

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: IN

APPLICATION YEAR: 2005

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

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

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

Assurances and Certifications are kept on file at the Indiana State Department of Health both in the Finance Department and in the office of the MCHS Grants Coordinator with the hard copy of the grant application. They are available upon request.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

The State Title V program solicited public comments for this application by placing an Executive Summary of the FY 2004 application on the MCH web page and by distributing the Summary to selected members of the MCHS/CSHCS Advisory Council and other interested parties. These individuals were encouraged to review the Executive Summary and provide comments. Copies of the Executive Summary 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.

ISDH will post the 2005 executive summary on the MCH web page and distribute the summary and the application electronically to the membership of the MCSHC Advisory Committee and to all public libraries in the State. All public comments are recorded to along with ISDH MCSHC response and all comments and responses are used during the preparation of the application for the following year. ISDH will announce the web location of the executive summary by legal notices placed in all major newspapers in the state.

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

***/2005/ Indiana's Maternal and Child Health Service staff suggests that this application be read in its entirety (rather than just reading the "/2005/" sections) to assist with clarity and flow in the conversion from the old grant guidance to the new. //2005//***

/2002/ Since FY 2001 began, three major events have occurred that may impact the health needs of the population of Indiana and the priorities of the Title V program within the State's health care delivery environment--the Census 2000 population figures, the slowing of Indiana's economy, and Indiana's legislative session. These events are interrelated. Based on Census 2000 figures, Indiana lost a seat in the House of Representatives and has an increase in minority populations. Because of a slowed economy, employee layoffs and business closures that jeopardize Indiana's state revenue base and individual incomes of Indiana's citizens have occurred. The unemployment rate has begun to increase. The three issues that the legislative session and the Governor focused on were: redistricting of the State House and Senate districts and the federal House districts; the two-year budget with no tax increase; and the control of the Indiana Health Coverage Programs (IHCP) (Medicaid) costs which are currently about 20% of the total state budget due to the expansion of eligibility.

/2003/ During FY 2002, the major events that may impact the health and well-being of Indiana's citizenry seem to be affecting most states: bio-terrorism and the economy. Efforts to prepare the state's emergency personnel have continued since the September 11, 2001 attack with many ISDH personnel resources being focused on this issue. Indiana's state revenue has plummeted due to increased unemployment and job losses of the economic slowdown. In the short legislative session of 2002, the legislature chose not to address the need for both tax reform (due to property tax changes) and for increased revenue for the state to continue basic services. The governor called a special session in mid May so the legislature could address these issues. A compromise bill was enacted that touches both issues. However, not enough increased revenue was included. Voluntary furloughs of state employees have been offered with the possibility of mandatory furloughs. Federally funded employees are not exempt.

/2004/ The state of the State in FY 2003 has not changed. There is a recession in Indiana. The legislature passed a two-year budget that freezes Medicaid expenditures ( which may not be possible since it is an entitlement program) and prisons, but increases money for schools and an economic development package. The Governor may ask them to revisit the budget in January. //2004//

***/2005/ Governor O'Bannon died on September 13, 2003 and Lt. Governor Joe Kernan was sworn in as Governor. Governor O'Bannon was very interested in educational issues. Governor Kernan continues to co-chair the Education Round Table with State Superintendent of Education. //2005//***

/2003/ All state agencies have reviewed their budgets and cut budgets by 7% plus cut some line item programs in 2002. It is anticipated that there will be at least another 7% budget cut in 2003. A hiring freeze is in place and state employee raises have been withheld for 2002 and 2003. Indiana Health Coverage Programs (IHCP) (Medicaid) have implemented a plan to decrease the cost of their programs without jeopardizing services for women and children significantly. Budget reductions from ISDH and MCHS include the discontinuance of all programs associated with the Governor's Council on Physical Fitness, and the decrease in state funds for Indiana RESPECT (adolescent pregnancy prevention education programs), the Office of Women's Health (OWH), and the Office of Primary Care (community health centers). In addition, \$1.7 million of CSHCS state and county revenue was reverted to the State to ameliorate the shortfall. /2002/ As part of his effort to contain spending and because Indiana Health Coverage Programs costs are currently about 20% of the state's budget, Governor O'Bannon vetoed three bills that included increased Medicaid spending: one that blocked Medicaid spending cuts to nursing homes and required mandatory HIV testing of pregnant women; one that required Medicaid to cover physician services in an emergency room; and one that would have prohibited Medicaid from limiting access to mental health drugs. Other changes in the Medicaid/SCHIP (State Child Health Insurance Program) programs to curtail rising costs may be forthcoming. Currently, there are no plans to reduce children's health care services.

***/2005/ While Indiana's state revenues for FY 2004 were \$55 million higher than projected, the***

**state still has a budget shortfall of over \$1 billion. Budget cuts to RESPECT and the Governor's Council on Physical Fitness have not been restored. The hiring freeze remains in place although the State Personnel Office has allowed a 3% raise for all employees and has loosened restrictions for developing new staff positions. Personnel is allowing ISDH to convert a number of contract positions to full time state staff. //2005//**

/2001/ 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.)

/2002/ Based on Census 2000 figures, Indiana did lose a seat in the House of Representatives and has an increase in minority populations. Indiana's population, while increasing by 9.7%, did not increase as fast as that in some southern and southwestern states. From Census 2000, the total population of the State is 6,080,485 with 1,574,396 being children less than 18 years and 4,506,089 being adults greater than 18 years. This indicates an aging population--a decrease in the percentage of children in the population and an increase in the percentage of adults in the population--as compared to the 1990 Census (25.9% in 2000 and 26.3% in 1990 for children; 74.1% in 2000 and 73.7% in 1990 for adults).

/2002/ As anticipated, Census 2000 figures reflect a more diverse population than in the past. While the percent of minority populations grew by only 1% (11.5% in 1990; 12.5% in 2000), the Black population increased by 23.9% (includes population reporting Black as sole race and those reporting Black as one of several races). The Hispanic population increased by 117.2%, and other minority racial populations together (American Indian, Alaskan Native, Asian, and Pacific Islander populations reporting a single race) increased by 241.8%.

/2004/ A Census Bureau Report indicated that Indiana over-counted its population by 1.6%, second only to Minnesota in the nation. This may have impact on the proportion of minorities listed for Indiana by lowering it. //2004//

/2003/ Census 2000 data revealed that manufacturing jobs in Indiana dropped by 2.3% to 22.9% during the last decade and agriculture, forestry, fishing, hunting and mining jobs dropped by 1.5% during the same time period. While unemployment dropped 0.8% to 4.9%, since 2000, Indiana has lost about 52,900 jobs. Most jobs that are available are in the low paying service category. The 2000 Census data also revealed a poverty belt that runs from the east border to the west border in south central Indiana. Knox County had the highest level of families living below the poverty level at 11.6%. The employment crisis is an issue even as 3.8% more citizens are college graduates and 6.5% more are high school graduates.

**//2005/ Indiana's economy remains in recession in FY 2004. To date, the state is 112,000 jobs short of peak employment in FY 2000, leaving the state with 13.4% fewer jobs. Indiana's unemployment rate is 5.2%. //2005//**

/2001/ 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.

/2002/ Of the ten most populous cities in Indiana, three lost population (Gary, -11.9%, and Hammond, -1.4%, in Lake County; and Muncie, -5.1%, in Delaware County). This is probably due to loss of industry. Bloomington and Ft. Wayne grew by more than 10% (14.3% and 18.9% respectively). Terre Haute, Anderson and South Bend grew by less than 5% (3.7%, 0.5%, and 2.2% respectively). Indianapolis/Marion Co. grew at 6.7%, a much slower rate than its surrounding counties. Twelve counties had population losses. The counties with the greatest population growth are those surrounding Indianapolis/Marion County and eight counties in the northeast corner of the state (including the city of Ft. Wayne). Of the 15 counties with the largest populations, eleven were included

in the 24 high-risk counties targeted by Maternal and Child Health Services (MCHS) for 2002 grant expansion.

***//2005/ A study of population shift inside Indiana by the Indiana University School of Business indicates suburban counties are growing rapidly. Lake and Marion (urban) Counties have large influx of international immigrants replacing the domestic population migrating away from those counties. Marion County's population has remained stable but the number of foreign residents has increased while domestic residents have migrated out of the county. //2005//***

*//2001/* 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 White 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 infant mortality. *//2002/* In 1999, Indiana's overall infant mortality rate was 7.8. The White infant mortality increased from 6.3 in 1998 to 6.8 in 1999 while the Black infant mortality decreased from 17.1 to 17.0 respectively. The disparity improved (because White infant mortality increased) but remains 2-3 times higher for Blacks. *//2003/* In 2000, Indiana's overall infant mortality rate dropped to 7.7. The White infant mortality rate dropped to 6.7; the Black rate dropped to 15.9; and the Hispanic rate was 5.2. The Black/White infant mortality disparity dropped from 2.5 to 2.4 with some improvement in both groups from the previous year. However, disparity ratio improvement is not adequate.

*//2003/* In addition, the United Health Foundation Report, 2001 Edition, which ranked states from 1-50 (best to worst) in several health categories, ranked Indiana 39th for total mortality, 47th for prevalence of smoking, 32nd for White premature death (years lost before age 75) and 48th for Black premature death, 34th for access to prenatal care, 32nd for occupational fatalities, 35th for death from heart disease, 30th for cancer cases, 32nd for infant mortality, and 9th for percent uninsured. In Indiana the African-American death rates compared to White death rates for the following categories are: heart disease and cancer death rates are 1.4 times higher; stroke death rate is 1.5 times higher; diabetes death rate is 2.6 times higher; AIDS death rate is 3.5 to 5 times higher; and homicide death rate is 13 times higher. (The data year used for these rankings is unknown and rankings do not take into account recent improvements.) Improvement in these areas is a priority for MCHS and for the Community Health Development Services Commission.

*//2004/* In 2001, Indiana's overall infant mortality rate dropped to 7.6. While White infant mortality rate increased to 6.8 and the Hispanic infant mortality increased to 8.5, the Black rate dropped to 13.6. This lowered the Black/White disparity ratio to 2, the lowest Indiana has achieved, but this still needs to improve. The marked increase in Hispanic infant mortality is of great concern. *//2004//*

***//2005/ In 2002, Indiana's infant mortality remained constant at 7.6 but the Black/White disparity increased with rates of 6.5 for White infants and 15.6 for Black infants bringing the disparity ratio up to 2.4. ISDH MCSHC is addressing these disparities through a series of Fetal Infant Mortality Reviews scheduled for FY 2005 with concurrent education programs to reduce infant mortality. MCSHCS and IPN will work with hospitals to ensure all newborns receive risk appropriate prenatal and perinatal care and is updating the state perinatal strategic plan with emphasis on disparities. (See performance measures 17 and 18.)//2005//***

*//2001/* 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 > 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) (TANF coverage 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.

*//2001/* 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. /2002/ Currently there are three risk-based managed care programs that contract with Office of Medicaid Policy and Planning (OMPP). Hoosier Healthwise has become a part of the Indiana Health Care Programs (IHCP), the umbrella term for all Medicaid and SCHIP programs. /2004/ Please see the FSSA website, [http://www.in.gov/fssa/hoosier\\_healthwise/index.html](http://www.in.gov/fssa/hoosier_healthwise/index.html) , for further information on Hoosier Healthwise and the Indiana Health Care Programs. //2004//

***/2005/ In 2004, Indiana became the fourth state in the union to obtain a community-based services waiver for Medicaid for the treatment of children with mental illness. The waiver allows more mentally ill children to receive treatment in their communities, delaying or preventing institutionalization. //2005//***

/2003/ During FY 2002 and 2003 the process of converting seven highly populated counties in Indiana to risk-based managed care will take place. This conversion is a cost saving measure for the state. However, in Indiana, HMOs held only 13% of the private health care market in 2000.

/2004/ In the Indiana's Children's Health Insurance Program (CHIP) Annual Evaluation Report for CY 2002 (dated April 1, 2003), enrollment of the CHIP clients below 150% of FPL in risk-based managed care increased from 18% to 39% from 2001 to 2002 (Phase 1 of CHIP in Indiana included expanding Medicaid eligibility for children > 1 year of age and <19 years of age from 133% FPL to 150% of FPL so that income eligibility was the same for all children and pregnant women); for CHIP clients over 150% FPL, the percentage grew from 14% to 37% during the same time periods. Thus, the conversion to risk-based managed care was somewhat successful in terms of risk-based client expansion. //2004//

***/2005/ The transition to risk-based managed care for Hoosier Healthwise has been completed for the northwest, central and north central counties, bringing the most heavily populated counties under the new system by July 1, 2004. As of Mar 2004, 17.4% of children under age 19 in families under 150% of poverty are now covered by risk-based managed care under Hoosier Healthwise. //2005//***

/2001/ Phase II of Indiana's SCHIP, Hoosier Healthwise/Package C, legislated in FY '99 to begin January 1, 2000 (I.C 273-1999), maintained the previously mentioned expansions of the Medicaid program, and established an Office of Children's Health Insurance Program and the Child Health Policy Board to oversee implementation of the state-designed Package C.

/2001/ 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. Children enrolled in Package C may be eligible for additional health and developmental services coverage from Indiana First Steps (the early intervention program) and CSHCS.

/2001/ 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 the Director of First Steps and 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. /2003/ The Advisory Committee for Children

with Special Needs has continued to meet but the Child Health Policy Board has not met as routinely as they did initially. /2001/ 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. 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. /2002/ The Child Health Policy Board has recommended continued study and the implementation of a pilot front-end screening and referral tool that consumers can use to determine probable program eligibility and a coordinated web page with links to all children's health programs.

/2004/ This software tool is being piloted in FY 2003. However, the Child Health Policy Board itself has not met for over a year. //2004//

/2001/ 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 an 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 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.

/2002/ The Independent Evaluation of Indiana's Children's Health Insurance Program, published April 1, 2000, was based on calendar year 2000 eligibility data and claims data from July 1, 1997 -- December 31, 2000. Because Package C expansion was relatively new, most of the utilization data was a comparison of the Hoosier Healthwise Package A (Medicaid) income eligibility expansion that occurred in Phase I of SCHIP. Phase I expanded age eligibility of teens with family income at 100% of the federal poverty level to < 19 years the first year. In the second year income eligibility for all children was raised to 150% of the federal poverty level. Consequently, the SCHIP program in Indiana has had the greatest impact on the teenage population in Phase 1. /2002/ Areas included in the evaluation were enrollment, provider supply, hospital, dental and physician services used, pharmacy utilization, and quality of services. The evaluation found that enrollment goals were met. As of December 2000 there were 47,760 enrolled in Phase I (Package A) and 6,762 enrolled in Phase II (Package C). Primary Medical Providers (PMP) in 11 mostly rural counties had full panels; in urban areas, 9 counties had panels at 75% capacity. Overall panel capacity for PMPs is about 50%. Eighty-two percent (82%) of the PMPs participate in the Primary Care Case Management (PCCM) managed care rather than risk-based managed care. Dental providers were also deemed to be adequate in this study. (Based on Indiana Family Helpline calls, access to dental providers is still the most difficult to accomplish.) Dental services were being used at a higher rate by the SCHIP population. However, only about 1/3 of the SCHIP members were seeing the dentist once per year.

**/2005/ In 2003, 32.7% of the SCHIP population visited a dentist. Currently there are 1,387 dental providers participating in Hoosier Healthwise. //2005//**

/2001/ In Spring 2000 the Indiana Health Insurance Study (IHIS), a telephone survey of about 10,126 households funded through SCHIP funds, was conducted to provide a current and accurate estimate of the number and percentage of Indiana's population under 65 years without health insurance. The study indicates that about 9.4% of Indiana residents under age 65 do not have health insurance. All but 5.1% of the uninsured were under 200% of the federal poverty guidelines. The IHIS indicates the lowest rate of uninsured is found in the full-time employed worker. The highest rate of uninsured is among the unemployed population.

/2001/ The economic slowdown may affect the number of uninsured families in Indiana. As more companies lay off or dismiss workers in the slowing economy, the number of uninsured may increase

dramatically, as will the number of children eligible for Hoosier Healthwise Packages A or C. The cost of premiums for COBRA coverage or even Hoosier Healthwise Package C may be more than an unemployed family can afford.

/2004/ In Spring 2003, the IHIS survey study revealed that 11.2% of Hoosiers under 65 are uninsured. //2004//

/2001/ The survey indicates that a greater proportion of children whose families have incomes that make them eligible for Hoosier Healthwise Package A (does not require a premium) remain uninsured than the proportion of children whose families have incomes that make them eligible for Hoosier Healthwise Package C (requires a premium). This upheld the observation that as marketing for SCHIP increased, more applicants were eligible for Package A than for Package C.

/2003/ At the end of SFY 2001 (June, 2001) Medicaid recipients included an estimated 355,000 children, another 79,000 children in SCHIP, 37,000 pregnant women, and 240,000 recipients in the aged, blind, disabled, and other categories. During SFY 2001, 77% of the Medicaid expenditures were for recipients in the aged, blind, disabled and other categories. Medicaid serves about one in eight Indiana citizens and with the economic downturn, Medicaid enrollment has grown as has the number of families receiving TANF and food stamps. The plan to control Medicaid expenditures focuses on controlling pharmacy and nursing home expenditures and enforcement of third party payer status. Three proposals in the plan will effect coverage of children: 1) a legislative change to eliminate the one-year continuous coverage of Medicaid and revert back to reevaluation at every change in family financial circumstance (this could fragment health care coverage); 2) the implementation of a disease management program for asthma (this may decrease emergency room usage in asthma cases); and 3) the enforcement of medical support orders to recover Medicaid expenditures for children whose non-custodial parents have been ordered to pay for medical support. The legislation was passed; beginning July 1, 2002 Medicaid eligibility is reviewed about every six months; a disease management program for asthma, diabetes, AIDS and congestive heart failure is being contracted out for both education and case management.

/2004/ ISDH and OMPP are collaborating to develop a chronic disease management program that was legislatively mandated. The pilot will begin in central Indiana July 1, 2003 with statewide expansion and inclusion of the four chronic diseases listed by April, 2004. Providers' staff will be provided training on chronic disease management in the office/clinic, nurse care manager assistance, clinical consensus guidelines for each chronic disease, and web-based software/data collection services. It is hoped that these strategies will provide the same care management to all patients. //2004//

***/2005/Total state implementation has been delayed until December,2004. Currently the central and northern thirds of the state have initiated case management for asthma, diabetes, and congestive heart failure. HIV efforts are separate. //2005//***

/2001/ 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. /2002/ In May 2001 OMPP released an "Action Plan to Increase Medicaid-Enrolled Children's Access to Dental Care". The Plan includes better and more marketing of dental services and reduction of barriers to payment for the dentists. Throughout the document the Oral Health Division of ISDH is sited as a partner in their efforts. /2003/ Dental providers for Hoosier Healthwise clients continue to increase in number. As of December 2001, there were 1,686 dental providers. In addition, through a Primary Health Care contract with the Indiana Rural Health Association, ISDH hopes to identify more Dental HPSA areas to leverage funds to support dental expansion and a mobile dental unit is being co-funded by the Indiana University Dental School and the Office of Primary Care to provide school-based dental sealant services. The ISDH Office of Primary Care is encouraging community health centers (CHCs) to expand services to include dental services; however, expansion is limited due to the budget deficit.

/2004/ Utilization data for 2000 revealed that Indiana had the highest dental utilization rate of any state in Region V at 28%. This level has been maintained for 2001 and 2002. //2004//

/2001/ 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 that 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.

/2002/ This task force is ongoing. In the MCHS RFP for FY 2002, one of the criteria for funding was for child health primary services in one of the twenty counties that OMPP designated at risk for filling PMP panel slots. /2003/ This criteria for the MCHS RFP remains in effect for FY 2003.

/2004/ This effort is ongoing. //2004//

/2001/ Outreach for the Hoosier Healthwise child insurance program has been improved. Non-profit agencies including some MCH projects have become enrollment centers for Hoosier Healthwise. 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. /2002/ Presumptive eligibility for pregnant women was piloted for a short time in the early 1990's and discontinued. To date, presumptive eligibility for children has not been embraced by OMPP. However, more enrollment sites are available.

/2001/ 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 TANF payments.

/2001/ 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 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.

/2001/ 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. /2002/ TANF rolls dropped about 56% from January 1, 1995 to January 1, 2000. Child care state support costs during welfare reform have doubled since 1996 with an increase of only 10,729 (12.5%) child care slots. On average 1.3% of the population in the state receives TANF. Thirteen counties meet or exceed that average with 4.1% of Lake County's residents, 2.2% of Marion County's residents, and 2.0% of St. Joseph County's residents meeting the criteria. Eleven of these thirteen counties were identified as high risk target counties by MCHS. The impact of a slowing economy on welfare reform remains to be seen.

/2004/ There has been a 38% increase in families on TANF from October 2000 to January 2003.

Families receiving food stamps have increased 41% during the same time period. //2004//

/2001/ To receive TANF an applicant must have an income of less than 27% of the federal poverty guidelines. (/2002/ In 2001 income eligibility for TANF cash assistance in Indiana is under 25% FPL and for supportive services is 250% FPL.) /2001/ 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). 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.

/2004/ See <http://www.in.gov/fssa/families/tanf/index.html> for information on Indiana's TANF program. //2004//

***//2005/ In June, 2002, Abt Associates, Inc., completed a study of the impact of welfare reform on Indiana's children. Their findings indicated a significant increase in arrests for children age 10-12 (2.2% in the welfare reform group vs. 0.5% in the traditional welfare group) but no other significant impact on young children. The study found no significant impact positive or negative on families and adolescents. //2005//***

/2001/ 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 an 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.

/2001/ 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.

/2001/ 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. Essentially all of the tobacco settlement money is to be used for health-related services. /2001/ 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.)

/2002/ Settlement spending includes support for a new state agency, the Indiana Tobacco Prevention and Cessation Agency, to create a statewide media campaign and increase enforcement of Indiana's youth smoking laws. This agency will also distribute grant monies for programs that emphasize smoking cessation. MCHS staff have held discussions with the director of this agency about the expansion of the Prenatal Substance Use Prevention Program (PSUPP).

/2004/ PSUPP expansion was funded for SFY 2003 and 2004. However, due to the state budget crisis half of the SFY 2004 funding has been rescinded. Title V funding will be used to continue the program at all sites. MCHS must reapply to obtain any funding for PSUPP in SFY 2005. //2004//

***//2005/ The Indiana Tobacco Prevention and Cessation Agency funded four PSUPP clinics in FY2004 and will only fund three in FY2005 due to the continued state budget crisis and redirection of funds. Title V funding will be needed to continue this smoking cessation program at four of the sites. //2005//***

/2001/ 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.

/2002/ The Tobacco Settlement monies designated for ISDH for community health centers was distributed to fifty-seven community health center sites for site operation (a total of \$15,000,000) on October 1, 2000. Twenty-two community health centers were awarded capital improvement grants (a

total of \$10,000,000) in the spring of 2001. /2003/ For SFY 2002 the State line item for Community Health Center (CHC) funding was reduced from \$15 million to \$13 million.

/2002/ The Tobacco Settlement spending for the next biennium continues to focus on health care and education. ISDH was also allocated \$3.1 million annually for discretionary projects. Public health priorities are developed and the State Health Commissioner will make final administrative decisions regarding this funding.

/2004/ Money for tobacco education was cut and diverted for use in the state general fund in the legislative session of 2003. //2004//

/2001/ 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. 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. /2003/ In addition to the aforementioned priorities, Dr. Gregory Wilson, the ISDH Commissioner (new in 2001), has added diabetes and other chronic diseases and infant mortality disparity to the list.

/2002/ For the 2002 MCHS Request for Proposal (RFP), the Director used health status indicator data to prioritize counties. In an effort to open Title V grant opportunities to counties and entities not previously funded by Title V, these prioritized counties were offered an RFP. These counties were identified at higher risk based on a ten year statistical average of the following health outcome and health indicators: infant mortality, low birthweight, very low birthweight, early prenatal care usage, Black prenatal care usage, Black infant mortality, Black low birthweight, Black very low birthweight, and postneonatal mortality. In addition, counties in need of child health providers (based on Office of Medicaid Policy and Planning data) was a criteria of need included in the RFP. Nine new sponsoring agencies submitted grant applications.

/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.

/2003/ According to the HRSA Bureau of Health Professions 2000, Indiana has only 46 public health personnel per 100,000 population. This must be compared to the national average of 138 and the Midwest-Region V of 76 per 100,000 population. Unlike many other states, the Indiana State Department of Health has only consultative input into the local autonomous county health departments. Some quality assurance input is added through funding contracts between ISDH and local health departments.

/2003/ In order to expand health personnel providing public health services, ISDH/MCHS also contracts and partners with not-for-profit and other state agencies to provide some of the direct, enabling, population-based, and infrastructure building services/activities needed to make progress on MCHB Performance Measures. With the budget crisis in Indiana, also came a hiring freeze that limits even further the number of vacant positions that can be filled and strains the effectiveness of ISDH/MCHS professionals to improve performance. Indiana MCHS and CSHCS are neither primarily nor solely responsible for many of the MCHB performance measures.

/2004/ The following should be a part of Agency Capacity but would not fit in the space limits. //2004// Statutes relevant to Title V program and their impact upon Title V Program

/2001/ In 2000 the Indiana General Assembly enacted the following laws affecting MCHS.

? A Childhood Hazards Prevention Law (IC 16-41-40) was adopted without funding, naming ISDH as the implementing agency.

/2002/ The legislature (in 2001) also enacted the following laws that may have had MCHS staff input in the development, but are not direct responsibilities of MCHS:

? HEA 2031 allows counties/regions to establish Child Fatality Review Teams (HEA 2031) that can review the deaths of children whose deaths are sudden, unexpected, or unexplained to determine

whether future similar deaths are preventable and what agencies/resources should be involved in prevention.

? HEA 1938 expanded Medicaid coverage (including presumptive eligibility) to include women screened and found to need treatment under the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000, whose family income is less than 200% FPL.

? SEA 431 requires each county Office of Family and Children to provide a list of county dentists who participate in Hoosier Healthwise to specified agencies that provide services to low income families.

? HEA 1487, an Indiana code change, enables ISDH to include in the mandatory newborn screens any disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities if the technology is available in a designated laboratory.

/2003/ Very few enactments of the short legislative session of 2002 had impact on MCHS or ISDH. However, a proposal in the Special Session to focus on the budget is to increase the cigarette tax to \$.55/pack. This should assist ISDH in deterring adolescents and children from smoking. Other laws that may have impact include:

? HEA 1171 requires that all blood lead concentration test results on children less than seven years of age be shared with certain federal, state, and local government agencies.

? SEA 139 requires ISDH to inform parents of children with birth problems about physicians and local community resources and to report to the legislative council any birth problem trends identified through data collected.

/2004/ In the 2003 legislative session, the following laws will enhance or impact Title V services in Indiana.

? HB1131 requires mandatory reporting of fireworks related injuries to ISDH by a health care practitioner or hospital administrator who treats a person for the injury. This will enhance the development of an injury surveillance system.

? HB1630 requires that a pregnant woman be tested for HIV during pregnancy or at the time of delivery unless she refuses (which must have chart documentation).

? HB1702 requires a child who enters kindergarten or grade 1 to be immunized against varicella unless the parent of the child signs a statement indicating the child has had the disease.

? SB343 creates a chronic disease management and registry administered by OMPP and ISDH that focuses initially on diabetes, congestive heart failure, asthma and hypertension.

? SB367 requires that all labs in Indiana report to ISDH all results from blood tests for lead that contain the presence of lead regardless of age.

? SB457 specifies the purposes for which the immunization data registry may be used and who may obtain the information. //2004//

**/2005/ Governor Kernan signed the following 2004 legislation:**

**? HEA1265 Aggregate purchasing of prescription drugs, requiring state personnel department to establish an aggregate prescription drug purchasing. This may improve drug purchasing power for the Children's Special Health Care program.**

**? HB1098 Requires Child Restraints in motor vehicles for children under age 16;**

**? HB1194 Establishes a child fatality review team and changing reporting requirements for child abuse cases;**

**? HB1133 Requires every child entering grades 9 and 12 to be immunized against Hepatitis B;**

**? HB1344 Establishes IN 211 Partnership, Inc. as the agency for 211 services in Indiana and establishes a line item through which funding for 211 can flow in the state budget under the Indiana Utility Regulatory Commission;**

**? SB188 Requires the Birth Problems Registry to report most birth defects up to age 3 and Fetal Alcohol Syndrome and Autism up to age 5;**

**? SB363 Establishes the Governor's Council for People with Disabilities.**

## **B. AGENCY CAPACITY**

**/2005/ Budget notes: In 2002, in response to a tight state budgets, Indiana implemented austerity measures for all state agencies including hiring freeze, furloughs, early retirement incentives. These measures resulted in a surplus in Title V funds that grew in 2003 and 2004. Indiana's MCH program is provided statewide through a series of grants to local health departments, hospitals, universities, clinics, and other non-profit organizations. In FY 2004,**

**ISDH MCH increased these grants from \$6.5 million to \$7.5 million partly in response to the growing surplus in federal Title V funds and in part to help these agencies defray the increased cost of service provision. ISDH also funded additional grantees. For FY 2005, ISDH offered a grant program for one-time, short-term MCH infrastructure grants. Many of these will be Fetal Infant Mortality Reviews and community-based needs assessments. Some pilot projects are also being funded. This additional allocation of \$1 million will reduce the surplus federal funds and provide lasting benefit from a short-term investment of Title V funds in communities across the state. See attached FY 2005 Grant Recommendation Documents. //2005//**

/2001/ 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 CSHCS. The MCHS staff also creates and implements population-based education on topics like tobacco use prevention and adolescent pregnancy prevention.

/2002/ The CSHCS program is in the process of reorganizing to provide centrally a Customer Service Unit, an Authorization Unit, an Eligibility Unit, and a Claims Unit. Regional offices housing state consultants will be closed. The Authorization Unit will complete prior authorization for services from providers in a more efficient, relatively paperless, and consistent manner than did the community-based care coordinators. The Customer Service Unit will assist clients with programmatic questions and facilitate program services using the Indiana Family Helpline for referrals as did the local care coordinators. This centralized effort will also improve access to hearing impaired clients and non-English speaking clients through a TTY number and translation services available in the IFHL. It can be more efficient because the new CSHCS data collection and reimbursement system is nearly fully implemented. Centralization should minimize paper flow and provide opportunity for more immediate response to clients and health care providers.

**//2005/ The new CSHCS data collection and reimbursement system is now fully implemented. The system has not been on-line long enough for a formal evaluation regarding impact on paper flow and response time, however informal response from staff indicates the new system has both reduced paper flow and improved response time to clients and health care providers. //2005//**

/2003/ CSHCS Program is providing systematic training to County Offices of Family and Children (OFC) staff throughout Indiana regarding the use of the Combined Enrollment Form and CSHCS services. The training includes the development of a standardized curriculum to enhance identification and outreach to eligible children. The training is a result of a new working agreement between DFC management and the CSHCS program. The training furthers the program's mission to promote systems development to improve the organization and delivery of services for children with special health care needs. The CSHCS Program also continued to provide outreach by paying a fee to FSSA for local OFC staff to take CSHCS applications, gather verifications, and send applications to ISDH for eligibility determination.

**//2005/ Eric J. Vermeulen, J.D., became the director for CSHCS in August of 2003 and is now administrative director of the combined MCH and CSHCS division. See section C -- organizational structure.**

**//2001/ 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.**

***/2004/ MCHS capacity to expand data integration and ISDH program integration was enhanced with receipt of the Genetics Implementation Grant in September 2002. This grant will assist with newborn screening, birth defect and other chronic disease data integration as well as establish medical home, folic acid and genetics education for professionals and consumers. //2004//***

***/2004/ The Genomics Program, the new name for the Genetics Disease Program described below, broadens the scope to include adult chronic diseases and general genetics education. //2004//***

***/2001/ 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 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.***

***/2002/ 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.***

***/2005/Maternal and Children's Special Health Care Services' Genomics in Public Health/Newborn Screening Program now houses the Indiana Birth Defects and Problems Registry (IBDPR). The IBDPR Coordinator and two full time and six part-time contractors have been added to the staff to carryout the activities of both the Genetics Implementation Grant and the IBDPR grant. IBDPR preliminary data from 2003 births should become available in 2005. //2005//***

***/2001/ 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.***

***/2001/ 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 that was initiated in 1994. /2003/ The Oral Health Division in addition to their fluoridation efforts is also the investigative authority regarding universal precautions and infectious waste management issues as they pertain to delivery of oral health services; legislatively mandated to annually survey a percentage of Indiana licensed dentists as to the effectiveness of the routine biological testing of their autoclaves; promotes the P.A.N.D.A. program (Prevent Abuse and Neglect through Dental Awareness) by providing educational presentations to local dental societies and organizations throughout the state; provides educational materials relative to Oro-facial Injury Prevention as requested.***

***/2003/ Asthma Prevention Program has Dr. Judith Ganser, MCHS Director and Medical Director for Community Health Development Commission now as the point person for asthma due to reorganization of CSHCS. ISDH has obtained \$198,000 per year through CDC to address asthma in conjunction with IDEM FY 2002-05. Additional grant funding is being pursued from the federal Environmental Protection Agency.***

***/2004/ MCH director is taking the lead role in organizing the Indiana Joint Asthma Coalition whose main goal is to develop a state Asthma Plan. OMPP and ISDH will implement an Asthma case***

management program for Medicaid clients in April 2004. This will be the last phase of the chronic disease case management program Medicaid is implementing as a cost saving measure. //2004//  
***/2005/ Asthma was added to the case management in April 2004 for the north and central thirds of the state. The southern third will be added by year's end. The Indiana Joint Asthma Coalition (INJAC) made up of professionals and consumers, is developing goals, objectives and strategies for a state plan. The Asthma case management program was implemented in April 2004. //2005//***

/2001/ 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. 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. /2002/ Prenatal care coordination (PNCC) is part of MCHS prenatal care services. This service is also reimbursable by Medicaid. HSD consultants and Office of Medicaid Policy and Planning (OMPP) staff worked together to develop a PNCC Outcome Report Form to collect evaluative data on PNCC. In 2001 through collaboration with OMPP, EDS (Medicaid reimbursement vendor), and Managed Health Services (OMPP contracted managed care organization), statewide analysis of the outcome data will occur. This should help determine the efficacy of the program.

/2001/ 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. <http://www.indianaperinatal.org> (web site), consumer information, Clinical Practice Alerts, critical reports, and consensus documents like the 1998 Indiana Prenatal Guide. /2003/ The Indiana Prenatal Care Guide was updated in 2000.

/2002/ After an IPN evaluation in spring 2001 IPN reorganized. IPN will now have in addition to the Executive Director a SIDS/Infant Death Support Coordinator; a Professional Education Coordinator to facilitate state and local conferences and prepare Practice Alerts and Consensus Statements; a Communications Facilitator to prepare the newsletter, web-site, and data books; a Community Liaison/Consumer Education Coordinator to work with local perinatal boards and coordinate the Baby First Campaign; and a Community Liaison/Friendly Access Coordinator to work with counties without organized groups and with the Friendly Access Pilot project in the Indianapolis/Marion County Health and Hospital Corporation facilities.

/2003/ The Indiana Perinatal Network has hired a full time "Friendly Access" director responsible for the planning, implementation and evaluation of the program to improve the perinatal outcomes of Indiana families. The program has been initiated in Marion County and will be taken statewide in future years. Funding for a full time evaluator for the program has also been obtained.

/2001/ Sudden Infant Death Syndrome (SIDS) Program is funded by Title V through the 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. 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. /2002/ The title of the SIDS Coordinator position in IPN has been changed to SIDS/Infant Death Support Coordinator to reflect her responsibilities in fetal/infant mortality case reviews, child fatality case reviews, and support group development efforts. Maternal deaths, which are rare in Indiana (0.02/100,000 in 1998), are reviewed by a task force selected and led by Dr. Haywood Brown, a perinatologist.

/2004/ The maternal death task force is currently led by Dr. Ed Campbell. //2004//

/2001/ Indiana Women's 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. /2002/ This project has obtained a HRSA Integrated Comprehensive Women's Health Service in State MCH Programs grant to demonstrate an innovative and replicable model of prison to community-based linkage of services for the women and their children. This three-year grant will expand the services currently provided to include more community-based support of the families statewide and more support and education for the women within the prison. /2003/ This program has hired an RN, MSN as Project Director and has established an Advisory Committee chaired by a State Representative. It also began its first family planning clinic in January 2002. A statewide meeting of MCH leaders was convened on June 13, 2002, to help work toward this integration of services. The number of pregnant women delivering while in prison has significantly increased and the program now serves about 85 pregnant women a year.

/2001/ Prenatal Substance Use Prevention Program (PSUPP) is funded primarily through a grant from FSSA, Division of Mental Health (DMH), Bureau for Mental Health Promotion and 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 perinatal 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.

/2004/ With the Indiana Tobacco Prevention and Cessation (ITPC) Agency funding, PSUPP expanded the program to fourteen additional sites during SFY 2003. In SFY 2004, this program will also be supported by Title V funds. It provides services in 23 of 92 counties in Indiana. //2004//

**//2005/ PSUPP will continue to be funded by the Department of Mental Health, the Indiana Tobacco Prevention and Cessation Agency and Maternal and Child Health Services. An addition of a program in St. Joseph County has PSUPP providing services in 24 of 92 counties in Indiana. A proposal was submitted to CDC to extend services to pregnant women using cigarettes. If accepted, the PSUPP site directors will work with Minority Health Coalition staff to offer more testing and home contacts/visits during pregnancy and postpartum to help reduction and continue cessation after birth. This program expansion will continue for two years. //2005//**

/2001/ 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 includes: (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; (4) assisting local communities and MCHS to assess for service gaps for planning of future programs; and (5) 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 developed and has provided MCHS with an ongoing database for assessment and evaluation of services offered and needed by sexually active, low income women. /2003/ There are 229 agencies in 87 counties participating in the HP/HB Campaign as of May, 2002.

/2004/ The Free Pregnancy Test Program (formerly known as the Healthy Pregnancy/Healthy Baby Campaign) was restarted April 2003. //2004//

/2001/ 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.

/2004/ Indiana Capacity To Provide Preventive And Primary Care For Children is as follows: //2004//

/2001/ 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.

/2001/ 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.

/2002/ In the spring of 2001 the CDC-developed Youth Risk Behavior Survey (YRBS) (which had not been done in Indiana since 1991) was completed using SSDI grant funds.

/2004/ YRBS was repeated in Spring 2003. A weighted sample was obtained and will allow better analysis and use of the data. //2004//

***/2005/ The State published the results of the 2003 YRBS which included the following indicators: 25.6 percent of youth used cigarettes, compared to 21.9 percent nationally; 28.9 percent of youth reported episodic heavy drinking, compared to 28.3 nationally, and 22.1 percent reported using marijuana, compared to 22.4 percent nationally; 93.8 percent rarely or never used bicycle helmets, compared to 85.9 percent nationally; 38 percent of youth said they were currently sexually active, compared to 34.3 percent nationally; 11.5 percent were overweight and 14.2 percent were considered at risk of becoming overweight, by self-reported data; and 31.9 percent did not participate in a sufficient amount of physical activity, and only 20.3 percent said that they ate fruits and vegetables the recommended five or more times per day. In the spring of 2005, the YRBS will be administered once again in randomly selected high schools across the state. If a weighted sample is obtained in the 2005 YBRBS administration, comparisons can be made about Indiana adolescent risk behavior over time. //2005//***

/2001/ Indiana RESPECT, Indiana's adolescent pregnancy prevention initiative uses State Adolescent Pregnancy Prevention funds and Federal Sexual Abstinence Education Block Grant funds 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. 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 that will include a pre/post/delayed-post design. 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." 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. /2002/ State funding for the next biennium remains the same for Indiana Respect.

***/2005/ In 2004, The Title V/Section 510 Abstinence Education block grant awarded Indiana \$770,198 and the state awarded the RESPECT program \$597,787. In the summer of 2003, 26 federally-funded grantees and 29 state-funded grantees were chosen for the RESPECT community grant program. These agencies administer programs that provide abstinence and pregnancy-prevention programs across the state. These grants run in two-year cycles. In the spring of 2003, a media evaluation for the RESPECT program is taking place. A new advertising agency will be chosen in the summer of 2004. This agency will be responsible for***

***implementing a new statewide abstinence and pregnancy prevention media campaign for Indiana. //2005//***

/2003/ Child Care Health Consultant program (CCHC) through funding from FSSA is being developed. MCHS will contract with an outside entity to provide a Project Coordinator who will hire two child care health consultants for the remainder of FY 2002 and four additional consultants in FY 2003 to provide health education and technical assistance to licensed and unlicensed child care providers serving children 0-8 years of age. MCHS will receive \$125,000 in FY 2002 and \$250,000 in FY 2003 from the Child Care Development Block Grant to facilitate this program. The child care health consultants will be health and early childhood professionals and will cover FSSA defined child care consultant regions. CCHC will also collaborate with other health and safety providers in the state and with injury prevention efforts within ISDH.

***//2005/ More than 40 individuals have completed the ICCHC training 6-day training and certification process and are providing consultation based on the National Child Care Health and Safety Standards within the agencies where they are employed. Five of the six Regional Consultants have been hired to date and are currently providing outreach in their assigned regions. Two of these consultants will be attending the National Training Institute for Child Care Health Consultants in North Carolina during the summer of 2004. The first annual ICCHC Training Reunion and Update was held on April 20 was attended by all 5 regional consultants and approximately 20 consultants who have completed the 6 day certification course and all the homework. //2005//***

***//2005/ ISDH received an Early Childhood Comprehensive Services (ECCS) grant from MCHB and has contracted with Emerald Consulting to assist in the development of a coordinated, comprehensive, community-based system of services for young children. ECCS is a collaborative process across public and private organizations. Core Partners include the Department of Health, the Family and Social Services Administration, the Governor's Office, the Department of Education, the Department of Corrections, the Indiana Department of Environmental Management, the Indiana Parent Information Network, the Indiana Association for the Education of Young Children, the Indiana Head Start Association, and Riley Hospital for Children/Child Development Center. To date, the Core Partners have met twice, five subcommittees have been established and will begin meeting this month, and an ECCS website has been created. Community meetings for public input will be held in Summer 2004. The goal of the project is the creation of a comprehensive plan, accurately reflecting priority outcomes for a coordinated early childhood system. //2005//***

/2004/ Indiana Capacity To Provide Services For Children With Special Health Care Needs are as follows: //2004//

a. Title XVI Beneficiaries

/2004/ Coordination with the Supplemental Security Income (SSI) Program continues to occur. SSI recipients and applicants are told about CSHCS and CSHCS receives referrals from SSI. SSI enrollment data will be collected by the Systems Point of Entry (SPOE) data system in First Steps and by the CSHCS new HIPAA compliant data collection system, Agency Claims Administration Processing System (ACAPS). //2004//

b. Family Centered, community-based, coordinated care:

/2001/ Sickle Cell and Other Hemoglobinopathies 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. /2002/ The Sickle Cell grantees are now facilitated through the Newborn Screening Section of MCHS. The other grants associated with other hemophilia

are being coordinated by a CSHCS manager.

***/2005/ All newborn screening follow-up programs are facilitated through the Newborn Screening Program. The Sickle Cell program continues to follow-up on all sickle cell screening test results. Penicillin is supplied to physicians for children with Sickle Cell Disease through one of the Sickle Cell Clinic's pharmacy. In 2004, the Parents Empowering Parents (PEP) program was implemented to assist families living with children with Sickle Cell Disease with parenting. //2005//***

/2003/ The CSHCS Program began development of a training program for Customer Service staff regarding third party reimbursement to ensure that all CSHCS participants fully claim allowable reimbursements under the state Medicaid plan and other available third party reimbursement. This will result in all other payment sources being fully utilized before a claim for services is paid by CSHCS.

/2004/ Indiana's Capacity To Provide Culturally Competent Care Appropriate To MCH Population is as follows: //2004//

/2001/ 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.

/2004/ Office of Cultural Diversity and Enrichment in ISDH, created in March 2001 to help address the public health needs of minorities in Indiana, offers two day training sessions in cultural competency to all employees of ISDH and to local health professionals and grantee staff twice per month and an advanced workshop every month for those who have attended the first. This office also distributes and analyzes a Minority Health Disparity Survey that ISDH contractors must complete. If contractors do not meet ISDH cultural competency goals, ISDH will seek alternate contractors. //2004//

/2004/ Office of Minority Health (OMH) in ISDH provides liaison and builds infrastructure with state groups working with minority populations like Indiana Minority Health Coalition, Indiana Perinatal Network, and Indiana Latino Institute. MCHS support some activities related to Title V target populations. OMH liaison attends MCHS team leaders meetings. //2004//

/2001/ 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.

/2004/ The IFHL has two bilingual employees, use ATT Language line, and a new TTY line to better serve the hearing impaired.

## **C. ORGANIZATIONAL STRUCTURE**

***/2005/ ISDH MCSHC provides Title V services through a series of grants to local health departments, hospitals, clinics and non-profit organizations. More than half the Title V federal allocation is granted out in Indiana. Grantees are selected competitively based on state determined priority services and underserved populations, strength of the organization and quality of the proposal and budget. The Grant Application Process for FY 2004 is attached as are notes about the recommendation process. These two-year grants provide direct, enabling, population based and infrastructure services. ISDH requires these grantees to meet state determined performance measures. See attached grant recommendation package for FY 2004-2005. Also see***

***<http://www.in.gov/isdh/programs/mch/grantopportunities/grantopportunities.htm> for the most recent grant application process. //2005//***

/2002/ In the November 2000 gubernatorial election the Honorable Frank O'Bannon was reelected. However, Dr. Richard Feldman resigned his post as the ISDH Commissioner. In February 2001 the new Health Commissioner, Gregory Wilson, M.D., was named. He is a developmental pediatrician who has worked for many years with the Children's Special Health Care Services Program. He was also the first director of the Indiana Poison Control Center. In 2000, Charlene Graves, M.D., FAAP, a

pediatrician, was hired to provide medical direction and consultation to the Immunization, Injury Prevention, and Indiana Childhood Lead Poisoning Prevention Program (ICLPPP). The latter two programs are a part of MCHS. The Office of Cultural Diversity has been added to the purview of Dr. Judith Ganser, the MCHS Director. Gloria Webster-French, RN, Director of the Office of Cultural Diversity, provides monthly cultural diversity training opportunities for both ISDH staff and grantee staff. This staff will also review brochures and other materials for cultural competency.

/2001/ 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. /2002/ The Indiana School for the Deaf and the Indiana School for the Blind are now under the oversight of the Department of Education.

/2003/ During the summer of 2001 a reorganization of the Public Health Services Commission occurred (See Organizational Chart in Appendix A) This commission was split into two: the Community Health Development Services Commission, directed by Assistant Commissioner Joni Albright, MPA with Medical Director, Judith A. Ganser, MD, MPH (who continues to be MCHS Director); and the Children and Family Health Services Commission, directed by Wendy Gettelfinger, MSN, DNS, JD with Medical Director, Charlene Graves, MD, FAAP. MCHS programs were divided between the two commissions. CSHCS, all Newborn Screening Services, and Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) were placed in the Children and Family Health Services Commission along with WIC, Oral Health, and Immunizations. A director, Shari Kinnaird, JD, was hired to manage CSHCS and to supervise Newborn Screening. ICLPPP with Nancy Cobb as the new director reports directly to Dr. Gettelfinger. The Community Health Development Services Commission retained MCHS (Health Systems Development, Grants Management, and Data Analysis Sections), Cultural Diversity and Enrichment, Local Liaison, Chronic and Communicable Disease, HIV/STD, and the Office of Primary Care which oversees grants to CHCs. However, Shari Kinnaird, Director of CSHCS, participates in MCHS management meetings.

/2004/ In spring 2003, the CSHCS Director position became vacant. A new management position, Chronic Disease Coordinator of Primary Care Services, also reports to Dr. Ganser and provides a liaison between the Office of Primary Care and MCHS. ICLPPP and Injury staff are no longer funded through Title V. Joni Albright became Director of Special Projects and her Commission was rejoined with that of Wendy Gettelfinger.

//2004//

/2001/ 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. /2003/ The expanded Prenatal Substance Use Prevention Program (PSUPP) and the Genetics Diseases Program continue to be a part of MCHS.

***/2005/ The MCH and CSHCS divisions have been joined into a single division -- Maternal & Children's Special Health Care (MCSHC) under Director Eric J. Vermeulen, J.D. Dr. Ganser is now the Medical Director for the new division. The new MCSHC division is part of the***

**Community & Family Health Services Commission under Dr. Gettelfinger. See revised organizational chart, Appendix A. ICLPPP is no longer administered by Title V. //2005//**

/2004/ The following programs are funded by Title V-Federal-State Partnership through MCHS. //2004//

/2001/ 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.

/2004/ The HSD Consultants provide training and technical assistance to the MCHS grantee agencies and each of them direct or facilitate a program previously described in Section B of the state overview--Indiana Family Helpline, Genomics Program, Adolescent Health Program, Prenatal Substance Use Prevention Program, Indiana Child Care Health Consultant Program, Free Pregnancy Test Program, Infant Mortality/Special Projects, and Prenatal and Family Care Coordination Services. In addition, they provide liaison to and build infrastructure with the agencies/groups within the communities/counties they are assigned to assist with health systems development in those communities/counties. //2004//

/2004/ Training Section facilitates training opportunities for in-house MCHS staff and ISDH employees as well as external grantee staff. This section was new in 2002. The Training Manager also works as an HSD consultant in his assigned counties. //2004//

/2001/ 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.

**//2005/ All contracting, purchasing and programmatic financial tracking for the combined MCSHC division has been brought under the Grants Coordinator, who is also developing a Policy and Procedure Manual for the combined division. //2005//**

/2001/ Data, Assessment, and Evaluation Section provides data entry, technical support, and data analysis to MCHS staff. The team leader has coordinated the current Title V Needs Assessment process. 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.

/2004/ The following programs are funded fully or in part by Title V-Federal-State Partnership through CSHCS (see the explanation of CSHCS in Part B) and are organizationally located under CSHCS. //2004//

/2001/ 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 Universal Newborn Hearing Screening Program, and the collection of summary data of targeted newborn meconium screens, the Meconium Screening for Drug-Exposed Newborns Program. /2002/ The Newborn Screening Section of MCHS has again expanded to include oversight of the community-based Sickle Cell (intervention) Program in addition to the three programs listed above. The latter three programs are legislatively mandated and the Newborn Screening Section has developed the infrastructure among the hospitals, local health departments, First Steps, and private physicians to ensure that all newborn screens are completed and appropriate care is established.

/2004/ The Newborn Screening Program has, by law, a mechanism to support the metabolic screen testing and follow-up Universal Newborn Hearing Screening, and the meconium screen testing. A recent increase in the charge for the metabolic screen will decrease the necessity of supplementation from Title V. Currently some of the staff are funded through Title V. //2004//

/2001/ 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 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. /2003/ The Newborn Screening Advisory Board recommended that newborn screens be expanded by 17 through tandem mass spectrometry.

/2001/ 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. 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. 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.

/2001/ 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. 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.

/2002/ The Sickle Cell (intervention) Program funded by the CSHCS program has five regional Sickle Cell Programs that provide outreach, care coordination, education, and counseling for Sickle Cell clients in the State. Penicillin is currently being provided directly to Sickle Cell clients through their physicians without regard to income.

***/2005/ All Newborn Screening programs, PSUPP, Sickle Cell intervention, Genetic Implementation, and the Indiana Birth Defects and Problems Registry have been brought under Nancy B. Meade, RD, MPH, Program Manager for Genomics in Public Health/Newborn Screening. This position reports to Division Director Eric Vermeulen. //2005//***

#### **D. OTHER MCH CAPACITY**

/2001/ The MCH 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 a MPH, a nurse with an MSN, an MSW, an MA/MPA, and a MPH student.

/2003/ With the commission reorganization, MCHS management team lost the NBS manager and the ICLPPP Director reports to the Assistant Commissioners for Child and Family Health Services.

/2004/ Since FY 2000 several changes have occurred in the MCHS management team. All staff are currently centralized in ISDH. The two HSD Team Leaders who also helped to manage CSHCS returned to full time with MCHS. Both positions will have new staff by submission of this grant?in 2000, the R.D./MPA was replaced with a Team Leader with two degrees (English and Psychology) and 20 years experience in disability determination and management; in 2003, the R.D./MPH took the position of Chronic Disease Coordinator of Primary Care Services with the new team leader having a BSW and a BA in Psychology with over twenty years experience working in disability and Newborn Screening. There have been two new team leaders in the Data Analysis Section?the current Team Leader has much information technology expertise and a degree in Education. All of these new Team Leaders had little experience in MCH. In 2002, a HSD Team Leader/Training Manager with a BS in Public Administration was added to the Management Team. In 2003, an offering of early retirement has caused a change in the grants coordinator position. This new Grants Coordination Team Leader has a BA degree with experience in Area Agency on Aging as credentials. Also, the MSN is retiring and her position will become a part of the HSD Team. //2004//

***/2005/ The MCH and CSHCS divisions merged under the leadership of a new Division Director who has a J.D. and administrative experience at Indiana Family & Social Services Administration. The previous MCH director is now Medical Director for the new division. One***

***HSD team leader (BSW and BA in Psychology) has resigned to take up a new post at FSSA. ISDH is seeking a replacement. //2005//***

/2004/ Three Health Systems Development Section Team Leaders supervise seven (one vacant position) professional consultants including one MSN, one Ph.D., one MSW, and three MSs (one an RN, one Genetics Counselor, and one a Certified Health Education Specialist [CHES]). The Genomics Program (formerly Genetics Disease Program) has had a turnover of Genetics Counselors since our initial Genetics Counselor/Director left in fall of 1999. The current director started in February 2003. MCHS has contracted with a MPH intern to assist with completion of and initiation of the Genetics Planning Grant and the Genetics Implementation Grant and by July 2003, a contractor (R.D.) and another MPH intern will be available to assist with implementing the IBDSS and the Genetics Implementation Grant. Also, an Adolescent Health Program Director began work in February 2003. This section has a support staff of one administrative assistant, one secretary, and one temporary secretary. The IFHL staff, part of HSD team, includes the supervisor, two full time communication specialists, one data coordinator/communication specialist, 2.5 FTE communication specialists and .5 data support contracted through a grantee, and two temporary support staff. This staff number will be reevaluated as the IFHL becomes an IN 211 Center. //2004//

/2004/ MCHS Data Analysis Section team leader is assisted by a secretary, two data entry staff, and a contracted technical consultant junior level. The Grants Coordination team leader is assisted by one administrative assistant (decreased by one retirement in 2002) and a program coordinator. MCHS also supports one dentist (position vacant), a dental hygienist, four fluoridation staff and two secretaries?one temporary?in the Oral Health Program; one lawyer in ISDH legal department; two Information Technology Services staff plus three contractual positions in ITS; and one Epidemiology Resource Center professional. //2004//

/2001/ CSHCS staffing has become more stable in FY 2000. The management team includes the Director, Program Manager, Eligibility Manager, Claims 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 a 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.

/2003/ With the centralization of CSHCS staff, the MCHS Team Leaders who also provided management for CSHCS were no longer needed in the CSHCS and returned to full time in MCHS.

/2004/ During 2002, the Program Manager was reassigned to another area of ISDH; her responsibilities were absorbed by the Prior Authorization and Customer Service (PA-CS) Unit Manager, who now oversees the Eligibility Unit. The new full time Director resigned; the position is currently vacant (responsibilities covered by the Assistant Commissioner of Family Health Services). The Care Coordination Team Leader began working as the HSD Team Leader/Training Manager for MCHS and the CSHCS computer expert is now part of the IT team. The Claims Manager, who is an army reservist, was called to active duty; his responsibilities are being handled by his assistant, a Program Director 2, who has a BS degree in history. The NBS Manager is currently the highest level manager in CSHCS. //2004//

/2004/ In addition to the PA-CS Manager, this Section includes 2 Nurse Consultant 3s, 2 PH Nurse Consultant 3s, 6 temporary RNs, 2 Welfare Consultant 3s, 1 contract staff, 4 secretaries (and 4 additional vacant secretarial positions), 5 temporary clerical staff. In the Claims Section, there are a program coordinator, a business administrator, a secretary, an account clerk, five temporary staff, 2 vacant social service specialists and a vacant account clerk position. CSHCS is planning to post 7 new clerical assistant positions soon to replace some of the temporary staff. //2004//

/2003/ With the expansion of the NBS Program to include Universal Newborn Hearing Screening tracking and follow-up and the tracking and follow-up of the additional 17 genetics screens, the Sickle Cell program, and the Hemophilia program, staffing for NBS has increased to include a Public Health Administrator 2, a Chief Nurse Consultant 2, a temporary Nurse Practitioner, two temporary Administrative Assistants, and a temporary secretary?all supervised by the Program Director1. This

improved staffing has occurred since the NBS Program has been organizationally relocated to the CSHCS Director. One permanent staff (RN) was transferred from the CSHCS staff. The hospital liaison position no longer exists.

/2001/ Within MCHS and CSHCS state staff are approximately seven parents or grandparents of children with special health care needs. One is 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.

/2003/ One CSHCS staff has a son that is hearing impaired. She has been very instrumental in assisting the IFHL in up-grading its TTY and training staff to work with the deaf and hearing-impaired community.

## **E. STATE AGENCY COORDINATION**

/2004/ The following are examples of MCHS coordination with other state agencies. //2004//

/2001/ 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.

/2002/ The MOU between MCHS, OMPP, and CSHCS no longer includes case management reimbursement for children with special health care needs. This MOU is in the final stages of development.

/2003/ Due to the reorganization in both agencies this MOU is still not completed.

***/2005/ Medical Director of the MCSHC is a member of the First Steps Interagency Coordinating Council and the Board for the Coordination of Child Care with FSSA staff and other state agencies and consumers. //2005//***

/2001/ 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 testing, children with special health care needs, prenatal care standards, diabetes, asthma, immunizations, 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.

/2001/ 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

/2001/ 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.

/2001/ 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.

/2002/ MCHS continues to contract with IFHC to monitor and provide technical assistance to Title V family planning grantees.

***/2005/ ISDH is coordinating with IFHC and the Indiana University School of Nursing to develop a comprehensive policy and procedure manual for Title V grantees and contractors. ISDH also contracts with IFHC to purchase supplies in bulk for all Title V grantees using the special discounts available to Title X providers. //2005//***

/2002/ Throughout the year (usually at holiday times) press releases are provided on childhood safety issues. These are done in collaboration with the U.S. Consumer Product Safety Commission.

/2001/ 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 Whitcomb 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.

/2002/ The internship for the genetics student is on hold until a genetics professional can be hired.

/2004/ During the summer of 2003, the Genomics Program will hire an MPH intern to assist with the expansion of the IBDSS in the State. //2004//

***/2005/The MPH intern is now the training/education contractor for IB DPR and Genomics through a contract with Indiana Public Health Association, another agency collaborator. //2005//***

/2001/ 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.

/2002/ The State Adolescent Health Coordinator attended the CDC Office of Smoking and Health/Division of Adolescent and School Health's School-Based Tobacco Control Workshop in Charlotte, NC as part of the Indiana team. This team will now serve as the School-Based Work Team to advise the new Indiana Tobacco Prevention and Cessation Agency. The State Adolescent Health Coordinator serves as a member of the Indiana Department of Education Safe and Drug Free Schools Advisory Council. This council, comprised mainly of local Safe and Drug Free Schools Coordinators, will advise the IDOE on providing training to local coordinators.

/2004/ In Spring 2003 CDC awarded IDOE and ISDH the five-year Comprehensive School Health

Program grant. Of the \$200,000 first year award, ISDH is receiving \$60,078 to hire a staff person to build the agency's capacity to implement and coordinate effective school health programs. Priority areas of the first year are to build infrastructure and partnerships, perform a needs assessment, and begin to market the concept of coordinated school health programs (focusing on increasing physical activity, improving nutrition, and decreasing tobacco use among school age children) to school districts and the public. //2004//

/2002/ Healthy Start Consultation is provided to both the Northwest Indiana Healthy Start and to Healthy Start Indianapolis by two HSD consultants. The federally funded Healthy Start initiatives to reduce infant mortality and disparity have submitted grant applications for July 1, 2001 funding. If their application is funded, Healthy Start Indianapolis will change their focus from prevention of pregnancy in adolescents to eliminating disparities in prenatal care through collaboration with five major hospitals, Marion County Health Department clinics, federally qualified health centers, community-based organizations, three consortiums, and ISDH/MCHS. Healthy Start Indianapolis has actively enlisted the services of MCHS and assisted with the funding of the Raphael Drop-In Center, located in a GIS high-risk area. This group is also involved in the Friendly Access Pilot Project. If the application is funded for Northwest Indiana Healthy Start, objectives and service interventions will remain the same? case management, outreach/recruitment, and health education for consumers and professionals. This collaboration among four culturally diverse cities/health departments in Lake County has requested and accepted less input from HSD consultants and MCHS in their efforts.

/2003/ Both the Indianapolis and Lake County Healthy Start grants have been funded and are working in collaboration with ISDH and other local agencies to impact perinatal outcomes in GIS targeted areas through multimedia efforts, health education, community outreach and prenatal care coordination.

/2002/ In February 2001, the PSUPP Director and the MCH ASK Consultant participated in preparing an application for funding available from the Association of Maternal and Child Health Programs (AMCHP) Tobacco-Free Futures III Mini-Grant. The application, "Smoke-Free Hoosier Families", was written in collaboration with Healthy Families Indiana Training and Technical Assistance Project, FSSA, Smokefree Indiana, and Indiana Head Start Partnership Office. The funding request of \$10,000 is for ongoing training purposes with a train-the-trainer plan to facilitate statewide access to smoking cessation training and a Smoke-Free Hoosier Families event. Although AMCHP did not fund the application, an attempt will be made to carry out the program with Tobacco fund dollars, MCH and other funding.

/2003/ The PSUPP Director responded to the RFP of the Indiana Tobacco Use Prevention and Cessation Agency to secure funds to expand PSUPP services. The grant was approved for \$913,220 over 2 years. PSUPP sites will be implemented in seven grantee agencies and will serve thirteen additional counties with high rates of pregnant smokers. During SFY 2003 with this expansion, PSUPP anticipates screening 3000 pregnant women for substance use, effecting a 47.5% reduction in cigarette use, a 90% reduction in alcohol use, a 76.4% reduction in street drug use, and an 89.3% reduction in over-the-counter drug use. Three prenatal smoking cessation trainings for professionals will also be held.

/2003/ During FY 2001 the Sealant Program Consultant, funded by Title V, took a position with the IU School of Dentistry (IUSD). Oral Health Division now works in collaboration with the IUSD to provide dental sealants. The IUSD received CHC funding in FY 2002 and 2003 for a mobile dental unit to provide school-based dental sealants in rural areas, particularly those near community health centers. Student dentists and hygienists will provide staffing for the unit. The mobile unit should be ready by fall of 2002.

/2004/ The Dental Mobile unit began providing sealants in schools in early spring 2003 with some additional funding from MCHS for short term staffing. //2004//

**//2005/ ISDH continues to support the Dental Mobile unit. //2005//**

/2003/ The Rural Health Association also received a CHC funded contract to assist ISDH in identifying and facilitating the designation of rural communities that are Dental Health Professional Shortage Areas. This will establish a mechanism for community health centers to fund provision of dental

services.

/2003/ CSHCS continued serving program participants at Riley Hospital for Children by funding a CSHCS satellite office at Riley Hospital. Through the CSHCS program's long-standing partnership with Riley Hospital for Children, CSHCN and their families have an easily accessible and expedited entry to the CSHCS program. The Riley Office includes full-time office staff including an R.N. who attends all CSHCS program staff meetings and Medical Review Committee Meetings. In FY 01, Riley Hospital completed 232 applications for the CSHCS Program.

/2004/ CSHCS routinely collaborates with OMPP, Indiana Comprehensive Health Insurance Association, First Steps, SSI and Indiana Parent Information Network to ensure children with special needs have access to preventive, primary, and specialty medical and dental care. //2004//

***/2005/ ISDH is now working with Indiana University School of Dentistry to expand craniofacial reconstruction for children born with severe dental problems. The university now has one full time dentist who serves as chair for this program, working with interns and with plastic surgeons to design and implement craniofacial reconstructive surgery for Indiana's CHSCN population. //2005//***

/2004/ During 2003 MCHS is implementing the Child Care Health Consultant Program with funding from FSSA. //2004//

***/2005/ CCHC funding continues from FSSA. This program has expanded as described above. //2005//***

## F. HEALTH SYSTEMS CAPACITY INDICATORS

/2004/ Since receiving the Genetics Planning Grant and an SSDI grant in 2000, improving data accessibility through improved technology, data integration and interagency data collaboration has been priority for MCHS and CSHCS. The Genetics Planning Grant and the initial data integration SSDI grants began the efforts at creating a Child Health Profile. CDC funding for IBDSS, a second SSDI data integration grant, a newborn hearing screening grant, and the Genetics Implementation grant has furthered the data integration effort through the completion of a prototype Operational Data Source (ODS) with Data Marts for IBDSS and NBS that integrates data from newborn screening labs, hospital discharge data for birth defects codes for children under 2 years, newborn hearing screening outcomes, and delayed birth and death data. Concurrently, Vital Records Section of ISDH is implementing a new web-based system that should improve quality and timing availability of birth and death data. The ODS will integrate data from vital statistics, cancer registry as well as NBS and IBDSS. It may be expanded to create a chronic disease registry. //2004//

***/2005/ In the fall of 2003, the supervision of the IBDSS grant and implementation was moved from Epidemiology Resource Center (ERC) to MCHS where additional staff had been contracted through the Genetics Implementation Grant to support the registry. The name was changed to Indiana Birth Defects and Problems Registry (IBDPR). Additional Information Technology consultants were hired to develop the truly functional Data Mart for IBDPR. A system is in place to confirm the targeted birth defect data submitted by the hospitals through chart audits. It is hoped that data for births in 2003 will be available by 2005.//2005//***

/2003/ In 2001, the ISDH CSHCS technology support team developed and implemented an integrated data system for newborn hearing screening data. First Steps also modified its data collection system and developed a tracking system for enrollments and referrals. This will allow timely diagnostic evaluation and early intervention services that are needed by children identified with hearing loss. An accurate and completed statistical report will be available by June 2002. A Grant Implementation Committee and Evaluation Committee have been formed to assist in monitoring the implementation of the program.

/2003/ During FY 2002 the CSHCS Program spearheaded the development of ACAPS (Agency Claims and Administrative Processing System), a replacement for the data collection and claims paying system designed at Y2K crisis, that will allow the program to meet HIPAA deadlines for

compliance with requirements related to protecting the confidentiality and security of health data. The ACAPS system will comply with HIPAA standardization for electronic patient health, administrative and financial data by utilizing EDI transaction and code set standards federally mandated by HIPAA. The new system will provide security by protecting the confidentiality and integrity of individually identifiable health information, past, present or future. Increased efficiency, through a more automated and improved workflow, will improve overall service to stakeholders.

/2004/ ACAPS is not currently operational but is in the testing phase. The current system is capable of obtaining data on SSI beneficiaries and asthma, but it should improve with ACAPS. //2004//

**/2005/ ACAPS was fully implemented on January 1, 2004. All modules of the system became operational on February 4, 2004 and greatly improved data access on SSI beneficiaries and asthma. Additional system enhancements will continue through the remainder of 2004. //2005//**

/2004/ The MCHS grantee data collection system, Federal Resource Enabling Data (FRED), was also made HIPAA compliant in 2003. This took precedence over creating useful reports for the grantees to use for their annual reports. An evaluation of the data necessary to collect is now underway. This database may be a source of data regarding childhood obesity for a percent of the population, along with the YRBS, WIC, and possibly Medicaid data. Youth smoking data, prenatal visit data, and data for comparison with Medicaid outcomes could be available on this database. //2004//

**/2005/ ISDH has developed a variety of FRED reports to extract demographic information for reporting and needs assessment. ISDH continues to modify FRED to make the system easier to use and more reliable. The majority of ISDH MCH statistical reports are now generated by this system. //2005//**

/2004/ Collaboration has improved between MCHS and Medicaid to retrieve the Medicaid and SCHIP related health system capacity indicators. Indiana Health and Hospital Association collaboration has improved ISDH ability to obtain hospital discharge data (e.g. asthma and birth defects) and legislation aided ISDH in getting hospital discharge data directly from the hospitals for IBDSS. The Indiana Youth Tobacco Survey is done every other year in selected schools. The Adolescent Health Coordinator tries to coordinate the YRBS with the tobacco survey to obtain the youth smoking indicator. //2004//

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

The mission statement of the Indiana State Department of Health (ISDH) is to "promote, protect, and provide for the public health of people in Indiana". The ISDH vision statement affirms, "The Indiana State Department of Health is committed to facilitation of efforts that will enhance the health of people in Indiana. To achieve a healthier Indiana, the ISDH will actively work to: promote integration of public health and health care policy; strengthen partnerships with local health departments; 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. This broader public health view also includes strengthening the social, economic, cultural, and spiritual fabric of communities in our state.

In order to fulfill our mission, the Indiana State Department of Health/Maternal and Children's Special Health Care Services (MCSHCS) continues to strive to meet the performance goals established by national initiatives (such as MCHB's National Performance Measures) as well as state initiatives, based on the latest needs assessment. The needs assessment results focused on the following health status indicators: Asthma Hospital Discharges, Medicaid/CHIP Screening, Prenatal Care Adequacy, Low/Very Low Birthweight, MCH Access to Data Sources, Fatal/Non-Fatal Injuries, Chlamydia Rates, Dental Screening, and Adolescent Tobacco Use. The needs assessment results have dictated the focus of the State Priorities listed in the following section, "B. State Priorities". Program and resource allocation issues are determined using the State Priorities for guidance. Utilizing the MCH "pyramid", program and resource funding has been carefully allocated to cover not only the State Priorities but also to cover all four of the "pyramid levels". Direct Health Care is being evaluated with performance measures (PMs) for Newborn Screening, CSHCS Family Involvement, and Asthma Hospitalization. Enabling Services PMs include the CSHCS Medical/Health Home and decreasing tobacco use in prenatal smokers. Population based PMs address: CSHCS Insurance, CSHCS Community Systems, CSHCS Transition Issues, Immunization Rates, Teen Birth Rates, Dental Sealants, Child Motor Vehicle Accidents, and Lead Screening. Infrastructure Building PMs include: Breastfeeding Improvements, Newborn Hearing Screening, Child Health Insurance, Medicaid Usage, Very Low Birth Weight, Teen Suicide, High Risk Deliveries, Prenatal Care, Data Access, Black Prenatal Care, MCH Family Involvement, and Genetics. State and National Performance Measures have been established and hold us accountable for the success (or failure) of each of these initiatives. Outcome Measure data for Infant Mortality, Black/White Infant Mortality Disparity, Neonatal Mortality, Postneonatal Mortality, Perinatal Mortality, and the Child Death Rate are also monitored and reported annually.

Specifically, within the "pyramid" level of Direct Medical Services ISDH/MCSHCS funds programs to provide genetics services, immunizations, dental sealants, sickle cell prophylactic medicine, lead poisoning prevention, direct medical care for pregnant women, infants, children, adolescents, family planning, STD screens, free pregnancy screens, and health screens for CSHCN. Funded Enabling Services programs provide genetics services education, prenatal and family care coordination, newborn screening and referral, sickle cell management, prenatal substance use prevention program (PSUPP), Child Care Health Consultation (CCHC) and coordination with Medicaid/WIC in addition to many other programs.

Population- Based Services that are provided by ISDH/MCSHCS or funded by MCSHCS include the Indiana Family Helpline, the Early Childhood Comprehensive Systems (ECCS) program, the newly formed asthma coalition, the adolescent pregnancy initiative, sudden infant death counseling, dental fluoridation efforts, and the infant mortality review to name a few. ISDH Infrastructure Building Services include efforts such as the Indiana Perinatal Network; the MCH, NBS and PSUPP data systems; the integration of data systems to facilitate the Indiana Birth Defects registry, the genomics and Newborn Screening Education efforts and other data analysis efforts for planning and reporting; policy and standards development; planning, evaluation, and monitoring; and quality assurance to MCH grantees.

Progress toward the achievement of our National and State performance goals is reported in Sections C and D following. ISDH/MCSHCS continues to build on previous year's successes. This year's Annual Report reflects that six of the thirteen National performance measures are met (not including

the five new measures which require new baseline data), and six of the seven State performance measures are met. Many of the performance measures that were not actually met were close and showed improvement from the previous year. As we look toward meeting future goals and establishing new priorities with the completion of the next Needs Assessment, ISDH/MCSHCS remains committed to the hard work, determination, (and proper funding and staffing) that are the keys to achieving successful health outcomes for the people of Indiana.

## B. STATE PRIORITIES

Indiana experiences high rates of low birthweight, infant mortality, and inadequate prenatal care with greater disparity among minority populations. Childhood immunizations, while significantly improving, are still below HP2010 targets and environmental hazards such as lead and second hand smoke threaten the health of tens of thousands of children and adults.

Risky behaviors among adolescents lead to teen pregnancy and childbearing and high rates of tobacco use. Obesity among children and adults contributes to higher incidences of chronic diseases like diabetes and cardiovascular diseases, which contribute to escalating health care costs.

A high priority must be given to expanding the availability of care for isolated rural residents and underserved urban and suburban persons and to assisting the MCH populations access to needed services, including the continued need to identify early and link children with special health care needs to appropriate services. At the same time, broad based education and outreach is needed to improve knowledge of healthy practices among the entire population.

The top priority needs identified in Indiana are:

1. To improve pregnancy outcomes especially infant mortality, fetal deaths, and low birth weight and to decrease disparities among minority populations.
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.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

### a. Last Year's Accomplishments

FY 2003 Performance Objective: Maintain or improve on the 99+ percent of newborns with at least one completed NBS test.

Status: In FY 2003 the percent of newborns in the State with at least one screening for selected genetic conditions increased from 99.4% to 99.6%. Objective met.

?Newborn Screening (NBS) program provided diagnosis, follow-up, management, family counseling, support, equipment, supplies, and formula, for infants identified as having these conditions. This program works closely with the community-based medical follow-up clinics, educational programs, and the MCH Genomics Program to ensure follow-up and treatment for

infants diagnosed as having one of the designated disorders. A NBS Advisory Group assisted with developing recommendations for additional screens and the protocols involved. CSHCS contracts with grantees to provide intervention services for infants with positive tests.

?The Tandem Mass Spectrometry screening began January 2003. As a result an estimated 25-30 positive metabolic cases were expected each year. A rule change for a service charge fee increase was approved.

?Penicillin was provided directly to 60 Sickle Cell clients by ISDH through their physicians. CSHCS has contracted with one of the regional centers that has a pharmacy to distribute penicillin to the clients' physicians. The NBS/ISDH/CSHCS staff worked with regional clinics and educational programs to develop an integrated data system that allows timely and accurate tracking and follow-up of children identified with Sickle Cell Disease, Sickle Cell Trait and other Hemoglobinopathies.

?In December 2002, NBS staff assisted Indiana State March of Dimes to develop an educational CD, which introduced NBS expanded screening to the primary care providers.

?The ISDH NBS program continued to monitor 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, as well as in--service training to hospitals. The NBS Section continued to increase its quality assurance and educational outreach activities in collaboration with the Indiana Family and Social Services Administration (FSSA). Revised hospital policy manual were provided to hospitals in June 2003. Both IU-NBS Lab and ISDH NBS program sent staff to training on tandem mass screening and follow up by the National NBS and Genetics Resource Center.

?NBS Section, IU-NBS Lab and Riley Hospital's NBS follow-up programs continued to work collaboratively to follow-up confirmed metabolic screening cases. Immediately after diagnosis, follow-up is to be done to ensure that infants confirmed to have one of the designated newborn screening conditions are receiving appropriate treatment and their parents receive appropriate counseling and information.

?Follow-up was conducted on 100% of newborns receiving invalid and abnormal metabolic screens.

## b. Current Activities

FY 2004 Performance Objective: Maintain or improve on the 99+ percent of newborns receiving initial screen and 100% of infants with confirmed positive receiving treatment and follow-up.

?The Newborn Screening Section will continue to monitor the Meconium Screening program data to determine if revisions are needed for meconium screening criteria, and will collaborate with other drug-screening programs to compare data.

?Training to professionals regarding NBS will be provided as needed

?Continuing to follow-up on all screening test results until they are complete and negative or receiving treatment.

?Continuing to refer to the Genetics, Sickle Cell, First Steps and CSHCS programs.

?The NBS Director is continuing to serve as the chairperson for the screening subcommittee of the Indiana Genetics Advisory Committee.

?Continuing to work closely with the Public Health Nurses for follow-up as needed.

?Providing in-service training to Public Health Nurses and hospitals.

?Completed computerized tracking via Access database. Beginning development of interfacing NBS into the Operational Data Store (ODS), in Indiana University lab data is integrated with vital statistics.

?CSHCS contracted with one of the local clinics to distribute Penicillin due to HIPAA concerns. The NBS/ISDH/CSHCS staff worked with regional clinics and educational programs to develop an integrated data system that allows timely and accurate tracking and follow-up of children identified with sickle cell trait and sickle cell disease and other blood hemoglobinopathies.

Hemophilia-Amish Outreach Program

?Continuing to provide services to the Amish population in northern Indiana by the Mennonite

nurse.

?Continuing to provide cord blood testing kits when IHTC is notified of an upcoming delivery. ?  
Continuing to provide services in the clinic established for family members of von Willebrand disease.

?Continuing to utilize the new database for carriers (genetic/carrier registry).

?Continuing to contract services (1 day per week) of a genetic counselor.

?Continuing to conduct an annual outreach clinic in Middlebury, Indiana.

Hemophilia-Amish Dental Intervention Project

?Continuing to provide dental care to the medically underserved and uninsured population of Amish children in northern Indiana.

?Continuing to provide water testing, education, and fluoride supplements to the medically underserved and uninsured population of Amish children in northern Indiana.

?Continuing to provide dental education in the Community Dental Clinic and in the schools.

?Continuing to employ services of a full-time dentist.

### c. Plan for the Coming Year

FY 2005 Performance Objective: Maintain or improve on the 99+ percent of newborns receiving initial screen and 100% of infants with confirmed positive receiving treatment and follow-up.

?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, First Steps and CSHCS programs.

?Continuing to work with the NBS Advisory Task Force to determine rules, procedures, and policies.

?The NBS Director will continue as the chairperson for the screening subcommittee of the Indiana Genetics Advisory Committee.

?Work closely with the Public Health Nurses for follow-up as needed.

?Provide in-service training to Public Health Nurses and hospitals.

?Continue integration of NBS data into the ODS.

Hemophilia-Amish Outreach Program will continue as described above.

Hemophilia-Amish Dental Intervention Project will continue as described above.

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

### a. Last Year's Accomplishments

Status: This Performance Measure has been redefined using the SLAITS Survey. The survey revealed 61.1% of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive.

?The CSHCS Program again required all CSHCN managers to attend a two-day cultural competency course.

?The CSHCS Program continued to utilize a medical review committee, staffed by a pediatrician and three eligibility nurses, which reviews unique cases, researches current treatment regimens, and pursues alternative-funding sources before expending CSHCS program dollars.

?The CSHCS Program continued development of a new telephone/communication system to improve family access to customer service consultants, developed a remote computer system connection to Riley Hospital that improved quality assurance of authorizations and payment,

increased outreach to eligible children, and provided easier identification of cases requiring closure.

?During FY 2003, the Indiana Parent Information Network's (IPIN), the group CSHCS supports to provide our parent participation efforts, activities included state policy development and family involvement in a myriad of areas including education and training in health care financing options for service coordinators of infants, toddlers, and preschoolers; participation on the Medicaid Select Task Force for Indiana Medicaid managed care for children and adults with disabilities; assistance to families and professionals using CSHCS; acting as lead agency for Healthy Child Care Indiana; a Core Partner in the Early Childhood Comprehensive System (ECCS) grant; and the Dyson Community Pediatrics Initiative at the Indiana University School of Medicine.

?CSHCS also supports IPIN Parent Liaisons at: the Family Resource Center at Riley Hospital for Children; the medical home model at North Arlington Health Center, an inner city health clinic; and the Ronald McDonald House. The program also supports a Parent Liaison in New Albany, Indiana.

?IPIN also contracts with Community Parent Liaisons to assist in the development of informational materials, implementation of public awareness activities, and attend educational case conferences.

?IPIN has a new website, <http://www.ipin.org/>, with a resource directory, web links, downloadable brochures, and training activities. The resource directory is also available on CD.

?IPIN publishes the Indiana Directory of Parent Information and Support Groups as well as the Directory of Indiana Parent Leaders of Children with Disabilities and Chronic Illness in an effort to keep families throughout Indiana involved.

CSHCS is also a partner with IPIN in the implementation of the Family to Family Health Information and Education Center through a grant from the Centers for Medicare and Medicaid Services.

## b. Current Activities

FY 2004 Performance Objective: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels will be satisfied with the services they receive. (63% baseline)

?Indiana Parent Information Network (IPIN) and Riley Hospital (RH) use Indiana State Department of Health (ISDH) Children's Special Health Care Services (CSHCS) funds to implement the Indiana Medical Home (MH) project. Activities include training new medical residents, parents, providers, and others and linking all to parent-advisory groups in other states.

?ISDH contracts with IPIN to train families regarding health care financing in the private insurance sector as well as state-funded systems such as Medicaid and the State's high-risk insurance pool program.

?Parents assist in the preparation and review of the goals found in the ISDH Maternal and Child Health (MCH) Title V Block Grant.

?The MSHCS Division Director serves on the State Transition Team made up of Early Intervention, Head Start, Special Education, and First Step (FS) representatives.

?ISDH contractually supports the Indiana Hemophilia and Thrombosis Center for outreach and direct services for care coordination, referrals, and dental coverage to the Amish Community.

?ISDH/MSHCS funded the Indiana Medical Home Project survey coordinated by Dr. Nancy Swigonski and IPIN to determine parents' and providers' levels of understanding and satisfaction with the ISDH CSHCS program and its associated policies that link children to primary medical homes. The survey results are in the process of being finalized this year for publication and will be used in the Early Childhood Comprehensive Systems (ECCS) Needs Assessment.

?Key partnerships have been established by ISDH with IPIN, families, participants, providers,

Indiana University, the Indiana Hemophilia and Thrombosis Center, First Steps, Indiana Family and Social Services Administration, Head Start, the Indiana Department of Education, and the Governor's Office.

?The CSHCS Program is also in the process of soliciting additional parents to sit and participate in the Advisory Committee for Children with Special Health Care Needs. The CSHCS Program continues to facilitate participation on the Advisory Committee by allowing participation by phone to ease the burden of child care and travel.

### c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels will be satisfied with the services they receive 63% from SLAITS data.

?The CSHCS Program will renew its contract with IPIN to ensure parental involvement and make funding available for parental training, newsletters, special projects, etc.

?The CSHCS Program will publish additional brochures and pamphlets in Spanish to promote outreach to Hispanic parents. Although it does not have a Spanish speaking consultant, CSHCS uses the translation services provided through the Indiana Family Helpline when needed.

?The CSHCS Program will revise its policies based upon the survey data obtained from parents of children with special health care needs.

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

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The percent of CSHCN in Indiana who have "medical/health" home will be maintained at 55.7% in FY 2002 and FY 2003.

Status: The percent of CSHCN in Indiana who have a "medical/health" home is 55.7% in FY 2003. (SLAITS Data). Definition changed, this is baseline.

?Hoosier Healthwise Package A, and are encouraged to apply and enroll in Hoosier Healthwise Package C. Hoosier Healthwise links all of its participants to primary medical providers to provide well child care. This linkage to Hoosier Healthwise allows the CSHCS Program to serve as a wrap-around service program for children who are dually eligible.

?The CSHCS Program continues to link all CSHCS participants to primary medical providers to ensure that the children received primary well-child care and coordinated specialty health care.

?The CSHCS Program transitioned all children receiving locally base care coordination services to centrally based care coordination services through the central office staffed with registered nurses.

?The CSHCS Program continues to work collaboratively with IPIN and Dr. Nancy Swigonski to obtain information from parents regarding their satisfaction with the ongoing medical care that they received.

?The CSHCS Program was re-organized to include Indiana's Newborn Screening Program, Hearing Screening Program, Sickle Cell Program, and Hemophilia Program to better coordinate early referral and follow-up for children with special health care needs. In addition, CSHCS and MCH are now housed under the same administrative structure, promoting additional coordination, and early referral and follow-up.

?ISDH received a CDC grant to develop an active Birth Problems Registry called the Indiana Birth Defects Surveillance System (IBDSS). The IBDSS was initiated. An Operational Data

Store, a platform to integrate data, has been developed for use by IBDSS and NBS. Each program will have its own data mart.

?Materials from the Provider Network Project in Lake County that tried to electronically link primary providers with tertiary providers in Chicago will be shared nationally.

?CSHCS continues to participate in the support of the Indianapolis Medical Home (MH) Project in one of the Marion County (Indianapolis) Health and Hospital Corporation community health centers.

?ISDH is using the SLAITS survey, a tool in formulating its MH model to include family needs, education, dental and medical care access, care coordination, health status, and customer service.

?Through the Genetics Implementation Grant, MCSHCS contracted with IPIN and the Unified Training Services (UTS) to provide two physician trainings and one medical home task force advisory meeting.

## b. Current Activities

FY 2004 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be increased to 56% in FY 2004.

?Through the Genetics Implementation Grant, the Indiana Parent Information Network and Unified Training Services (UTS) continued providing physician training in communities by holding 5 additional meetings with 5 more planned.

?Two advisory meetings were held. This has assisted in developing the infrastructure to promote the medical home concept. Practitioners have been identified who care for children with special health care needs. Professional training for newly contracted doctors is provided through a four-part video to physicians and their staff who provide primary care services to CSHCN.

?CSHCS customer services consultants assist CSHCS enrolled clients in linking to a medical home. First Steps service coordinators facilitate a medical/health home for all clients enrolled. The First Steps NICU outreach referral system for the 0-3 population links/enrolls NICU babies/families into First Steps and possibly into CSHCS before discharge and assists families into a medical home as part of the Individualized Family Service Plan (IFSP).

?ISDH pays for all in office primary care provider (PCP) services, specialty care providers (SCP) for services related to eligible diagnosis, most dental services, and all legend drugs at the maximum Medicaid-allowed rates for CSHCS participants.

?All CSHCS participants are linked to a medical home as a requirement of enrollment. SLAITS survey results will be used to assure the quality of the effort.

## c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of CSHCN in Indiana who have a "medical/health" home will be improved to 56% in FY 2004 and maintained through FY 2005.

?Continue to enhance the HIPAA compliant information system to facilitate the linkage and tracking of medical services for children with special health care needs. Establish data linkages.

?Implement HIPAA compliant data linkages for CSHCS, Newborn Screening, Sickle Cell and other programs within ISDH to facilitate early, appropriate referral and tracking of services.

?Continue to streamline the Provider Enrollment process to facilitate enrollment by primary and specialty providers to increase the choice of providers for families when selecting a primary medical home.

?The ECCS planning project workgroup on Medical Home and Access to Health Insurance will make recommendations by July 2005.

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

#### a. Last Year's Accomplishments

FY 2003 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will increase to 79% in FY 2003.

Status: 63.3% of children with special health care needs whose families have adequate private and/or public insurance to pay for the services they need per SLAITS data. Objective not met.

?Of the 8,809 children that the CSHCS Program served in FY 2003, 2,898 also had private insurance (non-Medicaid) other than that offered by the CSHCS program. This represents 33% of all program participants. Four thousand, five hundred forty-one children had Hoosier Healthwise (Medicaid), which represents 52% of all program participants.

?The CSHCS Program, First Steps, and MCH Programs continued to use the combined enrollment form that is also accepted as an enrollment form for Hoosier Healthwise. The continued use of this form allows children with special needs to simultaneously enroll for various types of public insurance and other program benefits.

?CSHCS also began participating in the Governor's Interagency Coordinating Council's initiative to achieve paperwork reduction. As it relates to CSHCS, the task has been to simplify and streamline the combined enrollment form where possible in an effort to make the form more client-friendly.

?All applicants for the CSHCS Program continue to be required to apply for Hoosier Healthwise Package A, and were encouraged to apply and enroll in Hoosier Healthwise Package C. Hoosier Healthwise links all of its participants to primary medical providers to provide well child care. This linkage to Hoosier Healthwise allows the CSHCS Program to serve as a wrap-around service program for children who are dually eligible.

?The CSHCS Division Director has continued to co-chair the Advisory Committee for CSHCN, to facilitate the integration of services across programs and state agencies.

?Both ISDH and IPIN staff received additional Indiana Department of Insurance training on maximizing private insurance coverage and leveraging public coverage. The combined enrollment form provides parents with a "one-stop-shopping" opportunity for MCH, Medicaid, First Steps, SCHIP, and CSHCS programs to increase access and minimize duplication. All participants must apply for Medicaid and are re-evaluated annually as a condition of continuing coverage.

?The CSHCS program implemented its HIPAA-compliant information system (ACAPS--Agency Claims and Administrative Processing System) that will soon have the capability to track and facilitate the updates for current insurance enrollment through changes in employment, income levels, etc.

?The CSHCS program published a CSHCS-specific Web Page to provide information to potential applicants to promote outreach. THE URL is <http://www.in.gov/isdh/programs/cshcs/>

#### b. Current Activities

FY 2004 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will be increased to 65% in FY 2004. The SLAITS survey is done every other year and the related fields are pre-filled on the grant application for all states. Next year new data will be available.

?The CSHCS Program is continuing to use the combined enrollment form to facilitate enrollment in various public insurance programs for children with special health care needs. The CSHCS Program is developing a HIPAA compliant information system, which will facilitate

the tracking of insurance for CSHCS participants. By capturing better, more accurate data, the CSHCS Program will be able to make data driven policy decisions regarding insurance coverage and outreach.

?A CSHCS Specific Web Page has been created to provide information to potential applicants to promote outreach. The URL is- <http://www.in.gov/isdh/programs/cshcs/>.

### c. Plan for the Coming Year

FY 2005 Performance Objective: Children with special health care needs who have a source of insurance for primary and specialty care will increase to 65% in FY 2004 and be maintained at 65% in FY 2005.

?Refine and enhance ACAPS to track and facilitate the updates for current insurance enrollment through changes in employment, income levels, etc.

?The CSHCS Program will provide better customer service through capturing and tracking better insurance enrollment data for participants.

?Continue to use a combined enrollment form that facilitates enrollment in multiple appropriate programs without the use of multiple, duplicate forms, and look for ways to revise the combined form to create greater ease of use for applicants.

?Investigate and assess the viability of on-line enrollment forms on a web-based system.

?Continue to bill Medicaid for travel reimbursement to maximize the CSHCS state budget while having no impact upon family services.

?Update and enhance the telephone/communication system that is currently in place to provide additional options to parents and providers.

?The ECCS planning project subcommittee on Medical Home/Access to Health Insurance will make recommendations by July, 2005.

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

### a. Last Year's Accomplishments

Status: 79.5% of families with children with special health care needs age 0 to 18 report the community-based services systems are organized so they can use them easily. (Baseline)

?The CSHCS program published web-based bulletins/information updates for providers that are specific to their specialty areas (i.e. Durable Medical Equipment, Pharmacy, Physical Therapists, etc.).

?The CSHCS program obtained signed HIPAA compliant provider agreements from all participating providers.

?The CSHCS program implemented the Eligibility, Prior Authorization and Claims Payment modules of the HIPAA compliant CSHCS claims payment and information system (ACAPS-- Agency Claims and Administrative Processing System). In the coming year additional enhancements will be done to the system to allow it to accept electronic billing from providers, thereby potentially increasing the number of participating providers.

?The CSHCS Program provided updated Provider Manuals to all CSHCS providers to promote better understanding of CSHCS HIPAA compliant billing procedures.

?The CSHCS Director position was filled, and the directorship of CSHCS and MCH was combined so that all Title V elements are now housed together administratively.

?14 new state Clerical Assistant II staff persons were hired to process and authorize for payment HIPAA compliant CSHCS claims.

?The CSHCS Program worked collaboratively with the IPIN and Dr. Nancy Swigonski to survey

parents about their satisfaction with the CSHCS Program and its associated policies that link children to primary medical homes.

?The CSHCS Program continued to enroll all providers who agreed to participate in the CSHCS Program through provider agreements. In addition, in some cases, CSHCS staff helped encourage and recruit specific providers to fill a particular geographic or service need when a family was qualified for the program, but did not have an enrolled provider to utilize.

?The CSHCS Program continued to have a close working relationship with the Indiana Family Helpline (IFHL) to provide referrals to families in need of other forms of assistance than those provided through the CSHCS Program. CSHCS staff are now invited to IFHL monthly staff trainings devoted to learning about various forms of assistance that are available to families.

## b. Current Activities

FY 2004 Performance Objective: 80% of families with children with special health care needs age 0 to 18 will report the community-based services systems are organized so they can use them easily. (Baseline SLAITS data)

?Dr. Swigonski's survey results were recently published. The results from this survey will be used to revise CSHCS policies, if indicated. Some of the results were as follows: 13% of the children were reported to be in excellent health, 25% in very good health, 38% in good health, 20% in fair health and 3.5% in poor health. Children in the Medical Home control group were significantly more likely to be in excellent health. 38% of those in CSHCS needed to get or replace special medical equipment or devices with no significant differences between urban and rural areas but differed from the Medical Home (21%) and control (49%) group.

?About a third of families report the need for child or daycare with fewer children in rural areas (25%) ( $p < .1$ ). Of those who needed child or daycare about 60% report a small or big problem getting the care they needed. About 1/8 families needed help getting medical bills paid but did not get the help they needed.

?More families in the Medical Home group reported that they needed and got someone to help them access other community or public programs (30% vs. 21% respectively;  $p < .05$ ). There were no significant differences among groups in who helped or how satisfied families were with the help they received.

?Recipients of CSHCS reported paying the inpatient hospital bills as very important (60%) followed by transportation (57%), prescriptions (56%), dental (51%), paying medical bills (44%), DME (41%), providing care coordination (38%), paying for special therapy (34%), and specialists care (29%).

?The CSHCS Program continues to devote one FTE, Social Service Specialist III position to provide current community based training to First Steps providers and the Division of Family and Children (DFC) providers. This training facilitates the CSHCS Program's mission to promote systems development to improve the organization and delivery of services to children with special health care needs. ISDH posted and filled 14 new Clerical Assistant II positions for the CSHCS Program. These new state positions have eliminated the need for temporary staff that were previously utilized to pay CSHCS provider claims. In addition, the creation of state positions has provided a more cost-effective, stable workforce that will hopefully will decrease overall training needs and reduce staff turnover. Timely, accurate payment to providers should increase the number of CSHCS Providers and increase the satisfaction of currently enrolled providers.

?IPIN parent liaison services provide peer support and education services to families interacting with schools, hospitals, and medical providers.

## c. Plan for the Coming Year

FY 2005 Performance Objective: 80% of families with children with special health care needs age 0 to 18 report the community-based services systems are organized so they can use them

easily.

?UNHS will train Parent Advisors (PA) to make home visits to families with infants diagnosed with a hearing loss. The PA's will become First Steps providers and build the professional infrastructure for early intervention for these children.

?Continue to update the Provider Manual and provide copies to all CSHCS providers to promote better understanding of CSHCS HIPAA compliant billing procedures.

?Continue to update and publish web-based bulletins/information updates for providers that are specific to their specialty areas (i.e. Durable Medical Equipment, Pharmacy, Physical Therapists, etc.).

?Continue to obtain signed HIPAA compliant provider agreements from all new participating providers.

?Enhance the HIPAA compliant CSHCS claims payment and information system so that it will accept electronic billing from providers to potentially increase the number of participating providers.

?Continue to have regular meetings with Clarian Health Patient Account Executives and CSHCS claims unit managers to facilitate payment of claims and ensure that all other appropriate sources of payment are utilized before CSHCS Program dollars.

?Continue to devote one FTE, Social Service Specialist III position to provide current community based training to First Steps providers and the Division of Family and Children (DFC) providers to facilitate the CSHCS Program's mission to promote systems development to improve the organization and delivery of services to children with special health care needs.

?The CSHCS program will continue to increase its collaboration with staff members from the Indiana Family Helpline (IFHL).

*Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

#### a. Last Year's Accomplishments

Status: 5.8% of youth with special health care needs received the services necessary to make transitions to all aspects of adult life. Baseline SLAITS data)

?The CSHCS program reinitiated a newsletter to CSHCS families and participants with listings for community resources and support systems.

?The CSHCS program created and implemented a program Web Page, which includes specific information that is age specific and appropriate for parents and participants to access.

?The CSHCS program implemented its new claims/information system (ACAPS--Agency Claims and Administrative Processing System), with capability currently emerging to generate mailing lists for adolescents to target specific mailings appropriate to their age categories and potential topics of interest.

?The CSHCS program updated materials for children with special health care needs, ages 14 and above, to facilitate transitioning into young adulthood. A "CSHCS Transition Booklet" was drafted which encourages adolescents with special health care needs to create a personal and medical history. The booklet educates youth on life skills, community resources and support systems, which will help them in successfully transitioning into adulthood.

#### b. Current Activities

FY 2004 Performance Objective: 6% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life. (Baseline)

?The CSHCS staff person that provides training is also the Program's transition specialist. This

staff person will continue to work closely with the IPIN parent liaisons to facilitate the transition of CSHCS participants to all aspects of adult life. The CSHCS Program continues to contract and work collaboratively with Dr. Tim Brie at the Spina Bifida Clinic at Riley Hospital to provide transition assistance services to children with spina bifida.

?ISDH contracts with IPIN to access parents' and participants' input on Title V grant writing and implementation.

?The Indiana CSHCS enrolls families with incomes below 250% of the federal poverty level; pays for premiums to the State high-risk insurance pool (ICHIA) for the HIV-infected and hemophiliacs; and links participants to SSI services.

?ISDH continues to distribute a four-part video to all participating primary health care providers, which includes enrollment information regarding CSHCS and the Medical Home.

?The Division Director continues to participate in the State Transition Team, which meets bi-monthly, and is made up of Early Intervention, Head Start, Special Education, and First Step (FS) representatives, as well as parent representatives.

?Publish specific information on the CSHCS Web Page that is age specific and appropriate for parents and participants to access including appropriate links to groups like the Indiana Parent Information Network, ISDH Family Helpline, Hoosier Healthwise, Child Care Answers, Social Security Income (SSI Disability), Vocational Rehabilitative Services, IN\*Source (Parent Information), and the Indiana Comprehensive Health Insurance Ass'n.

### c. Plan for the Coming Year

FY 2005 Performance Objective: 6% of youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life.

?MCH anticipates funding the IU School of Medicine to develop a model for transitioning children with special health care needs to programs they will need to access as adults. This three-year project will include a needs assessment to gather information from Indiana CSHCN, parents and care providers as well as a demonstration project in which a transition team will provide transitional consultation, information and referral and primary care. The transitional services may eventually be funded through ISDH CSHCS.

?Provide ongoing continued education to the CSHCS staff specialist, who in turn, will provide training and updates to CSHCS staff. This process will become more formalized through the Policy Review Group that includes staff from the CSHCS areas of Eligibility, Prior Authorization and Training.

?Continue to contract with Dr. Tim Brie at the Spina Bifida Clinic at Riley Hospital to provide transition assistance services to children with spina bifida.

?Enhance the newsletter to CSHCS families and participants by including direct submissions from parent information groups, in addition to listings for community resources and support systems.

?Utilize the new CSHCS claims/information system (ACAPS--Agency Claims and Administrative Processing System) to generate mailing lists for adolescents to target specific mailings appropriate to their age categories and potential topics of interest.

?Refine and augment the existing information on the CSHCS Web Page that is age specific and appropriate for parents and participants to access.

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

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus

Influenza, Hepatitis B will increase to 83% in FY 2003.

Status: The percentage of children (19 to 35 months old) complete for all antigens declined from 80.8% to 78.5%. This was likely the result of severe vaccine shortages during this time period. Objective not met.

?Free vaccine ((both VFC (Vaccines for Children) and 317)) continued to be provided to all MCHS sites providing immunization service to children. Immunizations are provided on site.

?All MCHS grantees continued to provide enabling services (prenatal and family care coordination) that facilitate clients into obtaining appropriate immunizations for children.

?Thirty-six (36) percent of MCHS sites that provide immunization services for children were included in CHIRP (The Children and Hoosiers Immunization Registry Program --the population based statewide immunization registry) in CY 2003.

?The Indiana Family HelpLine (IFHL) continued to provide education and referrals to callers regarding immunizations.

?All MCHS grantees providing immunizations to more than 25 children in the 19 to 35 month old age group received a Clinic Assessment Software Application (CASA) and follow-up (AFIX) to determine their immunization rate of this age group.

?All MCHS grantees providing enabling services (prenatal and family care coordination) facilitated clients into obtaining appropriate immunizations for children.

?The Indiana General Assembly allocated funding in SFY 2003 for the purchase of Hepatitis B vaccine for the ISDH Immunization Program. In conjunction with the Indiana Department of Correction, ISDH began a program for outreach and expansion to adolescents and juvenile detention programs. Vaccines for Children (VFC) funds were also made available to STD programs in order to vaccinate high-risk adolescents against Hepatitis A and/or B. MCHS and its grantees worked with the Immunization Program to expand services.

?The offering of Hepatitis B vaccine to incoming offenders ended in June 2003. Residual monies from that program were used to purchase Hepatitis A and/or B vaccine for immunizing high-risk (19 and over) adults attending STD programs throughout Indiana. This program is ongoing.

## b. Current Activities

FY 2004 Performance Objective: The percent of children through age 2 who have completed immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B has been reduced from 83% in FY 2003 to 80% in FY 2004.

?The Indiana State Department of Health (ISDH) Vaccines for Children (VFC) Program supplies all Advisory Committee on Immunization Practices (ACIP) recommended vaccines for VFC eligible children as well as all other children seen in MCH clinics with PHS 317 funds.

?All MCHS grantees either provide direct vaccination services or referrals to providers who do. All MCHS grantees providing enabling services (prenatal and family care coordination) facilitate clients into obtaining appropriate immunizations for children.

?All MCHS grantees providing immunizations to more than 25 children in the 19 to 35 month old age group will receive an Operational Program Review, Clinic Assessment Software Application (CASA) and follow-up (AFIX) to determine their immunization rate of this age group.

?All MCHS grantees are encouraged to conduct reminder/recall activities to bring children into their facilities to receive appropriate vaccinations. Grantees may use the CHIRP reminder/recall capabilities.

?The percentage of MCHS clinics utilizing CHIRP will increase to 60% in 2004.

?The ISDH Immunization Program received an award in May 2004 from the CDC for being the state with the second greatest improvement in vaccination of two year olds since 1999.

### c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of 19 to 35 month olds who have received full schedule of age appropriate immunization for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B will increase from 80% in FY 2004 to 81% in 2005.

?All MCHS sites that deliver immunization services will continue to receive both VFC vaccine (for VFC eligible children) and PHS 317 funded vaccine for all other children.

?All MCHS grantees providing immunizations to more than 25 children in the 19 to 35 month old age group will continue to receive an Operational Program Review, Clinic Assessment Software Application (CASA) and follow-up (AFIX) to determine their immunization rate of this age group.

?All MCHS grantees will be continue to be encouraged to conduct reminder/recall activities to bring children into their facilities to receive appropriate vaccinations. Grantees may use the CHIRP (the state-wide immunization registry) reminder/recall capabilities.

?The percentage of MCHS clinics utilizing CHIRP will increase to 75% on 2005.

?IFHL will continue to provide education and referrals to callers regarding immunizations.

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

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The rate of birth (per 1,000) for teenagers aged 15 through 17 year will drop to 23 in FY 2003.

Status: The Rate of Births (per 1000) for teenagers aged 15 through 17 years in FY 2002 is 22.5 (down from 23.7 FY 2001). FY 2003 data is not yet available.

?The Indiana RESPECT (Reduces Early Sex and Pregnancy by Educating Children and Teens) initiative uses State Adolescent Pregnancy Prevention funds and Federal Sexual Abstinence Education Block Grant funds to fund 3 components: Community Grant Program, Statewide Media Campaign, and Technical Assistance/Training.

?In September 2003, 55 agencies were chosen for the new RESPECT two-year funding cycle (FY '04 & '05). For this new funding cycle, 26 federally funded grantees were chosen to provide programs that stress sexual abstinence until marriage, and 29 state-funded grantees were chosen to provide state funded adolescent pregnancy prevention programs that stress sexual abstinence throughout the teen years. The programs are provided in a variety of youth-serving organizations.

?In FY' 03 the Federal Sexual Abstinence Education Block Grant Funds served 72,668 adolescents ages 19 and under with 318,490 encounters, while 10,397 adults were served with 24,211 encounters. State -- funded adolescent pregnancy prevention education programs were provided to 23,575 adolescents ages 19 and under in 64,033 encounters, while 4,178 adults were served in 4,538 encounters. Grantees provided these programs in a variety of youth-serving organizations including schools, faith-based organizations, and community organizations.

?During FY' 03, the "Sex Can Wait -- I'm Worth It" media campaign included statewide teen and parent media flights (TV, radio, billboards, print ads) scheduled for October to December 2002. Awareness/recall of the campaign was assessed by phone surveys completed with teens after each flight of the TV and radio spots. This campaign concluded in FY 2003.

?A media campaign, adapted from materials from the National Campaign to Prevent Teen Pregnancy, was introduced to the Spanish speaking community in November 2002 through January 2003. Ads were placed in all available Spanish media throughout Indiana, which was limited to print ads in newspapers and magazines, and radio. The campaign urged parents to talk to their children about their ideas regarding sex. Parent surveys conducted in churches and

community centers after the campaign aired revealed that 87% of the parents had a favorable response to the campaign.

?In July 2002, the State Adolescent Health Coordinator (SAHC) resigned to accept a position at the CDC. The position remained vacant until a new SAHC was hired in January 2003.

?For National Teen Pregnancy Prevention Month (May 2003), notice was posted on the ISDH and Department of Education's (IDOE) website announcing various activities and information.

## b. Current Activities

FY 2004 Performance Objective: The birth rate for teenagers aged 15-17 years will drop to 22 per 1000 in FY 2004.

?The Indiana RESPECT Initiative continued 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 teens.

For FY 03-05, 31 federally funded grantees provided programs that stress sexual abstinence until marriage and 28 state-funded grantees are providing adolescent pregnancy prevention programs that stress sexual abstinence throughout the teen years.

?The SAHC initiated the process of implementing a new statewide abstinence and pregnancy prevention campaign in the Spring of 2004. An RFP was developed and five advertising agencies responded to the opportunity to create a new campaign. The two-year ad agency contract will begin in Summer 2004. The new campaign will include parent and teen brochures, billboards, posters, radio and television and movie theatre advertisements and an interactive website.

?The Spanish language outreach media campaign targeting Latino parents had significant acceptance and success based on the research following the campaign. The campaign is being reinstated from May through July 2004 and will include the addition of television spots, which are now available on a Spanish station in Indianapolis.

?The SAHC worked on the release of the 2003 YRBS results in the spring of 2004. Release activities included a press release, fact sheets, as well as a web-based component. The official date of release was May 21, 2004. Some of the most significant findings in the 2003 Indiana Youth Risk Behavior Survey about risk behaviors among Indiana high school students are the following: 25.6 percent of youth used cigarettes, compared to 21.9 percent nationally; 28.9 percent of youth reported episodic heavy drinking, compared to 28.3 nationally, and 22.1 percent reported using marijuana, compared to 22.4 percent nationally; 93.8 percent rarely or never used bicycle helmets, compared to 85.9 percent nationally; 38 percent of youth said they were currently sexually active, compared to 34.3 percent nationally; 11.5 percent were overweight and 14.2 percent were considered at risk of becoming overweight, by self-reported data; and 31.9 percent did not participate in a sufficient amount of physical activity, and only 20.3 percent said that they ate fruits and vegetables the recommended five or more times per day.

## c. Plan for the Coming Year

FY 2005 Performance Objective: The birth rate for teenagers aged 15-17 years will drop to 21 per 1000 in FY 2005.

?MCHB Federal Abstinence Education Block Grant: The SAHC will develop and submit the FY' 05 Federal Abstinence Education Block Grant, which, in combination with State adolescent pregnancy prevention education funding, is used to fund the Indiana RESPECT Adolescent Pregnancy Prevention Initiative. Community grantee funding opportunities will be announced on the website by July 2005.

?In the coming year, the SAHC, along with the new ad agency, will develop a new and updated media campaign to reach all of Indiana's parents and teens.

?In August 2004, a panel on Adolescent Health and Social Services will be part of a statewide

mental health conference. Participants will include the MCSHCS Medical Director and Dr. Lloyd Kolbe of the Applied Health Science Department at the IU School of Health and Physical Education, and Recreation and Dr. Margaret Blythe, Adolescent Health Specialist. One of the objectives of the panel is to develop interest in the coordination of adolescent health services and the building of an adolescent health coalition.

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

#### a. Last Year's Accomplishments

FY 2003 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 35% in FY 2003.

Status: 42.7% of third grade children have received protective sealants on at least one permanent molar tooth. Objective met.

?Oral Health Services continued promoting community-based dental sealant programs, as well as collaborating with the IU School of Dentistry's Community Sealant program.

?MCSHCS stressed educational efforts to clients as to the preventive health aspects of dental sealants and facilitated dental treatment when needed.

?Oral Health Services continued to encourage dental providers to participate in Hoosier Healthwise (HH) and utilize sealants with HH clients to help eliminate disparity in preventive services rendered. It provided sealant educational information to accompany HH enrollment information. The State Oral Health Director served as a consultant.

?The IFHL provided referrals for dental services including sealants to callers that did not have access to dental care.

?Oral Health Services promoted the utilization of pit and fissure sealants to dental/dental hygiene students at the IU School of Dentistry and to current practitioners throughout the state.

?The dental hygienist developed a brochure for parents that addresses the issue of early dental care visits for children. The brochures were distributed to MCH/WIC, Head Start, Early Head Start, Baby First Packets, preschools, and childcare providers, in English and Spanish.

?Oral Health Services assisted communities in gaining designation as Dental HPSA. It collaborated with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future Community Health Centers (CHCs).

?Title V resources helped support ISDH-Oral Health by providing salaries for an administrative dental hygienist, a secretary, and four field fluoride specialists. Indiana's program focuses on education and prevention with emphasis on water fluoridation.

#### b. Current Activities

FY 2004 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth remains 42.7% in FY 2003 and 42.7% in FY 2004.

?A survey of school nurses was done to determine their perception of sealant usages. This was done in 2004.

?Continue to promote community and school-based dental sealant program.

?Continue to encourage Indiana dental providers to participate in Hoosier Healthwise and utilize sealants with those clients to help eliminate disparity in preventive services rendered.

?Continue to promote the utilization of pit and fissure sealants to dental/dental hygiene students at I.U. School of Dentistry and to current practitioners throughout the state.

?In May 2004, the Indiana State Department of Health's Oral Health Division received a Quality Achievement Award at the National Oral Health Convention in Los Angeles, California from the Centers for Disease Control and Prevention. The award, presented to only two other states, was in recognition of Indiana's high rate of maintaining optimal fluoridation in its water systems. Indiana currently has more than 260 water systems that fluoridate. Indiana was also recognized for having at least 50 years of fluoridation programs. Indiana began its program in 1950 in Ft. Wayne.

### c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of third grade children who have received protective sealants on at least one permanent molar tooth will increase to 50% in FY 2005.

?A survey in selected third grades in selected schools, throughout the state, will be completed. This will indicate the percentage of sealants based on parent/caregiver reporting.

?Oral Health Services will continue promoting community-based dental sealant programs, as well as collaborating with the IU School of Dentistry Community Dentistry's sealant placement program. The ISDH Director of Oral Health Services will continue to serve on the Board and planning committee of the IU School of Dentistry Mobil Dental Sealant Program.

?Oral Health Services will continue to encourage dental providers to participate in Hoosier Healthwise and utilize sealants with Hoosier Healthwise clients to help eliminate disparity in preventive services rendered.

?Oral Health Services dentists will maintain liaison with Office of Medicaid and Policy Planning (OMPP) on oral health issues.

?Oral Health Services will continue to promote the utilization of pit and fissure sealant to dental/dental hygiene students at IU School of Dentistry and to current practitioners throughout the state.

?Oral Health Services will provide oral health brochures for distribution to MCH/WIC, Head Start, Early Head Start, Baby First Packets, etc., in both English and Spanish. Newly translated to Spanish is brochure on Baby Bottle Tooth Decay (BBTD).

?Oral Health Services will assist communities in gaining designation as Dental HPSA. Collaborating with ISDH Local Liaison office and Indiana Primary Health Care Association.

?Oral Health Services will collaborate with the Indiana Rural Health Association and the Indiana Primary Health Care Association to provide technical assistance to establish dental services within existing and future CHCs.

?Oral Health Services will provide sealant educational information to accompany Hoosier Healthwise enrollment information.

?Oral Health Services will work toward finding resources for dental case managers in each community. The case manager will work on enrolling low-income children in Hoosier Healthwise and help parents/guardians to find a local source of dental services. These activities assure that each child will have a dental home.

?ISDH MCH projects funding IU Dental Sealant program to develop strategies to acquire parental consent for school-based oral health services.

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

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The rate of deaths to children aged 0-14 years caused by motor vehicle crashes per 100,000 children will decrease to 4.0 in FY 2003.

Status: 3.4 is the provisional FY 2002 rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children in CY 2003. Objective met for FY 2003.

?All MCSHCS projects educated on safety and injury prevention issues including the use of auto safety seats and booster safety seats.

?Maintained linkage with safety and injury prevention groups throughout the state and nationally.

?Published a monograph on Injury Mortality in Indiana in 2003.

?Continued involvement with Emergency Medical Services for Children (EMSC)

Advisory Committee continued. An ISDH staff member attended most of the meetings of this group.

?Ongoing communication continued with the Riley Hospital Automotive Transportation Safety Program.

## b. Current Activities

FY 2004 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease to 3.0 in FY 2004.

?State legislature passed a law requiring the use of booster seats.

?Linkage with safety and injury prevention groups both statewide and nationally is being maintained.

?The first analysis of 2002 hospital discharge database for hospitalization related to motor vehicle injuries is being completed.

?Activities to assist in accomplishing this objective include all MCSHCS projects educating on safety and injury prevention issues including the use of auto safety seats and booster safety seats. Linkage with safety and injury prevention groups throughout the state and nationally will be maintained.

?A grant application was selected for funding by the CDC as one of two new Phase I projects within the National Center for Injury Prevention and Control (NCIPC). The funding granted is renewable for 2 additional years. An Injury Epidemiologist was hired. The initial focus is on obtaining a 2002 hospital discharge database, analysis for E codes (the ICD-9 Supplementary Classification of External Cause of Injury and Poisoning); contacting 6 hospitals with trauma registries; and the scheduling of an Injury Prevention Advisory Council meeting. Preliminary work will include a data needs

assessment, and a report on Injury in Indiana. Additional work has been performed involving the Crash Outcome Data Evaluation System (CODES), a new National Highway Traffic Safety Administration project for Indiana. ISDH staff also is working collaboratively with the State Emergency Management Agency (SEMA) and the Purdue University Center for the Advancement of Transportation Safety (CATS) on the CODES project.

## c. Plan for the Coming Year

FY 2005 Performance Objective: The rate of death to children aged 0-14 caused by motor vehicle crashes per 100,000 children will decrease from 3.0 in 2004 to 2.9 in 2005.

?A monograph on Injury Mortality in Indiana will be published in August 2004. Hospital discharge data will be included.

?Report and statistical analysis on Injuries in Indiana to be completed in 2004.

?Continue working with the Indiana Automotive Safety Program for Children as well as the Safe Kids Program to promote automotive safety.

?Maintain linkage with safety and injury prevention groups in Indiana and nationally

?Communication of new developments related to childhood automotive safety to MCSHCS projects.

?The Injury Prevention Program staff will complete reports on the injury data needs assessment and begin preliminary work on an Injury Prevention State Plan.

?The staff will continue to promote expanded E coding by hospitals

for all injury-related discharges.

?ISDH will start on the development of a pilot injury surveillance system.

?The Injury Prevention Advisory Council will meet quarterly. (The previously listed bullet point activities are all part of the objectives denoted in the CDC Core Injury grant).

?ISDH will continue its involvement in the CODES project.

?ISDH projects funding Riley Hospital for Children to adapt and implement the "Checkpoints" teen driving program developed by Bruce Simons-Morton of the National Institute of Child Health and Human Development to promote parental involvement in teen driver training.

### Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

#### a. Last Year's Accomplishments

FY 2003 Performance Objective: Percentage of mothers who breast feed their infants at hospital discharge will increase to 63% in FY 2003.

Status: Percentage of mothers who breast-feed their infants at hospital discharge is 63.9%. Objective met.

?The Indiana WIC program continued to promote acquiring the IBCLC (International Board Certified Lactation Consultant) credential by WIC staff. Staffs were provided the opportunity for required pre-exam training with a 5-day comprehensive breastfeeding course followed by a 3-day test preparation course.

?The 53 local WIC agencies with 154 offices were supported in 2003 by 9 Regional Breastfeeding Support Centers. The centers are coordinated by an IBCLC and function to distribute literature and supplies, provide on-going staff orientations, trainings, and continuing education, manage a breast pump distribution program, coordinate community outreach, and consult with local WIC agencies when a WIC participant presents with a complex breastfeeding issue.

?During August 2003, three areas (Gary, Indianapolis, and Evansville) displayed a billboard promoting breastfeeding. Funding and design was a cooperative effort between the Indiana Perinatal Network and WIC.

?The Indiana WIC breastfeeding rates increased to 52.11% in 2003, an increase from 49.13% in 2002 with 23,378 infant being breastfed.

?With extensive consultation from the Indiana Perinatal Network (MCH's programmatic breastfeeding education designee), House Enrolled Act 1510 was passed by the 113th General Assembly (2003). The bill reads: "Breastfeeding, Sec. 1., Notwithstanding any other law, a woman may breastfeed her child anywhere the woman has a right to be." This is a small positive effort to provide breastfeeding support in Indiana.

?The Indiana WIC Program and the Indiana Perinatal Network undertook the initial steps for creation of a comprehensive State Breastfeeding Strategic Plan. Best Start Social Marketing facilitated a two-day meeting with community leaders on September 24 and 25, 2003. Best Start Social Marketing presented the program "Using Loving Support to Build a Breastfeeding-Friendly Community", a national effort by the United States Department of Agriculture and Nutrition Services (USDA/FNS). This program generated a wide range of additional WIC and community-based programs and activities that the participants felt are or have been effective in building support for breastfeeding in Indiana. The core areas to address in the plan are Mobilizing Staff, Client and Family Education, Public Awareness, Health Provider Outreach, and Community Partnership-Building.

#### b. Current Activities

FY 2004 Performance Objective: The percentage of mothers who breast feed their infants at hospital discharge will increase to 66% in FY 2004.

?The State Breastfeeding Strategic Plan will be published and distributed widely in FY 2004.  
?The Indiana WIC program requested and received \$849,935, using FY 2003 WIC food funds from USDA/FNS, to purchase and rent electric and manual breast pumps for WIC breastfeeding mothers. The pumps were delivered to local WIC agencies in second six months of 2003 for distribution to WIC participants during 2003 and 2004. This grant addresses a much requested need especially by working mothers and those with mother-infant separation issues.  
?National WIC is promoting establishment or enhancement of peer counselor programs. Indiana WIC has had a successful program for over ten years. WIC budget proposals include increased funding for breastfeeding programs. Preliminary WIC breastfeeding rates are currently 51.9%. The 2003 plans include a new program to loan electric pumps in addition to manual pumps. WIC established contracts and procedures for electric breast pumps for loan; all agencies received training on how to use electric pumps. Five hundred twenty pumps were rented in FY 2003 and manual pumps were replenished based on 2002 usage. An additional supply of electric pumps was purchased that can be given to families with severe problems such a premature or sick infants.  
?WIC is co-sponsoring a Bright Futures Conference in 2004 with Riley Hospital, the major Children's Hospital in Indiana, and had a speaker on breastfeeding the preemie both in the hospital and after discharge.  
?WIC worked on implementation of a Fathers Supporting Breastfeeding Campaign.

### c. Plan for the Coming Year

FY 2005 Performance Objective: The percentage of mothers who breastfeed their infants at hospital discharge will increase to 67% in FY 2005.

?In addition to now established activities including the Regional Support Centers, Peer Counselor Program, IBCLC programs, regular meetings of the WIC Breastfeeding Committee and IPN, educational offerings to increase competency among health providers and public health staff, and World Breastfeeding Week activities, the owing activities are planned:  
?The Peer Counselor Program will be enhanced/expanded.  
?WIC will be looking into more strategies to increase duration as well as initiation. Minority disparity will continue to be monitored.  
?MCSHCS Prenatal and Prenatal Care Coordinators will continue to encourage breastfeeding to all of their patients.  
?MCH will continue to support activities of the IPN Breastfeeding Subcommittee.

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

### a. Last Year's Accomplishments

FY 2003 Performance Objective: Increase universal newborn hearing screens to 99% in FY 2003.

Status: Percent of newborns screened for hearing impairment before hospital discharge: 99%. Objective met.

?Effective January 2003, Indiana's Universal Newborn Hearing Screening Program (UNHS) at ISDH/CSHCS implemented an audiologic evaluation report system and 168 audiologists in Indiana started reporting to ISDH of all diagnostic evaluation results. A new tracking and follow-up data system was developed to include diagnostic evaluation information on all questionable

hospital screens that are referred for further diagnosis and follow-ups.

?UNHS Program received a four-year MCHB (HRSA) grant of \$706,639 (March 31, 2001 -- March 30, 2005) to develop and implement an integrated data system and to provide family-centered, culturally sensitive, community-based technical assistance and education to local providers and consumers.

?Provided technical assistance to hospitals related to newborn hearing screening rules, protocols and reporting requirements through audiologist consultation.

?Tracked the newborn hearing screen statistics assisted by an integrated data system with First Steps.

?Followed up on all positive and questionable screens with First Steps to ensure the hospital referred the families for diagnostics and early intervention.

?Planned and implemented in-service training for 109 birthing facilities.

?Planned and implemented in-service training for Public Health Nurses.

?The twelve-member Newborn Hearing Screening and Intervention Advisory Board was established by PL 91-1999. The Board, which consists of consumers, primary care providers, professionals, an insurance and a hospital representative, a special education administrator, an early intervention service representative, and a maternal and child service manager meet three to four times a year.

?A Parent Focus Group has also been formed. It consists of 10 parents, who assist ISDH and the State Hearing Screening and Intervention Advisory Board in monitoring and evaluating the program.

?A survey was developed and delivered to all the 320 Indiana licensed audiologists in November 2002. A total of 150 audiologists were identified as active providers. A letter from the State Health Commissioner along with all the related UNHS information and request for diagnostic evaluation reports was sent to the active audiologists to inform them about the upcoming implementation of the new audiologist reporting system.

?A regional outreach program, which is fully funded by the MCHB (HRSA) grant and implemented in August 2001, continued. Six regional consultants with audiology backgrounds have joined the State UNHS team. They are available to provide technical assistance, information, and consultation to hospitals, First Steps, and Families in their regions.

## b. Current Activities

FY 2004 Performance Objective: Maintain or improve universal newborn hearing screens at 99% in FY 2004.

?Continue providing in-services to hospitals and Public Health Nurses.

?Continue to utilize Area Regional Audiologist Consultants to assist with in-services and work with UNHS hospital contacts.

?Contract with a statewide Audiologist Consultant to be in house to monitor all babies who need referral, further diagnostics, and early intervention through the CDC Early Hearing Detection Information (EHDI) grant.

?Continue statistic tracking via monthly summary reports and implement an integrated data system with NBS lab data and the ODS.

?Continue to attend educational conferences such as the Early Hearing Detection Information Conference held in Feb. 2004.

?Continue to support the Family Focus Group in conjunction with the Indiana School for the Deaf.

?Provide out-reach to mid-wife facilities to promote participation in the UNHS Program.

?Co-sponsor, with the Indiana School for the Deaf Outreach Services and the Parent Focus Group, a Family Conference at the Indiana School for the Deaf.

?Effective January 2003, UNHS at ISDH/CSHCS implemented an audiologic evaluation report system and 150 audiologists in Indiana started reporting all diagnostic evaluation results to ISDH.

?The DRF and WCHH report cards showed Indiana as having the largest percentage of babies

screened in the country for the year ending May 2004 (99.9% of total annual births of 85,081 babies).

### c. Plan for the Coming Year

FY 2005 Performance Objective: Maintain universal newborn hearing screens at 99% in FY 2005.

? Provide technical assistance to hospitals related to newborn hearing screening rules, protocols and reporting requirements through audiologist consultation.

?Track the newborn hearing screen statistics assisted by an integrated data system with NBS labs, ODS, and First Steps.

?Follow-up on all positive and questionable screens with First Steps to ensure the hospital referred the families for diagnostics and early intervention.

?Maintain access to a web site containing most up-dated data regarding the UNHS Program

?Co-sponsor a Family Conference with the Indiana School for the Deaf Outreach Office and the Family Focus Advisory group.

?Promote participation of mid-wife facilities in the UNHS Program.

?A regional outreach program implemented in August 2001 and in its third funding year, will end in August 2005. Newborn Screening funding will continue to support the Regional Audiologists.

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

### a. Last Year's Accomplishments

FY 2003 Performance Objective: To decrease the percent of children without insurance to 10% in FY 2003.

Status: Percent of children without health insurance: 7.6% in FY 2002. Objective met.

Please refer to NPM # 14 Last Year's Accomplishments section for this information.

### b. Current Activities

FY 2004 Performance Objective: To decrease the percent of children without insurance to 6% in FY 2004.

Please refer to NPM # 14 Current Activities section for this information.

### c. Plan for the Coming Year

FY 2005 Performance Objective: To maintain the percent of children without insurance at 6% in FY 2005.

Please refer to NPM # 14 Plan for the Coming Year section for this information.

## Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

### a. Last Year's Accomplishments

FY 2003 Performance Objective: To increase the percent of Medicaid eligible children who have received a service paid by the Medicaid program to 84% in 2003.

Status: 82.3% of Medicaid eligible children received a service paid by the Medicaid program in FY 2002. FY 2003 data is not yet available.

?MCHS grantees either are enrollment sites for Hoosier Healthwise or they refer clients to local Hoosier Healthwise enrollment sites.

?Preventive and Primary Child Health Care grantees provide comprehensive child health care programs. The goals 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 children 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 17 Title V sponsored comprehensive child health projects in the state during FY'03. They provided direct services to an estimated 1,411 infants, and 14,248 children and adolescents in 33 counties. 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.

?MCSHCS Health Systems Development - 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. Promoting public health insurance, Hoosier Healthwise is part of this technical assistance.

?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 615 IFHL callers referred to Hoosier Healthwise in FY 2003.

?Family Care Coordination - for MCHS, has a primary objective to facilitate children into primary care and into Hoosier Healthwise, if eligible. Six hundred forty nine families were provided family care coordination in FY 2003.

## b. Current Activities

FY 2004 Performance Objective: To increase the percent of Medicaid-eligible children who have received a service paid by the Medicaid program to 85% in 2004.

?The activities listed in FY 2003 are ongoing activities. Grantees either enroll or refer clients to Hoosier Healthwise. The Indiana Family Helpline evaluates clients for eligibility and refers if appropriate to Hoosier Healthwise. Indiana is participating in the "Covering Kids and Families" initiative with Health and Hospital Corporation of Marion County being the lead agency. The projects for this initiative are located in Cass, Fulton, Lake, St. Joseph, Delaware, Allen, Marion, and the seven counties surrounding Marion County. Additionally, some hospitals in Indiana have systems in place to provide health care services to the indigent, poor, underserved and underinsured population. One such system exists in Indianapolis at the Wishard Hospital; the program is known as "Wishard Advantage". Also, most of the MCH grantees providing child health services serve as Medicaid providers for those in need who are eligible for services.

?The MCHB funded project, the Indiana Early Childhood Comprehensive System (ECCS)

Program includes the Access to Health Insurance and Medical Homes subcommittee of parents, pediatricians, public health program staff and others who are providing information to the Core Partner Steering Committee regarding existing needs assessments and other pertinent information.  
?One of the measurable outcome objectives of the Indiana Child Care Health Consultant Program is to improve access to health insurance, a medical home and preventive health care.

### c. Plan for the Coming Year

FY 2005 Performance Objective: To increase the percent of Medicaid-eligible children who have received a service paid by the Medicaid program to 86% in 2005.

?MCHS grantees will continue to serve as either enrollment sites for Hoosier Healthwise or they will refer clients to local Hoosier Healthwise enrollment sites.

?The Indiana Family Helpline will continue to provide referrals and screen clients for Hoosier Healthwise eligibility.

?MCHS grantees providing primary care to children will continue to be Medicaid providers.

?Family Care Coordination grantees will have as a prime goal to facilitate children in to Hoosier Healthwise.

?ECCS plan will be written by July 2005 and include plans for increasing access to Medical Homes and Health Insurance.

## Performance Measure 15: *The percent of very low birth weight infants among all live births.*

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The percent of very low birth weight infants among all live births will decrease to 1.2% in FY 2003.

Status: 1.4% is the percent of very low birth weight infants among all live births in CY 2002. Objective of 1.2% for FY 2002 not met. (CY 2003 data not available)

?MCSHCS provided funding for direct perinatal and enabling services through grants to provide prenatal care, outreach, and education to high-risk pregnant women. Priority was given to grantees in the 24-targeted counties with sites in GIS determined high-risk areas. Grantees participated in IPN, reinforced to clients the perinatal health care points cited in the IPN Baby First--Right From the Start and Bright Futures for Babies, and provided direct services including Prenatal Care, Prenatal Care Coordination and Breastfeeding support. They worked 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 received cultural sensitivity training.

?The Baby First campaign had a revised advisory board; began working on Baby First digital toolkit with IU School of Informatics; continue with 2 billboards in Indianapolis -- initiated a breastfeeding billboard in August; completed smoking public service announcement with Channel 6 -- WRTV; local cable channel airing BF video and PSA's; sent series of educational mailings to Parish nurses throughout the state; working on revisions to packet to better target our audience and make it more affordable; working with Indpls Minority Health Coalition to develop concept of Baby First advocates; working with ALL Pro Dads to spread message of Fatherhood; worked with HealthVisions Midwest to launch BF in Gary with movie ads, exterior bus cards, PSA's; displayed at various health fairs, etc. including Black Expo, WTLC Women's Expo; worked with Bureau of Motor Vehicles to get BF posters up in each office in the state; working on "Back to Sleep" billboard with Evansville and SE Indiana Healthy Mothers Healthy Babies;

?PCEP -- (Perinatal Continuing Education Program) -- 35 Indiana hospitals now involved; pre

and post-test scores are remarkable; Morgan Co, Howard Community, Decatur Co -- hosted by St. Vincent; Marion General, Sullivan Co, Henry Co -- hosted by Ball Memorial  
?Perinatal Perspectives newsletter -- 4 issues; includes model programs; minority health; educational calendar, clinical information; focused issue;  
?Practice Alerts/Consensus Statements -- Prenatal Care Guide 2000 updated; Cytotec Practice Alert published and distributed; Postpartum depression Consensus Statement, guide and consumer brochure developed and distributed in collaboration with Indiana ACOG; Levels of Hospital Care -- working with all delivering hospitals to complete surveys; and Domestic Violence;

## b. Current Activities

FY 2004 Performance Objective: The percent of very low birthweight infants among all live births will decrease to 1.3% in FY 2004.

?MCSHCS continues to fund direct perinatal services and enabling services through grants to provide prenatal care, outreach, and education to high-risk pregnant women. It continues to work with minority health coalitions to provide prenatal care coordination in high-risk counties. Grantees educate and monitor clients on pre-term labor signs and symptoms, the risks of smoking, the importance of appropriate weight gain and other issues identified in the FIMR findings. IPN staff has convened the Issues Committee of the IPN Advisory Board (including MCSHCS staff) and First Steps staff to review VLBW issues identified by the group. MCSHCS and CHC funded projects use the Low Birthweight and Infant Death Review form to evaluate the circumstance surrounding each mother served to term that had a negative outcome. MCSHCS and IPN provide protocol/guidance to ISDH funded projects and CHCs regarding new evidence of etiology of preterm labor. Collaboration continues with IPN to present State Perinatal conferences geared to nurses and physicians.

?Continue to develop, implement and evaluate Baby First?Right from the Start multi-media campaign statewide as funding permits. The campaign will be expanded in to include messages regarding breastfeeding and Fatherhood and further development of a digital tool-kit for community implementation.

?Continue to expand PCEP (Provider Continuing Education Program) in at least 2 community hospitals. Dupont Hospital in Allen county is hosting DeKalb, Cameron and Kosciusko

?Continue implementation and evaluation of the Indiana Access Strategic Plan for Marion County.

?Publish and distribute Indiana Perinatal Newsletter (Perinatal Perspectives) four (4) times a year.

?Publish and distribute Indiana Perinatal Practice Alerts two (2) times per year. Working on levels of Hospital Care, convening Perinatal Support and Pregnancy Spacing

?Convene and facilitate three (3) State Perinatal Advisory Board meetings.

?Continue development of the Baby First Data Book Online for regions and state. Incorporating in AMCHP and state conference as well as toolkit.

?Further develop Indiana Perinatal Online Magazine pages for all regions of state, identifying resources for high-risk care, sharing model programs, publications, perinatal jobs available etc.

?Facilitate Maternal Mortality Subcommittee. Policies and procedures developed.

?Continue to facilitate the VLBW and Breastfeeding Subcommittees.

?Work with currently existing or new (as identified by the community) Regional Perinatal Advisory Boards or other local groups to hold three (3) Regional Perinatal Provider Education Conferences.

?Hold one (1) statewide Perinatal Conference; held "High Risk Pregnancy" in May; planning Disparities in Perinatal Health Outcomes for October.

?Implement components of Baby First in two (2) high risk communities.

### c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of very low birthweight infants among all live births will be maintained at 1.3% in FY 2005.

All of the FY2004 activities will continue with perhaps the following modifications:

- ?Indiana Access: Published report of "Best practices"; develop and implement curriculum for training and technical assistance; initiate data gathering and planning to at least one more community.
- ?Publish and distribute consensus statements for pregnancy spacing and family grief support.
- ?Implementing Doula pilot
- ?Working with 6 high risk counties as they implement their disparities strategic plan.
- ?Implement the Healthy Start grant (if we get it) in Allen and St. Joseph.
- ?Develop a Perinatal Training Institute for professionals.
- ?A Child Care provider Safe Sleep training will be held October 5, 2005.
- ?The community council will form an ad hoc committee to propose legislation mandating licensed childcare providers to receive training on SIDS and safe sleep practices.
- ?Development of an interactive website that includes a chat room for grieving parents.
- ?Expand grief-counseling materials to include all infant death and fetal loss. All materials will be provided in both English and Spanish.
- ?MCH will fund a research project in St. Joseph County, the county with the highest risk for lead poisoning, to conduct lead testing on pregnant women accessing WIC, to develop in collaboration with ISDH guidelines, protocols and educational materials that can be disseminated statewide.

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

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The rate (per 100,000) of suicide deaths among youths 15 -- 19 will decrease to 8.0 by the end of FY 2003.

Status: The rate (per 100,000) of suicide deaths among youths aged 15- 19 is 9.1 in FY 2002. Data is not available for FY 2003.

- ?Implementation of the child health standards, which include assessment of depression for adolescents and appropriate referrals.
- ?Bright Futures for Mental Health guidelines was provided to grantees for their use in evaluating depression in teens.
- ?All adolescent health centers funded by Title V will screen for risk of depression and refer as needed.
- ?The Indiana Partnership to Prevent Gun Violence, facilitated by Riley Hospital with a grant from the Joyce Foundation, convened a Suicide Prevention subgroup. This group, with representatives from the Indiana Mental Health Association, the Indiana State Department of Health, the Indiana Department of Education, the Indiana Division of Mental Health and other mental health professionals, reviewed current Indiana efforts to address suicide prevention and considered the recommendations in the recent Surgeon General's Report on Mental Health. Charlene Graves, M.D., medical consultant to the MCHS Injury Prevention program, served as co-chair on the group. The theme of the September 2003 conference of the Indiana Partnership to Prevent Firearm Violence focused on suicide prevention.
- ?A press conference held at the Indiana Statehouse in November 2002 focused public attention on suicide.

?In 2003, ISDH participated in the Indiana Youth Health Behavior Survey (also known as the Youth Risk Behavior Survey (YRBS)). This year the data was weighted and ISDH derived many important statistics about adolescent suicide issues in Indiana. YRBS results showed that during the past 12 months, 18.4 percent of Indiana teens seriously considered attempting suicide, 16.2 percent had made a plan about how they would attempt suicide, and 2.9 percent of attempts resulted in an injury, poisoning, or overdose that had to be treated by a doctor or a nurse. Indiana ranked lower than the national average on every YRBS suicide-related questions. ISDH/MCSHCS will continue to implement the YRBS in 2004.

#### b. Current Activities

FY 2004 Performance Objective: The rate of suicide deaths among youths aged 15-19 will be to 8.0 by the end of FY 2004.

?Funding provided for a 0.5 FTE Administrative Coordinator for the Indiana State Suicide Prevention Coalition; the State Coalition above developed a state Suicide Prevention Plan.

?Regional suicide coalitions being established throughout the state.

?The Suicide Prevention Coalition has matured from a volunteer group and has become a non-profit organization. Funding support was secured from MCHB which enabled the hiring of an administrative coordinator to be able to accomplish continued organizational growth. A mission statement and goals for the Coalition are being developed. The Coalition is working on a Suicide Prevention state plan.

#### c. Plan for the Coming Year

FY 2005 Performance Objective: The rate of suicide deaths among youths aged 15-19 will be maintained at 8.0 in FY 2005.

?Will continue funding of 0.5 FTE Administrative Coordinator for the Indiana State Suicide Prevention Coalition. The Coalition will continue to function as an "umbrella" organization for regional coalitions.

?To disseminate the State Suicide Prevention Plan to appropriate MCSHCS Projects.

?Will analyze the 2002 hospital discharge database for patients admitted for attempted suicide.

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

#### a. Last Year's Accomplishments

FY 2003 Performance Objective: The percent of very low birthweight infants delivered at facilities for high risk deliveries and neonates will increase to 58% in CY 2003.

Status: The percent of very low birthweight infants delivered at facilities for high risk deliveries and neonates is 56.4% in CY 2002 (up from 53.6%). (Data not available for CY 2003) Objective not met.

?Based on IPN Advisory Board consensus and recommendations, quality standards were established for each level of hospital care with input from all involved. The first draft was completed in June 2003.

?Established a framework based on results of the 2001 Hospital Survey Checklist to create better ways to ensure pregnant women deliver in appropriate hospitals. The framework will be incorporated into consensus statement and best practice guidelines.

?Issues Subcommittee of IPN State Advisory Board distributed an Emergency Room Care of

Prenatal Patient Care Guide or consensus statement to ensure proper referral and follow-up.  
?The IPN Prenatal Continuing Education Program (PCEP) was implemented as a standard hospital perinatal curriculum statewide (as interest and funding is available) to 3 hospitals in 2003.

?MCHS funded clinics and other individual providers are encouraged to use the ISDH/IPN Infant Death & Low Birthweight Review checklist, a form developed by an HSD consultant, to identify areas in their practice that need improvement to help decrease these problems.

?MCSHCS continues to maintain the Indiana Perinatal Network to assist with infrastructure building and population-based education. Four regional perinatal provider conferences were held. Care of the High Risk Mother and Neonate Conference was held May 8, 2003. The Perinatal Continuing Educational Program (PCEP) for the smaller hospitals provided by the high risk hospitals continues to improve their education as well as working relationships.

#### b. Current Activities

FY 2004 Performance Objective: The percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates will increase to 58% in CY 2004.

?Final draft of Levels of Hospital Perinatal Care in Indiana was presented to ISDH Commissioner for review June 2004.

?Continue to implement through IPN Prenatal Continuing Education Program (PCEP) as a standard hospital perinatal curriculum statewide (as interest and funding is available). Another 3 hospitals received training in 2004. Ongoing in 2005.

?State NICU Developmental Care Conference for providers was held on April 19, 2004.

#### c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates will be increase to 59% in CY 2005.

?MCSHCS and IPN will monitor the percent of very low birthweight infants delivered at facilities for high-risk deliveries and neonates delivering at Level II and III hospitals.

?MCSHCS and IPN will work with hospitals not appropriately transferring high-risk deliveries and neonates to develop a system of care that will ensures that all women, newborns and infants receive risk appropriate perinatal care regardless of their racial, cultural, economic or geographic differences.

?Continue to implement through IPN Prenatal Continuing Education Program (PCEP) as a standard hospital perinatal curriculum statewide (as interest and funding is available).

?IPN will convene a "Bereavement" committee to write a consensus statement and guidelines and plan a conference in conjunction with the Walk to Remember in October 2005.

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

#### a. Last Year's Accomplishments

FY 2003 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 80.2% in FY 2003.

Status: Percent of infants born to pregnant women receiving prenatal care in the first trimester: 80.5% in CY 2002. Objective met. The FY 2002 goal was 80%. (CY 2003 data is not available yet)

?In Marion County, MCSHCS and IPN supported and facilitated the implementation of Friendly

Access within the hospitals, public clinics, and public health system.

?To improve the comfort level of clients of different cultures, grantees were encouraged to implement techniques to promote cultural sensitivity. An attempt was made for grantee staffing to reflect the ethnicity of the target population.

?Each grantee was mandated to send one staff member per year to the cultural diversity training provided by the Office of Cultural Diversity.

?The Free Pregnancy Test Program reinitiated to provide to agencies working with women of childbearing age. Agencies used the tests for outreach and referred clients to appropriate prenatal care and primary care or family planning services, educational services, Medicaid, and WIC as appropriate. MCH and CHC grantees providing prenatal care took referrals from such agencies.

?For the FY 2003 grantee selection, applicants in the 24-targeted counties with sites in GIS high-risk areas were given priority. Grants were awarded for two years. In FY 2003, MCHS provided direct preventive and primary care service grants to 22 agencies. These grantees are providing prenatal care services in 24 counties to 6,130 pregnant women and primary care to 1,411 infants less than one year of age in 27 counties. Prenatal care coordination is offered by 30 grantees in 34 counties to 4,199 pregnant women.

?Grantees providing prenatal care services participated in all population-based perinatal education marketing campaigns sponsored by ISDH/MCSHCS or IPN.

?Grantees contributed 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. Regional advisory boards were only developed in Vanderburgh County, surrounding southeastern counties, and Vigo County. Other areas were not interested in forming regional boards.

?Grantees expanded 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. "Early Start" Program materials were placed on IPN website and can be downloaded for free. MCSHCS supports agencies interested in providing "Early Start" services.

?Grantees participated in community incentive programs, where available, to encourage early entrance into prenatal care.

## b. Current Activities

FY 2004 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 80.4% in FY 2004.

?MCSHCS consultant attends monthly/bi-monthly meetings with the two state Healthy Start Programs.

?Indiana is one of five states chosen to participate in the Association of Maternal and Child Health Programs (AMCHP) Action Learning Lab (ALL) on Reducing Perinatal Disparities.

?Indiana ALL State Team created an Action plan that includes strategies to reduce African American perinatal disparity in the five counties identified with the largest African American population and poorest perinatal disparities. The plan includes development of a comprehensive perinatal data book for each targeted county, technical assistance to each county to develop a county team or network to address identified county disparities, focus groups will be conducted in each of the five counties with persons living in high-risk neighborhoods to obtain information on perceptions of pregnancy, prenatal care, racial, cultural, and financial barriers surrounding pregnancy and prenatal care.

?MCSHCS is working collaboratively with the Indiana Office of Medicaid Policy and Planning and three Medicaid contracted Managed Care Organizations to ensure early entrance into prenatal care through increased prenatal coordination services in high-risk counties. All entities agreed upon new MCO contract language that supports contracting with existing community prenatal care coordinators, monitoring system for utilization of county prenatal care coordinators and their reimbursement, data collection forms, new Prenatal Risking Tool and revised Prenatal Care Coordination Medicaid Rule will be completed.

?Results of a Mini--PRAMS--like survey were shared with the three counties that participated and recommendations made on strategies to build infrastructure and health care systems to meet the unique county needs identified.

?Mini-PRAMS Survey and technical assistance for use made available to counties interested in conducting their own survey. MCSHCS consultant will follow-up with each county and assist in analysis of data and development of recommendations and strategies.

?Maternal Mortality Executive Committee formed and Abstraction forms furnished by CDC adopted, guidelines and protocols for the executive committee and review committee developed and reviewed. Abstraction database being developed to facilitate uniform collection of data on laptops from medical residents participating as abstractors.

### c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of infants born to pregnant women initiating prenatal care in the first trimester of pregnancy will increase to 80.6% in FY 2005.

?MCSHCS consultant continues to attend monthly/bi-monthly meetings with the two state Healthy Start Programs, offers technical assistance, trainings. Will begin data collection of Healthy Start care coordination services.

?Indiana ALL Action plan strategies will be implemented in the five-targeted counties identified. Countywide trainings will be conducted on data collection and use, community coalitions, community development. Technical assistance will be provided to each of the five-targeted counties by MCSHCS consultants.

?MCSHCS will continue working collaboratively with the Indiana Office of Medicaid Policy and Planning and three Medicaid contracted Managed Care Organizations (MCOs) to endure early entrance into prenatal care. An executive oversight committee consisting of representatives from ISDH, OMPP, IPN, and the three MCOs will be developed and maintained to address issues and monitor the mandated Medicaid Managed Care system for all MCH populations.

?MCH, OMPP, and the three MCOs will enter into a pilot program in Lake county to evaluate the effect of the Medicaid managed care system on obtaining Medicaid cards in a timely fashion, enrollment into an MCO within the first trimester, efficacy of outreach and home visiting services to identified high-risk pregnant women in the Medicaid MCO system.

?Begin update of the Indiana State Perinatal Strategic Plan with a focus on disparity issues. Will conduct regional town meetings, will restart FIMR programs in 4 of the 5-targeted counties. Results of town meetings and focus groups will be published and disseminated through placement on the MCSHCS website, IPN Newsletters, conferences/trainings, and by request.

?MCSHCS and IPN will work together to replicate the Indiana Access survey in at least one other perinatal disparity targeted county.

?Mini-PRAMS Survey results from three new counties analyzed and published. MCSHCS consultant will follow-up with each county and assist in development of recommendations and strategies.

?Maternal Mortality review team fully functional; completes prospective review; and executive committee publishes first report.

?Indiana Access begins implementation and dissemination phase.

?Baby First Media Campaign digital toolkit completed and available to download from IPN website. Technical assistance provided to all counties interested in developing countywide media campaign. An updated Baby First consumer educational video and educational folder will be completed and disseminated through IPN and the IFHL.

?A Doula Program modeled after Chicago Connections utilizing indigenous community health workers will begin implementation at two pilot sites in Marion County.

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. The NBS program (NBS) will continue to ensure follow-up services on infants w/pos newborn screens.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. NBS will continue to monitor the rate of infants screened prior to hospital discharge for QA.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. NBS will continue to collect & monitor Meconium screening data & collaborate w/other drug screens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. NBS will continue to provide training to professionals regarding all newborn screens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. CSHCS will continue to provide reimbursement for primary care services provided in a MD's office.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. CSHCS cont. to provide a Customer Serv/Prior Authorization helpline for clients.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. CSHCS will continue to assess licensure/credential status of CSHCS health care providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. CSHCS will continue to ensure parental involvement via contracts with the IPIN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. CSHCS will continue to train its employees in cultural competency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. CSHCS will publish brochures and pamphlets in Spanish to promote outreach to Hispanic parents.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. CSHCS will revise policies based upon survey data obtained from parents of CSHCN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. CSHCS to implement HIPAA compliant info syst to facilitate linkage/tracking of medical svcs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. CSHCS to implement HIPAA compl. data linkages for CSHCS, NBS,Sickle Cell & other ISDH prog.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. CSHCS will streamline enrollment process for providers to expand choice of providers for families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Genomics in Public Health Program will continue to support community physician training in Medical Homes through Genetics Implementation Grant (Infrastructure Building).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Implement HIPAA compliant info syst to track & facilitate updates of insurance enrollment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to use a comb. enroll. form that facilitates enroll. in Medicaid/First Steps also.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Evaluate the use of an online enrollment form.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop a CSHCS web page for potential applicants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Update current phone system to make more user friendly for parents and providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. MCH grantees will continue to enroll or refer to enroll uninsured children who are eligible into the Hoosier Healthwise Program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. IFHL will continue to screen callers for insurance coverage and refer to Hoosier Healthwise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. CSHCS will continue to require applications be made to Hoosier Healthwise as part of the CSHCS application.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			

	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Provide updated Provider Manuals to all CSHCS providers to promote HIPAA compliant billing process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Fill vacant positions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Publish web-based bulletins/info updates for providers specific to their specialty.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Obtain signed HIPAA compliant provider agreement from all participating providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Implement HIPAA compl. CSHCS claims payment/info system that will accept elect. billing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Continue to provide community-based training to First Steps providers and DFC staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NATIONAL PERFORMANCE MEASURE</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Provide continuous training to CSHCS staff on transition issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to contract w/Riley Hosp. Spina Bifida Clinic to provide transition assistance to children.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Publish newsletter to CSHCS families/participants w/ listings for comm. res. & sup. syst.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Mail adolescent clients transition educational materials using client database for mailing lists.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Publish transition information on the Web site.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NATIONAL PERFORMANCE MEASURE</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				

1. MCHS grantees will get VFC and 317 vaccine for children for on site immunizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. IFHL will continue to provide education and referrals to callers regarding immunizations.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. MCHS grantees giving imms. will receive Clinic Assessment Software App. & follow-up (AFIX).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. MCHS grantees will use the CHIRP (Immunization Registry).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. MCSHCS will continue Indiana RESPECT Adol. Preg. Prev. Init. w/funding thru fed. & state funds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. MSCH will continue funding local agency for abstinence education services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Indiana Respect media campaign will be continued.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. OHD & MCSHCS continue to support the Seal Indiana Mobile Unit that provides sealants at schools & CHCs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Seal Indiana & OHD staff will continue to provide technical assistance to local dentists.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Seal Indiana staff will work to estab. dental case managers in local communities to assist parents.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Parent Survey of selected third grade classes in selected schools will continue to monitor sealant usage.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Injury Prev Prog staff will complete reports on injury data needs assessment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Program will continue to promote expanded E coding by hospitals for all injury-related discharges.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. ISDH will start on the development of a pilot injury surveillance system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Injury Prevention Advisory Council will meet quarterly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. ISDH cont. collab. involvement w/SEMA & PU CATS on Crash Outcome Data Evaluation System.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Injury Prevention Program staff will complete an injury prevention resource directory.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Injury Prevention Program staff will begin work on injury prevention state plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Estab. activ. of Regional Support Ctrs,Peer Counselors, IBCLC Progs will continue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. WIC and Indiana Perinatal Network Breastfeeding Committees will continue meeting together.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. WIC will co-sponsor the Bright Futures Conf. with Riley Hosp & prov a premie Breast Feeding (BF) speaker.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. WIC plans the implementation of Fathers Supporting BF Campaign.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. MCSHCS Prenatal & Prenatal Care Coord. will continue to encourage BF to all of their patients.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. NBS will continue to ensure that 99% of babies born in Indiana are screened for hearing loss.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. UNHS data will be provided with metabolic screening data via the NBS lab and will be a part of the ODS.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. NBS will develop a new tracking & follow-up data system to include diagnostic information follow-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. The Regional Outreach Program, a 3-year grant, will continue.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Family Conference for families of infants with hearing loss will be co-sponsored by NBS, the School for the Deaf, and the Family Focus Advisory group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. MSHCS grantees will cont. to serve as or refer clients to enroll. sites for Hoosier Healthwise.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Indiana Family Helpline will continue to provide referrals and screen clients for Hoosier Healthwise	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. MSHCS grantees providing primary care to children will continue to be Medicaid providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Family Care Coordination grantees will facilitate children into Hoosier Healthwise.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. MSHCS grantees will cont. to serve as or refer clients to enroll. sites for Hoosier Healthwise.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Indiana Family Helpline will continue to provide referrals and screen				

clients for Hoosier Healthwise	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. MSHCS grantees providing primary care to children will continue to be Medicaid providers.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Family Care Coordination grantees will facilitate children into Hoosier Healthwise.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. IPN cont. the Issues Comm. of IPN Adv. Bd./First Steps staff to review VLBW issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. IPN and HSD consultants will provide consultation to groups doing Fetal & Infant Mortality Reviews.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. MSHCS and IPN will provide protocol/guidance to ISDH funded projects and CHCs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. MCHS & CHC grantees will use the LBW & Neonatal Death Review form to eval. syst. issues.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. MCHS staff will distribute PN risk assessment tool via the IPN Practice Alert to providers & OMPP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. MCHS will implement Community Health Worker training program at additional Ivy Tech locations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. MSHCS will identify common contributing factors to very low birth weight infants & collab. w/IPN.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. MSHCS will expand PNCC in large minority communities utilizing Lake County's strategy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. The Suicide Prevention Coalition will continue to function as an "umbrella" org. for regional coalitions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. The Coalition became incorporated and is funded through an MCHB grant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Suicide Prevention State Plan development will continue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Cont. to fund the IPN to assist w/IB & PBS education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Publish quality standards for ea. lvl of hospital care based on IPN Adv. Bd. consensus & recc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Establish framework based on 2001 Hospital Survey to ensure preg. women deliver in approp. hosp.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to implement the Prenatal Continuing Education Program (PCEP) as a standard hospital curriculum.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Encourage all level 3 and level 2 hospitals to participate in PCEP training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Monitor implementation of Guidelines by hospitals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Work to create regional centers for high-risk deliveries and neonates.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Grantees prov. PNC services will participate in all PBS perinatal education.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Grantees will contribute to regional IB by participating in an IPN Reg. Adv. Bd. & comm. grps.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Grantees may expand services to offer a basic 1st PN visit serv. while preg. women await MD.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. MSHCS will expand funded projects (as funding is available into more high-risk GIS identified areas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. MSHCS will continue to increase PNCC and outreach in high priority counties.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. MSHCS will continue to standardize PNCC.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. MSHCS will facilitate the successful Lake County MCH Network for PNCC to another county.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *SP # 09 To establish a system of routine data access with internal and external data sources.*

a. Last Year's Accomplishments

FY 2003 Performance Objective: MCHS will complete at least two of five data access measures by the end of FY 2003.

Status: Four of five data access measures have been completed. Objective met.

?The SSDI (FY 2002-03) grant, Genetics Implementation Grant, the CDC Indiana Birth Defects and Problems Registry (IBDPR) and the UNHS grant continue the data integration started by the first SSDI (FY 2000-01) grant, the Genetics Planning Grant, and the Universal Newborn Hearing Screening Grant. The Data Analysis Team Leader facilitates the internal steering committee for this grant. Grant goals are to improve data linkage, initially between birth records and infant death records, and to establish the foundation for accommodating future data linkages between other Vital Records data, the Birth Problems Registry, UNHS, First Steps and NBS program data. Funding from MCHB has been essential for the data integration efforts. An Operational Data Store (ODS), a platform on which to integrate data, has been developed for use by IBDPR and Newborn Screening. The ODS integrates vital statistics, lab data and hospital discharge data. Each program using the ODS will have its own Data Mart.

?The ISDH has made significant progress in five of the seven Health System Capacity Indicators shown on form 19, achieving 15 of a possible 21 points on the data access scale. The ISDH received a CDC grant to implement the Indiana Birth Defects Surveillance System (IBDSS), establishing an active Birth Problems Registry, which became the Indiana Birth Defects and Problems Registry (IBDPR). Data integration efforts continue through the Genetics Implementation Grant and the State Systems Development Initiative (SSDI) Grant obtained by MCHS and the IBDSS. The SSDI (FY2004-2006) Grant continues the data integration efforts begun under the SSDI (FY2002-2003) Grant, the Genetics Planning Grant, and the Universal Newborn Hearing Screening (UNHS) Grant. The Data Analysis Manager facilitates the internal steering committee for the SSDI Grant and coordinates the efforts of the data integration team. Grant goals are to improve data linkages, initially between the birth records and infant death records, and to establish the foundation for accommodating future linkages among other Vital Records data, the IBDPR, UNHS, First Steps, and Newborn Screening (NBS) program data. Funding from MCHB has been essential for the data integration efforts.

?An Operational Data Store (ODS), a platform on which to integrate data, has been developed to incorporate data from Vital Records, Indiana Birth Defects Surveillance System, Newborn Screening and hospital discharge data related to birth defects. Initial use of the ODS is being made by two Title V affiliated programs, the Indiana Birth Defects and Problems Registry and NBS. Each program using the ODS will have its own Data Mart application to support its specific requirements.

b. Current Activities

FY 2004 Performance Objective: MCHS will complete at least four of five data access measures by the end of FY 2004.

?Activities that will impact the completion of this objective include the development of an MOU with Office of Medicaid Policy and Planning that will include routine timely access to data, regular communication among ISDH Epidemiology Resource Center, MSHCS, and the Indiana Health and Hospital Association to develop routine access to data and the implementation of the lead surveillance data sharing with CDC.

?The data mart for the IBDPR and NBS are being developed.

?Data integration of NBS lab data, hospitalization discharge data and Vital Statistics data is being refined into the ODS.

?FY2004 Performance Objective: MSHCS will achieve "level 2" access (i.e. incomplete or inconsistent access) for four of five data access measures as by the end of FY 2004.

?Activities that will impact completion of this objective include: regular communication among the ISDH Epidemiology Resource Center (ERC), MSHCS, and the Indiana Health and Hospital Association to develop routine access to data; and the conduct of a "PRAMS-like" survey for 2004.

### c. Plan for the Coming Year

FY 2005 Performance Objective: MSHCS will complete at least five of five data access measures by the end of FY 2005.

?Continue to expand and define the ODS and develop data marts for additional programs including chronic disease, immunization, and the new vital statistics system.

?FY 2005 Performance Objective: MSHCS will complete all five State data access measures by the end of FY 2005. Future objectives for the data access measures will be revised and expanded in order to align with the Health System Capacity Indicators shown on form 19 and to better continue achieving access in additional areas.

?The ISDH will continue to expand the ODS and further develop Data Marts for the IBDPR and NBS programs to provide for input from additional data sources and to generate required reports. A new Data Marts will also be developed for the Maternal and Infant Mortality Review program. The timeliness of data availability will be positively impacted by the implementation of a new electronic Vital Records system and a new electronic NBS laboratory data system that will feed directly into the ODS.

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

### a. Last Year's Accomplishments

FY 2003 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will decrease to 75.1 in CY 2003.

Status: In FY 2002, the rate per 10,000 for diagnosed asthma hospitalization among children less than five years old decreased to 74.8. FY 2003 data is not yet available.

?The Indiana Joint Asthma Coalition (InJAC) convened three meetings resulting in consensus on the state planning process, parameters of the state plan, and development of the timeline for each benchmark component of the plan.

?Five InJAC workgroups of InJAC met monthly to develop state plan goals and objectives in the areas of: Children and Youth, Public Education, Environmental Quality, Data Collection and Surveillance, and Health Care Provider.

?For the Hoosier HealthWise Asthma Case Management Program, a collaboration between ISDH and the Office of Medicaid Policy and Planning, the Health Care Provider workgroup reviewed and recommended asthma treatment guidelines, physician education materials,

nurse care manager guidelines and education materials for asthma patients and their families. ?ISDH worked with IDEM through an EPA grant to address childhood asthma in Indiana. This funding was made available to Indiana prior to the receipt of the CDC funds. It provides for the development and production of an educational piece addressing specific environmental triggers and ways of reducing them. Assistance will be sought from the medical community, environmental experts and advocates and the public. This educational outreach piece will build on an existing IDEM educational piece, "Simple Steps to help your Child Breathe Easier." The outreach piece may be a web-based source to receive information on asthma and how to avoid the environmental triggers for individuals to download.

#### b. Current Activities

FY 2004 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will decrease to 73.3 in CY 2004.

?Indiana has made progress in beginning to develop state capacity for the Indiana asthma program. The ISDH and the Indiana Department of Environmental Management (IDEM) participate in an interagency operations committee planning the Indiana Joint Asthma Coalition (InJAC) coalition structure, formulating goals and objectives, extending invitations to potential members, and facilitating meetings for the state planning process.

?The Indiana asthma program staff provides management of state resources, development of collaborative relationships, implementation of a surveillance system, and evaluation of the planning process. A state plan will be produced by September 2004.

?Hoosier Health Wise Asthma Case Management Program: Statewide Training will be held through September 2004 and the asthma tool kit developed by the Health Care Provider workgroup, will be disseminated to health care providers around the state.

?Burden of Asthma Report: The initial asthma burden report will be used as a basis for determining populations, geographic areas, etc. for initial interventions and will be posted on the ISDH website in July 2004.

?Web-based environmental triggers tool: ISDH and IDEM are partnering to develop this tool through an EPA grant. The tool will have various components targeting various populations: housing (landlords/renters), schools, child care providers, caretakers of asthmatics, and medical providers. Focus groups will be established with these groups to develop the content for the tool.

#### c. Plan for the Coming Year

FY 2005 Performance Measure: The rate per 10,000 for diagnosed asthma hospitalization among children less than five years old will decrease to 71.6 in CY 2005.

?State Asthma Plan Development will be approved by InJAC and disseminated in January 2005.

?Data collection and surveillance continues with a research project testing the feasibility of using GIS technology to combine environmental data with clinical data as a monitor of how air quality impacts health.

?Minority/Health Disparities project: will assess strengths and weaknesses of the asthma state plan and make recommendations on implementation in minority communities.

### State Performance Measure 3: *SP # 11 The percent of live births to mothers who smoke.*

#### a. Last Year's Accomplishments

FY 2003 Performance Objective: Decrease the percent of mothers with live births who smoke to 19.8% in CY 2003.

Status: Percent of live births to mothers who smoke: 19.1% in FY 2002. FY 2003 data not yet available.

?The PSUPP Director responded to the RFP of the Indiana Tobacco Prevention and Cessation (ITPC) Agency to secure funds to expand PSUPP services. The grant was approved for \$913,220 for a two-year period and PSUPP sites were implemented in seven additional agencies and serve thirteen additional counties with high rates of pregnant smokers. PSUPP continues to be funded by the Division of Mental Health Addictions Prevention and supplemented by the Title V Federal -- State Block Grant. The expansion was funded for SFY 2003 and 2004. With the expansion, PSUPP will operate in fourteen sites, providing services to pregnant women in twenty-three of the ninety-two Indiana counties. Three Prenatal Smoking Cessation and Secondhand Smoke workshops were held each year throughout the state. The workshops attended by professionals/paraprofessionals that work with pregnant women and women of childbearing age. Three Prenatal Smoking Cessation and Secondhand Smoke workshops were held to train 91 professionals that work with pregnant women using ITPC funds.

?PSUPP director facilitated the expansion of PSUPP services in prenatal clinics.

?Required MCSHCS 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.

?MCSHCS direct service and enabling projects collected smoking cessation data on prenatal clients and primary and second hand smoking data on pediatric and family care coordination clients.

?MCSHCS collaborated with PSUPP staff and Smoke-free Indiana to provide training to providers to implement "You and Me Smoke-free" to assist people who smoke around children to quit smoking.

?State MSH and CSHCS staff participated in agency-wide smoking cessation educational efforts.

?MCSHCS participated in the Indiana Tobacco-Free Partnership supported by ISDH.

?PSUPP staff participated in training Indiana Healthy Families Support Workers in smoking cessation techniques.

?IPN prepared a Practice Alert on Smoking.

?PSUPP offered smoking cessation education materials to private physician offices.

?PSUPP held three smoking cessation workshops for providers working with pregnant women and women of childbearing age.

?Free posters, brochures, and other materials are available upon request from the Indiana Family Helpline.

## b. Current Activities

FY 2004 Performance Objective: Decrease the percent of mothers with live births who smoke to 19.5% in CY 2004.

?Goal remains the same and activities will deal with prenatal substance use issues a) identify and work with chemically dependent pregnant women b) facilitate training and education for professionals on how to identify and work with substance using pregnant women c) provide public education on the possible hazards to a fetus when alcohol, tobacco and other drugs are used during pregnancy.

?Decreased funding from the Indiana Tobacco Prevention and Cessation Agency (ITPC).

Three clinics received new funding from Maternal and Child Health Services. Prenatal Smoking Cessation workshops for providers were discontinued due to the decreased funding.

?The "You and Me Smoke-Free" material will be presented by an MCSHCS consultant to prenatal care providers at another 3 trainings in 2004.

?PSUPP will offer smoking cessation materials to private physician offices.

?PSUPP will hold two smoking cessation workshops for providers working with pregnant

women and women of childbearing age.

?PSUPP will continue to participate in community events, health fairs, conferences, and other public forums.

?PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

?PSUPP will distribute educational items to providers indicating the importance of identifying at-risk clients.

?PSUPP will distribute informational items about the impact of substance use among pregnant women to the public.

### c. Plan for the Coming Year

FY 2005 Performance Objective: Decrease the percent of mothers with live births who smoke to 19% in CY 2005.

?PSUPP will identify high risk, chemically dependent pregnant women.

?PSUPP will provide extra services to pregnant women that use cigarettes with the Minority Health Coalition using intervention and control groups if CDC funds are appropriated.

?PSUPP will offer smoking cessation materials to private physician offices.

?PSUPP will hold two smoking cessation workshops for providers working with pregnant women and women of childbearing age.

?PSUPP will continue to participate in community events, health fairs, conferences, and other public forums.

?PSUPP will educate women of childbearing age on the possible hazards of using alcohol, tobacco and other drugs during pregnancy.

?PSUPP will distribute educational items to providers indicating the importance of identifying at-risk clients.

?PSUPP will distribute informational items about the impact of substance use among pregnant women to the public.

?PSUPP will continue to be funded by the Department of Mental Health, the Indiana Tobacco Prevention and Cessation Agency and Maternal and Child Health Services. These funds will enable continued activities to address the PSUPP mission - the prevention of poor birth outcomes by assuring that babies are born to women who eliminate alcohol, tobacco and other drug use during pregnancy.

?Terry Zollinger and Associates at the Bowen Center of Indiana University and Purdue University at Indianapolis will continue to perform the data collection process at the PSUPP expansion sites.

?A proposal was submitted to CDC to extend services to pregnant women using cigarettes. If accepted, the PSUPP site directors will work with Minority Health Coalition staff to offer more testing and home contacts/visits during pregnancy and postpartum to help reduction and continue cessation after birth. This program expansion will continue for two years.

?MCSHCS consultant will continue to provide training on "You and Me Smoke-Free" program and on the "ASK" Protocol.

?IPN will publish a practice alert on evidenced smoking cessation materials for prenatal care providers.

?The "ASK" Protocol and the "You and Me Smoke-Free" brochures will available to download on the MCSHCS website.

State Performance Measure 4: *SP # 12 The percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate.*

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The percent of black women (15 through 44) with a live birth

during the reporting year whose prenatal visits are adequate will increase to 66% in FY 2003.

Status: In FY 2002 the percent of black women (15 through 44) with a live birth whose prenatal care visits were adequate: 61.6%. FY 2003 data not yet available.

?The Office of Minority Health (OMH) added a program coordinator to focus on infant mortality and other children's issues. Her focus was on the promotion of the 2nd annual Shower Your Baby with Love, Baby Shower.

?The OMH developed the Healthy Indiana Minority Health Plan--The Healthy Indiana Minority Health Plan's overall approach is to identify and apply relevant objectives, activities, and strategies within existing structures and processes. The Plan includes both general and specific objectives. General objectives are factors like workforce diversity and cultural and linguistic competency. Specific objectives are the seven most prevalent conditions affecting Indiana's racial and ethnic minority populations: heart disease; cancer, stroke, asthma, diabetes; HIV/AIDS; and infant mortality.

?All of the activities in NPM #18 affect this SP.

?Distribute and analyze an agency survey to grantees regarding cultural competency as determined appropriate by ISDH.

?Assured 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, facilitated 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, Indiana Hispanic Coalition and the Office of Cultural Diversity distributed culturally sensitive and bilingual materials. IPN educational materials being translated into Spanish.

?Trained additional black community health workers to assist Prenatal Care Coordinators in providing outreach and support for black pregnant women.

?Continued to work with Lake and Marion Counties with Healthy Start and other grant efforts.

?Continued to work with IPN, Minority Health Coalitions, Health Visions, Public Health Departments, Medicaid, and Managed Care Organizations to develop actions to improve adequacy of prenatal care for pregnant black women and other minorities in all affected counties. Ongoing

?Analyzed, produced, and distributed a "lessons learned" document from data obtained in the "PRAMS-like" survey obtained in 2002 from post partum women in areas at high risk for black infant mortality. Data found to be county specific. Unable to distribute a statewide "Lessons Learned" document. A document for each county compiled and distributed along with technical assistance from MCSHCS consultants.

## b. Current Activities

FY 2004 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 67% in FY 2004.

?The OMH executed and developed a program that surround the initiation and retention of African American mothers to breast feed their infants through the first six months of life. On May 15, 2004 the 1st Annual Grandmothers' Tea?Would You Like Milk With Tea? Generated great response and enthusiasm from three cities in the state, Indianapolis, Lafayette, (had one in English and one in Spanish) and South Bend, IN.

?During the events, Grandmothers had the opportunity to learn about the benefits of breastfeeding, and other attributes to infants who are breastfed vs. those infants who are not. Most importantly, Grandmothers learn to build a foundation of support for breastfeeding Mothers.

?Grandmothers had a chance to take advantage of information regarding their own health and well being. Information offered on osteoporosis, heart health, and good nutrition.

Grandmothers received free health education regarding their own health, such as heart disease, diabetes, stroke and osteoporosis screening, as well as other health care activities and demonstrations.

?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 OMH is coordinating a project to translate Indiana's public health information into Spanish over the course of the next year. General consumer information, health program announcements and the department's web site will receive priority under a translation contract signed late last year.

?OMH hired a chronic disease administrator. The administrator will develop a program on cardiovascular disease and stroke in the minority community.

?Provide free bi-lingual interpretation training to local health departments, community health centers, MCSHCS funded projects, etc by the Office of Minority Health in partnership with the Indiana Primary Health Care Association. The course can accommodate up to 25 bi-lingual participants to be trained as interpreters and covers: 1) basic interpreting skills (role, ethics, conduit and clarifier interpreting, intervening, managing the flow of the session); 2) information on health care (introduction to the health care system, how doctors think, anatomy, basic medical procedures); 3) culture in

interpreting (self-awareness, basic characteristics of specific cultures, traditional health care in specific communities, culture-brokering); 4) communication skills for advocacy (listening skills, communication styles, appropriate advocacy); and 5) professional development.

### c. Plan for the Coming Year

FY 2005 Performance Objective: The percent of Black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate will increase to 68% in FY 2005.

?Activities for Performance Measure 18 for FY 2005. All these activities apply to this State Performance Measure.

?Partner with Methodist Hospital and the Father Resource & Research Center to begin a father support group for breast feeding. A pilot will take place in August and ending in October to promote breast feeding and increase breast feeding rates among all women.

?Partner with Women (WIC), Infants and Children and faith-based organizations to promote Grandmother's Teas around the state to start breast feeding rooms and to give up-to-date specific lactation service information.

?Promote the 4th annual Shower Your Baby with Love, Baby Shower. Based on 2004 attendance, determine what other cities OMH needs to increase attention on infant mortality; and developing a web based interactive kit.

## State Performance Measure 5: *SP # 13 The degree to which the State assures family participation in program and policy activities in the State MCHS program.*

### a. Last Year's Accomplishments

FY 2003 Performance Objective: The Indiana MCHS will improve parental involvement in the program by progressing "10" degree points by the end of the fiscal year 2003.

Status: The Indiana MCHS has improved parental involvement in the program by progressing to "10" degree points by the end of the fiscal year 2003. Objective met.

?Utilized volunteers from current employees who use or have used MCHS or WIC services to provide input on program development.

?Included consumers and parents on the Indiana Genetics Advisory Committee (IGAC), the

Universal Newborn Hearing Screening Advisory Board, the Newborn Screening Advisory Board, the SIDS Community Advisory Board, the Early Childhood Comprehensive Systems project, and other ad hoc task forces that were developed. Two parents participate on Indiana Genetics Advisory Committee; Universal Newborn Hearing Screening Advisory Board includes two parents; Newborn Screening Advisory Board has two parents participating; and the Asthma Advisory group includes three parent consumers. UNHS program has a family focus advisory group with 10 participants.

?Provided reimbursement for consumer participation in statewide policy making activities.

?Required grantees to report on client satisfaction surveys as part of their annual report.

?PL 91-1999 established the twelve-member Newborn Hearing Screening and Intervention Advisory Board. The Board, which consists of consumers, primary care providers, professionals, and an insurance and a hospital representative, a special education administrator, an early intervention service representative, and a maternal and child service manager, met in 2003.

?A "Mini-PRAMS" survey in Lake, St. Joseph and Marion counties secured the input of postpartum mothers to help with program planning. Reimbursement was provided for consumer participation in statewide policy-making activities.

?Latino Parents were surveyed regarding their response to the Indiana RESPECT Spanish media campaign, which ran in November and December 2002.

## b. Current Activities

FY 2004 Performance Objective: The Indiana MSHCS will maintain parental involvement in the program by progressing to "11" degree points by the end of the fiscal year 2004.

?Volunteers from current employees who use or have used MSHCS or WIC services are utilized to provide input on program development. Consumers and parents serve on the Indian Genetic Advisory Committee, the Universal Newborn Hearing Screening Advisory Board, the Newborn Screening Advisory Board, the SIDS Community Advisory Council, the Early Childhood Comprehensive Systems project, and other ad hoc task forces that are developed. ?Parents are involved in the development of the State Asthma Plan and the Early Childhood Comprehensive System project.

?Universal Newborn Hearing Screening Program is sponsoring, along with the Outreach Services for the Deaf and Hard of Hearing, First Steps, and the parent focus group, a Family Conference weekend for 30 families with newly identified children with hearing loss in July, 2004. The families will start at the School for the Deaf. Other efforts to include families in advisory and other policy making situations will continue.

NOTE: This information differs from the progress of the Children's Special Health Care Network (CSHCN) programs presented in Form 13. CSHCN had been working on family participation before this became a priority for the Maternal and Children's Special Health Care division. Consequently, the point score for the MSHCSN division is lower than the score for CSHCN programs taken separately.

## c. Plan for the Coming Year

FY 2005 Performance Objective: The Indiana MSHCS will improve parental involvement in the program by progressing to "12" degree points by the end of the fiscal year 2005.

?Volunteers will be utilized from current employees who use or have used MSHCS or WIC services to provide input on program development.

?Consumers and parents will continue to be included on the Indiana Genetics Advisory Committee, the Universal Newborn Hearing Screening Advisory Board, the Newborn Screening Advisory Board, the SIDS Community Advisory Council, the Child Care Health Consultant Advisory Committee and other ad hoc task forces that are developed.

?Reimbursement will be made for consumer participation in statewide policy-making activities.  
?Grantees will continue to be required to report on client satisfaction surveys as part of their annual report.  
?Parents will continue to be involved in the implementation of the State Asthma Plan and the Early Childhood Comprehensive System (ECCS) project.  
?The ECCS project will continue Parent Mentoring program to encourage involvement of other parents on Subcommittees and at Town Meetings.

**State Performance Measure 6: *SP # 14 The number of children aged 6 months through 6 years on Medicaid screened for blood lead levels.***

**a. Last Year's Accomplishments**

FY 2003 Performance Objective: During SFY 2003, 15,000 children aged 6 months through 6 years on Medicaid will be screened. (In FY 2002, the target population for this performance measure was children who lived in targeted high-risk census block groups. However this data will not be available in the near future and the target population has been changed to children who are on Medicaid. CDC considers all children who are on Medicaid as high-risk.)

Status: In FY 2003, 17,926 Medicaid-enrolled children received a blood test for lead poisoning. Objective met.

?Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) continues to ensure that medical and environmental case management activities are occurring for all children who have confirmed blood lead levels of > 10 ug/dL in the five most populated counties of Indiana.

?ICLPPP supports, encourages, and maintains activities that promote the program purpose. Several local coalitions continue to work within their jurisdictions to enhance screening and related activities. ICLPPP staff provides technical assistance/training to local coalitions, health departments, medical professionals, and the general public. Free educational materials are made available to program providers, health departments, and medical professionals. Media is used to inform the general public of the need for screening. Focus has changed from direct services to monitoring medical and environmental intervention. Surveillance activities have been enhanced through program changes and interaction with OMPP to afford greater ability to target at-risk children. ICLPPP's involvement with the Managed Care Organizations (MCO's) throughout the state continues to provide avenues to enhance at-risk screening.

?MCSHCS grantees providing child health services follow standards that require screening all children at risk of lead poisoning. ICLPPP staff continues to provide education to grantees, physicians, and health departments on lead screening tools and new guidelines. ICLPPP will increase the screening of Hoosier Healthwise-enrolled children in the state. 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 will engage the support of an advocate group (Improving Kids Environment [IKE]) for the purpose of public awareness about the issue. ICLPPP will continue the interagency agreement with the State Medicaid Program that allows the sharing of medically sensitive, demographic information of children less than 6 years of age. This activity will be enhanced though FY 2004.

**b. Current Activities**

FY 2004 Performance Objective: During SFY 2004, 17,500 children aged 6 months through 6 years on Medicaid will be screened.

?MCHS grantees provide child health services will follow child health standards that require screening all children at-risk of lead poisoning.

?MCHS staff and ICLPPP staff will provide education to grantees, physicians, health departments etc. on lead screening tools, new guidelines etc.

?ICLPPP consultants will provide assistance and coordinate the medical services within a geographical area with the diverse cultural, racial, and socioeconomic groups.

?ICLPPP will engage the support of an advocate group (Improving Kids Environment [IKE]) for the purpose of public awareness about the issue.

?ICLPPP will ensure that medical and environmental case management begins for ninety percent (90%) of the children who have confirmed blood lead levels of > 10 ug/dL in the five most populated counties of Indiana.

?ICLPPP entered into the second year of the new three-year grant cycle with CDC during FY 2004. The focus was the elimination of childhood elevated blood lead levels of greater than 10 ug/dL as a public health issue by 2010. The focus was the development of the Lead Elimination Plan.

?State MCO's, OMPP, health departments, and local coalitions have actively partnered in this elimination process. Other strategic partners will be private and public funding sources and environmental entities with expertise in lead hazard reduction.

?ICLPPP began the process of implementing the Elimination Plan as follows:

?Six MCH grant applications submitted to implement pilots. The pilots if funded will address different aspects of primary prevention of lead poisoning.

?Six communities actively partnering to apply for Housing and Urban Development Healthy Homes and Lead Hazard Control Grants.

?ICLPPP is working with "The Lead Safe 2010 Project", a public/private partnership supported by the U.S. Department of Housing and Urban development (HUD) to develop new strategies to finance the elimination of lead paint poisoning in the United States. The goal is to leverage federal, state, local and other fiscal resources with new funding from foundations, banks, and corporations.

?ICLPPP staff has met with Indiana Housing Finance Authority (IHFA) staff to promote methods for including lead hazard control in the Child Development Block Grant application process.

?Established a group of experts that have met and began to look at other systems available and how those systems can be linked to a housing centralized database.

?ICLPPP staff met with Foster Care, Child Care, Healthy Families, Head Start, Medicaid, and Housing and Community Services to begin the process of sharing data for tracking of families and homes.

?ICLPPP is working with the Children and Hoosiers Immunization Registry Program (CHIRP) and Regenstrief to link lead data with CHIRP.

?ICLPPP staff is currently working with Minority Health Coalition to promote lead awareness.

### c. Plan for the Coming Year

FY 2005 Performance Objective: During SFY 2005, 18,000 children aged 6 months through 6 years on Medicaid will be screened.

?ICLPPP will ensure that medical and environmental case management is provided to thirty percent (30%) of the children who have confirmed blood lead levels of > 10 ug/dL & 70% to those > 20 ug/dL statewide.

?Four Housing and Urban Development Lead Hazard Control Grants and five Maternal Child Health grant applications will be submitted. Foundation Project implemented and funds for foundations Project increase by \$300,000 for lead hazard control.

?A sustainable incentive mechanism for property owners to remediate homes will be identified, established and available for 20 property owners.

?All agencies with pertinent demographic data identified and data analyzed for

appropriateness, and negotiations to start for the sharing of data. Memoranda of Understanding with State agencies will need to be in place.

?Funds obtained for campaign to determine awareness of parents of at risk children, property owners, real estate agents, contractors and home remodelers of known lead hazards.

Implement awareness campaign for State policy makers, and elected officials to measure awareness of lead hazard awareness.

?Determine number of providers currently testing and following-up on at-risk children who have been routinely testing for lead poisoning.

?Increase by 50 the number of Hoosier Healthwise, Women Infants and Children clinics and local health departments testing and following up children at-risk for lead poisoning.

?Increase to 10%, the State wide testing rate of at risk children. Increase to 20%, the testing rate of at-risk children in the 6-targeted areas. Increase to 20% the testing rate of children, less than seven (7) years of age and enrolled in Hoosier Healthwise.

?Develop and implement a state wide tracking system for case management of children with blood lead levels of = 10 ug/dL. Establish baseline for confirmed cases of children with blood lead levels of = 10 ug/dL that receive medical case management and home risk assessments.

?Increase to 16, the number of new trainers in place Statewide to provide lead safe work practices, lead assessor, lead abatement, and lead workers training classes.

?Develop and implement a method to track and maintain records of lead safe trainings that have occurred statewide.

?Develop and implement a method to encourage contractors, workers and home owners to be licensed and deal with lead hazards in a lead safe manner and paint retailers to have employees trained on lead-safe practices developed and in place.

## State Performance Measure 7: *SP # 15 To facilitate the integration of genetics and build genetics capacity within other areas of public health.*

### a. Last Year's Accomplishments

FY 2003 Performance Objective: MCHS will complete at least three of five defined measures of integration and capacity building by the end of FY 2003.

Status: Three of five defined measures of integration and capacity building by the end of FY 2003 were completed. Objective met.

?A needs assessment of genetic services has been completed.

?The Genetics Plan has been completed.

?A 4-year HRSA grant was awarded in mid-September 2002 for the implementation of the State Genetics Plan and we are currently in the second year of the grant.

?The integration of various public information systems to improve the quality of birth defects surveillance has begun with the Data Integration Steering Committee (DISC) of which the State Genetics Implementation Grant project director is an active member. The development of the Operational Data Store (ODS) continues with the Indiana Birth Defects and Problems Registry (IBDPR) now linking with Vital Records and Newborn Screening lab data. A prototype of a functional ODS was created in 2003.

?The development of educational materials for genetic conditions and services has progressed with the hiring of a State Folic Acid Campaign Coordinator and a Genomics/Genetics Education Consultant through funds from the genetics grant. The Genomics Program newsletter, "Transcriptions" was reinstated.

?The Indiana Genetics Advisory Committee (IGAC) met twice during FY2003.

### b. Current Activities

FY 2004 Performance Objective: MCSHCS will complete at least four of five defined measures

of integration and capacity building by the end of FY 2004.

?The Indiana Genetics Advisory Committee (IGAC) will be convened semi-annually.

?Educational materials for genetic conditions and services will include:

?Quarterly issues of the Genomics Program newsletter, "Transcriptions", will continue to be published and sent state-wide to approximately 3,000 health care professionals.

?Presentation of statewide talks about birth defect surveillance in Indiana and the benefits of folic acid for the prevention of certain birth defects.

?The integration of various public information systems to improve the quality of birth defects surveillance will continue through participation in the Data Integration Steering Committee (DISC) and integration of data through the Operational Data Store (ODS).

?Implementation of the State Genetics Plan has progressed with the following:

?Hiring of another Genetics Specialist to assist with activities of the grant.

?Development and implementation of a statewide folic acid campaign by the coordinator.

?Continued support of the IBDPR through staff and contractors providing chart audits to determine the accuracy of data provided by hospital discharge summaries.

?Development and implementation of a system to verify and integrate data from physicians reporting to the IBDPR.

### c. Plan for the Coming Year

FY 2005 Performance Objective: MCSHCS will complete at least five of five defined measures of integration and capacity building by the end of FY 2005.

?Continue the facilitation of the Indiana Genetics Advisory Committee (IGAC) through semi-annual meetings.

?Continue development of educational materials for genetic conditions and services through presentations and the newsletter "Transcriptions."

?Implementation of the State Genetics Plan will progress with the following:

?Development of a system to ensure all children with birth defects are receiving early intervention and other services for CSHCN.

?Development of educational packets for families of children identified with a confirmed birth defect through the Indiana Birth Defects and Problems Registry (IBDPR).

?Implement a method to determine the timeliness of hospital reporting to the IBDPR and dissemination of information to families.

?The integration of various public information systems to improve the quality of birth defects surveillance will continue through the DISC and development of the Operational Data Store (ODS) and will include a working data mart for the IBDPR.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) SP # 09 To establish a system of routine data access with internal and external data sources.				
1. Continue to expand the ODS & dev. data marts for addl. progs. incl. chronic dis., imm., & VS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) SP # 10 The rate per 10,000 for asthma hospitalization (ICD 9 Codes: 493.0-493.9) among children less than five years old.				
1. Improve data-sharing linkage btn IHHA & ISDH Epidemiology Resource Center.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Prepare a summary report of existing asthma data.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Thru consensus of the IN Joint Asthma Coal. (InJAC)dev. evidence-based guidelines for MDs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Develop a State Asthma Plan through InJAC.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop an asthma surveillance reporting system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Identify priority populations for greatest risk of mortality and morbidity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Identify resources and infrastructure needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Develop educational materials on environmental asthma triggers.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Determine organizations and agencies that can assist with implementation of strategies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Provide free educ./screening/counseling & follow-up for asthma at Black & Minority Health Fair.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) SP # 11 The percent of live births to mothers who smoke.				
1. PSUPP grantees will continue w/funds from DMH, ITPC, & MCHS.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cont. w/3 Prenatal Smoking Cess. Trainings using ITPC funds that are open to MCH & CSHSC staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Bowen Ctr of IUPUI will evaluate PSUPP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Pyramid Level of Service			
	DHC	ES	PBS	IB

STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
4) SP # 12 The percent of black women (15 through 44) with a live birth during the reporting year whose prenatal visits are adequate.				
1. MCSHCS will support the OMH "Shower Your Baby With Love--Baby Shower" into expanded cities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. IPN's Baby First Media Campaign will be continued in Gary, IN.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. OMH w/IPHCA will provide free bi-lingual med. interpreter training to HD's & CHCs.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. MCSHCS grantees cont. to receive cult. diversity training.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. In April 2003, the Healthy Indiana Minority Health Plan was published which addressed racial and ethnic health disparities and proposed strategies for intervention and improved health status indicators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Pilot doula projects will be available in Indpls.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Focus groups funded by MCH but sponsored by IPN, MCHD, and MCSHCS will be held to elicit information on appropriate interventions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. IPN will hold town meetings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) SP # 13 The degree to which the State assures family participation in program and policy activities in the State MCHS program.				
1. Vol. employees who use/have used MCHS or WIC service will be asked to provide input on pgm dev.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Consumers & parents will be included on the Adv. Bds. of: Genetics, UNBHS, NBS, et al.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. MCSHCS will provide reimbursement for consumer participation in statewide policy-making activities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Grantees cont. to be req. to report on client satisfaction surveys as part of their ann rpts.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Parents will be involved in dev. of the State Asthma Plan & the Early Childhood Comp. Sys Plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. UNHS screening will support Family Conference facilitated by Family Focus Group and IN School for the Deaf.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) SP # 14 The number of children aged 6 months through 6 years on Medicaid screened for blood lead levels.				



until they demonstrate acceptable levels of performance. If current ISDH contractors demonstrate a continued inability to meet ISDH goals regarding effective, efficient, culturally competent programs, ISDH will seek alternate culturally competent contractors. In order to address the public health needs of Indiana minority groups, the Office of Cultural Diversity and Enrichment began offering a two day Cultural Competence Workshop twice a month and a one day Advanced Cultural Competency Workshop that is held once a month. To date, 1,000 health care professionals have attended these workshops. The two day workshops emphasize cultural knowledge and cultural differences, strategies for working with racial/ethnic populations, the principles of interpreter services, and discussion of four different cultures. (African American, Hispanic/Latino, Asian, Native American). The Advanced Workshops focus on dissimilarities in areas such as values, communication patterns, religion, beliefs, and health care professionals limited knowledge of other cultural groups.

?The Indiana Child Care Health Consultant Program was established in FY 2003 with the Family Social Services Administration - Bureau of Child Development providing dollars from the Child Care Development Fund, Quality Initiatives Fund, to the State Department of Health to fund the project. The goal of the program is to increase the level of health and safety in out-of-home child care settings across Indiana through technical assistance and training for child care providers. The project provides another portal to services to increase the level of health and wellness that child care providers, the children they serve and their families, need. Program staff includes a contracted Project Director, six regional child care health consultants, and a part-time support person. The regional child care health consultants are located in the field and coordinate with the numerous individuals and agencies currently involved with child care providers. There are four programmatic functions of the program. They include:

- Identification of licensed, registered, and license-exempt child care settings;
- Collection of data such as the child care settings' programs, health and safety practices, the immunization status and health insurance coverage status of the enrollees, back-to-sleep practices, accident occurrences, and the smoke-free status of the setting;
- Creation or identification and distribution of appropriate health and safety educational materials for use by child care providers and parents;
- Provision of consultation for child care providers around health and safety issues in out-of-home child care settings.

Another major component of the program is data collection and report generation. Documentation of the activities of the regional child care health consultants and the resulting changes in health and safety practices in out-of-home child care settings, and the change in health status of the children enrolled in the programs are two of the major foci. The measurable outcomes include; improving the percent of fully immunized two-year olds, increasing the number of providers using safe sleeping practices for infants, reducing exposure to second-hand smoke, improving access to health insurance, medical home and preventive health care, and increasing the availability and quality of child care for children with special needs.

?Approximately 50 professionals currently involved in providing consultation and/or training to child care providers have been provided Child Care Health Consultant Training. Medical personnel, public health nurses, child care resource and referral personnel, Head Start/Early Head Start staff, youth services agencies staff and child care program support personnel have attended the training. The focus of the training includes health and safety issues of young children, development of health and safety policies and procedures, consultation skills, application of nationally recognized instruments to assess child care programs, and resource identification and utilization.

?In July 2003, the ISDH/MCSHCS received a two-year grant from MCHB to fund the Indiana Early Childhood Comprehensive Systems (ECCS) Program. The program will create an integrated, coordinated, comprehensive system of services for children from birth to five. The coordinated system will support ease of access to needed services, increase the utilization of appropriate services and support the role of the family as their child's first teacher. This initiative will help to ensure that a holistic system of care supports young children and they arrive at school ready to learn. A Core Partner (steering committee) group was created which met to establish the Vision, Mission and Values of the program that provided the focus for the planning process. The ECCS program staff with ISDH technical staff assistance established a website to promote public participation and facilitate communication across all committees. The site can be found at <http://www.in.gov/isdh/programs/mch/eccs/eccsindex.htm>. The ECCS Project Director is working

closely with other groups promoting healthy children and families that have been initiated by the Governor, Lt. Governor and federal grant opportunities to ensure the work is not being duplicated and that all the groups are communicating and moving forward together.

## **F. TECHNICAL ASSISTANCE**

MCH will continue to utilize the satellite downlinks and web cast provided by national organizations and universities as an efficient and effective way of providing training statewide. However it is anticipated that Technical Assistance will be needed for upcoming workshops around the issues of Bright Futures Mental Health and Oral Health. This will complete our first rounds of covering Bright Futures in a workshop format for MCH funded and Non-funded projects in Indiana.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

#### Annual Budget Expenditure Narrative

#### FY'03 Budget Expenditures

In response to the continued tight state budget, Indiana continued several cost-cutting measures, including early retirement incentives, a personnel furlough program, and a statewide hire freeze. These programs have been implemented for all state personnel positions, whether funded by state funds or other (Federal) funds. These measures resulted in significant expenditure reductions for both state and Federal funds, as reflected on Form 3, Form 4, and Form 5.

#### 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'03 the MCH Block Grant award was \$12,464,897 and the state provided \$23,665,050 in support. In FY 2005 the MCH award is expected to be \$12,500,265 and the state will provide \$26,364,816. State support is provided by state and local funds that MCHS is authorized to spend on behalf of children with special health care needs. Line item funding levels in FY'89, FY'03 and FY'05 are listed below:

#### State Funds

Expenditures in 1989

Expenditures in 2003

Budget for 2005

#### MCH Supplement

\$193,223 in 1989

\$176,700 in 2003

\$176,700 for 2005

#### Newborn Screening

\$33,669 in 1989

\$685,676 in 2003

\$1,211,737 for 2005

#### Children with Special Health Care Needs

\$11,312,628 in 1989

\$12,320,517 in 2003

\$25,001,863 for 2005

#### TDAB Meconium

\$0 in 1989

\$57,540 in 2003

\$62,496 for 2005

#### Local MCH Appropriations

\$0 in 1989

\$0 in 2003

\$678,670 for 2005

#### Other Matching Funds

\$0 in 1989

\$0 in 2003

\$2,401,513 for 2005

Program Income  
\$0 in 1989  
\$0 in 2003  
\$2,481,975 for 2005

RESPECT  
\$0 in 1989  
\$599,479 in 2003  
\$594,019 for 2005

TOTAL  
\$11,539,520 in 1989  
\$13,004,564 in 2003  
\$32,432,449 for 2005

Local MCH Appropriations, Program Income and Other Matching: Before FY 2004, ISDH MCSHC did not track Local MCH Appropriations, Program Income or Other Matching projections or expenditures. These are reported to ISDH by the MCH grantees. ISDH now tracks these projections and expenditures and will begin reporting these expenditures for FY 2004.

#### FY'03 Unobligated Funds

In FY 2003 there was a substantial increase in expenditures on contracts above the estimated amount for federal funds, reducing the amount of unobligated balance by more than 10% of the estimated amount for FY 2003.

In FY 2004, ISDH allowed ongoing MCH projects to apply for a 10% increase in requested funds to take into account years of flat-line allocations that did not allow for increased costs. Further, ISDH has implemented a one-time, short-term grant program to build infrastructure throughout the state. This will significantly reduce carryover amounts for FY 2005 through FY 2007. Indiana operates its program on a first in first out basis; therefore the unobligated carryover will be expended first.

## **B. BUDGET**

Annual Budget and Budget Justification

FY?05 Summary Budget

The following components are Indiana state descriptions and do not match the Federal A, B and C components. The amounts below are for the Projected Title V Federal allocation.

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

Component B: Preventive and Primary Care Services for Child 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 \$ 3,936,294 31.49%  
Component B \$ 3,752,570 30.02%  
Component C \$ 4,207,418 33.66%  
Administrative Cost \$ 603,983 4.83%  
Grant Total \$ 12,500,265 100.00%

#### I. Direct Medical Care Services

The \$7,292,335 budgeted at this level include all community grants that provide direct services and MCH State supplemental funds.

#### II. Enabling Services

The \$28,208,560 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 \$3,908,911 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 \$10,143,373 budgeted at this level include salaries of all staff and other operating expenses (minus insurance premiums and community grant funds) CSHCS/SPOE, the statewide needs assessment, data systems (MCH, lead, and PSUPP), the Indiana Perinatal Network, and quality assurance.

Total FY 2004 budget is \$49,553,180.

#### 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'03 the MCH Block Grant award was \$12,464,897 and the state provided \$23,665,050 in support. In FY 2005 the MCH award is expected to be \$12,500,265 and the state will provide \$32,432,449. State support is provided by state and local funds that MCHS is authorized to spend on behalf of children with special health care needs. Line item funding levels in FY'89, FY'03 and FY'05 are listed below:

##### State Funds

Expenditures in 1989

Expenditures in 2003

Budget for 2005

##### MCH Supplement

\$193,223 in 1989

\$176,700 in 2003

\$176,700 for 2005

Newborn Screening  
\$33,669 in 1989  
\$685,676 in 2003  
\$1,211,737 for 2005

Children with Special Health Care Needs  
\$11,312,628 in 1989  
\$12,320,517 in 2003  
\$25,001,863 for 2005

TDAB Meconium  
\$0 in 1989  
\$57,540 in 2003  
\$62,496 for 2005

Local MCH Appropriations  
\$0 in 1989  
\$0 in 2003  
\$678,670 for 2005

Other Matching Funds  
\$0 in 1989  
\$0 in 2003  
\$2,401,513 for 2005

Program Income  
\$0 in 1989  
\$0 in 2003  
\$2,481,975 for 2005

RESPECT  
\$0 in 1989  
\$599,479 in 2003  
\$594,019 for 2005

TOTAL  
\$11,539,520 in 1989  
\$13,004,564 in 2003  
\$32,432,449 for 2005

Local MCH Appropriations, Program Income and Other Matching: Before FY 2004, ISDH MCSHC did not track Local MCH Appropriations, Program Income or Other Matching projections or expenditures. These are reported to ISDH by the MCH grantees. ISDH now tracks these projections and expenditures and will begin reporting these expenditures for FY 2004.

#### FY'05 Unobligated Funds

The projected unobligated balance for FY 2005 is \$5,125,941. 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.

Carryover balances have grown from FY 2001 through FY 2005 as a result of tightened state

spending during FY 2002 through FY 2004. ISDH MCSHC has taken a number of steps to use these savings to build infrastructure throughout the state. Ongoing MCH project allocations have been increased by nearly a million dollars from FY 2003 to FY 2004 and an additional one-time, short-term grant program has been developed which will grant out up to an additional million dollars each year during FY 2005, 2006 and 2007. These short-term, one-time grants are primarily targeted to conducting Fetal Infant Mortality Reviews, community-based needs assessment and other infrastructure building projects.

#### Indirect Cost Rate Agreement

The rates listed below and 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. It should be noted that Indiana considers indirect costs to be the administrative costs of the programs.

#### SECTION I: INDIRECT COSTS RATES\*

RATETYPES FIXED FINAL PROV.(PROVISIONAL) PRED.(PREDETERMINED)

EFFECTIVEPERIOD

TYPES FROM TO RATES(%) LOCATIONS APPLICABLE

FIXED 07/01/03 06/30/04 8.7 All All Programs

PROV 07/01/04 until amended 7.0 All All Programs

\*Based:

Total direct costs excluding capital expenditures (building, individual items of equipment, alterations and renovations), subawards and flow-through funds. 7.0% is the maximum rate currently projected for FY'05.

## **VI. REPORTING FORMS-GENERAL INFORMATION**

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

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

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

## **VIII. GLOSSARY**

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

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

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

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

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

### **D. ANNUAL REPORT DATA**

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