priority for collaboration to integration of CSHCS with First Steps for dually enrolled clients. ISDH/CSHCS received an integrated services SPRANS grant to further this collaboration. The two programs already have combined enrollment and have identified the need to integrate data systems and care coordination efforts.

Combining data systems is critical so that all children identified by one program are referred to the other program as necessary. Families also discussed the need to transition care coordinators between programs. First Steps provides care coordination up to a child's third birthday, then CSHCS care coordinators take over, unless the care coordinator is certified and chosen by the family to provide both. By integrating the two programs, duplication of effort can be eliminated and families can experience a smooth transition between the programs as their child ages.

Other examples of interagency collaboration include CSHCS leadership of the state's Child Health Policy Board Advisory Committee on Children with Special Health Care Needs, creation of the Infant Mental Health Association to train care coordinators across programs about infant mental health needs, and the Integrated Services SPRANS Leadership Team that brings together Head Start and managed care providers.

State CSHCS support for communities is critical to building an infrastructure of services and advocacy for children with special health care needs at the local level. In recognition of this need, CSHCS is in the process of outsourcing all care coordination to community-based providers. By giving grants to local agencies to conduct care coordination activities, capacity is formed at the community level to identify and serve the needs of children with special health care needs. ISDH/CSHCS consultants are transitioning their roles from care coordination to assisting local agencies and addressing system issues such as data integration and common applications.

ISDH/CSHCS also supports communities by funding staff at three Marion county hospitals (Riley, Methodist, and St. Vincent) to assist community-based care coordinators whose clients need to use specialized tertiary care. ISDH/CSHCS also provides forms and brochures for families and providers of care to children with special needs and developed a medical passport for families of special needs and foster care children to carry important medical data between providers.

To strengthen coordination of health components in community-based systems, ISDH/CSHCS is conducting a pilot project that electronically links medical records, IEP/IFSPs and referral information between primary and tertiary providers to reduce duplication and share relevant information about a child's health.

Coordination of health services with other social services is a constant throughout the CSHCS care coordination system. Resources such as inclusive child care and respite care are a core part

of care coordination activities. ISDH/CSHCS provides continuing training and assistance to local care coordination grantees to help link families to social services.

Perinatal standards based on ACOG and AAP recommendations have been developed and distributed in collaboration with the Indiana Perinatal Network, Inc. These have been distributed by MCHS and IPN to public and private health care providers and OMPP. A Breastfeeding Consensus document is being distributed.

Using AAP guidelines and Bright Futures, MCHS has developed standards of care for children 0-21 years of age. These along with Bright Futures have been distributed to MCHS child health clinics and MCHS has shared them with OMPP. MCHS also distributed the AAP pediatric standards of care with non-funded public clinics.

Family care coordination standards of care have been developed and used in training of family care coordination grantees and CSHCS local care coordinators.

Family planning and women's health services standards have been developed by the Indiana Family Health Council (Indiana's Title X agency) with which MCHS has contracted. MCHS funded family planning/women's health projects use these standards.

Standards of care and training for first responders was developed by the SID'S Director in the late 1990's. This continues to be widely used in training firemen, police and EMT's.

Standards for perinatal HIV testing in hospitals have been developed and distributed by the perinatal HIV staff.

Best Practice Guidelines for prenatal care coordination were completed through the IPN in collaboration with MCHS, OMPP, and the two managed care organization contracting with OMPP. These standards have been disseminated to all local care coordinators and are a part of the National Association of Social Workers (NASW) training and certification process for local care coordinators.

MCHS grantee program effectiveness is evaluated through the annual reports they submit. Clients served as well as progress on performance measures or objectives are used to determine effectiveness grantees represent many approaches to care. For example direct service clinics may

provide services through nurse practitioners, nurse midwives, or physicians. Local sponsoring agencies generally determine what approach to care will best serve the community.

3.2 Health Status Indicators

See Section 5.4 pages .

3.2.1 Priority Needs

Indiana experiences high rates of low birthweight, infant mortality, and inadequate prenatal care. Child immunizations remain well below national targets and environmental hazards such as lead poisoning threaten the health of tens of thousands of children. Risky behaviors among adolescents lead to teen pregnancy and childbearing and high rates of tobacco use.

Effectively addressing key MCH problems requires simultaneous interventions using direct and enabling health services, population-based education and outreach services, and strengthening MCH infrastructures. High priority must be given to expanding the availability of care for isolated rural residents and underserved urban and suburban persons and assisting the MCH population reach needed services. At the same time, broad based education and outreach is needed to improve knowledge of healthy practices among the entire population. For children with special health care needs, stronger system are needed to identify children early and link them to appropriate services.

The top priority needs identified in Indiana are:

1. To improve pregnancy outcomes especially infant mortality, fetal deaths, and low birthweight and decrease disparities.

2. To lower high risk pregnancy and teen birth rate.

3. To reduce barriers to delivery of health and dental care of pregnant women, infants, children, children with special health care needs, adolescents and women.

4. To build and strengthen systems of family support and family involvement that will assist families in seeking and receiving health and social services, including families of children with special health care needs.

5. To reduce environmentally related health conditions like lead poisoning, asthma, and injury in all infants and children.

6. To decrease tobacco use in Indiana.

7. To promote systems that allow for early identification and tracking of children with special health care needs and that enhance the provision of services to them.

8. To lower risk behaviors in adolescents.

9. To increase immunization rates.

10. To reduce obesity in Indiana.

3.3 Annual Budget and Budget Justification

FY 2001 Summary Budget

Component A: Services for Pregnant Women, Mothers, and Infants up to age one.

Component B: Preventive and primary Care services for Children and Adolescents.

Component C: Family-Centered, Community-Based, Coordinated Care and the Development of Community-Based Systems of Care for Children with Special Health Care Needs and their Families.

Administrative Costs: Indirect Costs

	Dollars	Percentages
Component A	$ 4,178,554	33.50%
Component B	$ 3,804,927	30.50%
Component C	$ 3,943,976	31.60%
Administrative Cost	$ 548,820	4.40%
Grant Total	**$12,476,277**	**100.00%**

I. Direct Medial Care Services

The $4,864,506 budgeted at this level include all community grants that provide direct services and MCH State Supplemental funds.

II. Enabling Services

The $22,712,216 budgeted at this level include all community grants that provide enabling services, all Hemophilia insurance premiums, and CSHCS state funds.

III. Population Based Services

The $2,549,968 budgeted at this level include all community grants which provided population based services, Newborn Screening funds, and Indiana RESPECT funds.

IV. Infrastructure Building Services

The $7,029,131 budgeted at this level include salaries of all staff and other operating expenses (minus insurance premiums and community grant funds).

Total FY 2001 budget $37,255,821.

3.3.1 Completion of Budget Forms

See forms 3, 4, and 5.

3.3.2 Other Requirements

Maintenance of State Effort

In FY'89, Indiana's MCH Block Grant award was $10,527,556 and the state provided $11,539,520 in support of MCH activities. In FY'99 the MCH Block Grant award was $12,365,770 and the state provided $15,532,864 in support. In FY 2001 the MCH award is expected to be $12,476,277 and the state will provide $23,200,228. State support is provided by state and local funds which MCHS is authorized to spend on behalf of children with special health care needs. Line item funding levels in FY'89, FY'99 and FY 2001 are listed below:

State Funds	1989 Expenditures	1999 Expenditures	2001 Budget
MCH Supplement	193,223	115,000	190,000
Newborn Screening	33,669	575,110	708,576
Children with Special Health Care Needs	11,312,628	16,836,153	21,591,670
Meconium	0	0	67,200
Local MCH Appropriations	0	0	0
RESPECT	0	0	642,782
Local Medicaid	0	0	0
TOTAL	$ 11,539,420	*$ 17,532,864	*$ 22,557,446

*FY'99 Expenditures $642,782 project RESPECT funding is not included because it is used to match the federal Abstinence Education Grant.

*FY 2001 Budget includes the $642,782 state RESPECT funding because as of FY 2000 these funds are not being used to match the federal Abstinence Education Grant.

Indirect Cost Rate Agreement

The rates listed below and approved in the Rate Agreement dated 10/16/98 between ISDH and DHHS are for use on grants, contracts, and other agreements with the Federal Government subject to the conditions in Section III. It should be noted that Indiana considers indirect costs to be the administrative costs of the program.

FY 2001 Unobligated Funds

The projected unobligated balance from FY 2000 is $1,579,316. Indiana will always indicate funds in this category due to the length of time required to hire staff and the less than 100% payout on approximately sixty contracts per year. These costs are included in full in the projected budget each year. The unobligated balance will be used for program costs and to fund special projects that address Indiana priorities. Indiana operates its program on a first in first out basis; therefore the unobligated carryover will be expended first.

SECTION I: INDIRECT COST RATES*

RATE TYPES:	FIXED	FINAL	PROV. (PROVISIONAL	PRED. (PREDETERMINED)	
	EFFECTIVE PERIOD				APPLICABLE
TYPES	FROM	TO	RATE(%)	LOCATIONS	TO
FIXED	07/01/98	06/30/99	8.0	All	All Programs
FIXED	07/01/99	06/30/00	9.2	All	All Programs
PROV.	07/01/00	Until Amended	Use same rates and conditions as those cited for fiscal year ending June 30, 2000.		

*Base:
Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations), subawards and flow-through funds.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Figure 3: TITLE V BLOCK GRANT PERFORMANCE MEASUREMENT SYSTEM

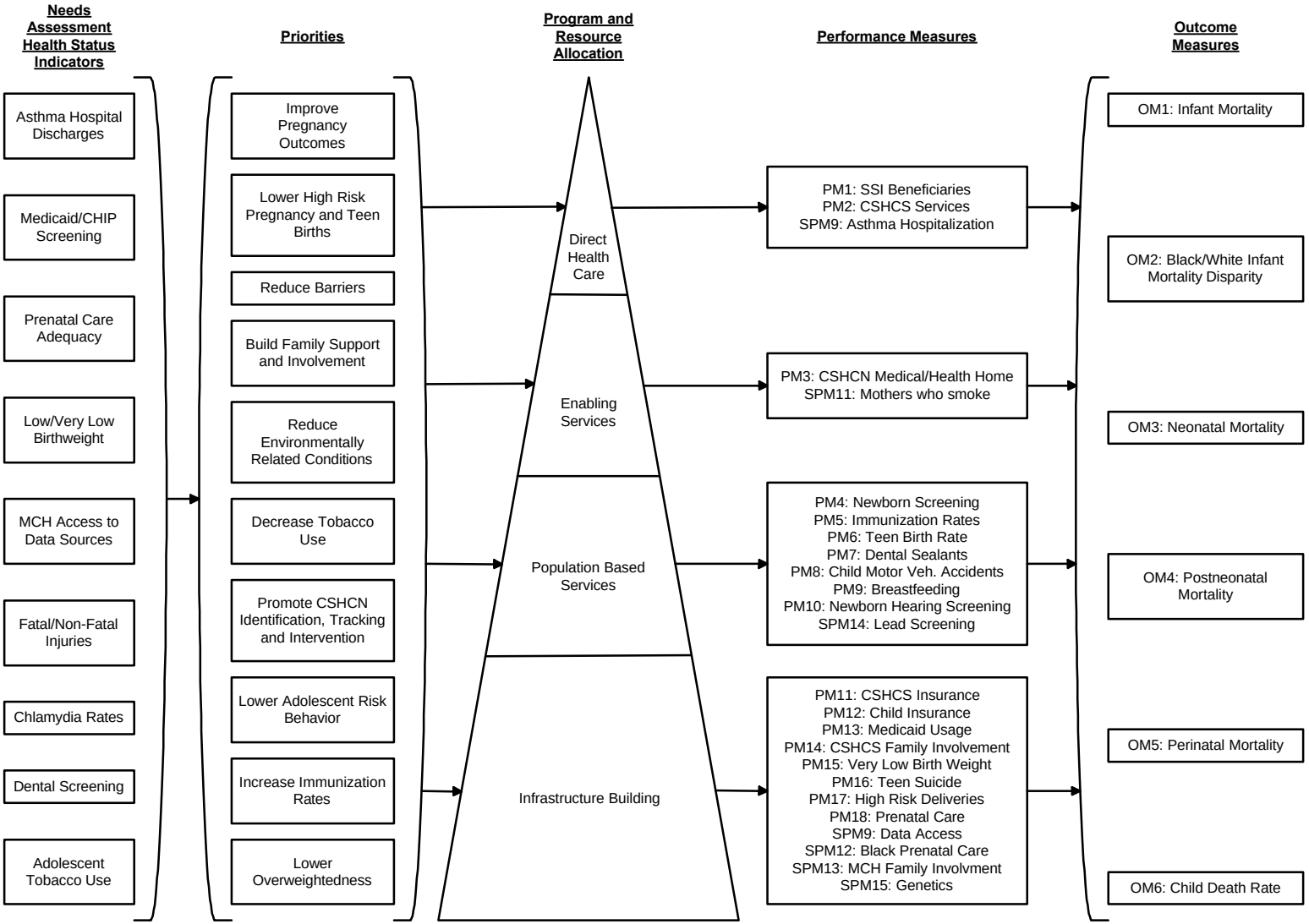


Figure 4

PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home"		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickcle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
SP #01) Establish a data collection and analysis system for family care coordination to evaluate the enabling effects on health outcomes of this service.		X				X	
SP #02) Establish a population-based Perinatal Education System to implement the education portion of the Perinatal Strategic Plan.			X		X		
SP #03) Maintain a lead poisoning surveillance and intervention system in Indiana.			X		X		
SP #04) Percent of prenatal population served by MCHS who reduced or stopped smoking.		X					X
SP #05) Establish a Perinatal Network in Indiana as established in the Perinatal Strategic Plan				X	X		
SP #06) Establish a method of tracking children with chronic and disabling conditions and babies born with chronic conditions predisposed to developmental delay.				X		X	
SP #07) Rate of HIV exposure cases as a result of perinatal transmission that remains sero-positive after 18 months of age.	X						X
SP #08) Percent of infants born to Black pregnant women receiving prenatal care beginning in the first trimester.				X			X
SP #09) To establish a system of routine data access with internal and external data sources.				X	X		
SP #10) The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less than five years old.	X						X
SP #11) The percent of live births to mothers who smoke.		X					X
SP #12) The percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate.				X			X
SP #13) The degree to which the State assures family participation in program and policy activities in the State MCHS program.				X		X	
SP #14) The number of children aged 6 months through 6 years screened for blood lead levels in targeted at-risk census block groups.			X				X
SP #15) To facilitate the integration of genetics and build genetics capacity within other areas of public health.				X	X		

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor
Italicized performance measures begin FY 2001

3.4.1.1 Five Year Performance Objectives

See Section 5.8, Forms 11

3.4.2 State "Negotiated" Five Year Performance Measures

See Section 5.10. Forms 16

3.4.2.1 Development of State Performance Measures

For the FY 2001 needs assessment, MCHS contracted with The Lewin Group to compile and facilitate the needs assessment. Included in this service were key informant interviews and a video conference to which consumers, professionals, and agencies working with the MCH populations were invited. The MCHS/CSHCS management team developed the State Priorities and State Performance Measures from the information found in the needs assessment and community input. Many of the priorities remain the same as in the previous five years. State Performance Measures have varied somewhat.

3.4.2.2 Discussion of State Performance Measures

For FY 2001 Indiana MCSH/CSHCS has defined seven new State Performance Measures (SP #09-15) that will impact the State Priority Needs. Consensus of MCHS/CSHCS leadership was that the Performance Measures chosen for the previous five year period were either completed, not specific enough or are on-going processes. Four of the new SP's are infrastructure building goals and there is one in each of the other levels of the Pyramid. Two of the SP are categorized as capacity building, four as risk factor, and one is process.

SP #09) To establish a system of routine data access with internal and external data sources.

This SP directly relates to the priority need "to promote systems that allow for early identification and tracking of children with special health care needs and that enhance the provision of services to them". It also addresses the fragmentation of data sources that contribute to the assessment and monitoring of maternal and child health issues and the data needs reflected in the previous state performance measures. This SP is a **capacity** service type at the **infrastructure building** level of the Pyramid. This relates to information necessary to plan programs that will impact on all of the Outcome Measures.

SP #10) The rate per 10,000 for asthma hospitalizations (ICD 9 Codes: 493.0-493.9) among children less that five years old.

This **risk factor, direct health service** SP relates to "reducing barriers to delivery of health care…" , "to reducing environmentally related health conditions…" among children with special health care needs, and (to some degree) "promoting systems that allow for …tracking of children with special health care needs and that enhance the provision of service to them. It will have impact on the OM #6, child mortality.

SP #11) The percent of live births to mothers who smoke.

This SP broadens the scope of SP #04 defined in the previous application from behavior change in MCHS funded projects to behavior change in the pregnant population of the whole state.

Because smoking cessation efforts are occurring on many fronts at this time in Indiana, it was felt that a wider impact will be made. This SP was classified as a **risk factor** service type at the **enabling** level of the Pyramid. It relates to the priority needs "to improve pregnancy outcomes…", "to lower high risk pregnancy…", "to reduce environmentally related health conditions…", "to decrease tobacco use…", and "to lower risk behaviors in adolescents". Efforts to impact smoking in any population has a positive effect on all of the Outcome Measures.

SP #12) The percent of black women (15 through 44) with a live birth during the reporting year whose observed versus expected prenatal visits are greater than or equal to 80% on the Kotelchuck index.

This SP is also a more specific variation of SP #08 in FY 2000 grant application. It reflects a **risk factor** service at the **infrastructure building** level of the Pyramid. This SP will evaluate the MCHS impact on the priority needs "to improve pregnancy outcomes…and decrease disparities", "to lower high risk pregnancy…", and "to reduce barriers to delivery of health care…to pregnant women…". Efforts to improve in this SP should impact all the infant and perinatal Outcomes (OM1-5), particularly the infant mortality disparity.

SP #13) The degree to which the State assures family participation in program and policy activities in the State MCHS program.

MCHS has long recognized that consumer input has been limited in the development of services provided by the program. This SP mirrors the PM #14 that focuses on family participation in the CSHCS program. The intent is to use the same criteria to show improvement in this **process** service type at the **infrastructure building** level. Consumer input in program planning is related to the effectiveness of activities that affect all the priority needs listed and all of the Outcome Measures.

SP #14) The number of children aged 6 months through 6 years screened for blood lead levels in targeted at-risk census block groups.

This SP also changes the scope of the previous SP #03 that developed a lead poisoning screening and intervention system. It focuses on impact of universal screening of a targeted population **risk factor** at the **population-based** level. It relates to the priority need "to reduce environmentally related health conditions…", " to promote systems that allow for early identification and tracking of children with special health care needs and that enhance the provision of services to them", and "to reduce barriers to delivery of health care…". It impacts all of the Outcome Measures.

SP #15) To facilitate the integration of genetics and build genetics capacity within other areas of public health.

This **capacity** building, **infrastructure building** state performance measure relates to all of the priority needs except "to increase immunization rates". Indiana MCHS Genetics program has been awarded an MCHB grant to develop a genetics plan. The grant objectives and activities will be incorporated in this SP. All Outcome Measures can be improved with a improved understanding of the role of genetics in health and well-being.

3.4.2.3 Five Year Performance Objectives

See Section 5.8, Forms 11.

3.4.2.4 Review of State Performance Measures

See Section 5.10, Forms 16.

3.4.3 Outcome Measures

See Section 5.8 Forms 12. Indiana did not choose to develop a state specific outcome measure.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a)(2)(A)]

The Annual Plan Performance Measures and related program activities will be discussed according to Pyramid level and population groups, beginning with the Infrastructure Building level of the Pyramid. Most of Indiana's priority needs and State Performance Measures (SP) can be categorized in this level of the Pyramid. Activities will be discussed by individual or multiple target populations, if the activities are the same. Indiana MCHS and CSHCS assume that any performance measure targeted at the population of children includes children with special health care needs as well. Annual Performance Objectives will also be listed under the appropriate Pyramid level and population.

4.1 Program Activities Related to Performance Measures

INFRASTRUCTURE BUILDING SERVICES

1. All Targeted Populations (Pregnant Women, Mothers, and Infants; Children; and CSHCN)

Needs Assessment/Evaluation/Monitoring: In completing the needs assessment for FY 2001, some improvements in data availability were noted while some deficiencies still exist. While available vital statistic data continues to be two years behind (1998 data is being used for FY 2001 grant), analysis of perinatal data for 1998 is available and on the ISDH webpage for the public. While no routine data matching or exchange exists between Title V services and Hoosier Healthwise (Medicaid), First Steps, SSI etc., the new CSHCS data system when complete is to interface with First Steps system. Through a Genetics Planning Grant to begin June 1, 2000, several intra-agency databases will be evaluated for interfacing for tracking purposes. Also, an SSDI grant is focussing on improving data on dental sealants utilization in Indiana and on adolescent health behaviors. Moreover, the climate for collaboration of data seems to have improved. The MOU between Title V and Title XIX is being updated and will include data exchange.

Other programs within MCHS that collect data on all populations that is used as part of the needs assessment, monitoring, and evaluation of services of MCHS and CSHCS include:

- The **Indiana Family Helpline (IFHL)** (1-800-433-9746) provides ongoing statewide health systems needs assessment/evaluation/monitoring data to MCHS and other ISDH and state programs (particularly population-based education initiatives). The IFHL is principally a population-based enabling service for information, referral, and occasional facilitation into health and social services. It is also used by several programs for population-based education initiatives. However, the number and types of calls received provide MCHS Health Systems Development (HSD) consultants, Oral Health consultants, Office of Minority Health, Hoosier Healthwise and others provide a barometer of issues in

the local community. Discussions are being held to expand the marketing and support of IFHL to include several programs in FSSA. There is also discussion among service agencies in the state to begin a "2-1-1" number for non-emergent social services. The IFHL will be a part of these discussions. In order to improve service to non-English speaking callers, the IFHL has the ATT Language Line and has a Spanish speaking communication specialist available.

- The **Grantee Direct Health and Enabling Service Data** collected through enrollment and encounter form entries also provides much more health outcome information for all population groups than has been utilized to date. While the new Y2K compliant systems for both MCHS and CSHCS are still being completed and implemented, the programs should have more accessible data to assist in determining the health of the MCHS and CSHCS populations and the impact these programs have on the general population.
- The **Health Systems Development Consultants (HSD)** in MCHS, when asked, work with grantees, the local health departments, community groups that focus on service delivery like the Step Ahead Councils, First Step Councils, hospitals, private physicians, and other groups which are concerned with health care infrastructure. The consultants facilitate the local communities in assessing the health need of a county or community. The HSD consultants assist these groups in filling the service gaps. These interdisciplinary consultants (nurses, social workers, nutritionists, and health educators) also provide programmatic technical assistance to local grantees and others requesting assistance. They monitor and evaluate grantees through site visits, grantee annual reports, grant applications, and electronic data.

One SP is defined that should improve MCHS in the assessment, monitoring, and evaluating MCHS programs.

SP #09) To establish a system of routine data access with internal and external data sources.

FY 2001 Performance Objective: MCHS will complete at least one of five data access measures by the end of FY 2001.

Activities that will impact the completion of this objective include:

- Development of an MOU with Office of Medicaid Policy and Planning that will include routine timely access to data for PM #13, Core Health Status Indicators (CHSI) # 2, 3, and 6, and Developmental Health Status Indicator (DHSI) 4. The Medicaid row of Form C3 of the Health Status Indicators is completed at the "2" level.
- Regular communication among ISDH Epidemiology Resource Center, MCHS, and the Indiana Health and Hospital Association to develop routine access to data for CHSI 1, DHSI

2, and a completion of first three columns of the Hospital Discharge row of Form C3 at the level of "3".

- Complete the implementation of the new CSHCS computer system with reports functioning.
- Implement lead surveillance data sharing with CDC.
- Implement the tracking system for Newborn Hearing Screening.

Quality Assurance/Standards Development: Quality assurance standards for perinatal, and child and adolescent health were completed in FY '98 and implemented in FY '99. Bright Futures protocols have been provided to child health clinics as well. Guidelines and standards for prenatal, family and CSHCS care coordination are in place, as well as quality assurance standards for HIV counseling and treatment. Within ISDH, several programs that work with hospitals like Newborn Screening (metabolic, hearing, and meconium), HIV perinatal program, immunizations, ICLPPP, et. al., developed a hospital survey to assess a hospital's need for technical assistance. As part of the survey, sample protocols are provided to each hospital and addition consultation will be available.

Consumer involvement in program and policy development and consumer satisfaction is an important part in the quality assurance of MCHS. SP #13 was development to improve in this area.

SP #13) The degree to which the State assures family participation in program and policy activities in the State MCHS program.

FY 2001 Performance Objective: The Indiana MCHS will improve parental involvement in the program by progressing from "3" to "6" degree points by the end of the fiscal year.

Activities that will positively impact this SP include:

- Utilize volunteers from current employees who use or have used MCHS or WIC services to provide input on program development.
- Re-establish the MCHS/CSHCS Advisory Board and include consumers.
- Reimburse for consumer participation in statewide policy making activities.
- Require grantees to report on client satisfaction surveys as part of their annual report.

Policy Development: Policy development for all MCHS programs and initiatives occurs with input MCHS staff, other ISDH programs and agencies with whom MCHS collaborates, ISDH management, associated Advisory Boards, local agencies affected and, occasionally, the Governor's Office. The level of input varies with the significance of the issue involved.

Coordination: Coordination efforts are continuous in MCHS and CSHCS. Several grants received by the programs are focused on coordination of services. The Indiana Integrated Services SPRANS Grant for CSHCS and First Steps has provided coordination that impacts more than the target population through the implementation of the combined enrollment form accepted by Medicaid, First Steps, CSHCS, and MCH, the development of the Health Passbook for CSHCS and foster children. An Infant Mental Health advisory group has been convened to focus on Infant Mental Health. Coordination among ISDH/MCHS, SCHIP, and Hoosier Healthwise continues as Hoosier Healthwise Package C in implemented. MCHS received an SSDI grant to develop a method of obtaining current information regarding the use of dental sealants in conjunction with the school, to facilitate an adolescent risk behavior survey through schools, and to coordinated data between OMPP and ISDH. Program directors and other management team leaders participate in the "Building Bright Beginnings" Campaign (*I am Your Child* Coalition in Indiana) subcommittees, OMPP Provider Access Task Force, Child Health Policy Board's Advisory Board for Children with Special Health Care Needs, and the Indiana Perinatal Network, Inc. Advisory Board. This infrastructure building coordination lays the groundwork for the implementation of both population-based education initiatives and statewide program endeavors.

While the Genetics Disease Program functions primarily as a population-based program (see Genetics Disease Program, p. 28), the Genetics Specialist has a two year grant to build infrastructure and develop a genetics plan. The development and implementation of Indiana's Genetics Plan is the focus of SP #15 that require both internal and external organizational coordination.

SP #15) To facilitate the integration of genetics and build genetics capacity within other areas of public health.

FY 2001 Performance Objective: MCHS will complete at least one of five defined measures of integration and capacity building.

Activities to accomplish this SP include:

- A Genetics Advisory Committee will be convened quarterly.
- A needs assessment will be completed through a contractor.
- Consumer focus groups will be convened for needs assessment.
- The feasibility of linking vital statistics and the database of CSHCS will be evaluated through a contractor.
- Educate public health areas as to their interface with genetics.

Training and Applied Research: MCHS nutritionists provide training and field experience annually for the Riley Infant and Child Nutrition Fellows. The Genetics Specialist provides an internship for graduate students. Two medical students did a rotation in MCHS. One did a project evaluating the cultural sensitivity of some the ISDH services like the IFHL and surveying the Latino population in regard to the utilization of Hoosier Healthwise. Changes were made within the IFHL because of his recommendations. MCHS Director has assisted with MPH candidates' field training experience. The Folic Acid Campaign is being evaluated for effectiveness this year.

2. Pregnant Women, Mothers, and Infants

Needs Assessment, Monitoring, Evaluation; Quality Assurance and Standards;
Policy Development; Coordination: In an effort to have impact on Indiana's priority need of improving pregnancy outcomes and reducing barriers of health care for pregnant women and infants, Indiana MCHS established the Indiana Perinatal Network, Inc. (IPN) to implement the Perinatal Strategic Plan, developed in 1996. To date the IPN has facilitated twenty regional Perinatal Advisory Boards, has implemented the *Baby First—Right From the Start* educational campaign and created the infrastructure for expansion, and has created professional education and resource infrastructure with the quarterly *Perinatal Perspectives* newsletter, the biennial *Indiana Perinatal Practice Alerts,* and the Indiana Perinatal Online Magazine. IPN is piloting the Provider Continuing Education Program (PCEP) in three hospitals and is facilitating the Marion County pilot of the *Friendly Access* initiative. IPN was instrumental in the legislation of the Newborn Hearing Screening law and in developing the tracking system. Through research and consensus IPN has developed the Perinatal Care Consensus Statement and Prenatal Care Coordination Consensus Statement and have Breastfeeding and Provider Consultation Consensus Statements ready for distribution. IPN will continue to contribute significantly to the infrastructure building of MCHS.

Three National Performance Measures (PM #16, #17, and #18) and a State Performance Measure (SP #12) also relate to improved pregnancy outcomes, lowering high risk pregnancy and adolescent rates, and reducing barrier to care priorities. SP #12 specifically relates to lowering Black/White disparity in infant mortality outcomes. While these performance measures are categorized on the Infrastructure Building level, they are very dependent on the direct health care and enabling service levels to be accomplished. To effect change, both public and private providers, business and community leaders and others must be involved and educated on the subject as well as the consumers. This is a health system behavior change that can be a long process.

PM #18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

FY 2001 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase from 78.2 % in FY 2000 to 78.4% in FY 2001.

Activities that will impact accomplishment of this objective:

- In Marion County, MCHS and IPN will support and facilitate the implementation of *Friendly Access* within the Health and Hospital Corporation hospital, public clinic, and public health system.
- To improve the comfort level of clients of different cultures, grantees will be encouraged to implement techniques to promote cultural sensitivity. Grantee staffing will reflect the ethnicity of the target population.
- The *Healthy Pregnancy/Healthy Baby Campaign* (free pregnancy tests) will continue to be provided to agencies working with women of childbearing age. Agencies using the tests for outreach will refer clients to appropriate prenatal care, Medicaid, and WIC. MCH grantees providing prenatal care will take referrals from such agencies.
- Grantees providing prenatal care services will participate in all population-based perinatal education marketing campaigns sponsored by ISDH/MCHS or IPN.
- Grantees will contribute to regional infrastructure by participating in an IPN Regional Advisory Board and in community groups working with mothers and children to market the prenatal services offered and educate agencies on the importance of early prenatal care.
- Grantees may expand services to offer a basic first prenatal visit service while pregnant women are awaiting a physician/provider visit in areas of high need and with physician provider cooperation.
- Grantees will participate in community incentive programs where available to encourage early entrance into prenatal care.
- *Baby First—Right From the Start* multimedia campaign through the Indiana Perinatal Network, Inc. will be initiated at some level throughout the state. Early prenatal care is emphasized in this educational package.
- Continued MCHS funding and technical assistance of prenatal support programs through culturally sensitive home visit programs.
- All IPN perinatal standards and educational materials to both professionals and consumers will include information on early entrance into prenatal care.

- MCHS staff and local grantees will coordinate with Healthy Start sites in Marion and Lake Counties.

SP #12: Percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate (80% on the Kotelchuck index).

FY 2001 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 from 61.4% in CY 1998 to 64% in FY 2001.

Activities that will impact accomplishment of this objective include:

- All of the activities in NPM #18 will affect this SP.
- Distribute and analyze an agency survey to grantees regarding cultural competency.
- Assure that each grantee operating in a county with a minority population of 5000 or more and providing prenatal health care or enabling services has at least one measurable outreach activity to Black and minority prenatal populations.
- Through IPN, facilitate awareness and competency in addressing the transcultural aspects of perinatal health care in collaboration with Minority Health Coalitions (state and local).
- In collaboration with IPN, Indiana Minority Health Coalition, and Indiana Hispanic Coalition distribute culturally sensitive and bilingual materials.
- Train additional black community health workers to assist Prenatal Care Coordinators in providing outreach and support for black pregnant women.
- IPN and MCHS will sponsor a booth at the Indiana Black Expo Black and Minority Health Fair to educate attendees regarding the need for early and adequate prenatal care.

The following two performance measures might also be placed in the population category of children with special health care needs. However, the prevention of low birthweight babies and early intervention for these children best occurs in the perinatal period.

PM #15: Percent of very low birthweight live births

FY 2001 Performance Objective: The percent of very low birthweight infants among all live births with be maintained at 1.3% in FY 2001.

Activities to accomplish this performance measure include:

- State MCHS will provide funding for direct perinatal services and enabling services through grants to provide prenatal care, outreach, and education to high risk pregnant women.

- Grantees will work with local individuals or groups that represent the racial/ethnic groups in their client populations to facilitate better communication with clients of varying race/ethnicity and /or receive cultural sensitivity training.
- Grantees will educate and monitor clients on pre-term labor signs and symptoms, the risks of smoking to a pregnancy outcome, the importance of appropriate weight gain and other issues identified in the Fetal and Infant Mortality Review findings.
- Grantees will participate in the Indiana Perinatal Network
- Grantees will reinforce to clients the perinatal health care points cited in the IPN *Baby First—Right From the Start.*
- Grantees providing direct services will follow Prenatal Care Consensus Statement guidelines approved by the IPN Board.
- Babies who are very low birthweight and are in the NICU will be enrolled in CSHCS and First Steps before they leave the hospital.

Indiana does not have a regional system that designates hospitals as basic, specialty and perinatal subspecialty level hospitals. The results of the IPN voluntary statewide survey of all hospital currently with obstetrical departments indicated that 26 hospitals were self determined to be basic; 27 hospitals indicated that they were specialty hospitals for neonatals and 8 described themselves as perinatal subspecialty hospitals. The Indiana Perinatal Advisory Board will develop a consensus statement with recommendations on hospital classification based on this survey and the standards found in *Toward Improving Outcomes of Pregnancy II* by March of Dimes and *Guidelines for Perinatal* Care by ACOG and AAP.

PM #17: Percent of very low birthweight infants delivered at facilities for high risk deliveries and neonates

FY 2001 Performance Objective: The percent of very low birthweight infants delivered at facilities for high risk deliveries and neonates from 56.5% in FY 2000 to 57% in FY 2001.

Activities to move toward obtaining this data include:

- Continue to maintain the Indiana Perinatal Network to assist with infrastructure building and population-based education.
- Based on IPN Advisory Board consensus and recommendations, establish quality standards for each level of hospital care with input from all involved.
- Establish a framework for a regional system of perinatal care in the State of Indiana.
- Issues Subcommittee of IPN State Advisory Board will develop an Emergency Room Care of Prenatal Patient Care Guide or consensus statement to ensure proper referral and follow-up.

Coordination and Training: HSD consultants provide regional networking meetings to prenatal and family care coordinators 2-3 times per year. This on-going Infrastructure Building activity was implemented to provide continued support and training for prenatal care coordinators (case managers) who have credentials to provide Medicaid reimbursed Prenatal Case Management. These meetings compliment the certification training provided by the Indiana Chapter of the National Association of Social Workers. In FY 2000, issues covered include how care coordination can interface with Medicaid Managed Care and how to be reimbursed for smoking cessation through Medicaid.

Coordination and Policy Development: Within ISDH MCHS consultants work with HIV staff to develop policies that promote the testing of pregnant women for HIV, and coordinates with the Office of Women's Health on women's health issues. MCHS has coordinated with the Quality Improvement Program in developing policies regarding community health center funding.

Training and Applied Research: MCHS continues to provide Community Health Worker training. These paraprofessionals are able to assist with Medicaid reimbursed prenatal care coordination (case management). Certification materials and a final test are provided to Certified Care Coordinators to train their community health workers.

2. Children

Assessment, Monitoring, and Evaluation: Two NPMs for children relate to assessing, monitoring, and evaluating access to care for children. The process NPM, "percent of Medicaid enrollment who received service…" affects the capacity objective, "percent of children without insurance…". Improvement in both of these objectives is dependent upon the success of OMPP in marketing Hoosier Healthwise and enrolling adequate numbers of providers to make access to care for the consumer easy and efficient. However, MCHS activities for both measures will be the same.

PM #12: Percent of children without health insurance.

FY 2001 Performance Objective: To decrease the percent of children without insurance from 11.5% in FY 2000 to 11% in FY 2001.

PM #13: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program.

FY 2001 Performance Objective: *To maintain the percent of Medicaid eligible children who have received a service paid by the Medicaid program at 80% in FY 2001.*

Activities that will impact these NPMs include:

- Require all MCHS and CSHCS grantees providing Medicaid reimbursable direct preventive, primary care and enabling services to be Medicaid providers.
- Require all MCHS and CSHCS grantees providing direct and enabling services to facilitate or provide outreach, education, referral, or enrollment to Medicaid/SCHIP eligible clients not yet enrolled in Hoosier Healthwise Packages A or C.
- Require all CSHCS applicants to make application to Hoosier Healthwise as part of the enrollment procedure so that an eligible client will use CSHCS as payer of last resort.
- The Indiana Family Helpline (IFHL) will provide outreach, education, referral or application for the Hoosier Healthwise Packages.
- Financial management training will be provided to CSHCS staff and local care coordinators.
- MCHS staff with ISDH Local Liaison and Quality Improvement staff will assist OMPP and their Hoosier Healthwise contractors to improve access to providers.

For the following NPM, the services of the Indiana FSSA, Division of Mental Health (DMH) would have more direct impact on improving the outcome. The improved adolescent health insurance coverage through Hoosier Healthwise expansion should also decrease the barrier of payment for mental health services. Access to care, however, is also dependent on the success of marketing the insurance coverage to parents of teens and to increasing the numbers of mental health care providers available.

PM #16: The rate of suicide deaths among youths aged 15-19

FY 2001 Performance Objective: *The rate of suicide deaths among youths aged 15-19 will decrease from 7.3 to 7.1 by the end of the fiscal year.*

MCHS activities that will be associated with the accomplishment of this objective include:

- All MCHS grantees will be provided with have a copy of the suicide prevention manual.
- Implementation of the child health standards which include assessment of depression for adolescents and appropriate referrals.
- Bright Futures guidelines will be used to evaluate depression in teens.
- All adolescent health centers funded by Title V will screen for risk of depression and refer as needed.

Other programs within MCHS or ISDH that provide major statistical input into assessment, monitoring, and evaluating services for children include:

- **Newborn Screening** is a population-based program that tracks some genetic abnormalities, newborn hearing screening, and meconium screening for follow-up and early interventions and for needs assessment, monitoring and evaluation.
- **Lead Surveillance** through the CDC grant provided MCHS with prevalence data and currently monitors for follow-up and intervention in the targeted high-risk communities.
- **Immunization Program** provides up-to-date access to immunization records for assessment, evaluation, and monitoring the utilization of vaccines. The Immunization Tracking, Information Management, and Evaluation System (ImTIME) has been installed in all local health departments throughout the state.

Policy Development/Coordination: See "All Target Population" in this section.

Training and Applied Research: The MCHS HSD Adolescent Health Consultant will provide training to the Indiana RESPECT grantees annually. The Indiana Family Health Council is contracted to provide training on Family Planning topics to Title V family planning grantees. MCH staff participate in the Center for Public Health Education at Indiana University, Indianapolis. The goal of the Center is to develop education for local public health workers. MCH staff also participate in training of medical students, MPH students, nutritionists and genetic counselors.

3. Children With Special Health Care Needs

Needs Assessment, Monitoring, Evaluation: CSHCS is currently testing and implementing the new data system for the application, enrollment and monitoring of clients, and the reimbursing of providers. In the near future this system is to interface with First Step's System Points of Entry (SPOE) enrollment application to minimize data entry duplication for dually enrolled children. Through a Genetics Planning Grant the feasibility of integrating several ISDH databases to improve birth defects surveillance will be explored in the next two years. CSHCS will implement statewide a system to ensure the opportunity of enrollment in CSHCS of SSI recipients who are eligible. Tracking of newborn meconium screening of infants at risk for intrauterine drug exposure and newborn hearing screening should assist is assessing the prevalence of prenatal drug use and hearing impairment respectively, evaluation of the tracking system, and promote early intervention for these special needs children.

In 1992 CSHCS began functioning as payer of last resort (after private health insurance and Medicaid) for primary/preventive health care services that occur in the provider offices and specialty care services (both office and hospitalization) that are related to the diagnosis/es for which the client is enrolled in CSHCS. (State matching allocation, not Title V federal funds, are used for service reimbursement.) For clients who are not eligible for Hoosier Healthwise and who do not have health insurance, CSHCS covers all primary care and specialty care related to the participant's eligible diagnosis. While the rules of CSHCS do not currently require client families to apply to Hoosier Healthwise Package C (SCHIP), families will be encouraged to do so. This should increase the number of families with full insurance coverage and lower direct costs to CSHCS.

The ability to report on this NPM for children with special health care needs at the infrastructure level of the Pyramid is directly related to the establishment of the new data collection system. Reports on insurance coverage of enrolled families will be readily available in the new system. (Our pervious interpretation for this NPM assumed that CSHCS coverage was appropriate insurance coverage.)

PM #11: Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.

FY 2001 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will increase from 77% in FY 2000 to 78% in FY 2001 (more accurate baseline data will be collected).

Activities to accomplish this goal include:

- First Steps, CSHCS, and MCH will continue using the combined enrollment form that will also be accepted as a Hoosier Healthwise application for Packages A and C.
- Continue requiring Hoosier Healthwise (HH) Package A application as part of the CSHCS enrollment process; encourage families to apply and enroll in HH Package C; change CSHCS rules to require application to HH Package C.
- Continue the policy of utilizing private health insurance and Medicaid as first payers for primary and specialty services.
- Continue the policy of reimbursing providers for in-office primary/preventive health care services and specialty care services (related to diagnosis) for CSHCS eligible children with no other method of insurance.
- Continue coordinating with First Steps for dually enrolled clients during the first three years of life.

- Co-chair and staff the Advisory Committee for Children with Special Health Care Needs of the Child Health Policy Board.
- The pilot system, established in Marion County, between SSI and CSHCS to ensure all SSI clients who are eligible for CSHCS are given the opportunity to enroll will be established statewide.

Quality Assurance and Standards and Policy Development: Because of the delay of implementation of the new computer system, CSHCS policy revisions will be completed in FY 2001. The CSHCS policies reflect standards of care for reimbursement and quality assurance. Local care coordinators follow standards of care for family care coordination and the Guidelines for Care Coordination for CSHCS. In FY 2000 a client satisfaction survey will be sent to all enrolled families. The Advisory Committee for CSHCN to the Child Health Policy Committee, the Genetics Advisory Group, Infant Mental Health Advisory Group and the Newborn Screening Advisory Group are available to provide a review of the needs, policy, rules, training needs and provision, and procedure development in each area of concern.

Family participation in program development, assessment, and evaluation in CSHCS and MCHS has been an area in need of improvement. The Indiana Parent Information Network has been the primary link to families of CSHCS through the Indiana Parent Information Project. This project provides telephone and mail support, education, and referral linkage, as well as conferences for parents and professionals on issues of families with children with special health care needs. However, with more local care coordination being provided, more parents have been hired as care coordinators. Both the Child Health Policy Board and its Advisory Committee for CSHCN have family representatives. MCHS still employs (through a grant) a SIDS parent to direct the SIDS program. Further emphasis in developing methods to include families in program and policy activities is intended.

PM #14: The degree to which the state assures family participation in program and policy activities in the State CSHCN Program

FY 2001 Performance Objective: Indiana CSHCS will maintain parent involvement in the program at 16 degree points.

Activities to accomplish this NPM include:

- The Leadership Team of the Integrated Service SPRANS grant will continue to have five parents of special needs children from a culturally diverse population as active members of the team for the next five years. Meetings are held semiannually.

- Through the IPIN grant, funding will continue to be available to families for training, for the IPIN newsletter, and Family Voices information dissemination.
- IPIN Director will assist in writing the MCH Block Grant Application and a parent representative will assist CSHCS in reading community grant applications.
- CSHCS will survey parents to assess the program.
- Grantees will need to show family participation at least through satisfaction surveys of their care coordination for their grants.
- Continue to include in local agency contract deliverables that the local care coordinators will participate on local First Steps Planning and Coordination Councils.
- The Advisory Committee for Children with Special Health Care Needs will include four parents of children with special health care needs appointed by the Governor.
- Parents will continue to participate on the MCH/CSHCS and Infant Mental Health Advisory Committees.
- At least three parents/consumers will participate on the Genetics Advisory Committee.

Coordination: The Indiana Integrated Services SPRANS grant that coordinates services for special needs children will continue for a third year. The linkages that have been made will be integrated into the current services. The combined enrollment form will continue to be used by First Steps, CSHCS, MCH and Hoosier Healthwise. Linkages for early identification and intervention will continues to be made through the Neonatal Intensive Care Units and hospital newborn hearing screening, SSI, and other agencies working with CSHCN.

POPULATION-BASED SERVICES

1. ***All targeted populations (Pregnant Women, Mothers and Infants; Children; Children with Special Health Care Needs)***

Outreach and Public Education: One of Title V's major contributions to public education and outreach is through the Indiana Family Helpline (IFHL), the mandated statewide telephone information and referral service (1-800-433-0746) which has been operational since April, 1988. This population-based service provides callers with county-specific primary and preventive care providers who accept Hoosier Healthwise (Medicaid), EPSDT providers, providers of services for children with special health care needs, social services agencies, local health departments, community and rural health centers, and community mental health centers. The IFHL also assists callers with access to food pantries, SIDS services, GED programs, vocational training programs, literacy programs, child care, Healthy Start, Step Ahead Councils, Indiana Minority Health Coalitions, substance abuse treatment, lead

screening sites, breastfeeding support resources, shelters, sexual abuse services and many others.

In addition, if programs within the ISDH, such as the Immunization Program, the Folic Acid Initiative, Indiana RESPECT, HIV/AIDS, or the Breast and Cervical Cancer Programs have a statewide educational campaign, the IFHL number will be the reference to answer further inquiries or send educational information. The number frequently appears on educational campaigns not sponsored solely by ISDH, including *Building Bright Beginnings* (Indiana's *I Am Your Child* Campaign) and *Baby First—Right From the Start* (an IPN media campaign).

FSSA and MCHS are currently evaluating the expansion of the marketing of IFHL to include FSSA programs that currently have an "800" number. The IFHL number is marketed through WIC offices, Division of Families and Children, Minority Health Coalitions, MCH-funded and non-funded clinics, CSHCS, and most educational initiative materials from ISDH. The demographic statistics collected from IFHL callers to this population-based service are used to assist, monitor, evaluate and plan in the infrastructure level of the Pyramid.

MCHS is funding much of the ISDH smoking cessation initiative targeted for teens and children through FY 2001. This campaign is a population–based educational effort of ISDH. During 1999 a media campaign, *It's Gonna Cost You,* was implemented through television, radio, newspapers, magazine spots, and billboards at sports venues. Print materials were created (posters and brochures) to reinforce the ads and are available to schools and the public. The goals of this effort are to decrease the initiation of smoking in Indiana's youth and delay the initiation of those who choose to smoke. MCHS has also funded the expansion of the national *Tar Wars* curriculum in the 5th grade classrooms. This program is sponsored by the Indiana Academy of Family Physicians and is coordinated at ISDH. It has targeted 36 central Indiana counties that could reach 43% of the youth 10-14 years of age. The Indiana Tobacco-Free Partnership, a coalition of agencies interested in promoting smoking cessation, has been developed.

2. Pregnant Women, Mothers, and Infants

Outreach and public education: Outreach and public education on topics related to perinatal health and improving pregnancy outcomes or early intervention has been carried out through the cooperation and coordination of the Indiana Perinatal Network. *Baby First--Right From the Start*, a multi media campaign developed by IPN with public and private funds has expanded to reach nearly the whole state. The Indiana Perinatal Online Magazine (IPOM) has

a site on the internet (Internet address: www.cpdx.com/ipom). At this site there are several professional and public education articles, data, and resources for perinatal services. *Perinatal Perspectives* is a bimonthly IPN newsletter that also provides perinatal education and resources. The mailing list for this publication is diverse, inclusive of anyone interested, and is intended to expand. In addition, "Provider Alerts" on topics such as HIV are published twice per year. Regional Perinatal Advisory Boards are encouraged to provide education seminars. The Breastfeeding Subcommittee of the IPN works with WIC Breastfeeding Committee to provide breastfeeding education at Black Expo and other health fairs and up-dated a Breastfeeding Resource Directory that was sent to libraries, birthing centers, family practitioners, obstetricians, and pediatricians. The SIDS Program, Back to Sleep Campaign, continues.

Findings from Fetal and Infant Mortality Reviews have been the basis for one public education piece, *Lessons Learned from Fetal and Infant Mortality Reviews* (available in English and Spanish), developed by IPN and widely distributed by MCHS. A fetal and infant mortality review in Lake County has prompted additional public and professional education and system protocol changes. Recommendations from the technical review team have initiated increases in grief counseling availability and genetics referrals and have upheld the need to educate the public with the above information in public places like grocery stores, beauty shops and drug stores, as well as physicians offices.

Annually, CSHCS and MCHS publish and distribute federally poverty level income guidelines for Hoosier Healthwise, CSHCS, WIC, and MCHS. Current child health care guidelines and prenatal care guidelines are provided upon request after initial distribution. Folic Acid Initiative materials, primarily from CDC and ISDH, and Genetics education materials continue to be distributed.

Indiana RESPECT, the State's adolescent pregnancy prevention initiative (see p. 20), has provided a statewide multimedia campaign *Sex Can Wait—I'm Worth It.* The IFHL monitors response calls.

In FY 2000 the major efforts to impact NPM #06 continue to be the Indiana RESPECT funding, programs in adolescent health centers, and Healthy Pregnancy/Healthy Baby Campaign for the teen birth rate. For NPM #09, breastfeeding at hospital discharge, the Indiana Perinatal Network Subcommittee on Breastfeeding in conjunction with the WIC Breastfeeding Committee has done the most to impact the statistics.

PM #06: The birth rate (per 1,000) for teenagers aged 15-17 years

FY 2001 Performance Objective: The birth rate for teenagers aged 15-17 years of age will drop from 27 in FY 2000 to 26 in FY 2001.

Activities to affect this performance measure include:

- Indiana RESPECT Initiative will continue to grant state adolescent pregnancy prevention education funds and federal sexual abstinence education funds to agencies providing services to elementary, middle, and high school youth and the parents of teen students.
- Indiana RESPECT will continue to fund an evaluation of the Indiana RESPECT Initiative community grant program.
- Indiana RESPECT will continue the statewide media campaign, *Sex Can Wait—I'm Worth It* for teens and parents.
- MCHS will ensure the Healthy Pregnancy/Healthy Baby Campaign agencies provide counseling/referrals to health care providers or provide abstinence or family planning information to sexually active teens with negative pregnancy tests.
- HSD Consultants will assist local entities (health departments, Healthy Start, Step Ahead Councils, Regional Perinatal Advisory Boards, hospitals, home health care agencies, etc.) to initiate interventions to address this problem.
- MCH perinatal and family planning grantees will provide appropriate health care education and services to client to encourage postponement of initial pregnancy or a second pregnancy until after the teen years.

PM #09: Percentage of mothers who breastfeed their infants at hospital discharge

FY 2001 Performance Objective: The percentage of mothers who breastfeed their infants at hospital discharge will increase from 60% in FY 2000 to 61% in FY 2001.

Activities to affect this performance measure include:

- MCHS will support the educational plans of the IPN Subcommittee on Breastfeeding by sending out mailings and providing educational materials.
- MCHS and WIC projects will have performance measures and activities to promote breastfeeding to prenatal clients.
- MCHS and WIC projects will participate in World Breastfeeding Week projects.
- The *Indiana Perinatal Network Breastfeeding Consensus Statement* will be distributed by MCHS, IPN and WIC.
- The "Approved Breastfeeding Resource List" will be revised and distributed to MCH funded and non-funded clinics/projects and WIC agencies.

- Establish a **Breastfeeding Warmline,** a user-friendly information and referral line for the public and have available qualified staff to answer questions from health professionals in conjunction with the IFHL.
- The IPN Breastfeeding Subcommittee and the WIC Breastfeeding Committee will interface and prepare a joint statewide plan together.
- IPN Breastfeeding Subcommittee and WIC Breastfeeding Committee will support the establishment of Baby Friendly Hospitals in Indiana.
- IPN Breastfeeding Subcommittee and WIC agencies will provide information on Breastfeeding at the Indiana Black Expo and other health fairs.

Newborn Screening: The following two NPMs are directed at infant screening in order to provide early intervention to prevent major disabilities. The Newborn Screening program in Indiana is well established and very effective. It is mandated and funded by state law. It assures that all infants born in Indiana, approximately 85,000 annually, are tested for eight genetic disorders (phenylketonuria, galactosemia, maple syrup urine disease, homocystinuria, hypothyroidism, hemoglobinopathies, including sickle cell disease, congenital adrenal hyperplasia, and biotinidase deficiency). Maintenance of this program to the effectiveness already attained will continue to be the objective.

Criteria for targeted screening for drug afflicted infants will be expanded in FY 2000.

Universal screening of newborns for hearing impairment before hospital discharge is to be fully implemented in July 2000. ISDH is to collect data and ensure referrals to First Steps have been completed for all questionable or positive hearing screens.

PM #04: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. sickle cell diseases) (combined).
FY 2000 Performance Objective: Maintain or improve on the 99+ percent of newborns with at least one completed NBS test.
Activities to impact this performance objective include:

- Continue to follow-up on all screening test results until they are complete and negative or receiving treatment.
- Continue to refer to the Genetics, Sickle Cell, and CSHCS programs.
- Continue working with the NBS Advisory Task Force to determine rules, procedures, and policies. The group will explore the feasibility of testing for further metabolic conditions with tandem mass spectrometry.

- Continue to track incidence of prenatal substance use found in meconium screening at birth.

PM #10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

FY 2001 Performance Objective: Increase universal newborn hearing screens from 75% in FY 2000 to 95% in FY 2001.

Activities to impact this performance objective include:

- Provide technical assistance to hospitals relating to newborn hearing screening rules, protocols and reporting requirements.
- Track the newborn hearing screen statistics.
- Follow-up on all positive and questionable screens with First Steps to ensure the hospital referred the families for diagnostics and early intervention.

3. Children

Population-based services and educational priorities related to childhood health in Indiana include lead poisoning prevention, injury prevention and childhood hazards, immunizations, and the use of dental sealants. The first three of these priorities affect all three populations, but will be listed under children.

The Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) has been honored for its use of Geographic Information System (GIS) mapping to expose areas at risk of having populations exposed to lead. Through this work it is been determined that it is more productive to focus on universal screening in these targeted areas than universal screening statewide.

SP #14: The number of children (6 months through 6 years) screened for blood lead levels at-risk in targeted census blocks groups.

FY 2001 Performance Objective: During SFY 2001, 15,000 children aged 6 months through 6 years from targeted areas will be screened.

Activities to assist with accomplishing this objective include:

- Provide universal lead screening in the targeted areas.
- All Hoosier Heathwise children in the state will be screened.
- ICLPPP consultants will provide assistance in the development of local screening sites and coordinate the medical services within a geographical area with the diverse cultural, racial, and socioeconomic groups.

- ICLPPP consultant will assist county/community lead task force groups and local health departments.
- ICLPPP will utilize the Statewide Screening Guidelines developed by the appointed State Advisory Lead Poisoning Prevention Task Force.
- ICLPPP will engage the support of an advocate group (Improving Kids Environment [IKE]) for the purpose of public awareness about the issue.
- ICLPPP will work closer with OMPP to improve the screening of children enrolled in EPSDT.

MCHS, CSHCS, and the Title V grantees assist the Communicable Disease Division in ISDH in completing the following performance measure. Major emphasis of this effort is to provide accurate public and private tracking of immunization records and data to avoid duplication and to improve access to immunizations to the public.

PM #05: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B

FY 2001 Performance Objective: The percent of children through age 2 who have complete immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase from 80% in FY 2000 to 81% in FY 2001.

Activities to assist with accomplishing this performance objective include:

- Free vaccine (both VFC and 317) is provided to all MCHS sites providing immunization service to children. Immunizations are provided on site.
- All MCHS and CSHCS grantees providing enabling services (prenatal and family care coordination) will facilitate clients into obtaining appropriate immunizations for children.
- MCHS will participate in discussions regarding the feasibility of developing an Immunization Registry in Indiana.
- IFHL will continue to provide education and referrals to callers on immunizations.
- MCHS grantees providing immunizations to more than 25 children in the 19-35 month old age group will receive a Clinic Assessment Software Application (CASA) yearly to determine their immunization rate of this age group.

Through a States System Development Initiative (SSDI) grant obtained for FY 2000-2001, MCHS is trying to develop a system to collect data on sealant utilization by third grade in Indiana. Currently, only the Behavioral Risk Factor Surveillance Survey provides interim data

on dental sealants. Baseline information was determined through an in-mouth survey done in the early 1990s. It is difficult to project or to estimate the outcome until a more regular and reliable system is in place in 2002. Title V supports the community-based pit and fissures sealant program, initiated in 1994. The program's objectives include (1) promoting the use of sealants throughout Indiana to promote reaching the 2000 national health objective of 50% of third grade children will be protected by sealants, and (2) promoting the cooperation of Indiana dentists, dental hygienists, and dental assistants in the community dental health programs.

PM #07: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

FY 2001 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will be maintained at 30% in FY 2001.

Activities to assist in meeting this objectives include:

- Oral Health Services will continues its on-going community-based dental sealant program that assists communities in setting up community sealant sessions.
- MCHS projects will screen for or inquire of clients whether their children have sealants.
- MCHS will educate clients as to the preventive health aspects of dental sealants and facilitate them into care where possible.
- Oral Health Services will continue to encourage dental providers to participate in Hoosier Healthwise.
- Oral Health Services dentists will maintain liaison with OMPP on dental health concerns.
- The IFHL will continue to provide referrals for dental services (sealants) as they are available.
- Oral Health Services will continue to promote the utilization of pit and fissure sealants to dental/dental hygiene students at IU School of Dentistry.
- Oral Health Services will develop and implement a plan to obtain annual data to support this performance measure.
- Oral Health Services will provide dental sealant information to targeted schools.

The development of an Injury Prevention Program for MCH and for ISDH has been a challenge since 1993. Presently the Director of the Childhood Lead Poisoning Prevention Program devotes 10% of her time on this topic. Efforts are being made to assign a full time staff to the development of an Injury Prevention Program and implement portions of the Childhood Hazards Law, (IC 16-41-40). While an injury prevention program has been listed

as an ISDH priority and is part of ISDH Applied Strategic Performance Plan, bureaucratic barriers have prevented a full program from being initiated.

PM #08: The rate of deaths to children aged 0-14 (as requested by Dr. Van Dyke's 6-21-2000 letter) caused by motor vehicle crashes per 100,000 children.

FY 2001 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease from 5.3 in FY 2000 to 5.2 in FY 2001.

Activities to assist in accomplishing this objective include:

- All MCHS projects will educate on safety and injury prevention issues including the use of auto safety seats and booster safety seats.
- Develop a resource directory of available safety programs.
- Survey all state agencies with injury programs and databases.
- Develop a plan for a childhood injury prevention program that will implement the Childhood Hazards Law.
- Maintain linkage with safety and injury prevention groups throughout the state and nationally.
- Implement the planned infrastructure for Traumatic Brain Injury developed through an MCHB grant in FY 2000.

3. Children with Special Health Care Needs

Sickle Cell Program: The Sickle Cell program is mandated by Indiana law. The program director receives referrals from the NBS Program. This program provides prophylactic antibiotics for infants diagnosed with sickling disorder and encourages enrollment into CSHCS. In addition, five community-based sickle cell programs provide genetic counseling and outreach for affected families. This program also funds the Indiana Hemophilia and Thrombosis Center to provide physician and health care practitioner education in hospital emergency rooms and targeted at-risk counties around the state. This center also provides outreach for 31 Amish hemophiliac patients, 28 hemophilia carriers, 8 von Willibrands, and 7 other rare diseases in northern Indiana to provide nursing services and annual medical clinic and blood clotting factor concentrate. In addition, the center is funded to facilitate dental services to the Amish. Hemophilia program pays annual premiums for health insurance for high-risk clients, Indiana Comprehensive Health Insurance Association, for eligible patients with severe or moderately severe blood clotting disorders, including hemophilia and von Willebrands disease. Currently, there are 38 client in this program.

Genetics Disease Program: The Genetic Disease Program has three primary goals: (1) To educate professionals and consumers about genetic disorders and available services; (2) To educate families and children with genetics disorder or birth defects; (3) To assure equal access to services regardless of socioeconomic status. The MCHS Genetics Consultant provides consultation and technical assistance to five Title V funded regional genetics clinics, the Indiana Congenital Hypothyroidism Follow-Up Program, and for the Statewide Program for the Detection and Management of Inborn Errors of Metabolism at Clarian's Riley Hospital for Children. The five regional clinics provide genetics counseling and testing, prenatal diagnosis, education for health care providers and the public, and coordination of referrals for consultation. Enhanced coordination between Healthy Start in Lake County and the genetics clinics has occurred with the implementation of a genetics screening tools used by the Healthy Start staff to identify at-risk clients for referrals.. MCHS Genetics Program Director provides educational outreach and consultation with health care providers to improve coordination of needed services. A quarterly newsletter is mailed to 5,500 individuals and agencies. Currently, as one of eight states to receive a grant from the National March of Dimes, the program director in conjunction with Indiana March of Dimes is facilitating the opportunities to use the *Genetics and Your Practice* curriculum to educate primary care providers. Also a Genetics Advisory Committee is being convened. (See p. 29)

ENABLING SERVICES

1. All targeted population (Pregnant Women, Mothers, and Infants; Children; and Children with Special Health Care Needs)

Enabling Service Activities Provided by Direct Health Service Grantees: Indiana MCHS clinic standards for MCHS-funded prenatal, child health, and family planning services include the requirement for appropriate professional staff to provide comprehensive services beyond just medical care delivery. To have social service and nutrition professional staff available to the clients to provide psycho-social needs assessment and intervention or referral and in depth nutritional assessment and intervention has been recommended for all direct health service grantees. These staff provide many of the enabling services such as case management activities including coordination of families with local Medicaid, WIC, transportation, and family support service. All clinics do their own outreach marketing of their services. Many clinics that have clientele who do not speak English hire staff who can assist in translation. All clinic professional staff provide age and health condition appropriate health education and safety education.

Case Management: Family care coordination, which by MCHS definition includes prenatal care coordination, CSHCS care coordination, Riley Hospital Newborn Follow-up, First Steps service coordination, Healthy Families Indiana family support program, etc., is an enabling service that provided service to all three populations. A past priority for Indiana MCHS has been to design a way to prove the effectiveness in improving health outcomes of this labor-intensive service at least within the MCHS and CSHCS projects. With the new data systems of MCSH and CSHCS, reports should be available to begin to evaluate these programs for the FY 2000 annual report.

2. Pregnant Women, Mothers, and Infants

Health education and support: Smoking cessation and reducing teen smoking is an ISDH and state of Indiana priority. $35 million of the Tobacco Settlement is to be used for smoking cessation efforts. It has long been an MCHS priority, due to the negative impact the smoking behavior has on pregnancy outcomes. MCHS has administered the Prenatal Substance Use Prevention Program (PSUPP) for many years. This program has expanded twice in the last two years to provide services in 8 clinics that serve pregnant women in 19 counties.

All MCHS grantees have staff trained in smoking cessation activities and continue to use a protocol to ask all clients about smoking habits and indirect smoke exposure. The new data system is able to collect and report on the smoking exposure of MCHS grantee clientele. Client education and support in changing the smoking habit or smoke environment are offered. Hoosier Healthwise also reimburses professionals for smoking cessation sessions. MCHS grantees are to monitor smoking change of prenatal clients. However, because the enabling service of smoking cessation should be more widely available in FY 2001, MCHS has elected to broaden the scope of performance to include statewide prenatal population.

SP #11: The percent of live births to mothers who smoke.

FY 2001 Performance Objective: Decrease the percent of mothers of live births who smoke during CY 2001 from 20.7% in CY 2000 to 20.4% in CY 2001.

Activities that will impact accomplishment of this objective include:

- PSUPP director will facilitate the expansion of PSUPP services in prenatal clinics.
- Require MCHS project staff to discuss smoking cessation with each family or prenatal client that is exposed to smoke and offer or refer to smoking cessation sessions.
- MCHS direct service and enabling projects will collect smoking cessation data on prenatal clients and primary and second hand smoking data on pediatric and family care coordination clients.

- State MCSH and CSHCS staff will participate in any agency-wide smoking cessation educational efforts.
- MCHS will participate in the Indiana Tobacco-Free Partnership supported by ISDH.
- MCHS will support as needed the ISDH media and school-based education programs.

Outreach, Case Management: Through the Indiana Healthy Pregnancy/Healthy Baby Campaign, free pregnancy testing is used as a marketing tool for local agencies providing services to women of childbearing age. These agencies provide enabling services (referrals and education) to their clients whether the tests are positive or negative. This program is population-based with no income limitation on its use and it impacts the teen pregnancy performance measure and all of the perinatal risk factor measures.

3. Children

Education: The Indiana RESPECT Community Grant Program has provided Federal Sexual Abstinence Education grants and State Adolescent Pregnancy Prevention Education grants. These grantees will be providing direct contact with the children for this enabling service. The Tar Wars smoking education curriculum also works through the schools.

4. Children with Special Health Care Needs

Case Management: During FY 2000 grantees providing community-based CSHCS care coordination continued to be expanded (see p. 33). These care coordinators ensure that the CSHCS clients have a primary and specialty physician and a dentist within 45 days of being enrolled in the program. They also facilitate any other services the family/child might need.

MCHS funds, through the Indiana Hemophilia and Thrombosis Center, Inc. (IHTC), a statewide outreach program for Amish persons with bleeding disorders. The program provides home visits and health care services. All members of the Amish Hemophilia community are invited to an annual outreach clinic. Factor concentrate is provided to 31 Amish patients with diagnoses and 28 carriers of hemophilia, 8 von Willibrands and 7 other rare diseases who require services.

During FY ’99 a Broad Agency Announcement was issued through First Steps to select a provider enrollment vender. A joint provider enrollment contract was developed and is now used by both CSHCS and Firsts Steps in enrolling providers for the 0-3 population. This should expand the provider matrix base and options for clients to have a local medical home.

The Indiana Integrated Services SPRANS grant leadership has disseminated a training video for physicians.

The limiting factor in Indiana's ability to achieve this performance measure is in the inability to determine accurately the population of children with special health care needs and then documenting those that have a "medical home". As the database in both CSHCS and First Step become more interfaced, perhaps this data will be more complete. The federal survey for CSHCN should also provide necessary information.

PM #03: The percent of Children with Special Health Care Needs (CSHCN) in the State who have a "medical/health home".

FY 2001 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be maintained at 87.8% in FY 2001.

Activities that will impact the accomplishment of this objective include:

- Implementation of a data collection/reimbursement system for CSHCS that will be integrated with First Steps SPOE/CRO system to identify enrolled CSHCN with medical homes.
- Provide professional training through a four-part video to physicians and their staff who provide primary care services to CSHCN.
- Continue to outsource provider enrollment to include outreach to providers.
- All CSHCS care coordinators and First Steps service coordinators will facilitate a "medical/health home" for all clients enrolled.
- The First Steps Neonatal Intensive Care Unit outreach referral system for the 0-3 population, that will link/enroll NICU babies/families into First Steps and possibly into CSHCS before discharge, will assist families into a medical home as part of the Individualized Family Service Plan (IFSP).

DIRECT HEALTH CARE SERVICES

1. All Targeted Populations (Pregnant Women, Mothers, and Infants; Children; Children with Special Health Care Needs)

In FY 2000 of the 67 grants issued (excluding Indiana RESPECT), 40 or 60% of them provide direct health care service to fill a need or service gap. Indiana MCHS relies on local direct health and enabling providers to impact the risk factor performance measures. CSHCS reimburses health care providers for services rendered to their clients.

2. Pregnant Women, Mothers and Infants; Children

Indiana has no specific performance measures for pregnant women, mothers and infants, or children in the direct service category.

3. ***Children with Special Health Care Needs***

During FY 2000, CSHCS has completed a pilot study with SSI to develop a system to ensure that all SSI recipients who are eligible for CSHCS are enrolled. This system is to be established statewide before the end of the fiscal year. The pilot study worked with SSI in Marion Co. For three months SSI forwarded the applications of new SSI recipients to a CSHCS consultant who followed up with the client. SSI also included in their denial letter information on CSHCS. Of the 52 referrals, 19 were eligible for CSHCS and only 4 completed an application. Because Hoosier Healthwise/Medicaid coverage is not automatic for SSI beneficiaries in Indiana, CSHCS covers the primary medical and specialty rehabilitative services related to the diagnosis of dually enrolled children. For those SSI children covered by Hoosier Healthwise/Medicaid, CSHCS will cover some services not covered by Medicaid, especially those related to diagnosis. The new computer system for CSHCS and SSI should allow for the data for NPM #01 to be collected.

The NBS Program provides testing for the total population (see p. 18). Through a grant NBS also facilitates families who meet the income requirements in receiving metabolic infant formula supplements for their special needs infant.

PM #01: The percent of SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

FY 2001 Performance Measure: During FY 2001, a system will be implemented to ensure all eligible SSI beneficiaries are enrolled in CSHCS if they are eligible. More accurate baseline data will be determined.

CSHCS activities associated with the accomplishment of this objective include:

- Develop an MOU with SSI in FSSA, which includes the annual sharing of this data.
- A system will be implemented statewide to educate SSI recipients and applicants about CSHCS.
- Data will be collected by CSHCS and the SPOE regarding enrollment in SSI.

The CSHCS program enrolls children with eligible diagnoses whose income is below 250% of the federal poverty guidelines. All applicants must apply to Hoosier Healthwise/ Medicaid and identify any medical insurance that the family may have. CSHCS will pay for primary care services provided in the physician's office not covered by another insurance source. CSHCS

will also pay for specialty care and hospitalization related to the diagnoses for which the child is eligible for the program. Care coordination is provided for all enrolled families.

PM #02: The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

FY 2001 Performance Objective: The Indiana CSHCS Program will continue to provide 8 of the 9 services listed in NPM #02.

CSHCS activities to accomplish this objective include:

- Develop an agreement with OMPP to have local care coordinators receive target case management reimbursement for CSHCS care coordination.
- The Director will participate/chair the Advisory Committee for CSHCN to the Child Health Policy Board.

Children enrolled in CSHCS with a diagnosis of asthma compose one of the largest groups of clients. Environmental and behavioral issues play a large role in controlling this disease. It was chosen because it is related to other environmental issues like lead poisoning and improvement in performance will result in decreased spending.

SP #10: The rate per 10,000 for asthma hospitalization (ICD9 Codes: 493.0 – 493.9) among children less than five years old.

FY 2001 Performance Measure: During FY 2001 baseline data for this measure will be set.

Activities to assist in accomplishing this objective include:

- CSHCS state consultants will explore how other states have approached the problem of the increasing prevalence of asthma.
- CSHCS state consultants will liaison with asthma professional and consumer groups.
- CSHCS state consultant will review educational materials about asthma.
- CSHCS state consultant will develop a plan to provide education to children enrolled with a diagnosis of asthma.
- Work with ERC to develop baseline data on asthma in children from the Hospital Discharge data, BRFSS data and mortality data.
- Work with IDEM coalition to increase awareness of asthma problem and decrease impact of asthma on Indiana children. So far the IDEM coalition has identified data, schools, and the environment as areas of concentration. The Coalition includes participants from state agencies, Head Start, American Lung Association, environmental coalitions, local

health departments and others. ISDH representatives include MCH Medical Director, Director of ISDH Data Analysis team, and CSHCS Consultant.

4.2 Other Program Activities

Most activities of the Pyramid are addressed in Section 4.1. Some form of all the activities listed in the Pyramid are provided by ISDH, MCHS, or CSHCS. The following activities may need further explanation.

INFRASTRUCTURE BUILDING/Information Systems: Throughout this document reference has been made to the collaboration between MCSH and CSHCS and ISDH External Information Systems (EIS) in completing the development and implementing the new data collection systems. This effort is still in process and will be completed before the end of the fiscal year. The data warehouse for all ISDH also continues to be developed.

ENABLING SERVICES/Respite Care and Purchase of Health Insurance: These activities are available through state sources other than CSHCS. Respite care is available through the CHOICE Program and the Medicaid waiver program in Indiana. CSHCS offers insurance coverage to hemophiliacs on the program through the Indiana Comprehensive Health Insurance Association. This insurance does not cover respite care.

Other programs that need to be addressed in this section follow:

The Indiana Family Helpline has been discussed in this plan (see p. 15). It is an integral part of all but the direct medical service level of the Pyramid.

Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) is a service that is a part of the Hoosier Healthwise (Medicaid) program in Indiana. There is no special enrollment for clients or providers. If a provider performs an EPSDT complete physical and screens, the provider requests reimbursement for the complete physical using specific codes. Reimbursement for EPSDT is at a higher rate than for a regular office visit. Unfortunately, in Indiana EPSDT exams are not well documented by the providers. MCHS projects serving children offer the EPSDT exam. MCHS Child Health Supervision Guidelines are being offered to OMPP and Hoosier Healthwise providers as a template for including EPSDT exams in the child health visit. At least one of the Hoosier Heathwise contracted managed care organizations has used and distributed the MCHS Child Health Supervision Guidelines to its providers.

WIC at ISDH has the same director as CSHCS and participates collaboratively with both MCHS and CSHCS in population-based education efforts. Efforts to further integrate the programs have not had priority recently.

Coordination with Social Security Administration, State Disabilities Determination Services Unit occurs in conjunction with Supplemental Security Income.

Vocational Rehabilitation, a program for adults and young adults (>16 years) with disabilities that assist them in determining career goals, is used by CSHCS care coordinators as a referral for young adults in CSHCS during transition. Eligibility for CSHCS is available to children up to the age of 21 years (except for people with cystic fibrosis). Vocational Rehabilitation can assist with this transition. IPIN, with CSHCS grant monies, has created a brochure for teens explaining this service.

4.3 Public Input [Section 505(a)(5)(F)]

The State Title V program solicited public comments for this application by distributing a draft to selected members of the MCHS/CSHCS Advisory Council and interested parties. These individuals were encouraged to review the draft and provide comments. Copies of the draft application were made available upon request and were also accessible in government document sections of thirteen public libraries across the state. A legal notice was placed in all major newspapers in the state alerting readers to the placement of the documents.

4.4 Technical Assistance [Section 509 (a)(4)]

See Form 15, Section 5.8

Form 15, Section IIA

MCH is reorganizing its data section into Data, Assessment and Evaluation Team. Technical assistance to help MCH staff and our partners identify the most important elements and how to collect, analyze and disseminate information on an ongoing basis would help MCHS set a realistic workplan for the section.

Form 15, Section IIIB

Because the CSHCS Program is re-tooling it's quality assurance and control practices, technical assistance is required. The technical assistance will insure that CSHCS consultants and their grantees who have limited knowledge in the quality improvement field can implement the Quality Improvement program.

V. SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see "Needs Assessment")

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, "What does the State need to achieve the results we want?"

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. *[Title V Sec. 501(b)(3)*]

Care Coordination Services for Prenatal Clients - also prenatal care coordination (See Case Management Services).

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous year's MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. *(Title V Sec. 501(b)(4)*

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - *(For budgetary purposes)* Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. *(For planning and systems development)* - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under "Pregnant Women," "Infants," "Children with Special Health Care Needs," "Children," and "Others."

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and education. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance,

standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care.*

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see "Types of Services")

Measures - (see "Performance Measures")

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is to aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also "Performance Objectives")

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDs monies, CISS funds, MCHS targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, "Why does the State do our program?"

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: "The rate of women in [State] who receive early prenatal care in 19__." This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies <u>other</u> than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under “Infrastructure Building”, “Population Based Services”, “Enabling Services” and “Direct Medical Services”.

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students. (Indiana conducts surveys bi-annually.)

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis

of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended,

(P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

(a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
(b) Establishing an ongoing drug-free awareness program to inform employees about-
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace,
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
(d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying

undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law doe not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

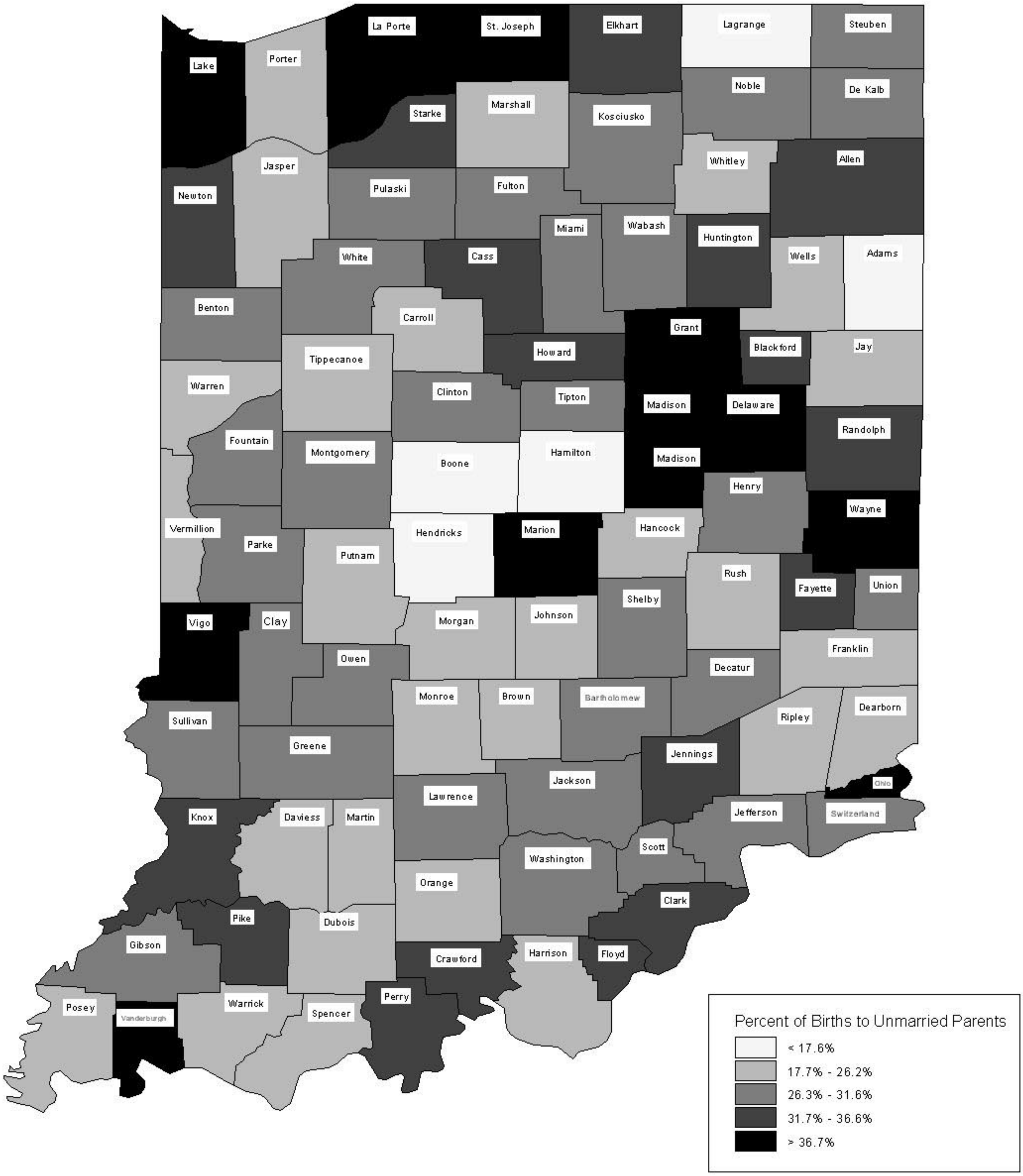
By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

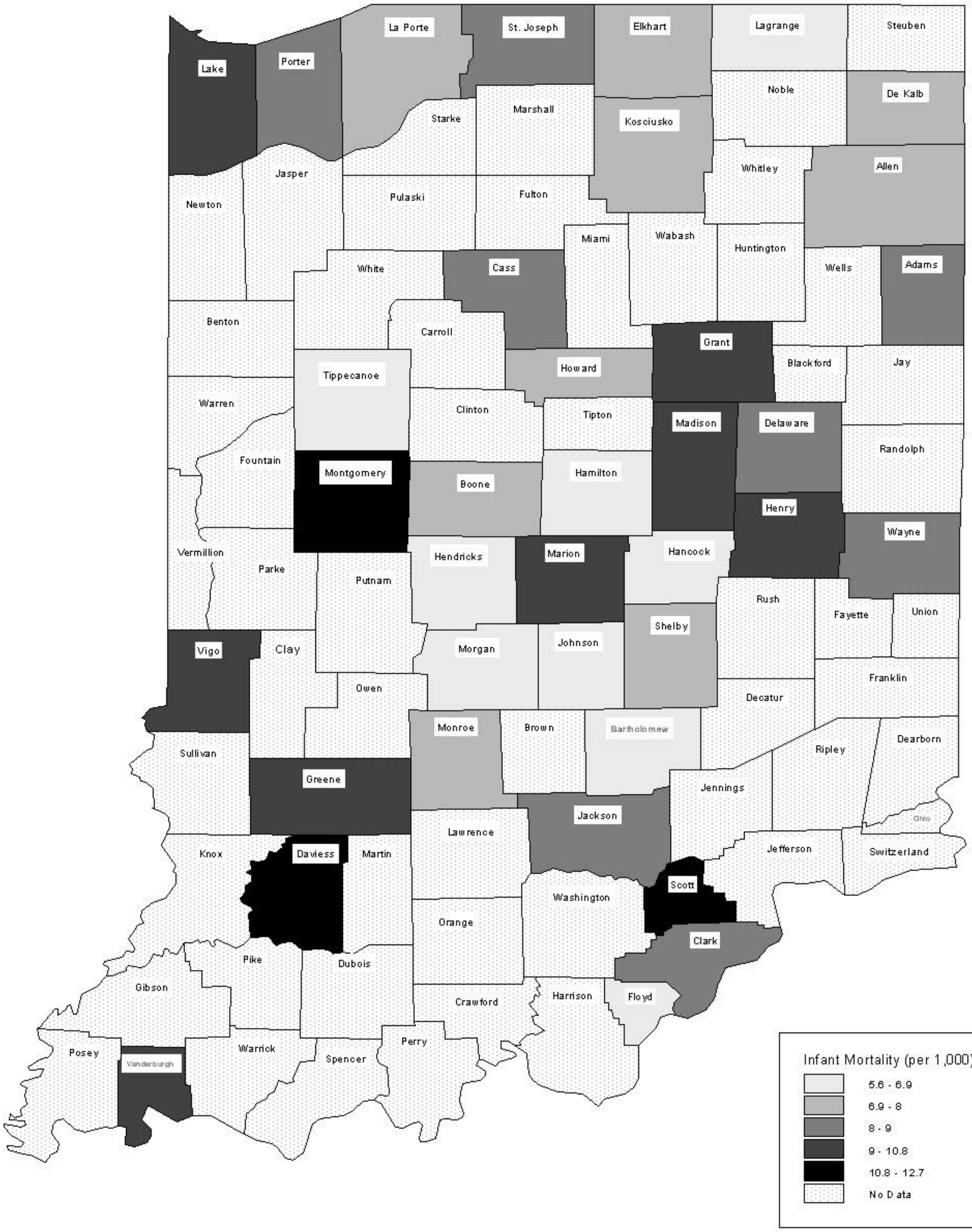
MAP A

Percent of Births to Unmarried Parents
1998



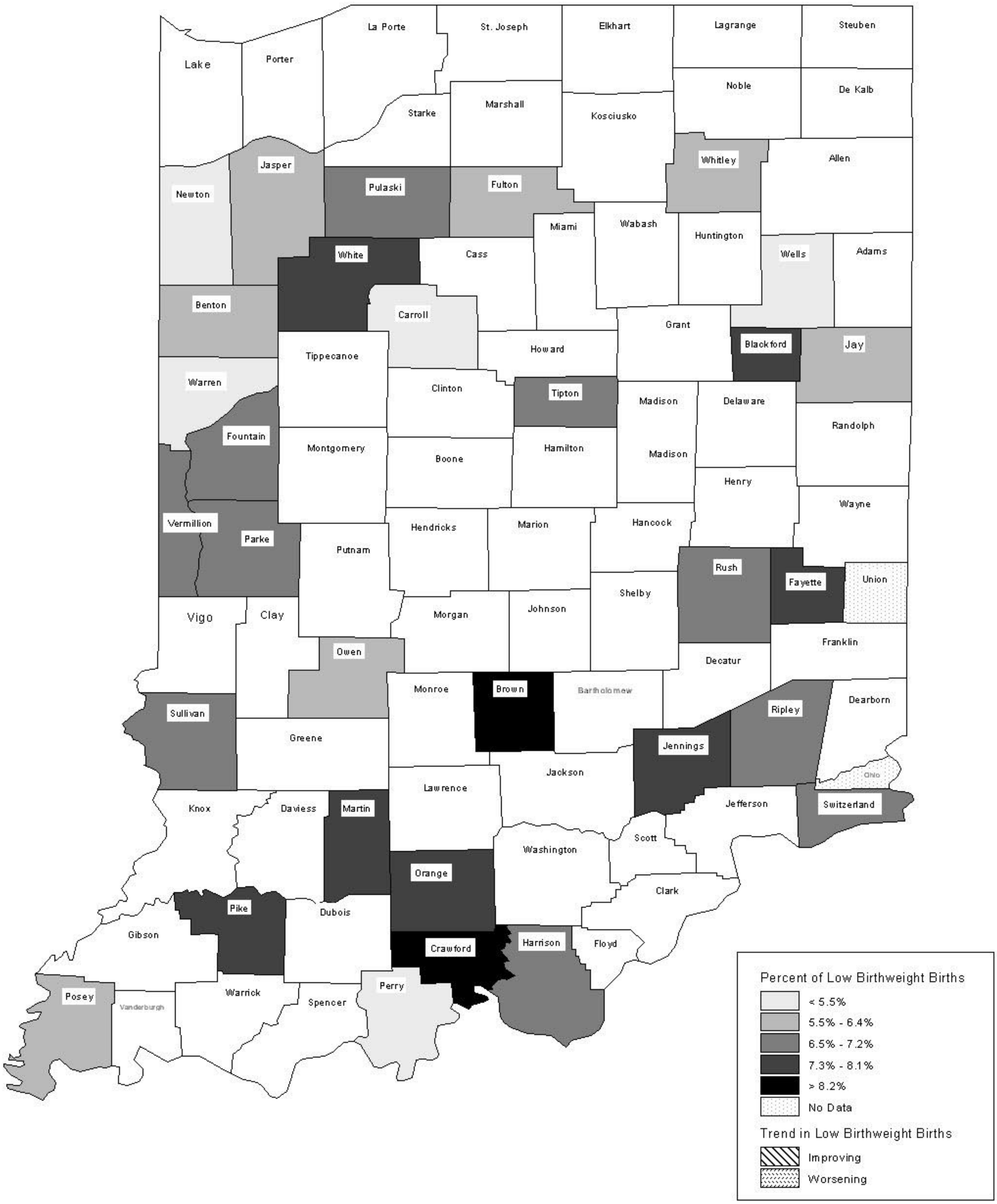
MAP B

Infant Mortality Rate (per 1,000 births)
Aggregate 1994-1998



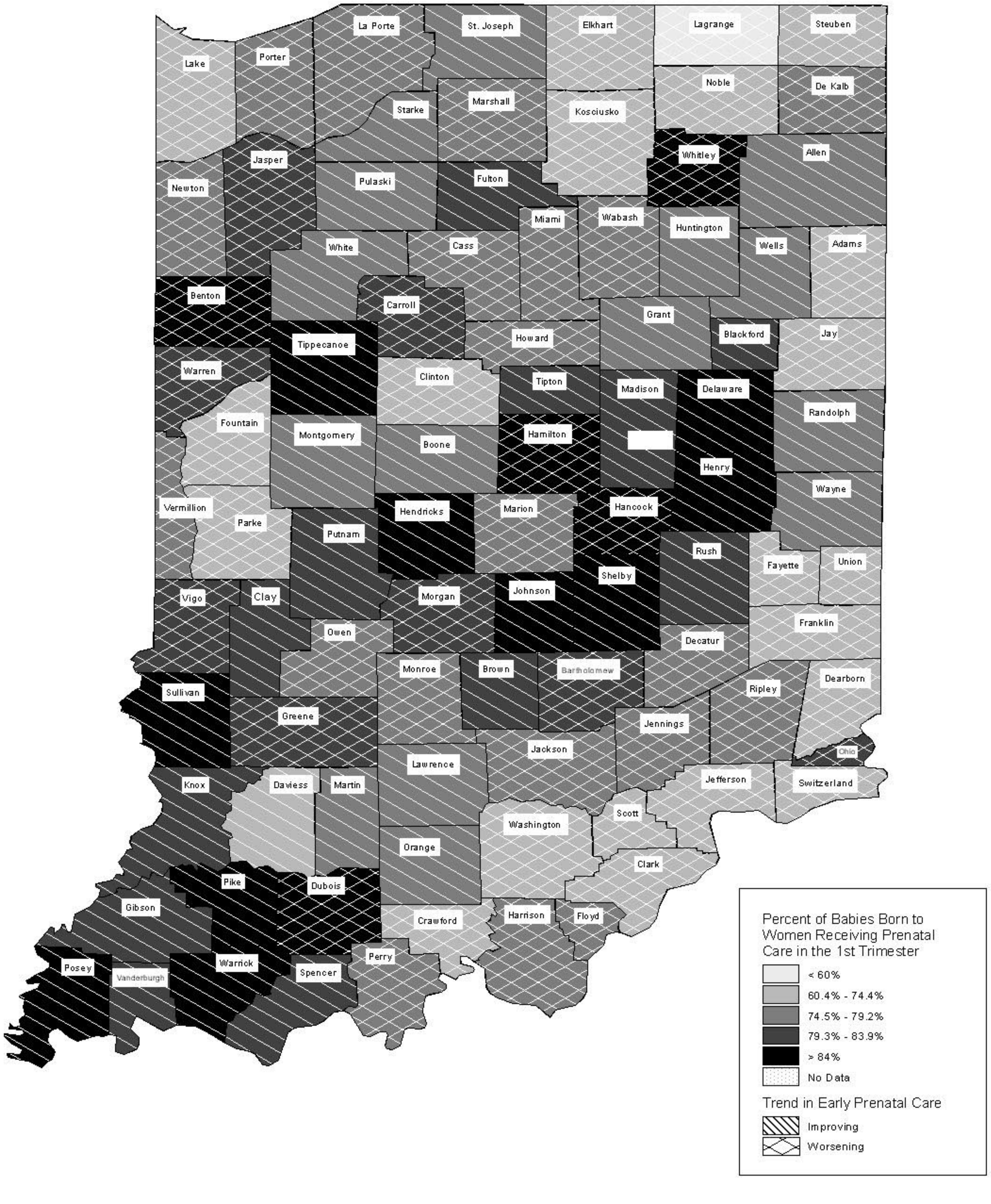
MAP C

Percent of Low Birthweight Births
Aggregate 1994-1998



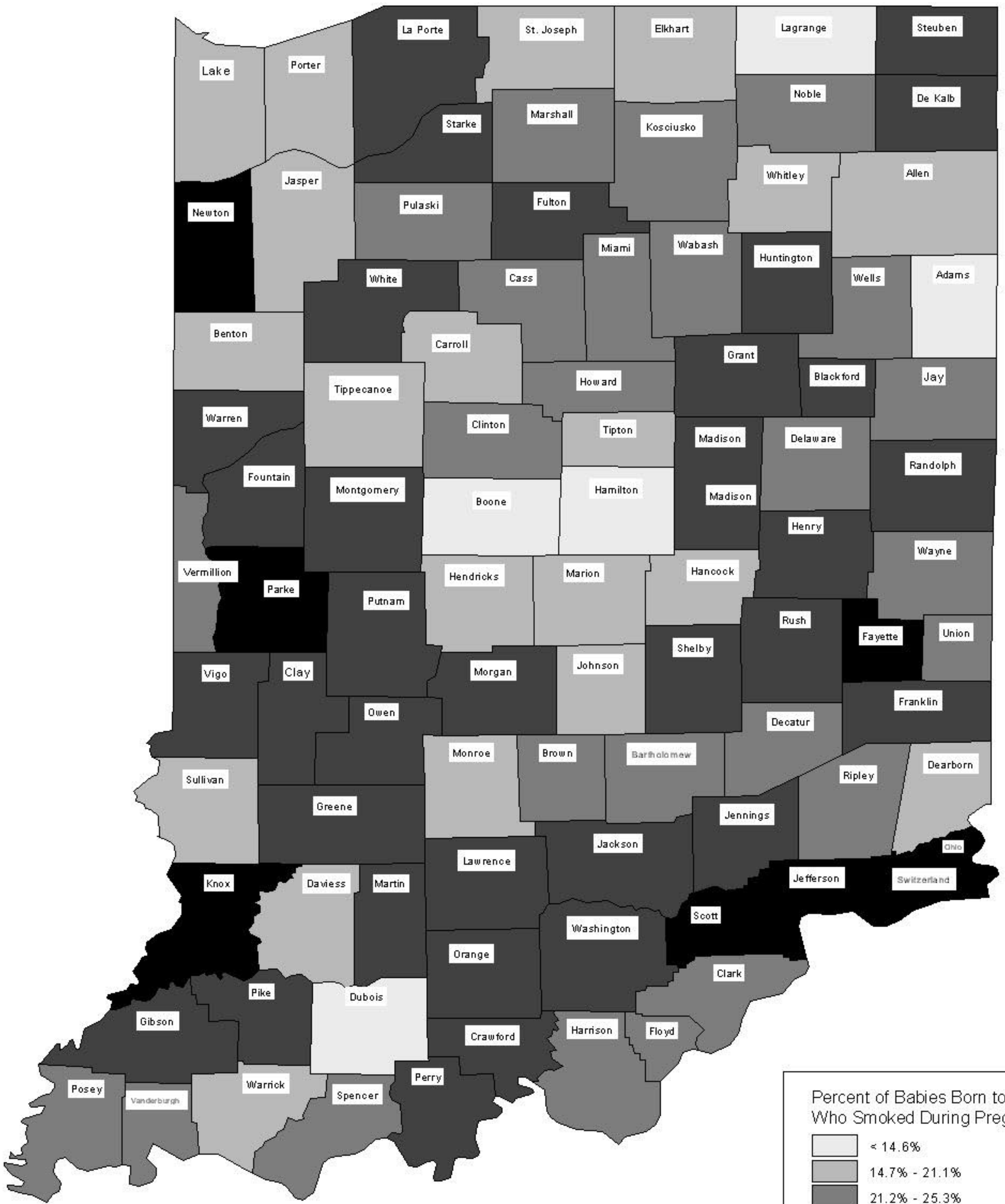
MAP D

Percent of Babies Born to Women Receiving Prenatal Care in the 1st Trimester 1994-1998 Aggregate



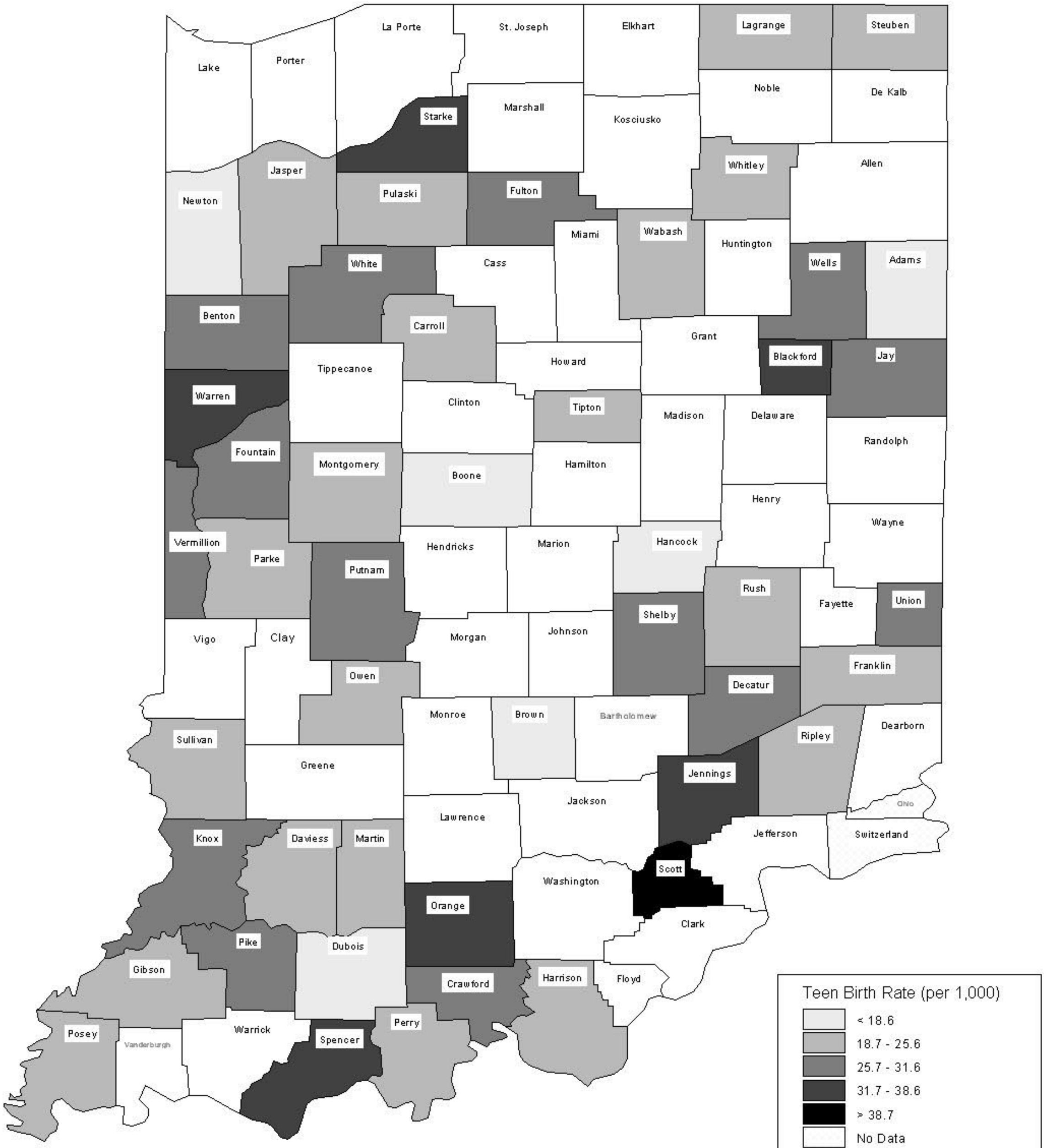
MAP E

Percent of Babies Born to Women Who Smoked During Pregnancy 1998



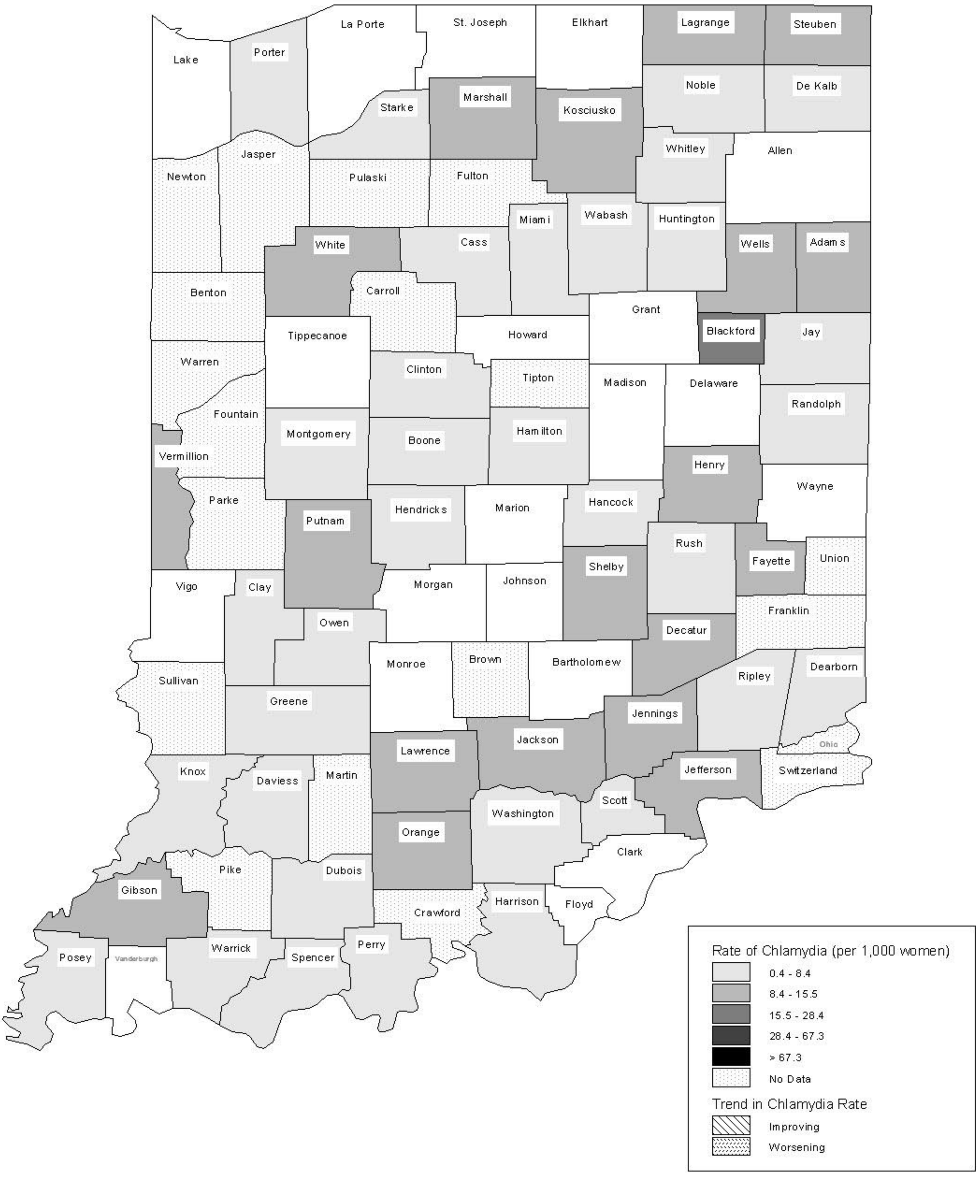
MAP F

Teen Birth Rate (per 1,000 births)
Women 15 - 17 years old
Aggregate 1994-1998



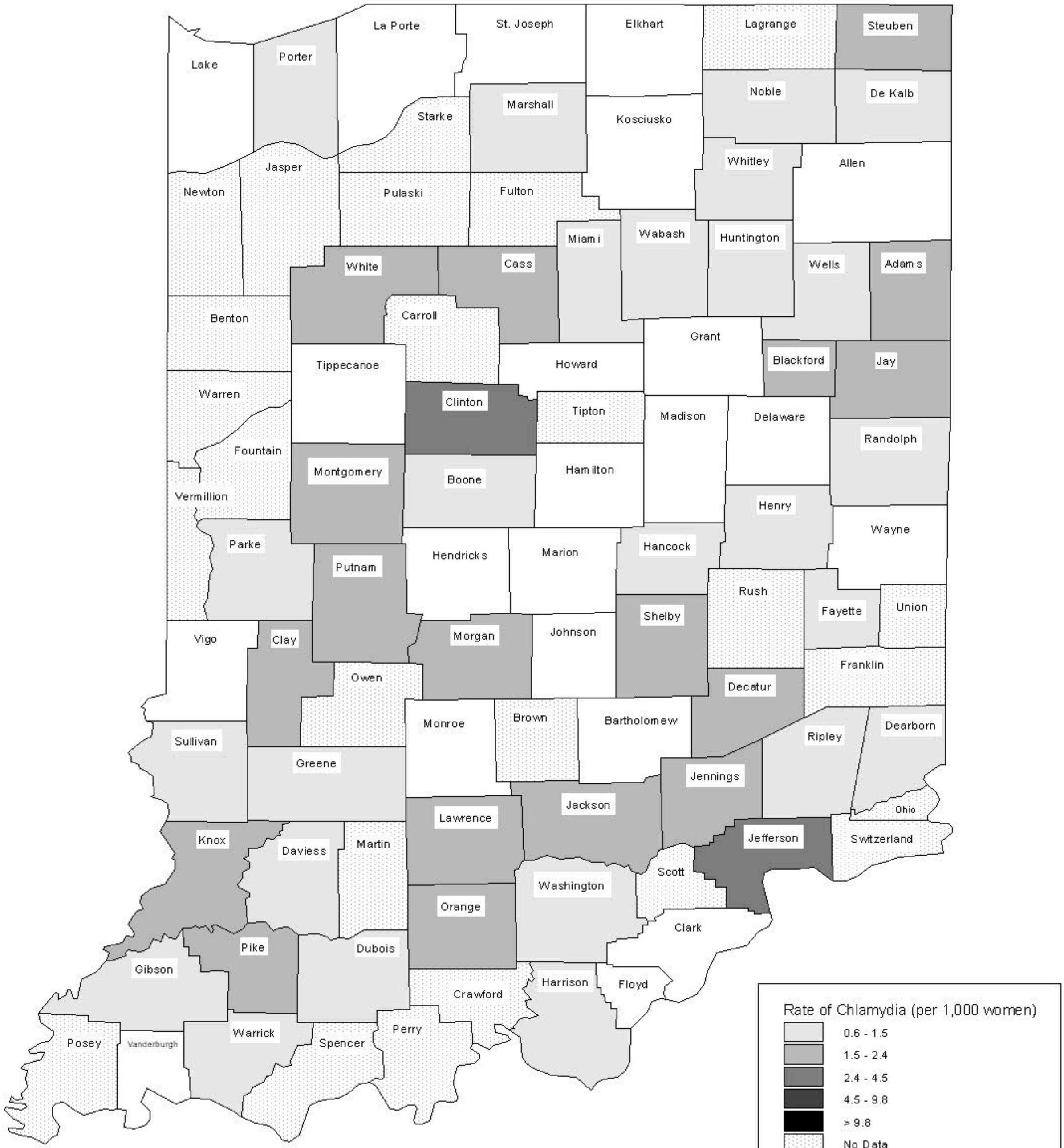
MAP G

Rate of Chlamydia (per 1,000)
Women 15 - 19 years old
Aggregate 1994-1998



MAP H

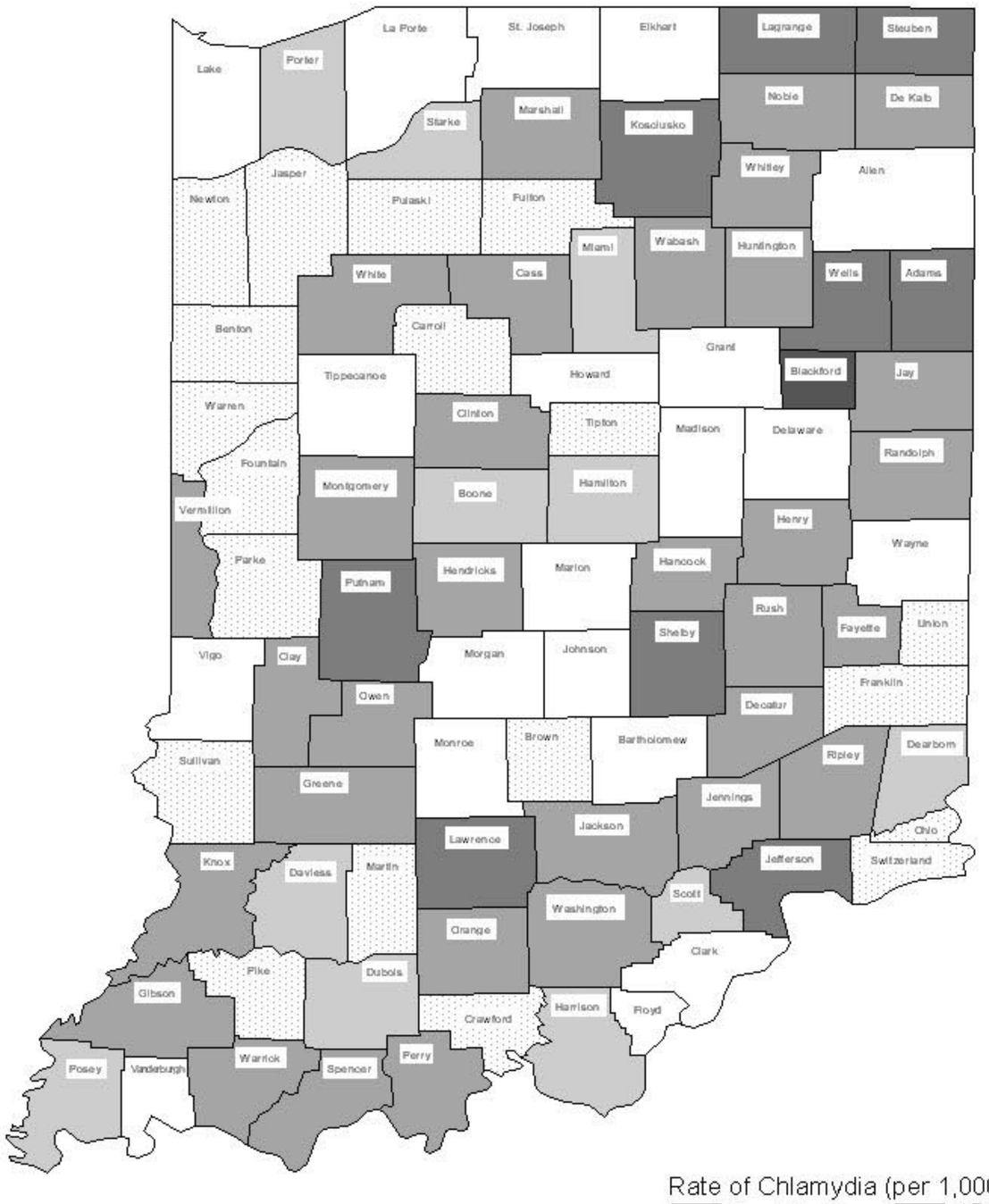
Rate of Chlamydia (per 1,000)
Women 20 - 44 years old
Aggregate 1994-1998



MAP I

Chlamydia Rates Aggregate 1994-1998

Rate of Chlamydia (per 1,000 women)
Women 15-19 years old



Rate of Chlamydia (per 1,000 women)
Women 20-44 years old

Rate of Chlamydia (per 1,000 women)

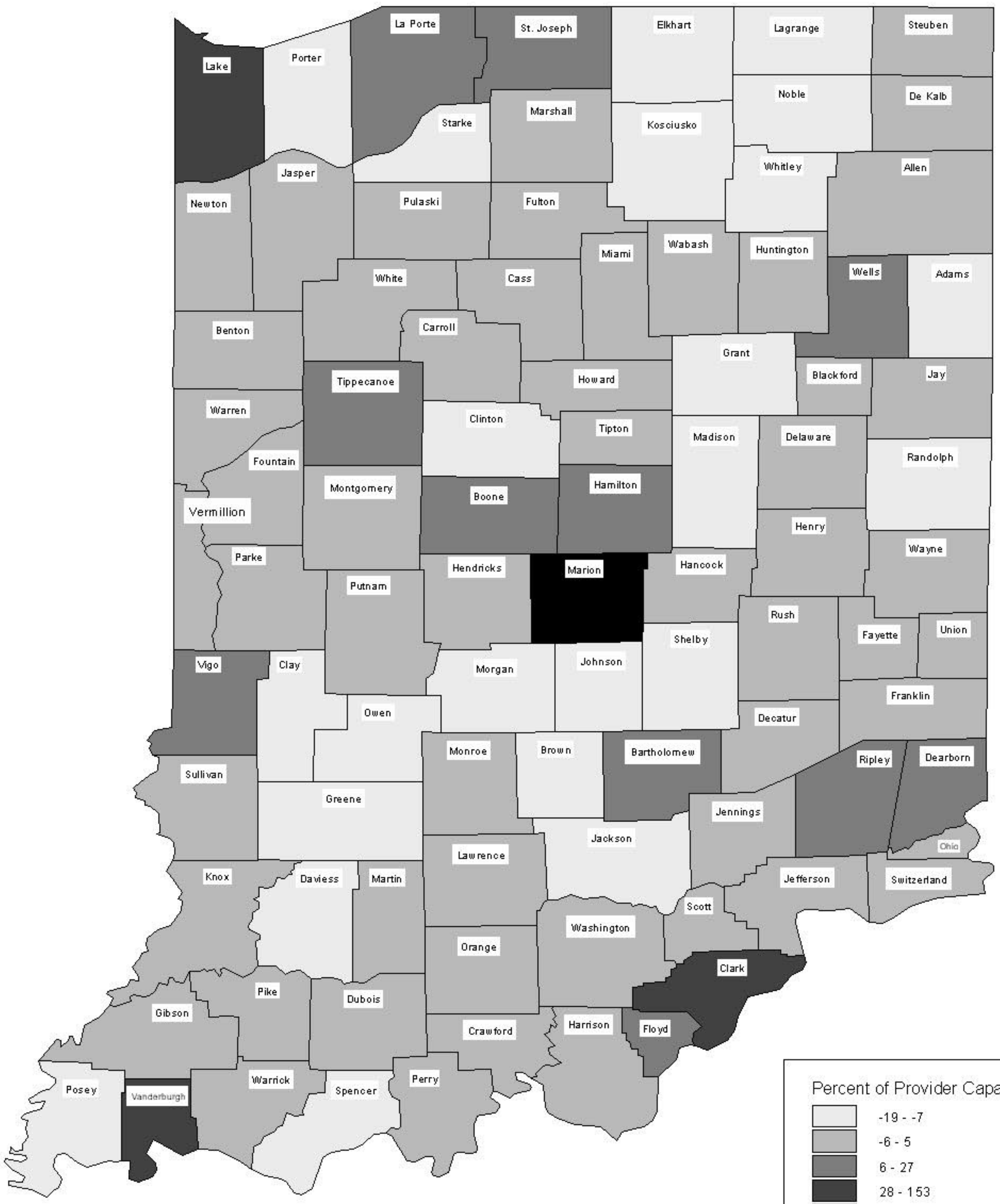
- 0 - 1.9
- 2 - 5.9
- 6 - 9.9
- 10 - 14.9
- 15 - 29.9
- 30 - 59.9
- > 60
- No Data

Trend in Chlamydia Rate

- Improving
- Worsening

MAP J

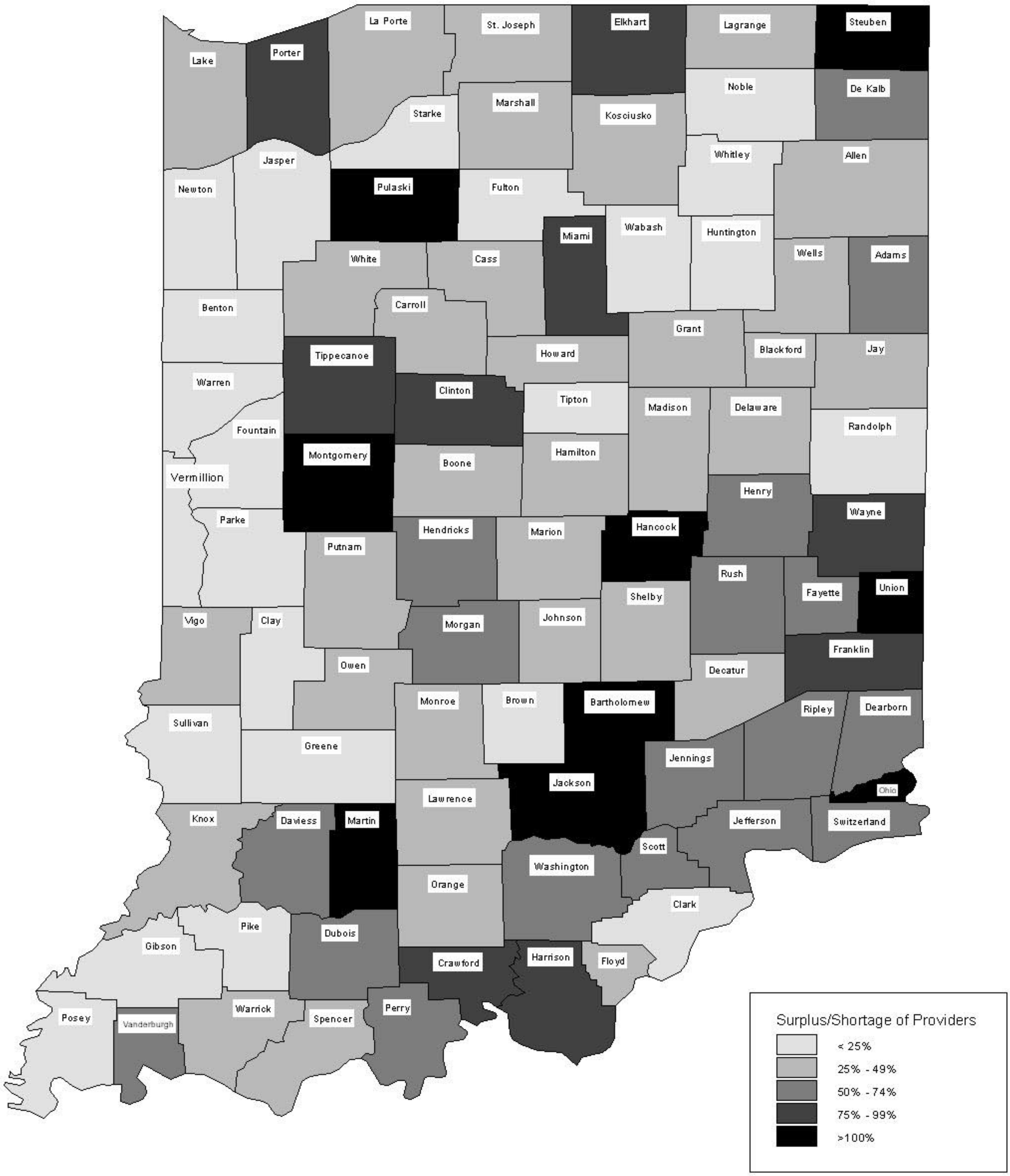
Primary Care and Obstetrical Physician Need 1998 (using 1:1700 ratio)



Note: Surplus/shortage of physicians is based on an ideal ratio of 1 physician to 1,700 population.

MAP K

Pediatric Hoosier Healthwise Enrollment as a percent of Provider Capacity, 1998



MAP L

Public Health Services in Indiana Counties